



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 26, NO.8
OCT-DEC 2019

FREEZE FRAME: THE PORTRAYAL OF NURSES IN POPULAR CULTURE

INSIDE

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Is the image of nurses in
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How does this emerging
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**Closing the Gap:
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A new way forward for
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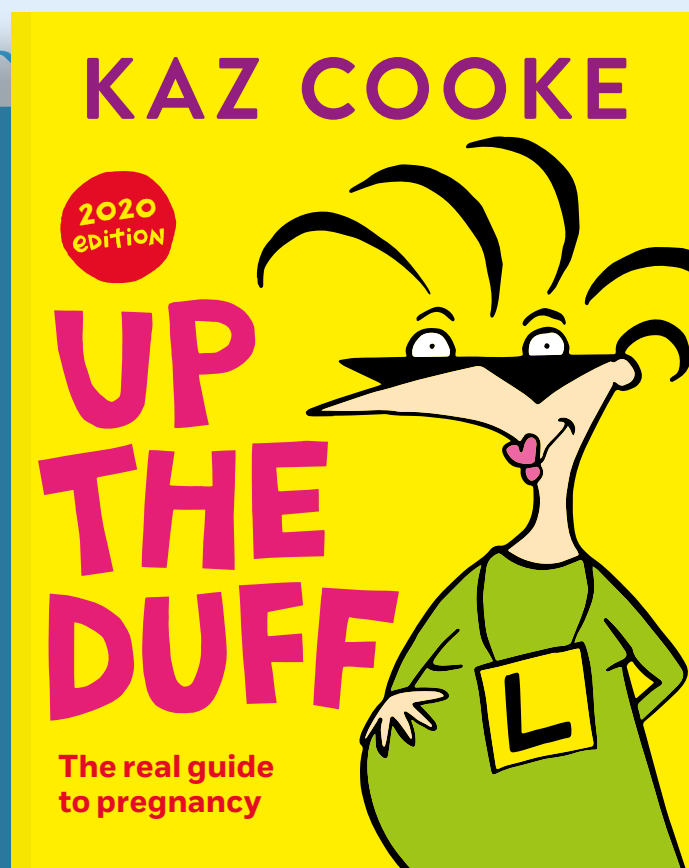
The essential new edition of Australia's most trusted pregnancy book!

A HUGE thanks to all the midwives, child & family health nurses and other medical experts who helped with the 20th anniversary edition of **UP THE DUFF** – fully revised and updated with best-practice advice.

UP THE DUFF has everything parents-to-be need to know about pregnancy and birth. In the new edition: week-by-week what's happening to the mum's body and the baby; hints on dealing with everything from pregnancy nausea to busybodies; explanations of diagnostic tests and the results; what not to eat; childbirth and pain relief; online sources patients can trust; help with social media and other anxieties; life with a newborn baby, and much more.

Please check out the new edition of **UP THE DUFF**.
I hope you'll be happy to recommend it to your patients!

—Kaz



fully revised & updated



Annie Butler

ANMF Federal Secretary

In recent months I had the privilege to attend and speak at the Annual Delegates Conferences of the ANMF's State and Territory Branches across the country.

All Delegates Conferences featured inspiring and informative programs highlighting major issues facing the professions.

As ANMF Federal Secretary, I used this opportunity to inform members about the action we are taking nationally, particularly our ongoing campaign for mandated minimum ratios in aged care.

The Aged Care Royal Commission is moving ahead and the spotlight will be placed on the aged care workforce this month during a Melbourne hearing focusing on making the sector a more attractive and rewarding place to work.

The ANMF remains actively involved throughout the Royal Commission and committed to supporting members taking part.

As it continues to unfold, I am repeatedly amazed by the courage of our nurses and carers in standing up to make their voices heard, whether by making submissions or giving direct evidence on the witness stand.

A prime example is 22-year-old registered nurse Emma Murphy, who bravely shared her story of at times being in charge of up to 100 aged care residents, at the Perth hearing in June examining person-centred care.

