ANMJ
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JUL–SEP 2019

INSIDE

GOING GREEN

TOWARDS ZERO WASTE

A PUBLICATION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

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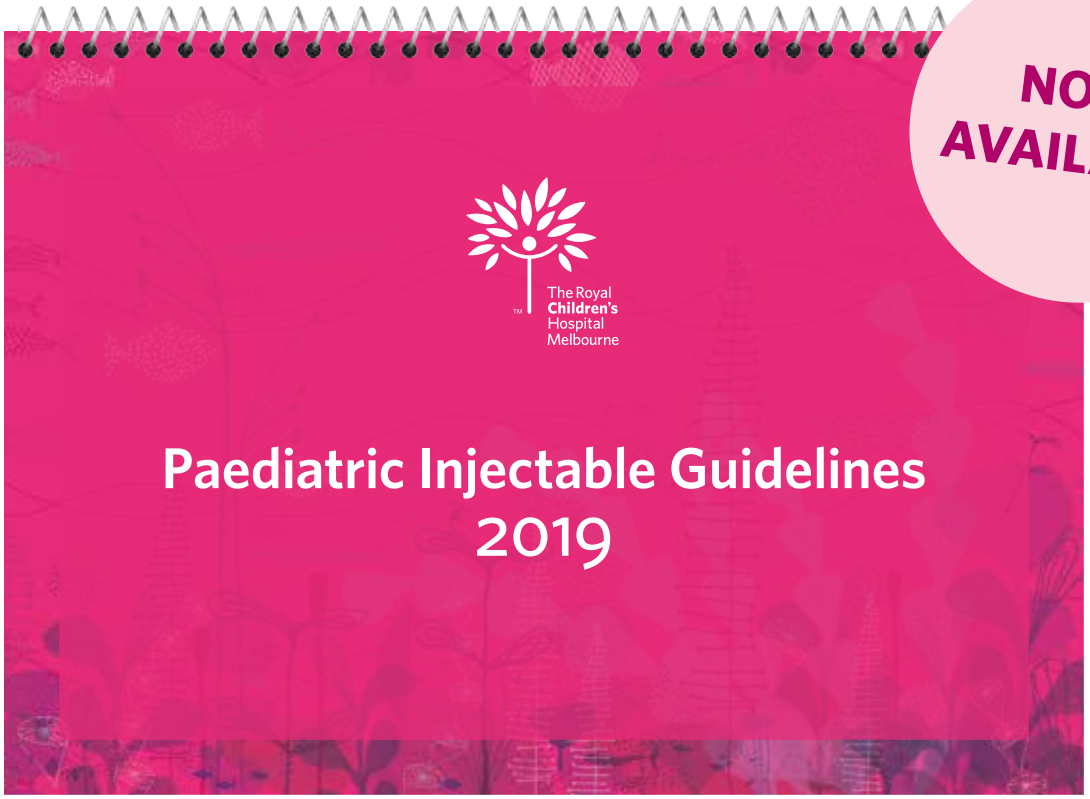

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After the recent federal election, we have been considering how to move forward working with a government that has made no commitment to aged care.

Annie Butler
ANMF Federal Secretary

Unfortunately, unlike other major political parties, the coalition government failed to pledge its support to improve the sector to ensure the wellbeing of vulnerable older Australians.

But now that the dust has settled we have reviewed our campaign and restrategised where to go from here.

This includes reflecting on our accomplishments, which have been monumental.

We have brought to the fore the significant issues in aged care that helped bring about a royal commission.

We have gained growing support from our communities, the media and politicians, all of whom as a result, want change in a sector that is in serious crisis.

None of this could have been possible without the tireless work of the ANMF branches, the ANMF federal staff, ANMF members and our supporters. Everyone has done an amazing job and I thank you all for your efforts so far.

Rest assured the campaign is far from over and your continuing support will be invaluable. We are stronger and more determined to fight for a better aged care system for all.

Our plan is to continue participating in the Royal Commission into Aged Care Quality and Safety and build stronger coalitions with key organisations and politicians.

Already we have requested meetings with the Prime Minister Scott Morrison, Greg Hunt the Minister for Health, and Richard Colbeck the Aged Care Minister as well as the corresponding opposition leaders - with the aim of discussing our position and the urgent need for change.

You can also participate by keeping up to date with the campaign via our **More Staff For Aged Care** Facebook page and being involved in ANMF branch activities.

Voluntary Assisted Dying laws in Victoria came into effect last month. Victoria is the first state in the country to legalise medically assisted dying for those with a terminal illness. The ANMF has supported and campaigned with other lobbyists for this legislation and now welcomes its implementation.

The union will continue to support these laws being introduced in other states and territories.

Currently, Western Australia's Joint Select Committee on End of Life Choices has recommended similar laws and an Inquiry into end of life care including assisted dying is planned in Queensland.

In this issue of the *ANMJ*, ANMF's Federal Professional Officer Tara Nipe discusses what this legislation means for terminally ill patients, nurses and other health professionals.

Also in the journal this quarter we discuss harm minimisation and the need for pill testing trials at music festivals. This is a call ANMF has pushed for some time based on a series of deaths at music festivals over the years.

The ANMF has recently developed a new national position statement advocating a range of strategies on harm minimisation, how nurses and midwives can provide leadership and education in this space and why the Australian government must urgently implement pill testing.

This statement can be found on the ANMF website at: **anmf.org.au/documents/policies/PS_Harm_minimisation.pdf**

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REGULAR COLUMNS

FEATURES

CLINICAL UPDATE

EDUCATION

FOCUS

Skipping breakfast and late dinners recipe for heart attack

People who skip breakfast and eat dinner near bedtime have worse outcomes after a heart attack, according to European research.

The study of 111 patients, average age 60 years, and 73% of men who had a STEMI found that people with the two eating habits had a four to five times higher likelihood of death, another heart attack, or angina within 30 days after hospital discharge for heart attack. Skipping breakfast was observed in 58% of study participants, late-night dinner eating in 51% and both behaviours in 41%.

The two eating behaviours were independently linked with poorer outcomes after a heart attack, study author of Brazil's Sao Paolo State University Dr Marcos Minicucci said. "People who work late may be particularly susceptible to having a late supper and then not being hungry in the morning. We also think that the inflammatory response, oxidative stress, and endothelial function could be involved in the association between unhealthy behaviours and cardiovascular outcomes.

"One in 10 patients with STEMI dies within a year, and nutrition is a relatively inexpensive and easy way to improve prognosis."

European Journal of Preventive Cardiology

QLD phases out junk food ads in hospitals

Queensland government plans to phase out junk food and alcohol advertising on government owned sites including the rail network, bus shelters, roadsides and major hospitals has been applauded.

QLD now joins the ACT, Victoria and WA in moving to protect children from exposure to harmful industry advertising, according to the Public Health Association of Australia (PHAA).

"Banning unhealthy food and beverage ads is not going to solve the problem on its own but is an essential first step. Banning these ads is a fairly easy first step because it doesn't cost state governments any revenue," PHAA member and public health nutritionist Rosemary Stanton said.

The PHAA called on other states to do more and for the Commonwealth to step up by taking a stronger interest in and action on childhood obesity.

Report uncovers gender barriers to leadership within nursing

Persistent gender related barriers preventing nurses from pursuing leadership positions must be addressed along with greater investment in the profession to allow nurses to work to their full scope, a new report has revealed.

While 70% of the total health and social care workforce is made up of women, just 25% hold health system leadership roles, the Gender Assessment of Nursing Leadership Report states.

Undertaken in collaboration with global campaign *Nursing Now*, the report found discrimination, bias and stereotyping are hindering opportunities for female nurses to develop skills and perpetuate the gender pay gap and result in unequal treatment within the health workforce between women and men worldwide.

Findings were drawn from a survey of 2,537 nurses and midwives from 117 countries as well as a literature review and key informant interviews.

When nurses were asked about factors keeping them from pursuing higher-level positions, 45% of respondents listed a lack of training in leadership.

Barriers preventing career progression included cultural perceptions about the specific roles of women and men, female nurses having to juggle paid and unpaid work, and nurses not feeling confident in taking on leadership roles.

Nurses and Midwives hailed in Queen's Birthday List

Nurses, midwives, researchers, academics, unionists, campaigners and advocates in their field around the country were awarded for their extraordinary work in the Queen's Birthday Honours List 2019.

The ANMF congratulates those awarded for their commitment, dedication, passion, service, achievement and contribution to Australia, in particular to:

OFFICER (AO) IN THE GENERAL DIVISION

Professor Debra Jackson: medical education in the field of nursing practice and research as an academic and author

Dr Megan-Jane Johnstone: medical education in the field of nursing and healthcare ethics, to patients' rights, and to professional standards

MEMBER (AM) IN THE GENERAL DIVISION

Ms Veronica Casey: nursing, to medical education, and to community health

Professor Mary Chiarella: nurse and midwifery education, and to healthcare standards

Professor Hannah Dahlen: midwifery, nursing and to medical education

Professor Phillip Della: nursing, midwifery, and to healthcare education

Mrs Margaret Green: veterans and their families, and to nursing

Ms Mary Kirk: midwifery and nursing, and to professional standards

Professor Kerry Reid-Searl: nurse education

MEDAL (OAM) IN THE GENERAL DIVISION

Ms Nicole Bolger: nursing

Ms Marie Burley: service to the communities of the Hunter and the Gold Coast

Mrs Elizabeth Giffard: nursing

Mrs Patricia O'Hara: nursing

Mrs Joanne Pearson: nursing, and to the community

'Night owls' can retrain body clock to improve health and performance

People with extreme late sleeping and waking habits who tweak their sleeping patterns slightly can experience improved sleep/wake timings, a decrease in depression and stress and improved eating habits and performance in the mornings, according to new international research.

Conducted by Monash University, the University of Birmingham and the University of Surrey (UK), the study found it was possible to shift the circadian rhythm of 'night owls' using non-pharmacological and practical interventions over a three-week period.

Published in *Sleep Medicine*, the study showed participants were able to bring forward their sleep/wake time by two hours, while having no effect on sleep duration.

As a result, they reported a decrease in feelings of depression and stress and daytime sleepiness.

The study suggests adopting regular sleep, meal and exercise times can make people happier, more productive and less stressed, and that the routine intervention could be applied within niche settings such as industry or sporting sectors.

According to the Australian Bureau of Statistics (ABS), about 1.7 million Australians worked shift-work as part of their main occupation in 2015.

The body clock of 'night owls' dictates later than usual sleep and wake times, with an average bedtime of 2.30am and a wake-up time of 10.15am used in the study.

"We now need to understand how habitual sleep patterns are related to the brain, how this links with mental wellbeing and whether those interventions lead to long-term changes," study co-author Dr Andrew Bragshaw, of the University of Birmingham said.

Australian children with mental health disorders not accessing care

The majority of Australian children with mental health disorders are not getting professional help, with girls and young children among the least likely to access services, new research has found.

Led by the Murdoch Children's Research Institute and published in the *Australian Journal of Psychology*, the study examined the mental health of almost 5,000 children by looking at data from the ongoing Longitudinal Study of Australian Children (LSAC).

As part of the research, parents reported on their children's emotional problems in a Strength and Difficulties Questionnaire and the results were linked with Medicare Benefits Schedule (MBS) data to see which families got help.

The research found less than one in four children with mental health problems saw a health professional in the 18 months after being diagnosed with an issue.

It also found girls were less likely to receive care than boys, families from non-English speaking backgrounds are unlikely to receive help (14% of children with emotional problems came from a non-English speaking background but only 2% received help) and that younger children were less likely to access services than older children.

Lead author, Professor Harriet Hiscock said families could be delaying getting help for their young children in the hope they will grow out of the mental health disorder but as the situation worsens turn to formal treatment but if left untreated problems can become entrenched.

Key recommendations included working to elevate the status and profile of nursing in the health sector, eliminating the perception of nursing as "women's work" and eliminating employer discrimination on the basis of gender or child-bearing status.

Victoria's Voluntary Assisted Dying laws take effect

Victorians at the end of life with a terminal illness and who meet strict eligibility criteria are now able to request access to voluntary assisted dying.

Victoria's Voluntary Assisted Dying Act 2017 came into effect on 19 June. Vic Health released further information last month, including on eligibility, how the service will be provided and by whom. Victoria's strict criteria include 68 different safeguards. Patients must be 18 years or older, be living in Victoria for at least 12 months, and be an Australian citizen.

The law allowed for an 18-month implementation period to give health services time to plan and prepare for voluntary assisted dying. A statewide Voluntary Assisted Dying Care Navigation Service includes two navigators to support anyone across Victoria seeking information about voluntary assisted dying or assistance going through the process. A range of resources are available for consumers and health practitioners, including information to support those ineligible.

health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying

ICN condemns deaths of nurses and midwives in conflict zones

The International Council of Nurses (ICN) has condemned attacks on nurses and midwives working in conflict zones and called for action from governments.

The 6th annual report *Impunity Remains: Attacks on Health Care in 23 Countries in Conflict in 2018* found nearly 1,000 violations of international humanitarian laws and United Nations resolutions designed to protect health workers in conflict zones. The violations led to the deaths of 167 health workers and more than 700 injuries in 2018.

"This report details how nurses and other health workers have been brutally attacked with knives, clubs, firearms, shells, bombs and fire. They have been intimidated, kidnapped, sexually assaulted and raped. They have been murdered," ICN CEO Howard Catton said.

While attacks caused immediate suffering and death, they also deprived populations of access to healthcare and interfered with outbreaks of disease and vaccination programs, he said.

"International leaders must now not just condemn these atrocities but take action to prevent them in the future and ensure health for all."

icn.ch

Coffee not harmful to heart

Relax. Drinking several more cups of coffee on a night shift may not be harmful to your heart, latest research shows.

Results of a study presented at the recent British Cardiovascular Society conference found that moderate coffee consumption did not adversely affect arterial stiffness.

The Queen Mary University of London researchers studied the effects of more than 8,400 people who drank coffee in three groups: less than one cup a day; one to three cups a day; and more than three cups a day. People who drank more than 25 cups of coffee a day and those with previous cardiovascular disease were excluded.

Arterial stiffness was measured using cardiac magnetic resonance and pulse waveform via finger probes. Results showed drinking 1–25 cups of coffee a day was not associated with significant changes in arterial stiffness. In fact, the researchers found that "coffee consumption was associated with a lower prevalence of coronary artery calcium, a marker of sub-clinical coronary atherosclerosis".

The study was published in *BMJ Heart*.

Lori-Anne Sharp

ANMF Assistant Federal Secretary

The future face of poverty should not be female: the barriers to superannuation equity women face

Superannuation is something many nurses and midwives don't think about until they are close to retirement age – financial planning can be daunting, it doesn't feel urgent, and it is very easy to 'set and forget'.

However, whether you are five years away from retiring, or 40, superannuation is important. We make a significant contribution to the healthcare workforce and it is vital that we are well placed to enjoy the benefits of that hard work in our retirement.

The Australian nursing and midwifery workforce comprises 89% women, who, on average retire with 40% less superannuation than men, even in female-dominated professions. According to the Association of Superannuation Funds of Australia (ASFA), the average superannuation balance in 2015/2016 for women was $68,000; for men it was $112,000. This translates to a less comfortable retirement, but is also a contributor to women over 55 being the fastest growing demographic for housing stress and homelessness in Australia (Riach et al. 2018).

There are a number of reasons why woman retire with less savings than men do. One obvious factor is the gender pay gap, which is currently 14.6% for a full-time employee, a difference of $244.80 per week (Workplace Gender Equality Agency, 2018). Women perform a higher proportion of the unpaid work, and are more likely than their male partners or family members to take time out of the workforce to care for children or elderly relatives.

They need to balance income-earning and career advancement with these responsibilities by working in casual positions or undertaking part-time work (Household, Income and Labour Dynamics in Australia survey, 2018). All these factors affect retirement savings.

So what are the solutions?

First, we need to advocate on policy that addresses the current gender pay gap, increase the superannuation guarantee from 9.5 to 12% and include the super guarantee in the commonwealth parental leave scheme so that women aren't penalised for taking time to raise their families.

It's also time to remove the exemption that allows employers to avoid paying super to employees who earn less than $450 per month. Under current legislation, if you work in three positions (perhaps at an aged care facility one night a week, a medical clinic one day a fortnight, and a surgical unit twice a month), you would be working eight shifts each month.

If earning less than $450 per month in each role, none of your employers are currently obliged to pay superannuation. As women are overrepresented in part-time and casual positions in the workforce, this $450 exemption to the superannuation guarantee disproportionately affects women.

Working full time and/or making additional payments (where possible) to your superannuation account at the beginning of your career has a significant long-term effect on your balance, because compound interest makes every dollar invested today worth many times that value when you come to retirement.

Take the time to review, and consider consolidating multiple superannuation accounts, so fees don't erode your savings. Changes to super legislation taking effect on 1 July means that there will be no exit fees for doing this.

Regardless of the sector you work in, nurses, midwives, assistants in nursing all have access to not-for-profit industry super funds, which deliver returns, and profits back to the members instead of shareholders.

These organisations, overseen by boards include an equal representation model of both employer and employee representatives. For nurses, midwives and assistants in nursing it will be reassuring to know that industry super funds have consistently outperformed other funds since the superannuation scheme was first introduced in the early 1990s.

Average annual long term net returns of industry funds exceeded those of retail funds by over 2% in the period of 2004–2018 (Industry Super Australia, April 2019).

Engaging in superannuation to consolidate accounts, making extra contributions and choosing a fund that delivers profits to members not shareholders will all have positive impacts on retirement savings. In order to boost the living standards of women in retirement, it also remains critical that we continue to advocate for increases in the super guarantee and lobby for policy reform that effectively addresses the barriers women face when saving for their retirement.

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Disclosure

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GOING
GREEN

Darren Bradbrook at FMC, South Australia. Photo by James Elsby

Green crusader and anaesthetic nurse Darren Bradbrook has been on a sustainability campaign in the operating room at Flinders Medical Centre (FMC) in South Australia since 2017. As a result, FMC has diverted over 60–70% of its operating room waste from landfill to a number of renewable streams in just over 18 months.

Anaesthetic ANUM Darren Bradbrook talks to Natalie Dragon about what has been achieved to date at FMC.

"I was getting fed up with opening packaging from companies who had a one size fits all motto. With the volume of waste each day we use that goes to landfill I thought we have got to have a better solution to our problem. What can we do ourselves?" says Darren, an anaesthetic nurse of 21 years.

So in early 2017, Darren embarked on a project to make the operating theatres a greener place to work.

"It all started with me contacting the key accounts manager for waste that services the SA public sector. We met one day to discuss some diversion from landfill options with me giving her samples of the kinds of products that we were aiming to have a solution with."

As the second largest hospital in the public sector in Adelaide, Darren says it was imperative that any sustainability initiative couldn't add too heavily to the existing workload of staff.

"We have 350 people in SALHN perio-operative and it couldn't impact too heavily on them. PVC recycling was being done in hospitals in Victoria and New South Wales, the structure was already established, we were tapping into an existing framework. It was cost neutral to us which was a massive drawcard.

"After a few months of negotiations, we finally decided on a twin stream for the products which was both high and low grade plastic waste. We had posters made up and bins (240ltr) were ordered with specific coloured lids and signage to make them identifiable to the people collecting. We started to also look into the prospects of being able to divert from landfill PVC (poly vinyl chloride) which mostly consisted of IV fluid bags, Hudson masks and oxygen tubing. This stream however was with another waste contractor so I engaged them in conversations which eventually led to us also participating in a PVC and aluminium recycling program independent but simultaneously with the plastic streams."

Over the next few months FMC introduced the system in the main operating theatres, starting with PVC and then rolling to the larger stream being plastics.

"We were the first hospital in South Australia to do PVC recycling. We started in PACU (recovery) first, as this space was smaller and staff compliance was always going to be simpler as educating this group traditionally was easier," says Darren.

Education and promotion included in-servicing, and lots of visual aids such as posters.

"We started to explain to people the 'why' and to strongly empower and encourage everyone to be part of this change - that this was an important part of our practice and

Darren Bradbrook at FMC, South Australia. Photo by James Elsby

that we could easily achieve this. People gained some knowledge of just how much waste our department produces, where it goes, and what our impact was locally and globally.

"We did a pilot in recovery and staff really grabbed on to it with both hands. People could see the benefit as an organisation, department, and community in how we deal with huge volumes of clean rubbish."

After enormous success in PACU and after many education sessions, FMC theatres introduced the plastic streams. FMC was the first hospital in the public sector to be recycling low and high grade plastics with SUEZ ResourceCo and PVC and Aluminium with Veolia/Baxter Healthcare, says Darren.

"This process went quite smoothly, however we worked out very quickly that we were going to need a lot more bins as the volumes were enormous."

All plastics are made into a renewable fuel source used by local industry in SA, such as Adelaide Brighton Cement. The plastics are chipped and compressed into bricks to be used as a Processed Engineered Fuel (PEF) which has a significant calorific value in the production of cement, reducing the use of fossil fuels by approximately 30%.

"This alternate fuel source is heavily regulated by the Australian government's Clean Energy Regulator under the Emissions Reduction Fund, so we know this means the fuel source is being closely watched to ensure it complies with all local and state emission control policy," Darren says.

News began to spread rapidly about what was being achieved in the FMC operating theatre, and the department was being contacted by other departments to follow suit. A FMC Green Team, which holds monthly meetings, was subsequently formed in late 2017 to help spread the success to other areas. The Green Team initially consisted of three members and today has over 25 representatives from approximately 18 different departments within SALHN (Southern Adelaide Local Health Network).

"Before long, theatres at FMC had a 2/3 diversion rate from landfill to recyclables, meaning that the general waste had been diverted by up to 70% to a renewable/recyclable stream, with a potential significant cost saving," says Darren.

Darren became an addition to FMC's Waste Committee, to tap into existing processes, and was liaising with senior corporate services and nursing managers in SA Health.

"I am extremely proud that this is a nurse-led initiative; that we are not just about caring about people. It's about us locally as well as globally and how we impact our own communities sustainably for better outcomes for future generations."

The results have been nothing short of amazing, says Darren proudly. Since November 2018, FMC doubled its volume of waste diversion compared to 2017, reflecting the support from those who have joined in the war against waste.

"We have diverted over 60–70% of our operating room waste from landfill in a number of streams. PVC, aluminium, low and high grade plastics, single use metal instruments, paper/cardboard etc. We now proudly recycle all of these items as well as printer cartridges and E-waste."

Such has been the success and engagement of the sustainability initiative at FMC, it has potential to become a whole of health strategy, says Darren.

"We are now in approximately 15 departments within SALHN, and hope to be the first hospital organisation-wide to be participating in making SALHN a green and sustainable place to work."

Darren says the vision is to achieve zero waste. "We want to move away from rubbish and as close to zero waste as we can as an organisation. We now ask product companies if they recycle or renew and to provide information on that. I am up front: if they say they don't, I say we are probably not interested in the product. When future tenders expire, new partnerships will include moving towards products which can have a second life in a recyclable stream, holding companies to account."

Darren has also been busy spreading the message of sustainability. He featured in a Channel 10 news segment in late 2018 showcasing the work being done at FMC, also in a national waste magazine (*Waste Management Review*) and has presented locally and at conferences. He is currently working on a combined media strategy with SA Health and Baxter Healthcare hoping to take place in the next couple of months; and is also eager to present at the next ACORN conference held in Sydney.

"We simply have to spread the word of sustainability in health as far and wide as possible. The results speak for themselves."

STATISTICS TO DATE

- Over 2.7 tonnes of PVC diverted from landfill: about 20km of garden hose produced or 850 children's play mats
- Over 860 cubic metres or 35 shipping containers of compressed plastic diverted from landfill
- Over 2,000 aluminium anaesthetic agent canisters recycled into about 45 children's bike frames

RETURNING TO THE FOLD

RE-ENTRY TO NURSING PRACTICE

The Nursing and Midwifery Board of Australia released a revised policy on re-entry to nursing practice this year. Natalie Dragon talks to several nurses who have recently returned to nursing.

After almost 10 years out of nursing, Western Australian RN Nadine Tomizzi says she always felt the pull to go back.

"I was always passionate about nursing and nursing education. I just really enjoyed being a nurse, it was always what I wanted to do. In a nutshell, I think it's part of my identity. I felt incomplete not doing it, a little unfulfilled."

Nadine left nursing with two children aged six and eight years and her husband building a business. "I played a big part in that. Nursing just disappeared; I didn't do enough shifts."

Two years ago, Nadine looked at re-registration. WA Health and private healthcare provider Ramsay Health no longer offered re-entry to practice or bridging programs.

"I thought I was done. I had done a critical care postgraduate diploma and my undergraduate degree and it was all gone. Then I saw the re-registration course at Notre Dame University. It couldn't have come at a better time: my kids were at uni and in Year 12 and the business was established. I am nearly 50 and I just thought now it's my time: it's [nursing] my thing."

The first intake of the University of Notre Dame Graduate Certificate in Nursing (Registered Nurse Re-entry) was in July 2018. The 14-week fulltime blended learning program features online and face to face learning and is based in Fremantle. There were about 12 participants in the first intake of the course; and more than 100 applications for the second intake in July 2019.

"The course was fantastic. I really enjoyed being in an environment with others in the same situation. Initially I thought the academic writing was going to be challenging. There was a lot of support. I basically said to my family do not expect anything from me during the clinical," Nadine said.

"In the practical, I would have liked higher acuity but I appreciate there is a problem getting placements. When I did my undergraduate degree there were two nursing schools now there are six or seven."

Nadine's background is predominantly intensive and coronary care; she completed postgraduate study in critical care. On completion of the re-entry course and registration with the Nursing and Midwifery

Returning to university can be both exciting and overwhelming

Board of Australia, she has returned to Ramsay Health where she did her grad program and previously worked.

"I have ended up in postoperative recovery; my specialty is airway management. Things have changed; practice has changed – drugs, pain control and management of nausea."

Nadine's advice to others contemplating going back into nursing is to just go for it. "Back yourself. I hesitated; I wasn't sure I had the confidence to go back and I'm so glad I did. Be highly organised. You need to have time management and balance your family and uni life. But it's such a short time – embrace it."

The Nursing and Midwifery Board of Australia (NMBA) released a revised re-entry policy in December 2018 which took effect on 11 February 2019. The *Policy for re-entry to practice for nurses and midwives* (the re-entry policy) applies to people who have previously held registration in Australia as a nurse and/or a midwife and are seeking to re-enter the professions.

According to AHPRA, the revised policy is aimed to improve the approach to re-entry by making the process clearer for applicants and employers while ensuring public safety.

SO WHAT'S CHANGED?

The revised policy provides direction on the application and assessment categories, which are:

1. People who are no longer on the register and have not practised for a period of between five to 10 years.
2. Nurses and midwives holding non-practising registration who have not practised for between five to 10 years seeking general registration as a registered nurse, enrolled nurse, or midwife.
3. Nurses and midwives holding general registration who have not practised for between five and 10 years.
4. Persons who have not practised for a period of 10 years or more.

"The revised policy broadens the options where clinical supervised practice can be undertaken. It also provides clearer guidance for those with dual registration and information for those looking to return to practice in a non-clinical role," according to an AHPRA spokesperson.

Former ANUM in theatres at Peter MacCallum Cancer Centre in Victoria, Georgina Masood left nursing with three little ones, now aged seven, eight and 10 years. She decided to go back to nursing when her son was in prep after almost 10 years out.

"It was then that I looked at my nursing and applied to do it part time online at CQU.

"It was daunting. I feel that the uni was very good, the course was great and the support from the lecturers was amazing."

The Central Queensland University (CQU) Graduate Certificate in Nursing (Re-entry) is offered online 0.5 full time or one year part time.

"The subjects in the course prepare us and make it very clear about what we are able to do on clinical placement. The hospitals are not always clear about what we can do as re-entry nurses. This meant that it was important to work together with our preceptors and educators. It's really important to practice knowing your limitations, ask for help and seek clarification when needed."

Advances in machinery and technology such as cardiac output monitoring, anaesthetic machines and new drugs were all a new challenge, says Georgina.

"I know my basic nursing skills, I've never lost them and I am confident in my ability to care for people but with an extra bit of support."

With more lived experience, Georgina considers she brings more empathy and understanding to the role.

"I have changed and I have been a patient myself and been vulnerable. It's shown me how important our role is as a nurse and as an advocate."

Returning to study has had the added benefit of role modelling to her children, Georgina says. "My family has been very supportive and they can see I am achieving something and I think are a little bit proud."

Returning to university can be both exciting and overwhelming, says Deakin School of Nursing and Midwifery's Associate Head of Teaching and Learning Associate Professor Lauren McTier.

"Once students meet the supportive, experienced academics and are guided through the learning management system, their initial concerns about returning to study are allayed.

"While the course is definitely viewed by students to be demanding regarding time commitment as it is a short, intensive course, the students' feedback is that they enjoy the content and activities associated with the Return to Practice Course.


Nadine Tomizzi


Associate Professor Lauren McTier


Georgina Masood

AHPRA'S TIPS FOR APPLICATIONS

- The most common omission in applications for re-entry is evidence of work history in the form of statements of service from previous employers. For some applicants, their previous roles may not have had 'nurse' or 'midwife' in their title, but their position description clearly demonstrates the need for their nursing or midwifery knowledge. The mandatory submission of mapping against the relevant standards for practice allows the applicant to demonstrate how they have been meeting the standards.
- Evidence of ongoing connections to the profession can also assist the assessment of an application, including any related courses, study, or ongoing professional memberships where an active role can be demonstrated.
- The **Fact Sheet: Re-entry to practice** now provides detailed examples to support applicants through this process.

Supporting documents are all available on the Re-entry to practice page on the NMBA website.

nursingmidwiferyboard.gov.au

They bond quickly with other students undertaking the course as they have a shared experience of previously working as registered nurses in Australia."

Deakin University currently offers The Return to Practice course twice a year.

Applicants to the course must have obtained approval from the NMBA to participate.

Graduates from the course, which is accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC), are highly sought after by healthcare organisations, Associate Professor McTier says.

"The curriculum at Deakin provides a broad overview of nursing practice in the contemporary Australian society and healthcare system. The course is underpinned by quality and safety in healthcare and ensures students are prepared for the current clinical environment in Australia by addressing topics such as current legislation and best available evidence for nursing practice."

The Deakin Return to Practice course is a 10 week course involving six weeks of academic learning on campus and four weeks of clinical learning in the healthcare setting.

"They [students] should be aware that the course is relatively short, 10 weeks, and to be successful it demands commitment outside of the classroom facilitated activities and clinical placement," Associate Professor McTier says.

South Australian's Bronwyn Lock left nursing as a single mother with five children under the age of seven, including twins. She decided to return to nursing with her eldest, aged 16 and her twins nine.

"I thought the lights are bright enough for me to be able to go back to it. I am really pleased I made the decision. I've really enjoyed it."

Bronwyn completed the University of South Australia Graduate Certificate in Nursing (Bridging and Re-entry) 0.5 years full time externally.

"I did it full time as part time wasn't an option. Studying at home was fine for my family but the two months full time placement was challenging. I said to the family 'we all just have to knuckle down for two months'. I wasn't sure how I'd go with the study but I wanted to do it, I wanted to relearn the theory and that's when I thought 'I can do this'."

Bronwyn initially thought she'd be able to work part time while she undertook her studies but after two weeks at university quickly dismissed the idea.

"Its full time study and it requires the study. I was literally exhausted by the end of the placement, and definitely ready to stop studying and start working."

The obvious tip on return to university life is to be organised, she says.

"Be on top of your essays. Get on to them quickly. You are stewing away thinking about them anyway, so you might as well get stuck into them early.

"Make sure your computer is set up well. Get computer organised and have a 'go to' person that can sort out any problems you have. You don't want computer problems or not being able to log on or open up resource material to impede your study. Make it easy for yourself and get it sorted before the course commences so it doesn't become a logistical nightmare."

Bronwyn says she negotiated to do her clinical placement four days per week over eight weeks instead of full time for six weeks.

"I found the uni was flexible given I had a valid reason and know, as a mature age entry student, that it's worth identifying any specific learning concerns or support that you need, and then asking for help with these."

Having completed the course, Bronwyn is currently waiting on the NMBA for approval for registration. Her advice is to factor in the application processing.

"Factor in the AHPRA timeline. I have been waiting eight weeks. I expected it might be approved at the end of February when I completed my course but it might not be until May or June."

Bronwyn says she is eager to return to practice. "It's not all bells and whistles. But it's that connection with people who are vulnerable. To be at the bedside, I do really enjoy that."

How does a patient with a Colles fracture end up on non invasive ventilation?

By Kelly Percy

Heart failure is a cardiac disorder that decreases the ability of the ventricles to fill (diastole) or eject (systole).

The heart is unable to supply enough blood to meet the metabolic needs of the body. Structural and functional causes of heart failure include diabetes, coronary artery disease and hypertension (Kemp & Conte 2012).

Beta-blockers, Angiotension Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB), diuretics and Digoxin are the mainstay of treatment, designed to reduce myocardial workload (Patterson & Felicilda-Reynaldo 2018).

Therefore, a patient with heart failure on medication will commonly present with a lower than normal mean arterial pressure (MAP) and a heart rate towards the lower end of normal.

Nurses caring for patients with heart failure need an understanding of the disease pathophysiology and treatment, to enable accurate interpretation of vital signs to avoid causing or contributing to iatrogenic complications.

The following case study follows the assessment and treatment of Mabel (not the patient's real name), brought into the Emergency Department (ED) by ambulance. It follows her trajectory from triage, to the resuscitation bay, procedure room, Coronary Care Unit (CCU) and finally an acute medical ward.

TRIAGE

A 70 year old lady complaining of pain and swelling to her left wrist following a mechanical fall, whilst transferring from a car to her wheelchair. The triage nurse observed obvious swelling and deformity to Mabel's left wrist.

The likely assessment was a Colles fracture, secondary to fall on outstretched hand (FOOSH).

Mabel's past history included – permanently wheelchair bound, type II diabetes mellitus on insulin, ischaemic heart disease, previous myocardial infarct, paroxysmal atrial fibrillation, congestive heart failure with an ejection fraction of 28% and a 1.5L fluid restriction.