In October, the ANMF will also hold its 14th Biennial National Conference in Melbourne and our theme is FAIRER, STRONGER, HEALTHIER: Nurses and midwives make it happen.

The Biennial presents an opportunity for the ANMF to set the national agenda and direction for the next two years so we can maximise our influence politically and professionally as we forge ahead into 2020 and the International Year of the Nurse and Midwife.

The conference will include a focus on WHO and ICN's global Nursing Now campaign that aims to raise the profile and status of the professions worldwide and empower nurses to maximise their contributions to improving the health of their communities.

Key issues on the agenda at Biennial will include rising workplace violence and the need to implement a national strategy to address the problem, tackling

climate change, a variety of social justice issues, as well as how to achieve greater funding to support nurses and midwives.

In the lead-up to Biennial, I met with several politicians in Canberra to further our lobbying and bring nursing and midwifery into the political sphere.

This push will form a key part of the conference with nurses and federal MPs Ged Kearney and Helen Haines set to deliver keynote addresses at Biennial.

The ANMF's latest quarterly issue features a wide selection of interesting and informative articles delving into important issues.

Of great importance to the ANMF is the emergence of the Ensuring Integrity Bill 2019, a piece of legislation that poses a real threat to unions and workers' rights.

Make no mistake, if passed, this Bill will result in a serious erosion of workers' democratic rights and the ability of unions to stand up and campaign on behalf of members so they can protect the safety of their patients and residents.

For example, under the Bill, activities such as members wearing T-shirts and highlighting inadequate staffing levels as part of the ANMF's aged care ratios campaign could be grounds for an employer to make an application for orders against a union or union officials.

Our cover story this quarterly issue takes a look at the portrayal of nurses in pop culture and what impact it continues to have on the professions.

I hope you enjoy reading these stories and more in the latest issue of the ANMJ.

The outlook for the remainder of the year is promising and we are committed to growing our influence as we capitalise on the fast approaching 2020 International Year of the Nurse and Midwife.

Annie

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Moving state?

Transfer your ANMF membership

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

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Poor water quality link to sugary drink consumption in Aboriginal infants

Consumption of sugary drinks among Aboriginal and Torres Strait Islander infants and toddlers could be down to water quality, according to Australian National University (ANU) researchers.

Families living in regional and remote areas expressed concern about the safety and quality of drinking water, lead author of ANU Research School of Population Health Dr Kate Thurber said.

“This can leave families with no choice but to avoid tap water and instead buy bottled drinks, cordial or other sugary drinks.”

The study involved more than 900 Aboriginal and Torres Strait Islander children aged up to three years.

“The good news is we found that half of children aged zero to three years in the study had never consumed sugary drinks. The bad news is that the other 50% in the study had consumed sugary drinks, and this started as early as the first year of life,” Dr Thurber said.

Cordial (47%) was the most consumed sugary drink, followed by soft drink (19%) and sweetened tea and coffee (13%).

The researchers found babies and toddlers living in cities and regional centres were significantly less likely to consume sugary drinks than children in remote areas. This was linked to reduced access to safe drinking water and reduced accessibility and affordability of recommended beverages.



Nurses to help improve cardiac rehab in rural and remote

A \$1.35 million NHMRC research grant to help reduce the risk of repeat heart attacks in people living in rural and remote Australia has been awarded to Flinders University.

The Country Heart Attack Prevention (CHAP) project aims to boost the completion of cardiac rehabilitation. Statistics show only 20-50% of patients attend rehabilitation in rural and remote areas.

Clinicians including nurses will be encouraged to recommend cardiac rehabilitation, develop an auto referral system, and provide a range of delivery methods including face to face, telephone support, apps, websites and general practice models, to improve long term support for heart health.

Pollution associated with higher risk of dementia

Latest research shows air pollution can increase the risk of dementia.

The Australian study is the first global study of its kind.