Vital signs at triage were:

Airway	patent
Breathing	respiratory rate 22, oxygen saturation (Sp02) 94%
Circulation	heart rate 85 bpm, blood pressure (BP) 79/54 (MAP 62mmHg). Parathesia to left wrist, otherwise neuro-vascularly intact
Disability	afebrile, alert, GCS 15, complaining of left wrist pain 8/10

- The triage nurse gave Mabel paracetamol for analgesia. A sling was applied to Mabel's left wrist.
- The triage nurse informed ED Medical Officer (MO) of Mabel's low BP. MO ordered 2x500mls boluses of normal saline (N/S) in total to run stat for her.
- Post fluid boluses, Mabel's BP increased to 100/65 (MAP 76), but she became short of breath (SOB), Spo2 on room air decreased to 92%. Supplemental oxygen 2L via nasal prongs (N/P) was commenced.
- SOB and work of breathing (WOB) increased, Spo2 decreased to 90% despite being on 2L oxygen via N/P.
- Mabel was moved to the resuscitation bay.
- A diagnosis of acute pulmonary oedema was made.
- Mabel was commenced on Non-Invasive Ventilation (NIV), IV Frusemide was given, Indwelling Catheter was inserted to accurately monitor diuresis.
- Mabel improved, she was weaned off NIV and commenced on a high flow nasal prong oxygen (HFN/P 02) circuit.
- Mabel continued to stabilise, her SOB improved.
- She was moved to the procedure room for reduction of Colles fracture. A back-slab plaster of Paris cast was applied to Mabel's left wrist.
- Mabel's left wrist pain continued to resolve post reduction. She was assessed as stable for transfer to Coronary Care Unit (CCU) for close monitoring.
- In CCU Mabel was weaned off HFN/P O2 circuit, her BP remained low between 78-85 SBP but Mabel was asymptomatic.
- With hypotension in mind, CCU nursing staff withheld Mabel's beta-blockers and ACE inhibitors.
- The medical team was notified of Mabel's BP and a stat fluid bolus of 500mls N/S was ordered. Mabel became SOB again, requiring supplemental N/P oxygen and IV Frusemide.
- This pattern continued for the next two days and included two Medical Emergency Team (MET) calls for low BP. Mabel's beta-blockers and ACE inhibitors continued to be withheld.
- Mabel was eventually stabilised on day three post medical review - no further fluids were ordered, her 1.5L fluid restriction was implemented and all of her regular medications were administered.
- Mabel was stepped down from CCU and transferred to an acute care medical assessment unit. She remained there for three days, then was discharged home with her wrist in a cast and a follow up fracture clinic appointment in outpatient's department.

Reduction of a Colles fracture with traction and counter traction, followed by immobilisation with a plaster of Paris back-slab cast is a routine ED procedure (Nimmagadda, Prabha, & Tapandar 2017).

Typically, patients are seen, treated and discharged the same day. Mabel's length of stay was six days. Her treatment was complicated by administration of fluid for asymptomatic BP.

This case highlights that nurses need to be aware of the pathophysiology and treatment of heart failure to prevent iatrogenic complications and increased length of stay.

In patients with heart failure, failure to receive regular medication is a major determinant of a poor outcome. Patients with HF can be managed successfully with maximum therapy even when hypotension is present (Akosah et. al. 2009; Krum & Driscoll 2013). Low asymptomatic SBP (MAP >60mmHg) indicates optimal afterload and decreased workload of the heart. In the case of a symptomatic hypotensive patient with CCF treat very gently with IVF boluses and consider inotropes early (Mohsenin 2015).

IMPLICATIONS FOR PRACTICE

Nurses need to be information highlighters, memory keepers and process organisers (Gilardi, Guglielmetti & Pravettoni 2014).

- **Information highlighter** – listen to the patient/paramedic at triage, listen for key words – congestive heart failure – ask about ejection fraction, fluid restriction, enquire about medications - if the patient is beta-blocked, a HR of 85bpm may indicate a compensatory response to pain and that more than simple analgesia is required. Ask the patient/paramedic what BP is normal for them, look for signs of hypoperfusion, are they symptomatic or asymptomatic?
- **Memory keeper** – Keep in mind the pathophysiology of heart failure, if patients are in hospital for another reason – a heart failure diagnosis needs to be taken into account. Check with the MO first before deciding to withhold the patient's normal medication. If fluids are ordered, administer them cautiously.
- **Process organiser** – When handing over a patient with heart failure remember to include – what the patient's normal BP is, if they are on a fluid restriction and if they are on fluids to monitor for fluid overload.

Author

Kelly Percy is a Clinical Nurse – Rapid Assessment Medical Unit/Early Assessment Medical Unit/Day Unit Investigations Therapy at The Prince Charles Hospital in Queensland.

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FEATURE

IN HARM'S WAY

A series of drug overdoses at music festivals last summer triggered growing calls for the introduction of pill testing trials. The Australian Nursing and Midwifery Federation (ANMF) has backed the push for several years and has now developed a new national position statement on harm minimisation advocating a range of harm minimisation strategies, how nurses and midwives can provide leadership and education in this space and why the Australian government must urgently implement pill testing. Robert Fedele reports.

Deaths at music festivals from drug overdoses have become all too familiar in Australia.

Last summer, a series of five tragic deaths, including two teenagers aged 19, occurred at various events across New South Wales, triggering national headlines and again shining the spotlight on longstanding calls to introduce pill testing.

Pill testing as a harm minimisation intervention remains politically controversial in Australia but has been common in Europe since the 1990s and proven successful in countries such as Spain, France, Switzerland and Belgium.

Many groups, including the ANMF, believe national leadership and coordination regarding pill testing in Australia continues to fall short.

According to last year's annual report on overdose deaths from the Penington Institute, deaths by accidental drug overdose increased over the past 15 years and the risk of overdose is often heightened by the fact multiple drugs are commonly mixed together.

In 2016, the report uncovered 2,177 drug-related deaths in Australia, up from 1,231 in 2002, noting that the majority were accidental.

ANMF Federal Secretary Annie Butler says the union has advocated for drug and alcohol related harm minimisation measures, including opioid substitute therapy programs and supervised injecting centres, for years.

Harm minimisation aims to address alcohol and other drug issues by reducing their harmful effects on individuals and the community.

The philosophy considers drug use, both legal and illicit, an inevitable part of society.

It also states drug use occurs across a continuum ranging from occasional use to dependency, that a range of harms are associated with different types and patterns of AOD use, and most importantly that many strategies can be employed to respond to these harms.

Ms Butler says the Australian government must show leadership by supporting international evidence and local experts, such as nurses and doctors working in drug and alcohol, to introduce pill testing.

"The evidence shows that pill testing is effective," Ms Butler says.

"Not only does it directly reduce harm from drug taking by preventing overdosing and unnecessary deaths, it can also lead to behavioural change amongst young people. Data has shown that when the results of pill testing are presented to young people a majority will modify their drug taking behaviours and share the message with their friends."

The ANMF acted on the need for pill testing and broader harm minimisation measures by ratifying a new National Position Statement on Harm Minimisation at its Federal Executive meeting in late May.

ANMF Federal Professional Officer Elizabeth Foley says although Australia is internationally recognised for its approach to harm minimisation in regard to drug and alcohol use, it lags behind when it comes to pill testing at festivals.

This is despite widespread support from peak health bodies including the ANMF, Australian Medical Association (AMA), the Public Health Association of Australia, and the Australasian College for Emergency Medicine and the Pharmaceutical Society of Australia.

Ms Foley says the ANMF's National Position Statement on Harm Minimisation provides leadership and education on pill testing and broader drug and alcohol interventions.

"I think it's important our members know the ANMF's position on drug and alcohol use and harm minimisation measures to prevent and avoid unnecessary deaths," Ms Foley says.

"Nurses and midwives are non-discriminatory in their practice. Through this national position statement, we are aiming to reinforce drug misuse as a public health issue instead of a criminal one.

"People out in the community are always going to experiment with drugs so from a health professional point of view we must be making sure there are strategies in place to reduce harm."

Ms Foley believes the push for pill testing typically ebbs and flows and intensified in the wake of the latest deaths to Australian youth.

"When young people die it strikes a chord, especially with frontline health professionals who witness young people enter into their emergency departments suffering the effects of taking these substances and possibly losing their lives."

Ms Foley says the Australian government can no longer sit back and do nothing.

While progress in Australia has been slow, campaigners such as Pill Testing Australia are making inroads.

In 2018, the group, led by Dr David Caldicott, an Emergency Consultant at Calvary Hospital's ED in Canberra, convinced the ACT government and Groovin the Moo music festival organisers to conduct the country's first government sanctioned pill testing pilot.

Equipment involves an infrared spectroscopy (IR) test to identify ingredients.

KEY POINTS IN THE POSITION STATEMENT INCLUDE:

- Drug misuse should be considered a public health concern, rather than a criminal issue
- Many people use alcohol and other drugs for recreational purposes or management of dependency, and they are generally unaware of the potential for harmful effects
- Harm minimisation measures are required to prevent harm from alcohol and drug use and avoid unnecessary deaths, reduce the burden of disease and decrease hospitalisations for the benefit of the individual and the community
- The ANMF supports several existing harm minimisation strategies employed across various states/territories effectively, including needle and syringe programs, methadone and suboxone programs and supervised injecting centres
- The Australian government must show national leadership and collaborate with frontline health experts such as nurses to urgently introduce pill testing trials
- Nurses and midwives should be aware of, educated and informed about issues relating to harm minimisation for drug and alcohol use and be prepared to deliver opportunistic education within their practice settings

Test results alert patrons to drugs associated with increased harm and multiple overdoses or death and provide general advice on the potential effects and harms of ingredients.

If potential harm is detected, patrons are advised to dump their pills in amnesty bins provided.

"Our philosophy is not abstinence, it's to provide systems, supports, resources, education, and medication to reduce harms associated with taking drugs and or alcohol." John (not his real name) NP in Drug and Alcohol

In 2018, about 125 people used the service.

A second pilot, carried out earlier this year in April at the same festival in Canberra, was this time accessed by more than 230 people.

Some 171 substances were tested, with MDMA, more commonly known as ecstasy, the most common identified, and cocaine, ketamine and methamphetamines emerging to a lesser extent.

For now, the ACT is the only jurisdiction in Australia to give pill testing the green light.

John (not his real name), a nurse practitioner (NP) working in Drug and Alcohol, supports pill testing being legalised.

"It's multifaceted but from working in this field, we work under a national ideological framework of harm reduction," he explains.

"Our philosophy is not abstinence, it's to provide systems, supports, resources, education, and medication to reduce harms associated with taking drugs and or alcohol."

John says pill testing is not a panacea but does provide a progressive harm reduction tool that can potentially save lives.

He cites UK organisation The Loop, a not-for-profit established in 2013 which provides drug safety testing, welfare and harm reduction services at festivals and nightclubs, as a leader in the prevention of drug related harm and a model Australia could follow.

Its website has an archive of drug alerts circulated via the organisation's Twitter account that names substances uncovered through drug testing believed to be harmful.

As a nurse working in Drug and Alcohol, John encounters differing views on pill testing.

"What some people tend to think is if you say yes to doing this you're promoting it [taking drugs] but the reality is we've lost the war on drugs.

"We work in harm reduction, we don't work in abstinence. This is not about telling someone they're doing something wrong. This is providing them with support."

Even health professionals can pass judgement, he adds.

"There's a lot of stigma and discrimination, even from health professionals, in regards to patients with drug or alcohol use disorders. Some believe it's a loss of control rather than possibly looking at what's going on underneath."

In this vein, John suggests policymakers' general reluctance to discuss drugs openly is blocking progress.

"The fact is, because it's still illegal it is taboo and we don't educate and we put people further at risk," he says.

John labels the lack of political will to introduce pill testing disappointing.

Despite the resistance, he believes momentum is growing and that pill testing will be legalised.

"It's about changing the discourse of what drug and alcohol use and dependence is. We've got to move away from that until we can start seeing it as another health condition like chronic asthma or chronic diabetes."

Like pill testing, the introduction of supervised injecting rooms is another prominent harm minimisation strategy strongly supported by the ANMF.

David Pemberton is the head nurse at North Richmond's medically supervised injecting room in Victoria.

The facility, which is run by North Richmond Community Health and opened in July 2018 under a two-year trial, provides a safe space for people to inject drugs.

"I knew it was going to be a challenge, but I guess I was looking for something different and interesting," David says about joining the service.

"I have always been attracted to complex, demanding work environments. I also have an interest in providing healthcare to people who are often marginalised."

At the centre, David manages the roster, supports staff, orders supplies, handles recruitment and writes policies.

When working on the floor, the objective is to do everything possible to reduce harm to clients entering the facility and provide them with education and support to make harm reduction sustainable on the outside.

Clients who enter the service are assessed by a nurse and harm reduction practitioner.

Another staff member, typically a nurse, then provides the person with injecting equipment before they are shown to a booth.

Staff are on hand to provide safe injecting advice, ranging from which needles to use to caring for damaged or infected veins and wounds.

"We provide a lot of wound care at the service. Many of our clients are homeless or do not have funds to pay for dressings," David says.

"They are often not linked to health services or have difficulty accessing those services."

David reveals more than 650 overdoses have been safely managed at the facility, many which could have caused death, since the service opened.

"What I enjoy the most is working with clients. Each of them has a unique story. I am really proud of the fact we are saving lives – not just through responding to overdoses but through giving people better access to other health treatments, which will have long term benefits on their overall health."

David says harm minimisation strategies like the MSIR and pill testing are essential.

"Abstinence from an addictive substance is often unrealistic for a person with substance dependency. Harm reduction strategies meet the client where they are at, [assess] what their needs are and how to support them to make their lives safer."

View the position statement – **anmf.org.au/documents/policies/PS_Harm_minimisation.pdf**

James Lloyd

ANMF Federal Vice President

Nurses, gun control and why we have a stake: an update

For those dedicated readers of the *ANMJ*, I wrote an article in October 2019 titled 'Nurses, gun control and why we have a stake'. The theme of this article was the Tasmanian Liberal government's attempt to soften gun laws, and the lived experience of those at the Royal Hobart Hospital who were affected by the Port Arthur Massacre.

I am writing this article in mid-April, just over a month after the Christchurch shootings, where 50 people perished from one man and his high-powered military-style gun. New Zealand citizens, like Tasmanians in the 1990s, could have never imagined they would have had a US-style massacre in their peaceful nation. Like John Howard in 1996, NZ Prime Minister Jacinda Ardern quickly moved to tighten their gun laws and ban military style weapons.

It appears that our Premier does not have the same commitment as those two. The Upper House Inquiry into a pre-election state Liberal government's policy on firearm law reform was abandoned after the Liberal state government backtracked on its pre-election policy in mid-August 2018. Unfortunately, on 29 August 2019 our Tasmanian Liberal government has now set up a House of Assembly committee to examine firearm laws: **tinyurl.com/y4983uz9**

One of the statements on the Inquiry's website states, "Our firearms laws are among the toughest in the world and that is how they should remain, *while allowing practical improvements to support the needs of legitimate firearms users*." I find the part in italics deeply unsettling. It appears the state government is still pursuing watering down Tasmanian gun laws, whilst stating they fully support the National Firearms Agreement (NFA). I believe that the Tasmanian government should use its Lower House Inquiry to strengthen Tasmanian gun laws; for example, restricting access of guns to children, adding checks and balances that consider mental health status before issuing gun licenses, and shortening gun license periods.

Tasmanian Premier Will Hodgman has stated publicly he will not water down Tasmanian gun laws, but despite the incident in Christchurch, the Lower House Inquiry continues. For me and many of my colleagues in Tasmania, the state Liberal government's continued pursuit of the Inquiry is disturbing. ANMF Tasmanian Branch has been invited to front this Inquiry in support of its original submission to the Legislative Council Inquiry. To see the ANMF upper house submission go to: **tiny.cc/ANMFtasSub**

I am also disturbed by the possible influence of US gun lobbies in the Australian political system. Many of you would have seen the Al-Jazeera report on One Nation and the possible collusion with America's NRA to influence our political system and modify Australian gun laws. Australia does not have the same gun culture as the United States and the alleged possible influence of a foreign lobby group should be a concern for all our citizens.

We live in a peaceful nation where gun violence, although still existent, does not compare to US-style mass shootings. This is due to the Australian community's commitment and support of the National Firearms Agreement.

We must thank state government and former PM John Howard for standing up and acting on the community's expectation.

Their strong moral compass and fortitude regarding gun control should be something that all Australian politicians should embrace.

I fear the current state Liberal government does not have the same courageous philosophy regarding the NFA and gun control in Tasmania.

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

The Coroner's Court: extracting tips for improved documentation

Every jurisdiction in Australia has legislation that establishes the role and function of the Coroner and the Coroner's court.

Of particular relevance to healthcare professionals is the power of the Coroner to conduct an Inquest into a reportable death which is defined in each jurisdiction and includes deaths that are unexpected, unnatural, as a result of violence or unknown causes.

In some jurisdictions more specific criteria include deaths within 24 hours of a surgical, some medical procedures or discharge from hospital or whilst the person is in custody or care.

The primary purpose of a Coronial Inquiry is to identify the person, the circumstances, cause and manner of their death (Coroner's Act 2003 (Qld)). However, the Coroner's office also has a broader role in prevention which is achieved through making recommendations aimed at reducing or preventing a recurrence of a similar event that was the subject of the Inquest.

This is achieved by identifying shortcomings or failures of individuals or organisations in connection with a person's death rather than assigning blame or fault, in order to ensure lessons are learnt from mistakes in the hope that this will improve public health and safety in the future (The Inquest into the death of Ahlia Raftery (2017) NSW).

That said a Coroner will not hesitate to identify system failures and name poor conduct and practice where evidence suggests these contributed to the death of a patient. Such comments create opportunities to reflect upon practice and workplace systems and perhaps question long standing practices. One important area of practice that frequently attracts the attention of the Coroner is record keeping. Documentation in patients case notes whether in paper or electronic form continues to be a major concern and feature in Coronial Inquiries.

From risks associated with exception based record keeping, to the impact of a failure to document and false documentation, comments from cases such as Coronial Inquests help to provide organisations and practitioners with a framework of what is good documentation and what you should avoid when writing in the patient's notes.

Coronial comments are not confined to content. There are many styles or forms of record keeping and which style is used is a matter of organisational discretion based in part on the service they provide.

Organisations involved in the long term care of clients commonly rely on 'exception based' record keeping. In this style of record keeping comment is made in the client's record when something exceptional or out of the ordinary occurs.

A Coroner has recently highlighted the potential risk in this approach - determining what is exceptional. In that case the residential care facility was managing a resident's (who assaulted the deceased) ongoing physical and verbal aggression. The Coroner raised the point that in cases such as this when the behaviour is not uncommon and records of episodes of aggression are only recorded when 'out of the ordinary' it is possible that not all episodes will be recorded as the behaviour becomes normalised (Non - Inquest into the death of Betty Quayle 2019). As such what becomes 'exceptional' and who determines this?

The value of the Coroner's comments and findings lies in the point that there are few specific legal guidelines on what is good documentation despite this being an area of practice that clinicians are often looking for clear direction in. What you actually write in the patient's record is up to a point a matter of professional judgement – what you determine is important information to include in the contemporaneous account of patient care delivery.

There is a list of points that help guide basic documentation. These are to ensure that your documentation is:

- Complete
- Accurate
- Consistent
- Adequate
- Contemporaneous
- Truthful
- Edited – checking for ambiguity and spelling mistakes
- Absent of unapproved abbreviations

Unfortunately, the failure to follow these simple and basic guidelines has the potential to have an adverse effect on good patient care outcomes.

Examples from courts and tribunals as to what has been identified as flaws in documentation and how these can be used to improve record keeping will be explored in the next edition of this journal.

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Industrial manslaughter – moving towards a national regime

Daniel Crute

ANMF Federal Industrial Officer

THE LAW

In Australia, only the ACT and Queensland have laws covering the crime of industrial manslaughter, whilst Victoria is considering passing similar legislation.

Queensland passed its laws in response to tragedies at Dreamworld amusement park and the death of workers at Eagle Farm in Brisbane, although curiously these laws only apply to workers and not visitors.

In late April, federal ALP committed to working with state and territory governments to establish a uniform industrial manslaughter offence across Australia. The ALP has promised to establish a national advisory committee made up of representatives from each state and territory who have been personally impacted by a serious workplace injury or death. Representatives would provide advice to Australian workplace health and safety ministers and develop recommendations to governments.

The federal Coalition government believes existing laws to be adequate and has consistently argued against industrial manslaughter laws. In Queensland, the Liberal National Party opposition voted against the laws introducing the offence of industrial manslaughter.

RECENT REVIEWS – MOMENTUM BUILDS SAFE WORK AUSTRALIA 2018

In 2018, Safe Work Australia conducted a review of the national model Work Health and Safety (WHS) laws which all jurisdictions except Victoria and Western Australia have implemented. The former Executive Director of SafeWork SA conducted the review which led to a final report being published in February of this year (Boland 2019). One of the report's recommendations was a new offence of industrial manslaughter being introduced into the model WHS laws. The ACTU strongly supports this recommendation.

Part of the problem identified in the review was that laws in this area were inadequate. Under existing laws, there is the offence of "negligent manslaughter" for corporations. But convictions are rare with big hurdles to getting a conviction. Prosecutors need to identify a grossly negligent individual who embodies the company and whose conduct is attributable to the corporation.

SENATE INQUIRY 2018

In late 2018, the Australian Senate Education and Employment References Committee completed its Inquiry into industrial deaths in Australia. It recommended that Australian governments work together to introduce a nationally consistent industrial manslaughter offence into the model WHS laws, using the Queensland law as a starting point.

Unsurprisingly, Liberal National coalition senators on the committee issued their own dissenting recommendations in the report. They did not support implementing industrial manslaughter laws, stating that "focus on holding companies and managers accountable for breaches (sic) in their WHS duties regardless of outcome…is the appropriate approach to continue to drive a reduction in fatalities and injuries in the workplace" (Australian government 2018).

HOW WOULD SUCH LAWS AFFECT ANMF MEMBERS?

Compared to many industries and occupations in Australia, health does not have as many workplace deaths. However, health workers are not immune from deaths in their workplace.

The tragic case of Orange nurse Robert Fenwick is one sad example of a workplace death suffered by a nurse. Mr Fenwick was stabbed by a patient at the mental health facility he worked at in 2011. Had there been industrial manslaughter laws at the time of his death regulators could have looked at the surrounding circumstances of Mr Fenwick's death to see if an offence had been committed.

THE AUSTRALIAN PUBLIC SUPPORT INDUSTRIAL MANSLAUGHTER LAWS

Many Australian unions have long pushed for nationally consistent industrial manslaughter laws. It is also clear that the general public support such laws. Polling conducted for the ACTU in February this year shows that a majority of Australians support the introduction of industrial manslaughter laws and an expanded role for unions in ensuring workplace safety. Nearly 60% of Australians want laws that would see employers who are responsible for workplace deaths held accountable and ultimately sent to jail, with only 21% of people opposed to such laws. Even a majority of Liberal National coalition voters support such a law (uComms 2019).

As the ALP lost the recent federal election, Australia has missed any immediate chance of having a nationally consistent approach to industrial manslaughter. Australian unions will be working hard wherever they can to get industrial manslaughter laws implemented. The short term will most likely see pressure on state governments to amend their legislation. In the long term, a nationally consistent approach will be worked towards.

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Nurses on the beat

Registered nurse Hugo Chatwin-Smith was drawn to the diversity of Custodial Nursing and opportunity to deliver healthcare to Victorians experiencing the lowest point in their lives, writes Robert Fedele.

Underneath the bustling Melbourne Magistrates' Court on William Street, the Melbourne Custody Centre is a police jail, essentially a stopover used to hold prisoners attending court hearings, or those who have been arrested and placed on remand.

Victoria Police's Custodial Health Service is based at the centre and provides healthcare to people held in police custody across the state, including daily visits to police jails such as Sunshine, Ballarat and as far as Shepparton.

The Melbourne Custody Centre holds about 70 people with nurses rostered on 24 hours a day to ensure people in custody maintain good health.

Out and about, cell nurses drive around to police jails and conduct health assessments, ensuring all prisoners are seen within their first 24 hours in custody.

They are supported by a triage nurse working on the phone line that provides health advice to police and custody officers in police jails beyond the centre.

A team of more than 20 nurses, including one nurse practitioner (NP), and four doctors lead the Custodial Health Service.

They hail from diverse backgrounds such as bush nursing, intensive care, mental health and cardiology and most have emergency experience.

"I'm not good with dressings but I know my boss was a burns nurse in the Northern Territory," Hugo explains.

"I don't know too much about HIV and AIDS but my colleague is a sexual health nurse as well. What experience we don't have, there's always someone around who knows something."

The healthcare service includes a pharmacy, which stocks a wide-range of medications so people in custody can keep up their regular medication, and a small doctor's clinic.

Prior to joining the service, Hugo specialised in cardiac nursing, including a stint at the Royal Children's Hospital looking after kids with congenital birth defects.

It was there, in the middle of a nightshift, that he stumbled across a job advertisement for a Custodial Nurse and immediately became intrigued.

"I have always been raised as a community-minded person," Hugo says.

"If you do a little bit of research into the population of people in prison at the moment, one out of three in Australia haven't finished year 10. At least one in every five has had at least one incarcerated parent at one stage of their childhood, half have been homeless a month prior to seeing us and a third haven't seen a health professional in the community in the preceding 12 months when they needed to. Rates of infectious diseases are incredible."

Hugo says a routine day at the Custodial Health Service's headquarters runs much like a hospital ward.

It begins by handing out morning medications to up to 20 people in custody.

"That's a good place where you can also do your blood pressures and blood sugars and auscultate if you need to," he says.

At least two guards shadow nurses at all times and a strong focus on safety means problems are rare and rates of clinical violence low.

After medications, Hugo prepares for the doctor's clinic, where prisoners who have been flagged for review the night before are examined.

Some of the biggest health concerns include Hepatitis C, diabetes, asthma and mental illness.

A doctor's visit can entail prescribing regular medication for people in custody, with alcohol and opiate withdrawal widespread, as well as anything from dressings to minor surgeries.

Lunchtime medication handout usually involves a round of Opioid Substitution Therapy Program, methadone and suboxone, for those who are currently prescribed the drugs out in the community.

Afternoon medications follow a similar pattern before handover.

Hugo says he finds the other side to the role, visiting police stations across the

> *"You're seeing people that are accused serial rapists, murderers and drug dealers whose behaviour has led them into custody."*
>
> **Custodial Nurse Hugo Chatwin-Smith**

Acting Inspector Greg McWilliam and Custodial Nurse Hugo Chatwin-Smith

state and conducting health assessments on prisoners, even more interesting and rewarding.

"Ultimately this job, when you get down to the bare nuts and bolts, is about risk assessment," Hugo says.

"What's the risk associated with this person staying in our custody? Can we manage any of their medical issues? If we can't, do we escalate it by sending them through to the assessment prison sooner or do they need to go to hospital?"

A recent focus at the Custodial Health Service has introduced sworn police officers into the unit.

Head of the Custodial Health Service, Acting Inspector Greg McWilliam, says it's enabled the service to achieve better outcomes.

"These guys [like Hugo] come in with a particular set of skills in the clinical field whereas we come with operational policing experience so the two working hand in hand is becoming more necessary," Acting Inspector McWilliam says.

He says the Custodial Health Service team works within a challenging but rewarding environment.

"People who come into our custody are at the lowest point in their lives. They come in with drug and alcohol issues, mental health issues, and all sorts of things. They're at their lowest ebb when they come to us and we have a duty of care and responsibility to make sure they don't get further harmed or injured whilst in our custody."

Hugo says every day on the job is different and that he feels proud that the service often detects health issues that fall through the cracks.

From acute drug intoxication, to chronic wounds and poor health education, custodial nurses see it all.

Hugo says custodial nursing demands good assessment skills, compassion and fairness, and a strong belief in primary healthcare.

"For me, this job is the ultimate version of unbiased healthcare.

"You're seeing people that are accused serial rapists, murderers and drug dealers whose behaviour has led them into custody.

"But you always need to have in the back of your mind, the perspective that says, these people may not be here because of one action. There may have been a culmination of missteps: their upbringing, their lack of access to health and education, everything that we define as disadvantage that has contributed."

Hugo believes the Custodial Health Service, the only one of its kind in Australia, provides a service to people who cannot get it anywhere else.

"These are the most disadvantaged people in Victoria and there's no real way of arguing it because every single walk of disadvantage is here," he says.

"It's challenging. It's exciting. It's like nothing else. The sounds, the noises, the sights that you see, the stories that you collect and the interaction with people that you would never actually interact with within a hospital [is unique]."

The Custodial Health Service will be recruiting nurses and nurse coordinators/managers in the near future.

Job opportunities within Custodial Health Service can be found at careers.vic.gov.au

Aseptic Technique (ANTT®) Tutorial

By ANMF Federal Education Team

The following excerpt is from the ANMF's Aseptic Technique (ANTT®) tutorial on the Continuing Professional Education (CPE) website.

Aseptic Non Touch Technique (ANTT®) is based upon a set of foundation principles and safeguards set out in the ANTT® Clinical Practice Framework. ANTT® has become the de facto national standard aseptic technique in England, Australia and Wales and is now used in over 30 countries and is rapidly expanding (ANTT® website).

Aseptic technique is a procedure used to prevent the spread of infection. It aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites.

Aseptic technique protects patients during invasive clinical procedures by employing infection control measures that minimise, as far as practicably possible, the presence of pathogenic organisms (Tasmanian Infection Prevention and Control Unit).

While the principles of aseptic technique remain constant for all procedures, the level of practice will change depending upon a standard risk assessment (Qld Department of Health).

In Australian healthcare settings, patients are often treated in close proximity to each other. They undergo invasive procedures, have medical devices inserted, and receive broad-spectrum antibiotics and immunosuppression therapies. These conditions create ideal opportunities for the adaptation and spread of pathogenic infectious agents (NSQHS 3).

A hospital-acquired infection may occur in the presence or absence of an invasive procedure or device. Depending on the site of infection, patients with this complication may experience a range of distressing symptoms including fevers, chills, pain, hypotension and dizziness, tachycardia, collapse, delirium, cough, shortness of breath, urinary frequency, diarrhoea, purulent discharges, wound breakdown, and even death (NSQHS 3).

Each year, patients in Australia develop a large number of hospital-acquired multi-resistant organisms (MROs), with 3,768 occurring in public hospitals in 2015–16. Patients with MROs experience challenges related to failure to respond to routine antibiotics, causing prolonged therapeutic regimens and use of antimicrobials with potentially problematic side effect profiles (NSQHS 3).

When discussing aseptic technique it is important to understand the relevant terminology. The use of accurate terminology is important in order to promote clarity in practice.

The terms 'sterile technique' and 'aseptic technique' have been used interchangeably in the past, however they mean very different things.

STERILE

'FREE FROM MICROORGANISMS' (WELLER 1997)

Due to the natural multitude of organisms in the atmosphere it is not possible to achieve a sterile technique in a typical healthcare setting. Near sterile techniques can only be achieved in controlled environments such as a laminar air flow cabinet or a specially equipped theatre. The commonly used term, 'sterile technique' ie. the instruction to maintain sterility of equipment exposed to air, is obviously not possible and is often applied inaccurately (Victorian Department of Health 2014).

ASEPSIS

'FREEDOM FROM INFECTION OR INFECTIOUS (PATHOGENIC) MATERIAL' (WELLER 1997)

An aseptic technique aims to prevent pathogenic organisms, in sufficient quantity to cause infection, from being introduced to susceptible sites by hands, surfaces and equipment. Therefore, unlike sterile techniques, aseptic techniques are possible and can be achieved in typical hospital and community settings (Victorian Department of Health 2014).

CLEAN

'FREE FROM DIRT, MARKS OR STAINS' (MCLEOD 1991)

Although cleaning followed by drying of equipment and surfaces can be very effective it does not necessarily meet the quality standard of asepsis (Ayliffe 2000). However, the action of cleaning is an important component in helping render equipment and skin aseptic, especially when there are high levels of contamination that require removal or reduction. To be confident of achieving asepsis an application of a skin or hard surface disinfectant is required either during cleaning or afterwards (Mcleod 1991).

ASEPTIC NON TOUCH TECHNIQUE (ANTT®)

The aim of any aseptic technique including ANTT®, is asepsis.

ANTT® is a technique used to prevent contamination of key parts and key sites by microorganisms that could cause infection. In ANTT®, asepsis is ensured by identifying and then protecting key parts and key sites by hand hygiene, non touch technique, using new sterilised equipment and/or cleaning existing key parts to a standard that renders them aseptic prior to use (Rowley and Simon 2011).

KEY SITES AND PARTS

Key sites are any breaches in skin integrity which could be a portal of entry for microorganisms to colonise the patient. This includes wounds and puncture sites.

Key parts are any parts of the equipment which come into contact with procedural equipment or the patient. This includes invasive devices connected to the patient and liquid infusions. *Examples include:*

- IV cannula bungs; needle tips; sterile gauze used to clean a wound.

If key parts become contaminated they can transfer microorganisms to the patient (Victorian Department of Health 2014).

ASEPTIC FIELD

An aseptic field is a controlled workspace used to promote asepsis during a clinical procedure. There are three types of aseptic technique:

1. **Sterile** – a technique that aims to achieve total absence of microorganisms. This is only ever achieved in an operating theatre or using a laminar air flow cabinet (Royal Children's Hospital).
2. **Standard** – a technique that utilises a general aseptic field, critical micro aseptic fields, hand hygiene, non touch technique and non sterile gloves to achieve a safe level of asepsis for:
   - Technically simple and short procedures
   - Procedures that involve few key parts or key sites (Royal Children's Hospital).
3. **Surgical** – a technique that utilises a critical aseptic field which is treated like a key part and also utilises:
   - Full barrier precautions such as sterile gloves, sterile gowns, cap, mask
   - Critical micro aseptic fields
   - Hand hygiene
   - Non touch technique where practical to do so (Royal Children's Hospital).