The research showed that rates of dementia were more likely when people were exposed over a long period of time to two types of air pollutants; particulate matter 2.5 (PM_{2.5}) and nitrous oxides (NO_x) which are pollutants commonly found in cities around the world.

“This is concerning because the World Health Organization (WHO) estimates that 91% of the world’s population lives in places where air exceeds WHO guideline limits. The research shows that government regulation that reduces our exposure to air pollution has a huge potential health and economic benefits,” said study lead Dr Ruth Peters at Neuroscience Research Australia.



Eating nuts can reduce risk of heart attack and stroke

Eating nuts at least twice a week is linked to a 17% lower risk of death from cardiovascular disease (CVD), according to research presented at the recent 2019 European Society of Cardiology (ESC) held in Paris.

The study examined the association between nut consumption and the risk of CVD in 5,432 Iranian adults aged 35 and older with no history of CVD every two years from 2001 to 2013. Nuts consumed included walnuts, almonds, pistachios, hazelnuts, and seeds.

After 12 years, there were 751 cardiovascular events (594 coronary heart disease and 157 stroke), 179 CVD deaths and 458 all-cause deaths.

Eating nuts two or more times per week was associated with a 17% lower risk of cardiovascular mortality compared to consuming nuts once every two weeks. Current ESC guidelines recommend 30gm of unsalted nuts per day in a healthy diet.

“Raw fresh nuts are the healthiest. Nuts should be fresh because unsaturated fats can become oxidised in stale nuts, making them harmful. You can tell if nuts are rancid by their paint-like smell and bitter or sour taste,” study author Dr Noushin Mohammadifard said.



Twins and triplets at increased risk of errors in NICU

Multiple birth babies are at significantly increased risk of medication and treatment order errors in the neonatal intensive care unit (NICU), US research shows.

The study published in journal *JAMA Paediatrics* involved 10,819 infants treated at six NICUs run by two healthcare systems in New York City between 2012 and 2015. About 85% of babies were singletons.

Results showed multiples in the NICU were 75% more likely to have wrong patient orders than singletons. The risk increased with the number of siblings in the NICU. A wrong-patient order error occurred in one in seven sets of twin births and one in three sets of three or more births. Researchers considered the excess risk due to misidentification between siblings. Strategies to reduce the risk included encouraging parents to select names for multiple births before they are born.

Red wine good for gut health

An occasional glass of red wine may be good for your gut health, according to researchers at King's College London.

The study explored the effect of beer, cider, red wine, white wine and spirits on the gut microbiome (GM) and subsequent health of 916 UK female twins and cohorts in the US and Belgium.

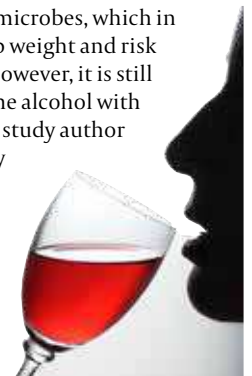
The GM of red wine drinkers was more diverse compared to non-red wine drinkers; not observed with white wine, beer or spirits consumption.

The researchers hypothesised the many polyphenols – defence chemicals naturally present in many fruits and vegetables – in red wine could be the main reason for the benefits.

The study also found that red wine consumption was associated with lower levels of obesity and ‘bad’ cholesterol, in part due to the gut microbiota.

“If you choose one alcoholic drink today, red wine is the one to pick as it seems to potentially exert a beneficial effect on you and your gut microbes, which in turn may also help weight and risk of heart disease. However, it is still advised to consume alcohol with moderation,” first study author Dr Caroline Le Roy said.

The study was published in journal *Gastroenterology*.



SEA SNAIL COMPOUND REDUCES CANCER RISK

A colourful purple compound produced by a sea snail to protect its eggs is a potential new anti-cancer pharmaceutical.

Researchers at Flinders University, Southern Cross University and Monash University isolated one compound in the gland secretions from the Australian white rock sea snail which has not only antibacterial and anti-inflammatory qualities, but also anti-cancer properties.