It achieves a safe level of asepsis for procedures that are:

- Technically complex procedures
- Extended periods of time
- Large, open or multiple key sites
- Example is PICC insertion (Royal Children's Hospital).

The use of aseptic technique during invasive clinical procedures minimises the risk of introducing infectious agents into sterile areas of the body. Effective aseptic technique is vital in all areas where invasive devices

are used and invasive procedures are performed, and for patients at greater risk of harm associated with healthcare interventions (ACSQHC 2018).

All clinicians who use aseptic technique in their practice need to have their competency assessed from time to time. If necessary, they should be retrained where practice is below accepted levels of performance. A risk matrix can be used to assist health service organisations prioritise competency assessments, and identify clinical areas and/or procedures of high risk (ACSQHC 2018).

The **risk matrix** provides a score for each of the following factors:

- The clinical context where aseptic technique is to occur and how frequently it occurs in that setting.
- The treatment type or procedure and how frequently that treatment/procedure occurs.
- The recency of assessment of the healthcare professional for competence in aseptic technique.

For two of these factors, clinical context and treatment type, frequency of occurrence is also a factor (ACSQHC 2018).

A risk rating is determined by adding the scores for each of the three risk factors (detailed information provided in the tutorial). This information can assist in planning the organisation's response to improve aseptic technique in practice. The higher the risk rating, the greater the risk and need for action to be taken.

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Dr Micah D J Peters

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Nurse and carer experiences of working in aged care: research for policy impact

The evidence provided by nurses, carers, and community members is vital to ensuring improved policy and real-world outcomes for aged care staff and residents.

Almost 2,800 aged care staff and over 350 community members from around Australia participated in the 2019 ANMF National Aged Care Survey. They contributed their valuable time and knowledge to enable us to report on the current situation in aged care, bring this evidence to the Royal Commission into Aged Care Quality and Safety, and to continue to campaign for mandated minimum staff ratios and staffing levels. Over the last few weeks, I have been involved in writing the reports based on the data provided by participants and have read through every heart-breaking story they shared.

In previous columns I wrote about the importance of nurses, midwives, and carers getting involved in research – often focusing upon the importance of carrying out research and utilising research outputs to improve clinical and professional practice. In this column I focus on another way that nurses, midwives, and carers can – and should – get involved; participating in research themselves.

I first drafted this column prior to the federal election, and in the lead up, we heard discussions and the positions of many politicians and parties regarding aged care. Notably, compared with one politician (Derryn Hinch) at the time last year, 96 politicians had pledged their support for the Ratios for Aged Care campaign. We have also seen countless stories in the media about the crisis in aged care and there will be more to come. Overwhelmingly, participants in our survey wanted change. They wanted more staff and better skills mixes to provide safe, appropriate, quality care for residents. And they wanted a government that would ensure accountability for aged care funding and to be confident that providers are using that money on the care of residents. The election results may be disappointing for those who wanted real change for aged care, but many politicians and their parties did hear our message; the Greens committed to supporting nurse-to-resident ratios, 24/7 registered nurse rostering, and a 15% pay rise for aged care workers, and the Australian Labor Party commited to improving staffing levels, publishing skills mixes, and ensuring 24/7 registered nurse rostering. The election results tell us that we have more work ahead of us and need to keep using evidence to demonstrate the strength of our position.

Without evidence – the data – and often, even more importantly, the stories, and perspectives of staff and community members, working effectively to address the apparent crisis in aged care would be all but impossible. Policy makers, politicians, and the general public need to hear from those who work at the coal face and who have lived experience of the aged care sector. Our survey allowed us to collect and bring together the voices and perspectives of thousands of aged care stakeholders. And while news stories can be excellent for gaining an insight into a few peoples' experiences, qualitative analysis means that we can identify, analyse, and report on themes that arise out of rich, in-depth stories and question responses provided by many participants.

Policy makers are increasingly reliant on evidence to make decisions due to a growing understanding that policy making should be based on evidence rather than ideological perspectives. Policy makers, however, need evidence quickly and often desire evidence that supports their goals. Policy and political landscapes are also ever shifting, priority issues quickly change, leaving researchers scrambling to provide solid evidence to support their case. Aged care has been in the public and policy makers' eye for some time now, however, and with the Royal Commission, and the ANMF's ongoing campaign, attention will persist. By participating in the ANMF's survey, respondents became part of the research-policy process, providing detailed evidence to take to policy makers and knowledge to argue for the cases of all those who gave their time and stories to us.

Participating in research – either by providing insight and information about what's going on in a sector like Australian aged care through the ANMF National Aged Care Survey or by agreeing to participate in an academic research project promoted by the ANMF or its Branches from time to time – gives voice to the people working on the ground. The federal election was but one opportunity to use this evidence to advocate for changes and improvements, and with many waiting on the results of the Royal Commission before deciding on a course of action, there are further opportunities ahead. As we found through the Survey, people in aged care have felt voiceless, but it is hoped that our work will be able to amplify the voices of those who participated and make a meaningful, evidence-based difference to Australia's aged care sector.

The Survey reports and Executive Summary and Key Messages documents can be found online here: **anmf.org.au/pages/anmf-reports**

Footnote

1 Nurses, carers, and members of the public can also still makes submissions (until September 2019) to the Royal Commission into Aged Care Safety and Quality here: agedcare.royalcommission.gov.au/submissions/Pages/default.aspx#Making

Tara Nipe

Acting Federal Professional Officer

What Australian nurses need to know about voluntary assisted dying

After an 18-month implementation period, voluntary assisted dying (VAD) has been made legal in Victoria.

While Victoria is the first state to legalise medically assisted dying of terminally ill people (an Act that was also legal in the Northern Territory from March 1996 to March 1997), Western Australia's Joint Select Committee on End of Life Choices recommended the introduction of similar laws, (WA government 2018) and Queensland Premier Annastacia Palaszczuk has ordered an Inquiry into end-of-life care, including assisted dying (Queensland Parliament's Health Committee 2019). Similar legislation in New South Wales and South Australia was narrowly defeated in 2017, and it is highly likely future attempts will be successful in the next few years, making the question of VAD a national issue for nurses.

The Victorian legislation is the most stringent of its kind in the world, and it is almost certain that any other legislation will follow with very similar conditions. To begin the process, applicants must:

- be aged 18 or over;
- be competent to make healthcare decisions;
- have been a resident in the state for at least 12 months;
- have a life-limiting illness with a prognosis of six months or less (12 months for neurodegenerative conditions); and
- be experiencing suffering that cannot be adequately relieved in a way that is acceptable to them.

The legislation details the series of steps required, including evaluation by two experienced medical practitioners (one of whom must be a specialist in the patient's terminal condition and the pharmaceutical management).

It is one of the honours of our profession that patients are more likely to discuss fear and concerns about death and dying with nurses before other members of their healthcare team or even, sometimes, family.

Canadian Nurse Practitioner Tanya Burr attributes this, in part, to nurses having, "the blessing of time to spend with our patients, even if only in three or five minute snatches" (Victorian VAD Conference 2019). This characteristic of our interactions, combined with the fact that nurses are often a constant presence against the ebb and flow of changing medical and allied health practitioners, means that while nurses will not be involved in any of these regulated steps, we still have a significant role to play.

VAD is an emotional and polarising issue for many people. Like many things, our attitudes to VAD exist along a spectrum, from outright opposition to advocacy. In all jurisdictions where these kinds of laws have been introduced, conscientious objection has been a key component for health practitioners – voluntariness applies to everyone, not only the dying person.

So far, at least one Victorian public hospital has banned staff from participation, regardless of their personal opinion about VAD (ABC 2017).

Whatever the facility's position, a nurse who is approached about VAD by a patient or family member may respond by saying (professionally, politely, and without harming the therapeutic relationship) that it is an act they are opposed to, and are not comfortable speaking about. In other cases nurses may not be comfortable discussing VAD themselves, but are prepared to suggest a colleague, literature, or other source of information, and that's also fine.

All nurses need to be aware that it is a crime to initiate a discussion about VAD with a patient, so patient conversations about VAD should be well documented.

Note that patients don't need to use the words 'voluntary assisted dying,' but a statement by the patient that they want to die or they've had enough are insufficiently specific. It is recommended that practitioners respond with neutral, open-ended questions like 'What do you mean by that?' rather than 'Are you asking about assisted dying?'

Be aware people will often react badly if told that they do not meet the criteria for VAD.

For specific information and resources about VAD, please see the Victorian Department of Health and Human Services website (Victorian government 2017), keeping in mind that laws introduced in other states and territories will be at least a little different.

TAKE HOME MESSAGES

- whatever your position, ensure your interactions with patients are professional and supportive
- you may conscientiously object to any participation in VAD, including patient discussion
- you may not mention VAD before a patient does
- carefully document any discussions

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Presentation during and 'out-of-hours' at three emergency departments for hyper-acute stroke patients

By Danny Kinsella, Ian Mosley, George Braitberg

ABSTRACT

Background: Contemporary treatments for hyper-acute stroke rely on prompt arrival following the onset of symptoms. Although the negative influence of an '*out-of-hours' effect* on stroke outcome is well documented, little is known about variations in time delay in arrival and mode of arrival to emergency departments (ED) during *'out-of-hours'* service delivery.

Aims: To evaluate, whether an *'out-of-hours' effect* is associated with mode of arrival and/or delay in arrival time to ED.

Methods: This study evaluated a retrospective cohort of 1,976 patients with hyper-acute stroke, who presented to three metropolitan ED services.

Results: Analysis indicated that there was no significant difference in pre-hospital time delay or mode of arrival (ambulance or private transport) for '*out-of-hour's* arrival.

Conclusion: These encouraging results indicate that an '*out-of-hours'* admission for patients with hyper-acute stroke symptoms is not impacted by pre-hospital delay or a reduction in arrival by ambulance.

INTRODUCTION

Rapid hospital arrival is integral for patients with hyper-acute stroke accessing contemporary treatments within emergency departments (EDs) (Meretoja et al. 2014).

The *'out-of-hours'* effect (consisting of *'weekends'* (Pauls et al. 2017), *'public holidays'* (Walker et al. 2017), and *'after-hours'* (Vest-Hansen et al. 2015) is a known predictor for stroke outcome, including reduced adherence to stroke care guidelines (Turner et al. 2016), increased time in receiving stroke thrombolysis (Meretoja et al. 2013), and higher mortality (Hsieh et al. 2016).

Suggested explanations include reduced ED capacity and reduced senior hospital staff during these time periods (Smith et al. 2013).

However, this literature has predominantly only examined the impact of *'out-of-hours'* during the inpatient hospital journey has commenced.

The potential of a delayed presentation or variation in mode of arrival to EDs contributing to an *'out-of-hours'* effect has yet to be investigated in a stroke-specific cohort. This is especially important within ischaemic stroke as the benefits of hyper-acute treatments for ischaemic stroke are critically reliant on timely access (Powers et al. 2018). In this population, the window of time for treatment benefit is commonly considered to be less than six-hours from the onset of stroke symptoms (Wardlaw et al. 2014).

AIM

To evaluate, within hyper-acute ischaemic stroke patients, whether an '*out-of-hours*' effect is associated with mode of arrival and/or delay in arrival time to ED.

METHODS

This study used a cohort analysis of retrospective data retrieved from three EDs over a three-year period. The three investigated EDs form a local health district located in Melbourne, Australia; responding to a population of 1.3 million people and treating 180,000 people annually. Patients were identified by ED discharge diagnosis of ischemic stroke, in accordance with ICD-10 Classifications (ICD-10-AM, 2015).

STUDY POPULATION

The number of patients presented with ischemic stroke during the study period was 3,295- 59% ($n = 1,976$) arrived within six-hours from the onset of their stroke symptoms and formed the study population.

DEPENDENT VARIABLES

Each patient was grouped according to arrival time at ED:

1. weekday during-hours (9:00am–5:00pm Monday–Friday),

2. weekday after-hours (5:01pm–8:59am Monday –Friday),
3. weekend during-hours (9:00am–5:00pm Saturday–Sunday),
4. weekend after-hours (5:01pm–8:59am Saturday–Sunday). Public holidays were coded as weekend presentations.

INDEPENDENT VARIABLES

1. Mode of arrival: arrival to ED by ambulance or by private transport.
2. Time delay in arrival: the delay between symptom onset time (as documented within the patient electronic records) and documented arrival time at ED (hours/minutes).

STATISTICAL ANALYSIS

Descriptive statistics presented patient demographic variables (age, gender, language spoken at home, and country of origin). Data was analysed using STATA version 12 (StataCorp. 2011).

Two separate one-way analysis of variance (ANOVA) followed by univariate *t*-tests and post-hoc analyses investigated group differences in the independent variables. A *p*-value of < 0.05 was considered statistically significant.

ETHICS APPROVAL

The research study adhered to the *National Statement for the Conduct of Human Research* by the Australian National Health and Medical Research Council. Ethics approval was obtained through the health service's (Monash Health) research ethics committee, as a quality assurance activity as the analysis was undertaken on a de-identified patient database.

RESULTS

PATIENT CHARACTERISTICS

For patients who arrived less than six-hours from onset of their stroke, ($n = 1,976$), 948 (48%) were greater than 75-years (mean age 70-years). Males accounted for 52% ($n = 1,031$). English was the language most commonly spoken at home (86%, $n = 1,712$), and most

TABLE 1:

Demographics characteristics of the total hyper-acute sample (n = 1,976) and each sub-group.

Variables	Total sample	Weekdays during hours	Weekdays after hours	Weekends and public holidays during hours	Weekends and public holidays after hours
	N = 1,976 (100%)	**n = 745** (38%)	**n = 581** (29%)	**n = 340** (17%)	**n = 310** (16%)
Age in mean yrs (SD)	**70** (15)	**70** (16)	**69** (15)	**73** (15)	**67** (16)
Male sex (%)	**1,031** (52%)	**391** (52%)	**305** (52%)	**171** (50%)	**164** (52%)
English spoken at home (%)	**1,712** (86%)	**659** (88%)	**503** (86%)	**293** (86%)	**257** (82%)
Born in Australia (%)	**1,043** (52%)	**429** (57%)	**429** (73%)	**155** (45%)	**164** (52%)

TABLE 2:

Mode of arrival and pre-hospital delay time for the total hyper-acute sample (N = 1,976) and each subgroup.

Variables	Total sample	Weekdays during hours	Weekdays after hours	Weekends and public holidays during hours	Weekends and public holidays after hours
	N = 1,976 (100%)	**n = 745** (38%)	**n = 581** (29%)	**n = 340** (17%)	**n = 310** (16%)
Arrival by ambulance (%)	1,597 (80%)	598 (80%)	488 (83%)	265 (77%)	246 (79%)
Mean delay Time (hours: min)	1:44 min	1:44 min	1:43 min	1:44 min	1:40 min

were born in Australia (52%, $n = 1{,}043$) (**Table 1**).

ARRIVAL BY AMBULANCE

The most frequent mode of arrival for the total hyper-acute sample was by ambulance (80%) (**Table 2**). There were no significant sub-group differences in mode of arrival, $F(3, 1{,}973) = 2.05$, $p = 0.10$.

PRE-HOSPITAL DELAY TIME

The delay in arrival time for the total hyper-acute sample was 1:44-minutes (**Table 2**). There were no significant sub-group differences for delay in arrival time to the ED, $F(3, 1{,}973) = 0.05$, $p = 0.98$.

DISCUSSION

The results of this study indicate that for patients with ischaemic stroke symptoms there was no variation between *'out-of-hours'* and *'during-hours'* for mode of arrival or delay from symptom onset to ED arrival.

An advantage of this study was its focus only on patients presenting to ED within six-hours of stroke onset, as this is the patient group likely to benefit from hyper-acute stroke treatments.

In addition, this study included analysis of a range of sub-groups (ie. 'weekend', 'after-hours', 'public holiday') to evaluate *'out-of-hours'* effects, which allowed investigation of the multitude of *'out-of-hours'* presentations.

In an era of hyper-acute stroke treatments, public health campaigns have improved community response to early stroke symptoms, including increased use of ambulances for stroke (Mellon et al. 2015; Ragoschke-Schumm et al. 2014). In the study cohort, 80% arrived by ambulance, with a non-significant variation between subgroups (79-83%). This is important as arrival by ambulance minimises pre-ED delay, and increases access to hyper-acute treatments (Evenson et al. 2009). Furthermore, the present study positively highlights that arrival by ambulance is not influenced by the *'out-of-hours'* effect.

Nevertheless, it should be noted that 20% of the hyper-acute presentations cohort did not arrive by ambulance.

Therefore, ongoing public health campaigns and health professionals need to continue to reiterate the importance of the 'FAST' message (Addo et al. 2012).

LIMITATIONS AND FUTURE RESEARCH

This study focussed on the *'out-of-hours'* effect but there may be additional interpersonal factors that influence speed of response to stroke symptoms.

It has been reported that patients presenting to ED during the hyper-acute phase of stroke show greater knowledge of treatments being time-critical and higher education levels (Duque et al. 2015), as compared to patients who present later. Conversely, identified personal factors for not initiating an emergency response during the hyper-acute phase of stroke include emotions of fear or denial, and not wanting to inconvenience other people (Mackintosh et al. 2012).