“After a decade of work, we have found an active compound derived from the substance produced by the mollusc’s gland which could be used as a preventative in bowel cancer,” Flinders University senior lead scientist Professor Catherine Abbott said.

The discovery has the potential for a new drug to reduce development of colorectal cancer tumours.





Lori-Anne Sharp
ANMF Assistant
Federal Secretary

Have you considered introducing a RAP at your workplace?

RAP stands for Reconciliation Action Plan (RAP) and is an initiative of Reconciliation Australia to promote reconciliation between our First Peoples and non-indigenous Australians.

It provides a step-by-step framework for organisations to develop a plan of engagement that aims to support the national reconciliation movement. For the ANMF this involves truth telling, education, engagement with our First Peoples and direct actions that seek to address health inequalities affecting Aboriginal and Torres Strait Islander communities. Through the program, organisations are supported to develop Reflect, Innovate, Stretch or Elevate RAPs; with each phase representing workplaces' different stages of their reconciliation journey.

It is widely known that significant injustices exist between our First Peoples and non-Indigenous Australians. A sad history of invasion, dispossession, stolen children and disproportionately high incarceration rates are a shameful part of our history and are the cause of the severe disadvantage Indigenous Australians experience in all aspects of health, education, social and economic areas.

I have spent a significant part of my nursing career working with Indigenous communities from when I studied transcultural nursing spending time at the Framlingham community, near Warrnambool in South West Victoria, working at Cairns Base Hospital, QLD and in more recent years with Indigenous communities in the suburb of Fitzroy, Melbourne. I have witnessed firsthand the severe disadvantage and systemic racism faced by many Aboriginal and Torres Strait Islanders and I am fully aware of the importance of recognising this truth before embarking on a path of reconciliation.

I am proud of the ANMF values of inclusiveness, fairness, respect, responsibility and integrity, all of which align well with our RAP. Progressing through our RAP is one small part our organisation can play in the reconciliation journey and strive for health equity for Aboriginal and Torres Strait Islander peoples. We seek to achieve this by modelling respect for our first peoples; promoting an understanding of their rights as well as leading the nursing and midwifery professions in respect and sharing knowledge with Aboriginal and Torres Strait Islander peoples. We aim to build relationships with Aboriginal and Torres Strait Islander nurses, midwives and broader communities. Our RAP working group is assisted greatly with the participation from Faye Clarke, a Gunitjmarra, Wotjobaluk and Ngarrindjeri woman, an ANMF member and member of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). Faye has provided invaluable advice during the development and implementation of the ANMF Federal office RAP

and is a vital member of our RAP working group. The working group meets twice a year and is responsible for developing, implementing, reviewing and reporting progress against the RAP within ANMF's Federal office. In the last 12 months some of the ways we have sought to achieve this include:

- Supported CATSINaM through promotion of their cultural safety and respect program.
- Two-day cultural respect training attended by our Federal Secretary.
- Ran social media coverage on Australia Day on impacts of that official day on first peoples.
- Map of Indigenous Australia and framed copy of the Uluru statement from the heart in our Boardroom.
- Publicly supported Uluru statement from the heart.
- Raised awareness in ANMF submissions of the specific implications for Aboriginal and Torres and Islander nurses and midwives, and impact of proposed health policy on Aboriginal and Torres Strait Islander peoples.
- Continued collaboration with CATSINaM, including through joint participation in the South Pacific Nurse Forum (SPNF), where we play a leadership role throughout the event, and support Aboriginal and Torres Strait Islander nurses/midwives to attend.
- Advertise available nursing/midwifery positions in Koori mail and on the CATSINaM website.
- Procurement of Indigenous business to provide travel services.
- Developed Protocols for 'Welcome to Country' and 'Acknowledgement of Country'.
- Seek advice from CATSINaM on Aboriginal and Torres Strait Islander perspectives to inform relevant policy and project development.
- Support the following events: Close the Gap day, National reconciliation week, National Sorry Day and celebration of NAIDOC week.

A RAP is just one important step workplaces can take to advance reconciliation between our First Peoples and non-Indigenous Australians. I encourage all members to start conversations with their colleagues and consider introducing a RAP at your workplace, in doing so, together we can support the national reconciliation movement and work towards closing the gap on the health inequities facing our Aboriginal and Torres Strait Islander communities.

Our updated 2020-2022 RAP is due to go to Federal Council for endorsement later this year, a copy of our 2018 RAP can be found on our website: anmf.org.au/pages/reconciliation-action-plan

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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 (part 2)

The most frequent criticism concerning documentation made during an Inquest is the failure of practitioners to document care and decisions in the patient's case notes.

Not only does this reduce effective communication, it often leads to adverse outcomes for the patient.

In the first case, a 42 year old woman committed suicide whilst detained in a mental health facility. A major concern was the lack of supervision the patient received whilst detained as it became apparent that she had left the ward on two previous occasions without staff missing her.

The third and final time she left followed a review by her MO who was concerned about her deteriorating mental health and asked that she be closely supervised. There was no documented evidence that this concern was communicated to the nursing staff, nor evidence of close supervision being provided.

The coroner described the case notes in relation to her treatment as '*grossly inadequate*' and reflective of inadequate communication amongst the nursing staff about concerns over the patient's safety.

The Coroner held the view that had there been appropriate documentation the patient would have been more closely supervised and wouldn't have been able to leave the ward undetected.

The lack of relevant documentation as to her whereabouts was described as *especially serious* in the case of a detained patient (Inquest into the death of Sandra Sanders (2000) SA). Alterations in the patient's case notes have also been questioned.

Whilst amendments and late entries can reflect accountable practice, amendments in the following cases raised concerns regarding the motivation to and purpose of the amendment.

The first Inquiry followed the death of a newborn baby from birth asphyxia (Inquest into the death of Samara Hoy (2011) Qld).

During the Inquest it became apparent that the midwife had accessed and altered the medical records after the coronial investigation had commenced recording a different timing of events. The Coroner questioned whether this action led to a false version of the events and an untruthful story.

Determining that the alteration was not to correct an inaccurate recording the Coroner concluded that the midwife's actions could have been:

'... calculated to mislead the police during an investigation and may amount to an attempt to pervert the course of justice ... would have the tendency to frustrate ... the course of curial or tribunal proceedings' (p 22).

Finding this behaviour 'totally unacceptable', the matter was referred to the Director of Public Prosecutions for consideration as to whether an offence had been committed.

In the next case, the Coroner found that the patient '*died as a result of a series of errors albeit lack of care on the part of the medical and nursing staff*' providing post-operative care following elective surgery.

Concerns over the alteration of notes included where the EN wrote over her original entries with a higher reading on each occasion in the observation chart - initially explained as an error due to unfamiliarity with the chart layout. However, the nurse was unable to explain why she repeatedly made the same error.

The EN also gave evidence that she had witnessed the RN remove pages from the case notes and asked her to copy them before he made alterations to the observations which were not disclosed to anyone (Inquest into the death of Christopher Hammett (2012) Qld).

Removing pages calls into question the integrity of the case notes.

In the Hoy case it became evident that the midwives involved in the incident made contemporaneous notes but didn't include these in the medical file that was handed to the Coroner's office - the Coroner concluded this was an endemic and totally unsatisfactory practice.

A failure to include patient assessments in their medical file, keeping them separately, has also been seen as reflective of a low standard of record keeping (Inquest into the death of Graham Rollbusch 2018).

This emerged as an issue in the Inquest into the death of Paula Schubert [2018] NT, where the treating practitioner made notes of his consultation with the patient in an old diary that didn't always get transferred to the CCIS system and not contemporaneously.

The case manager who saw Paula weekly also didn't include their notes on the system. These practices were in breach of the organisation's Mental Health standard which required a contemporaneous written record of all consultations be made in the patient's record.