This highlights the need for further research, investigating educational and personal factors influencing decision-making for initiating an emergency response to stroke symptoms.

This would provide greater understanding and clarity of the barriers and enablers influencing rapid access to EDs for patients with ischaemic stroke in the hyper-acute phase.

Furthermore, future research investigating access to EDs for patients in non-metropolitan regions would provide a more comprehensive analysis of the *'out-of-hours'* effect. With increasing use of telemedicine for stroke there are opportunities for smaller or non-metropolitan EDs to provide hyper-acute treatments (Cadilhac et al. 2014). However, benefit of these treatments will continue to rely on timely arrival of patients to the ED.

CONCLUSION

An *'out-of-hours'* effect has been proposed as a potential barrier to timely access to hyper-acute treatments for stroke. This may be explained by multiple factors in service delivery; however, in respect to mode of arrival and delay in initial arrival time to ED, this study found no evidence to support a pre-hospital *'out-of-hours'* effect.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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Accessibility – a pivotal factor in maternal and neonatal outcomes

By Geoffrey Clark, Christopher Rouen, Karen Yates and Caryn West

Australia is one of the safest countries in the world in which to give birth or to be born. Despite this, women in rural areas continue to experience higher rates of maternal mortality (Kildea et al. 2008) and fetal and neonatal deaths (AIHW 2005).

Aboriginal and Torres Strait Islander women are three times as likely to die as non-Indigenous women, with a maternal mortality ratio of 16.4 deaths per 100,000 Indigenous women giving birth (AIHW 2014). Women also express dissatisfaction with the absence of choice in both rural and metropolitan areas (Department of Health 2009).

The spatial configuration of health services is known to influence their uptake. It has also been demonstrated that better access to health services and skilled practitioners is one of the keys to improving maternal mortality ratios and neonatal outcomes (Department of Health 2009).

Access is, nonetheless, a rather complex concept and the term is often used interchangeably with coverage or utilisation.

The ability to use services when they are needed is associated with factors related to both service provision and service usage - ie. to supply and demand factors (Gulliford et al. 2002).

On the provision side, there has to be an adequate supply of quality services that are efficacious. To what extent a person uses a service however depends on many factors. Rogers et al. (1999) defined optimal access as providing the right service at the right time in the right place. Physical accessibility to services is one measure of accessibility. Even if services are physically accessible, they may not be culturally appropriate or may not be able to provide services when needed due to capacity issues.

Queensland has three out of the top 10 most populous Indigenous Regions (IR), with the Torres Strait IR having the highest proportion of Aboriginal and Torres Strait Islander persons (81.8%) of all IRs in Australia, Cape York having the seventh-highest proportion at 55.8% and Cairns – Atherton IR having 3.8%.

In 2017 Aboriginal and Torres Strait Islander women in Queensland gave birth to 6,548 infants which accounted for 10.7% of all Queensland births (ABS 2017).

Although maternity services in Queensland are designed to offer women the best care, they largely reflect modern western medical values and perceptions of health, risk and safety with little or no incorporation of the Indigenous world view, which incorporates not just physical wellbeing, but also the social, emotional and cultural wellbeing of individuals and the whole community (Kildea 2016). This can impact on accessibility for Aboriginal and Torres Strait Islander women, particularly those in rural and remote areas such as Cape York and Torres Strait.

An imbalanced access to healthcare services can be a cause of inequality in health outcomes and is therefore important to identify (Wang 2012).

Using geographic information systems, physical accessibility can be quantitatively measured to appraise the spatial configuration of opportunities in obtaining services and the geographic disparity of such opportunities (Wang 2012; Guagliardo 2004).

In 2018, closure of maternity services and an associated community backlash prompted the Queensland government to create the Rural Maternity Taskforce.

The taskforce is to advise on the safety of current rural maternity services in Queensland and identify steps that will minimise risk for mothers and babies in rural and remote communities whilst providing services as close as possible to where they live (Queensland Health 2018).

To support optimal access to maternity services in Far North Queensland, a project is in design to develop a specific fit-for-purpose accessibility metric using a spatial modelling method. The data obtained will not only assist in improving services for consumers, it will also support the effective allocation of resources whilst balancing the healthcare needs of urban and rural populations.

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Reducing catheter associated urinary tract infections

One of the most common infections occurring in hospitals are urinary tract infections, with approximately 1% of admitted patients acquiring this infection in Australia- or 71,000 cases per year. (Mitchell et al. 2016; Mitchell et al. 2017).

By Brett G Mitchell

A large proportion of these are associated with the insertion, care and or maintenance of urinary catheters – also referred to as catheter associated urinary tract infections (CAUTIs).

Urinary catheter use is also very common, with 25% of patients in an Australian hospital on any given day having a urinary catheter (Gardner et al. 2014).

Strategies to prevent CAUTI are therefore important, not only because of their frequency, but also because:

- they contribute to an increased length of stay in hospital (Mitchell et al. 2016);
- treatment is and will continue to become more difficult, with increasing antimicrobial resistance (Fasugba et al. 2015; Fasugba et al. 2016) and,
- the incidence of CAUTI can be reduced through a program of work (Saint et al. 2016).

There are some elements of catheter care where the evidence is less clear. Cleaning the meatal area prior to urinary catheter insertion is an important step in the insertion process, but which agent is most appropriate- saline or chlorhexidine?

The evidence base to answer this question is unclear, as evidenced in a systematic review (Fasugba et al. 2016).

This gap in evidence has led to different recommendations in guidelines, hospital policies and clinical practice.

To address this question, we undertook a stepped wedge randomised control study in three Australian hospitals.

The aim of the study was to determine the effectiveness and cost-effectiveness of chlorhexidine 0.1% (sterile) solution, compared to normal saline.

Brett G Mitchell

Full details of the study approach taken have been published (Mitchell et al. 2017).

In this study, all hospitalised patients who received a urinary catheter received either saline (control) or chlorhexidine (intervention) for meatal cleaning as part of catheter insertion practice.

The primary outcomes for the study were the incidence of CAUTI and catheter associated asymptomatic bacteriuria (CA-ASB) and the cost-effectiveness of the intervention (Mitchell et al. 2017).

After the introduction of chlorhexidine, we identified a 94% reduction in the incidence of CAUTI (0·06, 0·01–0·32; p=0·0008) and a 72% reduction in the incidence of CA-ASB (IRR 0·26, 95% CI 0·08–0·86; p=0·026) (Fasugba, 2019).

Using cost-effectiveness analysis, we then modelled the changes in health cost associated with the introduction of chlorhexidine (ie. switching from saline).

A switch to chlorhexidine was found to be cost-effective and cost saving.

On average, the use of chlorhexidine was estimated to save hospitals AUD$387,909 per 100,000 catherisations and release valuable bed days as a result of a reduction in infection.

Full results on the cost-effectiveness analysis have been published (Mitchell et al. 2019).

There were no reported adverse events in patients who received chlorhexidine.

All three hospitals (large public hospital, a large private hospital and a regional hospital) saw reductions in both CAUTI and CA-ASB following the introduction of chlorhexidine. Furthermore, even after the additional cost of using chlorhexidine (compared to saline) and using conservative estimates (we only modelled the effect on

CAUTI), the switch to chlorhexidine was cost effective and cost saving.

If reductions in CA-ASB were also included in our cost effectiveness model, further cost savings and benefits, would be expected, through a reduction in antimicrobial consumption.

In the era of antimicrobial resistance, any reduction in antimicrobial use should also be welcomed.

Potential limitations in our study include a Hawthorne effect*.

This is potentially mitigated by any communication with staff just focussing on a change of product.

In addition, we saw a reduction in infection both CAUTI and CA-ASB in all three hospitals, immediately after the intervention commenced.

The nature of the stepped wedge design also meant that the timing of the intervention was staggered and potential confounders such as case-mix are controlled.

There is now high quality evidence suggesting that hospitals and health services should modify their guidelines, to reflect the use of chlorhexidine for meatal cleaning, prior to urinary catheter insertion.

Funding: The study was supported by grant from the HCF Foundation.

Study team: Professor Brett Mitchell, Dr Oyebola Fasugba, Professor Allen C Cheng, Victoria Gregory, Professor Nicholas Graves, Dr Jane Koerner, Professor Peter Collignon and Dr Anne Gardner.

* *The Hawthorne effect* refers to a phenomenon in which participants alter their behaviour as a result of being part of an experiment or study.

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AGED CARE

Age Friendly Communities – achieving positive outcomes by working together

By Mark Jones, Lorna Moxham, Justin Placek and Toby Dawson

Across a broad scope of global challenges the decade from 2020 to 2030 represents a decisive time. It will, in many respects, be a time for action, one where we have the chance to formulate concrete solutions and enact strategies to ensure we all live well, longer.

Ageing and all that is associated with it, is indeed one of the greatest global challenges. Let's be clear - the proportion of people 55 years and over in the current Australian population is 1:4 but over the next few decades this will be 1:3.

Drilling this down to a more local level, across the Illawarra it is estimated there will be an increase of 40,000 persons aged 70+ over the next 20 years. We also know that the majority of people still age in place and only 5.4% are in retirement villages.

This tells us that ageing is an issue for everyone and isn't just the business of the 'aged care industry'. Just like the proactive approach to patient discharge, which is actually considered on patient admission; ageing issues (positive and negative) need to be considered before we age and they need to enhance inclusion.

The World Health Organization (WHO) reminds us that a key strategy to facilitate the inclusion of older people is to make communities more age friendly. Age friendly communities enable all people to actively participate in activities whilst treating everyone with respect, regardless of their age.

Age friendly communities are places that make it easy for older people to stay connected to people that are important to them, and are environments that help people stay healthy and active even at the oldest ages (WHO).

Age Friendly Illawarra (AFI), which is working across four council areas, is being proactive and thinking about ageing. AFI is an alliance that aims to create opportunities for older people to lead active, engaged lives and contribute positively to Illawarra communities. The eight domains of an age-friendly community provided the framework for AFI. These domains are outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information and community support and health services.

AFI is made up of business, government and community organisations working to drive social, civic and employment participation by Illawarra seniors and access to transport, housing and support services.

One of the ways that AFI is working to raise awareness and progress the concept of aged friendly communities is to develop toolkits in relation to 'How age friendly is your establishment?' and 'How age friendly is your event?' These toolkits are being developed in consultation with Age Friendly Illawarra members and the community and are based on the principles of the WHO's Age Friendly Cities guide with ideas from network members across the globe.

AFI knows that better outcomes come when people work together and collaborate. If you want any information you can email **contact@agefriendlyillawarra.org**

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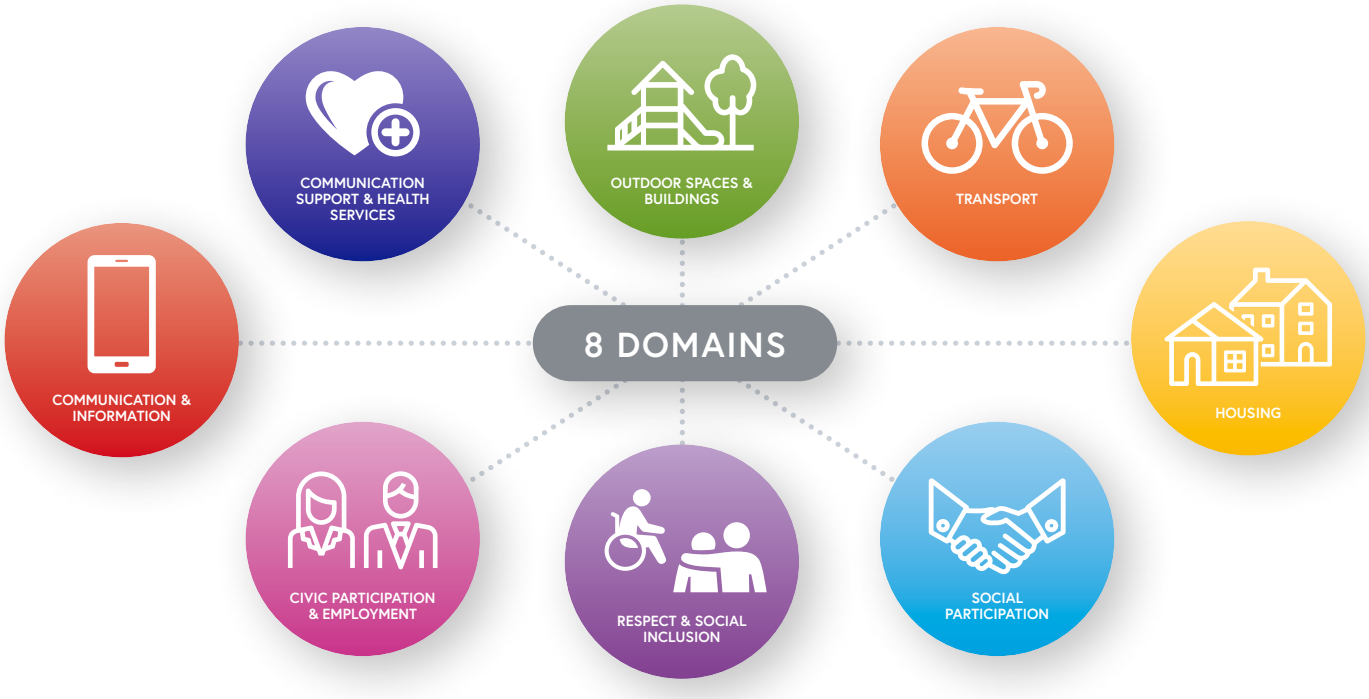
WHO – who.int/ageing/age-friendly-world/en/



The referral: 'Please fix this out of control, dementing aged diabetic'

By Trisha Dunning AM and Jane Speight

Clinical referrals need to be succinct and specific, identifying both the presenting problem and the purpose of the referral. The words in this referral may be succinct but they beg the question: 'Who or what to 'fix'?

The referring clinician was imprecise and used negative, demeaning, stereotyping language and, consequently, did not communicate effectively.

The referral reflects ageist attitudes, elderspeak and stereotypes of older people, and pervasive prejudice. Ageism has no place in a quality healthcare system (Sims 2016). In addition, the referral implies negative attitudes about the so-called 'challenging behaviour' of people with diabetes and dementia, which actually says more about the clinician's challenges than those of the person with diabetes/dementia.

Conversely, person-centred language emphasises the person first: eg. a person with diabetes/dementia. Importantly, it avoids paternalistic language, eg. 'fix' and 'control'.

Effective communication is essential to safe, quality care and is embodied in the Australian Commission on Safety and Quality in Health Care Standards (2017). Significantly, the language and words clinicians use often label people and impair the therapeutic relationship and outcomes (Fick and Lundenbjerg 2017).

Respecting an individual's dignity, personhood and autonomy is essential to therapeutic relationships, shared decision-making and personalised care planning.

Respect involves knowing the person, choosing words carefully, being mindful of body language, and above all, listening. Clinicians give people they respect more information than those they do not respect (Beach et al. 2014).

Further, clinicians' words can provoke a range of behavioural responses from people with diabetes and/or dementia. We wonder whether the clinician would choose other words if addressing the letter to the person rather than the consultant, which is now considered best practice (Academy of Royal Medical Colleges 2018).

Significantly, older people's life and illness narrative/story usually differs from clinicians. Clinicians tend to focus on the 'disease or diabetes narrative' and use the diabetes dialect, which is often negative and judgemental (Dunning et al. 2017; Dickinsen et al. 2017; Speight et al. 2012), as the referral clearly illustrates.

So – have you thought about the words you use when speaking with or about an older person with diabetes/dementia, today?

Resources that can help clinicians choose their words wisely include Diabetes Australia's language position statement (Speight et al. 2012), Dementia Australia's language guidelines (Dementia Australia 2018), and the Declaration on Patient-Centred Healthcare (IAPO 2006).

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Listening to older people and valuing their personhood

By Rebekkah Middleton

In a busy environment such as health, we often feel a sense of being rushed and an inability to spend time with people to really listen and respond to their needs.

With an ageing population, where one in seven people are aged over 65 (AIHW 2018), it is certain that we will have many encounters with older people in our health settings. So how can we have meaningful interactions where we listen to and value older people? How can we contribute to helping older people maintain a sense of personhood (Tanner 2010) when in healthcare environments that can challenge their identity and autonomy as a competent and independent adult?

Autonomy encompasses having control and choice (Ryan et al. 2008). By recognising autonomous personhood, we establish the human rights of the individual and also our responsibility to deliver ethical healthcare (Smith 2016).

For the older person, autonomy can be (or feel) removed through various means in the healthcare process. Person-centred approaches and practices in nursing and midwifery are critical to delivering ethical, safe and compassionate care where personal autonomy is valued.

When this occurs, person-centred approaches in our practice ensure we develop and enhance effective workplace cultures (Manley et al. 2011).

When considering older people, Hess et al. (2011) found in their research that the quality of older people's experiences were founded in their care experience and the communication they had with healthcare providers. So our challenge as healthcare providers is to move towards person-centred care, a practice that explicitly requires that we see *people*, not patients or clients.

This can mean suspending judgements, beliefs and attitudes in order to develop care that promotes healing (McCormack and McCance 2010). McCormack and McCance (2010) also acknowledge that the provision of truly person-centred care can feel thwarted by structural elements of our healthcare systems, which leads to our frustration as healthcare providers. One of these elements is the 'busyness' we experience daily. Despite this, we have a responsibility as health professionals to listen actively to older people. This will thereby promote and support a sense of autonomy, feeling valued and maintaining personhood in this population which not only is increasing, but has much to contribute to our own learning.

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Diagnostic accuracy of Delirium Assessment Tools in Critical Ill Patients

By Mu-Hsing Ho, Amy Montgomery, Kevin Shu Leung Lai, Kee-Hsin Chen, Hui-Chen Chang and Victoria Traynor

SYSTEMATIC REVIEW AND META-ANALYSIS: ABSTRACT

Aims: To evaluate and compare the diagnostic performance of the confusion assessment method for the intensive care unit (CAM-ICU) and the intensive care delirium screening checklist (ICDSC) in diagnosing delirium in critical ill patients.

Methods: PubMed, Embase, CINAHL databases were searched for studies published in English or Mandarin up to December 2018. The meta-analysis was limited to studies in the ICU settings, used the diagnostic and statistical manual of mental disorders (DSM) as a standard reference to test the diagnostic accuracy of delirium assessment tool. Two investigators independently assessed study eligibility and extracted data. Bivariate random effects meta-analysis models were conducted for pooling and comparing diagnostic performance. The outcomes assessed were pooled sensitivities and specificities, summary receiver operating characteristic curve (sROC), the area under the curve (AUC), and diagnostic odds ratio (DOR). The possibility of publication bias was evaluated using Deek's funnel plot in Stata software.

Results: Of 29 studies met the inclusion criteria of which 23 and eight focus on CAM-ICU and ICDSC, respectively. The pooled sensitivities of 0.85, 0.87, and pooled specificities of 0.95, 0.91 for CAM-ICU, ICDSC respectively. The AUC of the CAM-ICU was 0.96 (95% CI, 0.94-0.98), with DOR of 99 (95% CI, 55-177). The AUC of the ICDSC was 0.95 (95% CI, 0.92-0.96), and the DOR was 65 (95% CI, 27-153).

Conclusions: Both CAM-ICU and ICDSC performed high accuracy, good sensitivity and excellent specificity. However, the CAM-ICU demonstrated a better diagnostic accuracy and is recommended for the most specific and comprehensive delirium assessment tool.

Keywords: delirium; critical care; intensive care unit; CAM-ICU; ICDSC

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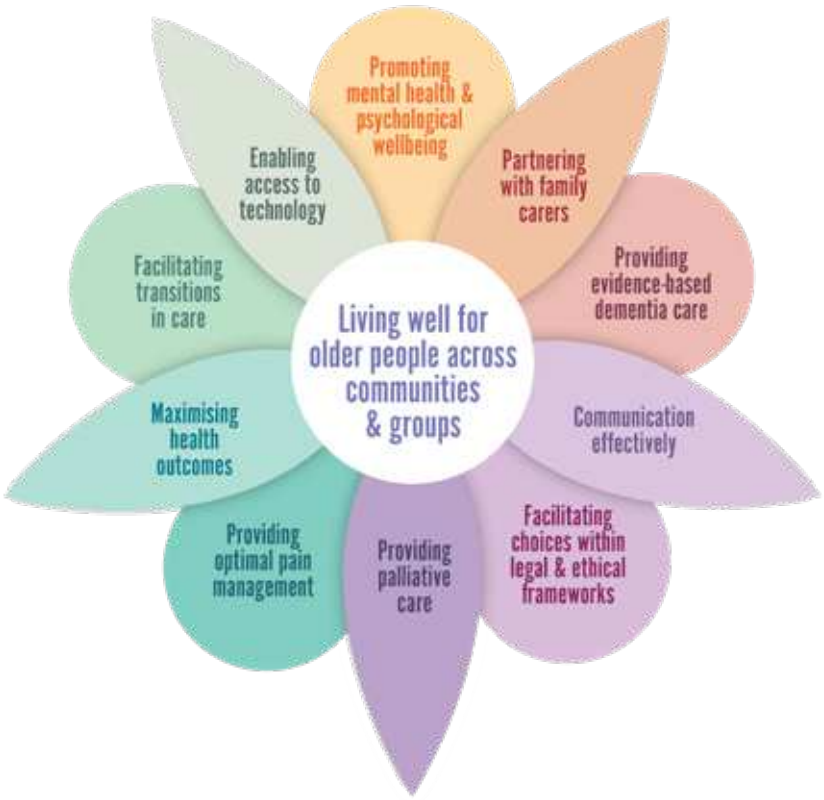
Amy Montgomery and student

Evaluation of the implementation of the Gerontological Nursing Competencies

By Nicole Britten, Victoria Traynor, Jolan Stokes and Lynn Chenoweth



BACKGROUND

The paper presents the results of implementing the Gerontological Nursing Competencies (GerNurs Competencies) with registered nurses (RN's) working in residential care.

The development of the GerNurs Competencies was previously discussed in the February 2018 issue.

This research is timely considering the crisis in the care of older people across the world and questions about how to recruit and develop a skilled workforce and retain staff to deliver effective and consistent care to older people.

In 2019, the percentage of RN's working in aged care has decreased by more than 6% since 2003 (Australian Ageing Agenda 2019).

METHODS

This was a multi-method study undertaken within the five* organisations of the Nursing in Aged Care Collaborative (NACC). Participants were RN's and managers working in residential aged care in Australia. Participants were mentees (n=32) who used the GerNurs Competencies to develop a portfolio of evidence and mentors (n=16) who guided them in the process. The data were online surveys (five rounds) used during the implementation and focus groups (n=20) at the completion.

Descriptive statistics were generated from the surveys and thematic analysis from the focus groups.

RESULTS

The mean response rate for the surveys was 66% (±34) (Rounds 1-5).

The survey findings indicate that the implementation of the GerNurs Competencies was a positive experience for mentees and mentors. One respondent reported 'it gave me some guidance to go through, ensuring maximising health outcomes'.

There was overwhelming support for the accompanying documentation.

Mentees agreed (88% ±10) that it helped them articulate their gerontological nursing career path and mentors agreed (87% ±8) that it helped them guide the mentees to focus on their clinical roles. The themes identified were:

1. Achieving competence in practice: Individual development;
2. Realising leadership responsibilities;
3. Articulating the role of a new graduates and early career nurse in aged care;
4. Guiding mentoring activities is crucial; and
5. Embedding a strategic approach to recruitment, retention, education and quality strategies. One respondent reported they could use it 'when you recruit people, picking questions that you ask at the interview from the competencies'.

CONCLUSION

The implementation of the GerNurs Competencies was a success for both mentees and mentors. We are currently implementing the GerNurs Competencies into other aged care providers.

The University of Wollongong are now working with aged care providers to incorporate the GerNurs Competencies into new graduate/early career RN education module for the aged care sector. The GerNurs Competencies are available on the Ageing and Dementia Health Education and Research (ADHERe) website **adhere.org.au**

** Anglicare, BaptistCare, HammondCare, Scalabrini and Uniting*

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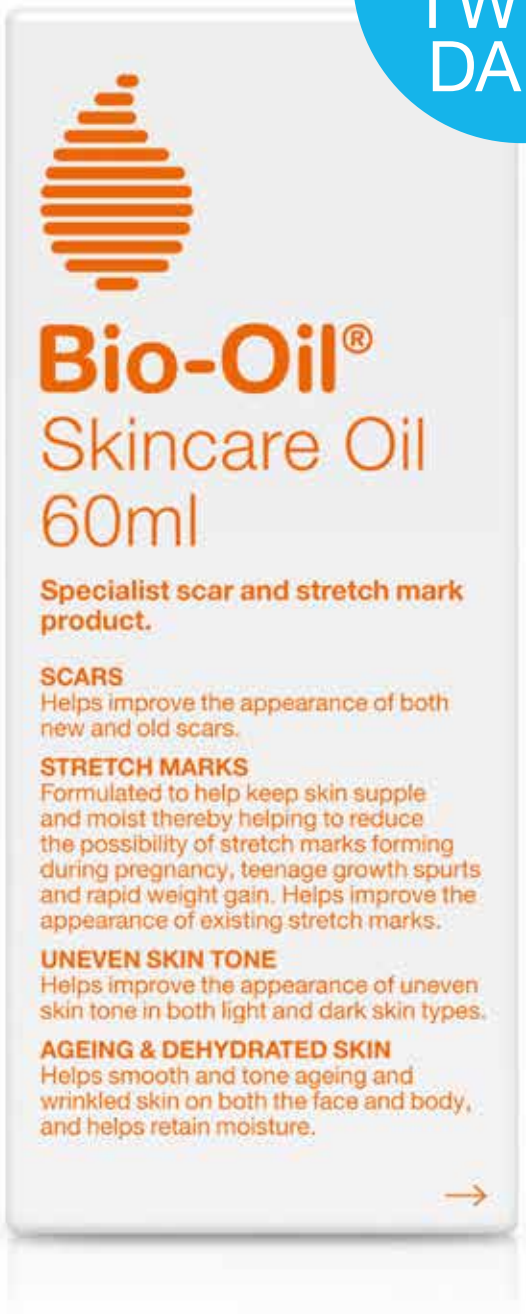

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Trialling an option for the frail elderly to attend to their own hygiene safely at home

By Vickie Archer, Helen Murray, Wendy Smith and Cate Nagle

On conclusion of their Transition Care program, many recipients regain their full independence with bathing however, others remain dependent on the assistance of another person to attend to their personal hygiene needs.

WHAT WE KNOW:

Bathing wipes are available as pre-packaged disposable washcloths that contain a quick drying cleansing emollient. No other equipment is required and personal hygiene can be undertaken anywhere that is convenient to the user.

Studies have concluded that bathing wipes have a positive effect on skin hydration and are equally as effective as traditional bed bathing methods at cleaning the skin.

The use of bathing wipes negates the risk of wet bathroom floors and thus reduces the risk of falling in this vulnerable population. They may also negate the need for expensive bathroom modifications such as grab rails.

WHAT IS THE PROBLEM?

Society's long-held traditions, rituals, and perceptions of bathing practices delivered both in hospital and in the community, are limiting consumers of aged care services exploring other potentially autonomous and sustainable options for achieving all over basic skin care hygiene after discharge and in the longer term.

WHAT ARE WE DOING TO RESOLVE THE ISSUE?

At Townsville Hospital and Health Service, a team led by Transition Care program Clinical Nurse, Vickie Archer, has initiated a study to explore the enablers and barriers to frail elderly persons using bathing wipes to assist with their hygiene in the community setting. Townsville Transition Care program recipients are given the opportunity to experience firsthand, in their own home, an alternative new way of attending to their own personal hygiene using the same product that nurses' use in the hospital setting. Using a descriptive exploratory design, the study is exploring the views, experiences and preferences of Transition Care program recipients and those of their health workers towards the use of bathing wipes.

Vickie Archer, Clinical Nurse, Transition Care Program explaining the study to Rohan Betcher, Unit Manager Sub Acute Unit, Townsville Hospital

WHAT IS THE SIGNIFICANCE OF THIS STUDY?

This is novel research; there is a paucity of peer reviewed publications exploring the experiences of frail, elderly persons using bathing wipes to assist with personal hygiene in their own homes. An evaluation of the acceptability and utility of bathing wipes is required as they have the potential to provide an alternative, safe, cost effective bathing option for vulnerable members of the community. Additionally, if bathing wipes are positively evaluated, providers of Australian government subsidised aged care packages may be able to spread their allocated care hours/dollars further on other aspects of their community support.

Authors

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Let's reflect on the fall

By Vanathy A David, Joanne McLoughlin, Miriam Nonu, Denise Edgar, Valerie Wilson and Victoria Traynor

Hospitals are places where one comes for treatment and, a place where people should feel safe.

Healthcare professionals have a vital role as patient advocates, providing a safe environment for our clients. Nonetheless, the hospital can be a risky place for older people.

Falls-related injury is one of the leading causes of morbidity and mortality in older Australians, with 40% of injuries in acute care attributed to falls (Oliver 2004). Healthcare professionals are very diligent in assessing the risk for falls and implementing the multiple prevention strategies to prevent falls, but patients are still falling and being injured.

Injuries from falls can be detrimental for the older people and can cost them their life. There is a common question whether; these strategies are having an impact on preventing falls in acute care.

Recently, a Cochrane systematic review of 41 clinical trials of studies to reduce falls in elderly residents of nursing homes, long-term care facilities and hospitals, outlined that the overall effect of multifactorial interventions on fall reduction was inconclusive (Cameron et al. 2010).

Nurses and patients themselves play a vital role in preventing falls in acute care (Chang et al. 2004).

Empowering staff and the patients to become active participants and partners in fall prevention during hospitalisation could be a solution to prevent falls in hospital. Reflection plays a pivotal role in the development of self-awareness, ability to influence others and increase the interpersonal skills among nurses (Somerville and Keeling 2004). Moreover, evidence suggests that many health professionals fail to reflect on their own practice, which can potentially contribute to errors (Stein 2003). There is a paucity of research around utilising a reflective model for nurses and patients to prevent falls. Reflection post fall will enable nurses to explore their own accountability in the events and ways to prevent the incident from occurring again (Hoke and Guarracina 2016).

The proposed study hypothesis, using a reflective model by the staff and the patients post fall will create a deeper understanding and insight into the event and help highlight potential measures taken to prevent the future incidents (Maclean 2006).

This study will use an action research approach following the Plan-Do-Study-Act (PDSA) model as clinicians are very familiar with this process and the concept is easy to explain to patients.

The aim of the study is to minimise falls by involving staff and patients in taking action through critical reflection of what has occurred (leading up to and during the fall), developing ideas about how things could be safer, implemented a number of these ideas and evaluating them to see what works in reducing falls.

This study is also aimed more broadly at culture change for which an action orientated approach through use of evidence is best suited as it engages people in looking at their own practices and enables them to create potential solutions for 'real problems' in this case, falls.

Three wards at Wollongong Hospital are participating in the project. These wards had high incidence of falls and were keen to decrease their falls rate. The study is conducted in three phases.

Phase 1 is initial data collection, engagement sessions;

Phase 2 is giving staff and patients an opportunity to reflect on their falls incident, and

Phase 3 focused on feedback from Phase 2 and code signing the solutions with the staff on the individual pilot wards.

We are currently in Phase 3 working towards exploring the solutions and looking at opportunities to implement these solutions to prevent falls on the pilot wards.

This project idea has won ROSCARS award in 2018.

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Solving the Delirium Puzzle

By Amy Montgomery, Victoria Traynor, Hui Chen (Rita) Chang and Peter Smerdely

Delirium is a highly prevalent medical condition, with up to 50% of older hospitalised patients developing the condition.

Despite the high morbidly and mortality of delirium, it is often under recognised. Through our years in aged care, we have witnessed the gap between evidence-based research and delirium care. This gap is often due to a lack of knowledge, negative attitudes and a misconception that confusion is a normal part of ageing.

Finally, with the release of the Comprehensive Care Standard by the National Safety and Quality Health Service (NSQHS) (2019), delirium is getting much needed attention. This new standard now mandates delirium screening for all at risk patients and the development of individualised care plans. These mandated requirements will require addressing the existing knowledge gap on delirium assessment and management.

However, due to the complexity of delirium, it requires more than just a one-hour face to face session, which is the main form of teaching in the hospital setting.

Our aim was to develop an education program that was feasible to be delivered to nursing staff during their normal inservice time.

The education program that has been designed is an innovative multi-modal delirium education program. The innovative part of the program being hands-on simulation using objective structured clinical examinations (OSCEs).

OSCEs are becoming common place in the undergraduate setting but are rarely used in postgraduate level nursing. Simulation, such as OSCEs, provide a safe environment to reinforcement of learning and to relate theory to practice.

The education program consists of the following:

- face to face sessions with a booklet resource,
- online learning activities,
- OSCE and
- reflection exercise.

The four components require a total of two hours and can be broken up into individual sessions. The OSCE scenarios can be developed and adapted to any clinical speciality.

We have conducted this education program across aged care wards at three different hospitals. With the results highlighting an increase in participants self-perceived confidence and competence in their knowledge and assessment skills of delirium. And we have demonstrated that the knowledge gained is translated into clinical practice. The project and data collection has expanded to non-aged care wards.

Amy Montgomery, Victoria Traynor and Hui Chen (Rita) Chang

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Early career researchers in aged care: International connection and support

By Karen Rennie and Kelly Marriott-Statham

In late 2017 we were both sitting in a large room, strangers, and about to start a PhD. Commencing a PhD in nursing was an exciting, yet a daunting prospect for us both.

Before starting our doctoral journey, we had heard a PhD can be a hugely rewarding undertaking, but can be intertwined with loneliness and isolation. However, for us this hasn't been our experience. We have found that a strong connection with another individual during a doctoral journey can enhance support, social learning and immense knowledge exchange. We want to share our story of how a positive and supportive relationship can really help an individual with their PhD research.

Additionally, what makes our story unique is that our support and connection flourishes despite being on opposite sides of the world.

Both of us are currently progressing with our PhD at Queen Margaret University, Edinburgh within the Centre for Person-centred Practice Research. Nervously starting our doctoral journey on the same day sparked conversation, and we soon realised we had common interests in person-centredness and in the care of the older person.

Karen is from Edinburgh and is doing her PhD full-time over three years exploring sexual expression in peope living with dementia and the impact on nursing care.

Kelly is a part-time PhD candidate doing her studies by distance, living and working in New South Wales, Australia.

Kelly's PhD will be exploring shared decision making between the nurse and the older person within residential aged care facilities.

We quickly realised that even though our PhD topics are different we share similar values and vision. Our shared passion for the care of the older person, including people living with dementia, had drawn us both to nursing practice in aged care and then inevitably to research. We both agreed that our clinical practice experiences demonstrated how rewarding, valuable and challenging it is to work within the aged care sector and with older people.

There is a huge need for more research in providing person-centred care for the older person and individually, this was a major reason for us both commencing doctoral studies. We both are passionate about dignity in care and person-centred practice with older people.

As we anticipated there are many highs and lows whilst undertaking research and having support is fundamental. We often will call on each other for support. Even though we only get together once or twice a year in person, we connect virtually on video platforms and through emails to share our experiences, challenges and celebrations. We always share what we are learning and have critical discussions about nursing and person-centred practice, philosophy, research methodologies, challenges and struggles with research.

Kelly visits Edinburgh to engage with other doctoral candidates in the person-centred Student International Community of Practice (SICoP) twice a year to share and learn about person-centred research.

But as a change of scenery for us, Karen recently was able to visit Australia and see the aged care context here after being awarded some funding. Karen engaged with the University of Wollongong, NSW, during her stay to share her research and connect with the nursing and doctoral community.

During Karen's visit down under, we were able to collaborate on preparing and delivering meaningful workshops for an aged care facility. We recognised that there was a strong overlap between our research and passion and that we could combine forces to deliver meaningful messages to nursing staff working in aged care.

We discovered that working together enabled us to have a bigger impact in getting our shared passion and vision across, right at the aged care coalface. Learning from each other's experiences and research seemed to strengthen our own individual research projects and is contributing to our learning and development as new researchers. We attended a heart-breaking community forum lead by the Royal Commission into Aged

Kelly Marriott-Statham and Karen Rennie

Care Quality and Safety, which just further ignited our fire to fulfil our research goals and bring practical solutions to the aged care sector in Australia.

Our PhD journey has been strengthened and shaped by our connection with one another, and this has been so meaningful for us. Our anticipated lonely doctoral journey has instead ended up being one of hope; hope that this connection will give us a louder voice to make thoughtful and meaningful change to care in the aged care sector. Today we aren't strangers, but two early career researchers full of hope!

After all, two heads are better than one! We want to finish our story with an inspirational quote from a famous actor. We feel that his words portray an important message that gets to the heart of our experience and can strive us to continue to work together. His famous words are: "Together we are stronger, our voices are louder and the synergy of our actions more powerful" Pierce Brosnan.

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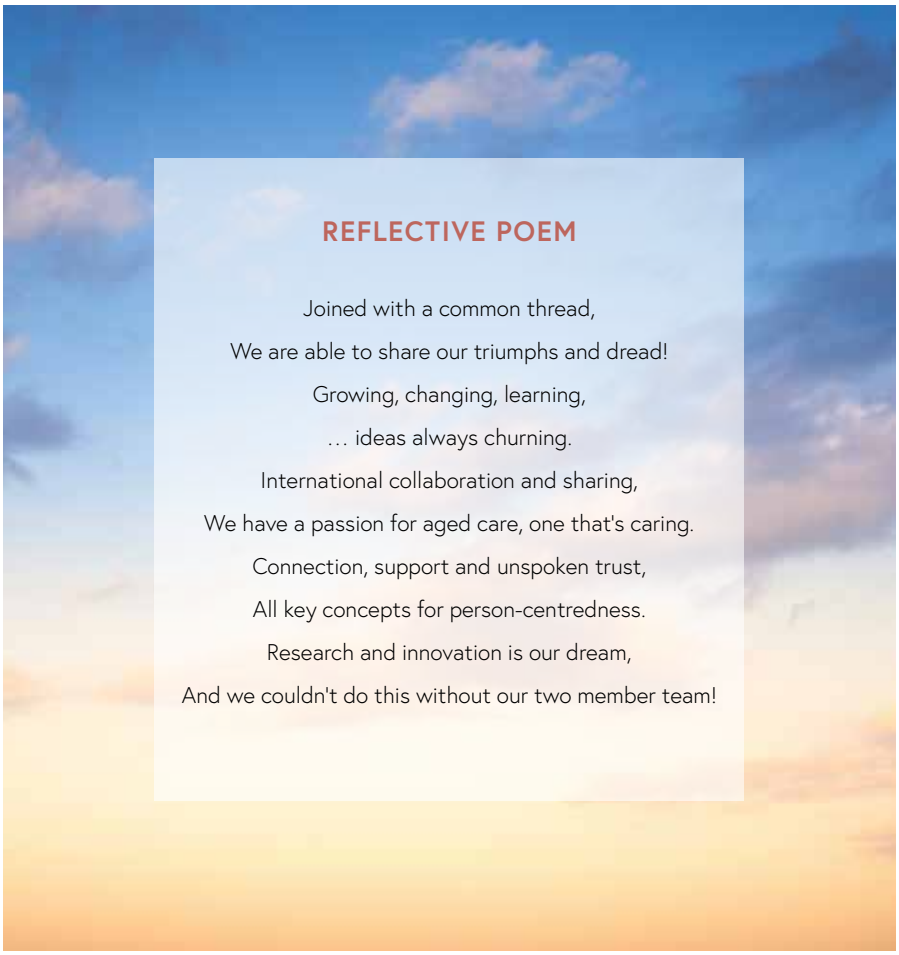

REFLECTIVE POEM

Joined with a common thread,
We are able to share our triumphs and dread!
Growing, changing, learning,
… ideas always churning.
International collaboration and sharing,
We have a passion for aged care, one that's caring.
Connection, support and unspoken trust,
All key concepts for person-centredness.
Research and innovation is our dream,
And we couldn't do this without our two member team!

Understanding the practice of 'Specialling' older people with cognitive impairment in hospital by using Concept Analysis

Miriam Anne Coyle

By Miriam Anne Coyle, Valerie Wilson, Samuel Lapkin and Victoria Traynor

Population ageing is a success story of our time. Unfortunately healthcare, especially in hospitals has been slow to adapt to the changing needs of the community.

When in hospital the care planning can be focused on safety concerns which can devalue older people and fail to provide them with dignity and choice, especially when there are signs of cognitive impairment such as dementia or delirium. Delirium is a common adverse outcome for the older person in hospital due in part to the challenges of complex treatments and the busy environment.

For the older person with dementia and/or delirium in hospital the experience can be frightening. Family and staff are impacted too as safety concerns are real for the person who is confused, possibly disoriented and who may have hallucinations, compounding their capacity to understand and navigate the unfamiliar care environment. In hospitals a common 'go-to' for nurses to manage the safety risks is the practice of 'specialling', the provision of one-to-one care. The use of 'specials' however lacks evidence, and the costs are escalating. As a topic important to the role of Dementia Delirium Clinical Nurse Consultant and an area needing further research a concept analysis was undertaken with the goal of developing a research focus.

The literature search for the concept analysis evidenced international interest in 'specialling'.

The method used was Rogers evolutionary concept analysis which recognises how concepts can adapt overtime, causing them to become vague (Rodgers & Knafl 1993). Rodgers' recommended eight activities provided a means to understand the attributes, antecedents and consequences of the concept to develop a contemporary definition. The attributes required data explaining what 'specialling' looked like and how the term was used by the journal articles and the other sources obtained. The antecedents explained the 'what happened before?' and the consequences 'what happened after?' By exploring these aspects of the concept knowledge gaps and clinical challenges became evident.

Concept analysis provided focus in a complex topic. Overall it was evident the practice of 'specialling' lacked person-centred approaches, important to dementia and delirium care. Also, the opportunities for nursing leadership emerged. The definition determined through evolutionary concept analysis will provide opportunity for shared understanding of what is meant by the term 'special' and a guide for reflection as clinicians and researchers consider what the older persons care needs are, and whether 'specialling' will be beneficial to them.

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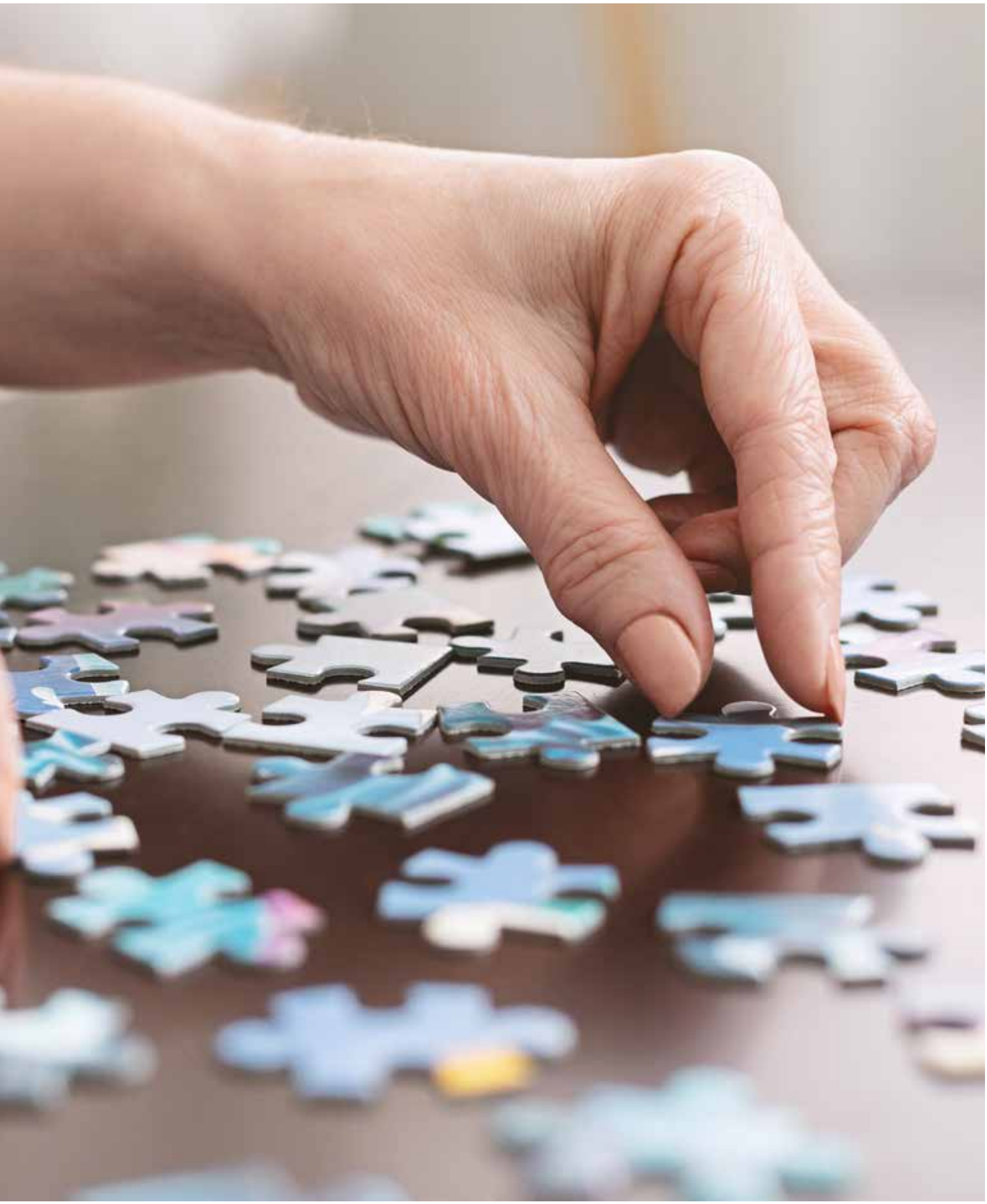

What Assistant in Nursing (AIN) employment in aged care can teach our nursing students

By Maricris Algoso, Lucie Ramjan, Leah East and Kath Peters

The Australian aged care sector has recently been the subject of widespread public concern in relation to the quality of care being provided to older Australians.

Reports of substandard care practices and elder abuse have sparked a Royal Commission into the quality of care being provided to residents. In addition to a funding deficit that places restrictions on resources necessary to provide quality care, a comprehensive report by the Australian Nursing & Midwifery Federation (2016) has emphasised that issues in staffing ratios and skills mix are among the primary concerns plaguing the aged care sector, and that the consequences of these issues strongly relate to patient safety.

The aged care sector in Australia is staffed primarily by Assistants in Nursing (AINs) or Personal Care Workers/Attendants (PCW or PCA), comprising 68.2% of the aged care workforce (Willis et al. 2016). These nursing assistants play a valuable role in the delivery of direct care, promoting the health and wellbeing of residents in their care (Burrow et al. 2017).

The nursing assistant workforce in aged care includes nursing students enrolled in undergraduate nursing programs who are working towards becoming registered nurses. This subgroup of nursing assistants are through formal tertiary education, obtaining the necessary nursing knowledge and skills required of an entry level registered nurse. This subgroup, commonly referred to as undergraduate AINs, have the potential to alleviate some of the strain on the aged care workforce through improved skill level and skill mix.

Undergraduate nursing students typically find aged care nursing unappealing due to the lack of resources and heavy workloads (Gillespie 2013; Abbey et al. 2006; Henderson et al. 2008). Despite the negative perceptions of aged care nursing among students, results from the *Preparation for Clinical Practice* survey distributed to new graduate registered nurses, who were previously employed as undergraduate AINs in the aged care sector, revealed that fundamental nursing skills (assisting residents with activities of daily living) were consolidated through work experience in aged care.

Humanistic nursing skills were also enhanced through work experience in aged care facilities as the survey results revealed the development of emotional literacy, which related to navigating human relationships (Algoso et al. 2018). Other essential nursing skills that nursing students developed in aged care were managing complex patient needs, and the confidence to provide education to residents and their families to maintain the resident's wellbeing (health promotion). The survey results also indicated that effective communication skills were developed, as well as the ability to prioritise complex needs through effective time management (Algoso et al. 2018).

From an education perspective, undergraduate AIN employment in aged care facilitates professional growth by immersing students in the care of a person as they experience the process of ageing. The shared experience of declining health between the undergraduate AIN and the resident can help 'plant the seed' for compassionate care (Algoso et al. 2018).

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Is it pain?

By Vanathy A David, Sonia Markocic, Valerie Wilson, Rachel Mikleus, Lina Madathikudiyil Paul, Olga Thomas and Nicole Davies

Pain is common in people with Dementia. Evidence shows that pain in one of the most underrecognised and undertreated symptom in patients with cognitive impairment and unsurprisingly, can lead to multiple complications if not treated (Rantala et al. 2014).

Assessment of pain can help with appropriate management of pain. Various barriers involving caregiver, patient related factors and system related factors affect adequate pain assessment and management in patients with cognitive impairment. Lack of knowledge among health professionals concerning pain assessment and management are significant themes in the literature. Literature also identified heavy reliance on nurse's own subjective judgements as other major barriers in pain assessment and management. Clinicians need to have a wide base of knowledge about pain, its assessment and management principles, and consequences of inadequately managed pain.

Pain needs to be regularly assessed using an appropriate tool in patients with cognitive impairment to prevent complications (Schofield 2018). Various observational tools are reported to be both reliable and valid to use in patients who cannot verbalise the pain (Hadjistavropoulos et al. 2014).

Use of a reliable tool to assess pain makes subjective experience objective, facilitates continuity of care, facilitates effective communication, makes pain more visible, makes pain measurable and reduces the chance of bias or error.

In NSW Health, two common tools used are Abbey's pain scale and PAINAD. These tools are available for the nurses on the patient's electronic medical record and easy to use. As part of a quality improvement project, an audit was conducted to understand the current pain assessment practices on three pilot wards at two different hospitals. Audit results showed inconsistent pain assessment practices on all three wards and in particular low uptake of any behavioural pain assessment tools when assessing pain in the elderly with cognitive impairment. A group of researchers, wanted to address the gap and improve the practices around pain assessment and management through a formalised research approach. The first part of the project is focussed on improving the pain assessment in the elderly (65+) with cognitive impairment utilising a validated behavioural pain assessment tool (PAINAD and Abbey's) to assess pain in the acute care setting. The second part of the project will be looking at improving the management of the pain. This research study used the Promoting Action on Research Implementation in Health Services (PARIHS) framework, which is a widely used research framework that contains three key interacting elements.

The three elements of the PARIHS framework are evidence, context and facilitation which provides a broad basis for the research being conducted in healthcare. This framework can influence a successful implementation of evidence based practices in healthcare settings and was used to implement evidence into practice. The research project is still ongoing, part one is anticipated to be completed by the end of this year.

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CARTOON COMPETITION

Cartoon by Madie Palmieri

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CONGRATULATIONS!

Christine Hayne

**for your winning entry.
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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.

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