Most practitioners provide sound documentation in the patient's records that reflect their professional standards of care - however, a review of these cases serves to remind us of the impact poor documentation practices can have.

Mindfulness app in Aboriginal communities helps improve mental health

A unique Indigenous mindfulness app is helping Aboriginal communities tackle stress and maintain mental health.

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) and Smiling Mind have developed a meditation program that incorporates Aboriginal language and culture.

"Research shows that mindfulness-based programs can significantly improve mental health, however, until now there haven't been programs available that cater to the language and culture of Indigenous Australians," NPYWC program manager Angela Lynch said.

The app-based program provides accessible and engaging tools for the 28 Aboriginal communities in the cross-border region of Northern Territory, South Australia and Western Australia.

Smiling Mind, which produces not-for-profit web and app-based meditation programs, helped record the meditations, songs and breathing exercises in Ngaanyatjarra and Pitjantjatjara languages.

The meditations are available for free on the Smiling Mind app for adults and children alike.

The aim of the app is to create a shared language for Indigenous people and non-Indigenous health workers that enables families and communities to make sense of how they feel, talk about their emotional state, and ask for help if they need it

"With the incidence of mental illness being disproportionately higher amongst Aboriginal and Torres Strait Islander peoples, there was a real need for the creation of a targeted program," Ms Lynch said.

"We believe that greater mental health literacy will lead to increased help-seeking and better communication between Indigenous people and mental health workers."

The program forms part of NPYWC's Uti Kulintjaku project, meaning 'to think and understand clearly' which was established in 2012 to bring together ngangkari (traditional healers), senior Anangu women, interpreters and Western mental health practitioners committed to improving mental health.

"The program explores language and cultural concepts surrounding mental health and wellbeing as a means to addressing current health issues," Ms Lynch said.

"A series of meditations have been scripted and recorded by senior Anangu women in the languages of Ngaanyatjarra and Pitjantjatjara."

NPY Women's Council and Smiling Mind launched the meditations developed by the Uti Kulintjaku team last December. The mindful meditations, created and recorded by Pitjantjatjara and Ngaanyatjarra speakers, have been piloted through schools in the APY Lands.

Smiling Mind CEO Dr Addie Wootten welcomed being involved in the development of programs in local languages, particularly during International Year of Indigenous Languages.

"As a proud Australian organisation we are very excited to offer the world's first Indigenous language mindfulness program to the world through our app. We think it has the power to change lives and we hope everyone can benefit."

npywc.org.au



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The portrayal of nurses in pop culture has seen the profession predominantly stereotyped as self-sacrificing caregivers, sex objects, doctors' helpers or villains. But what effect does this misrepresentation on screen have on the profession and how it is broadly perceived?

By Robert Fedele



FREEZE FRAME:

THE PORTRAYAL OF NURSES
IN POPULAR CULTURE

Local TV series *The Young Doctors* was the first time Victorian Nurse Tara Nipe encountered nurses in pop culture.

“It was an evening soap that was about doctors and nurses having complex relationships against a backdrop of patients and they had student nurses because it was still during hospital training and the sister who was in charge was very scary looking and had an enormous starched cap and seemed to be forever protecting the nurses from poor behaviour and the lecherous doctors,” Ms Nipe, then 10, recalls.

A decade later, in her first year of nursing education, she walked into the TV lounge and witnessed more senior students panning the way nurse Shirley Gilroy frantically squeezed a bag of blood on *A Country Practice*, quickly realising that the depiction of the profession on screen didn’t necessarily reflect reality on the wards.

“We’re either the sexy nurse or kind of starched with a bit of compassion thrown in there without the technological side of what we do really being showcased,” Ms Nipe says.

“Then more recently there is the nurse that is ethically flawed. *Nurse Jackie*, for example, portrayed a skilled clinician but was all about drug addiction.”

Ms Nipe says the portrayal of nurses in pop culture across the decades has caused varying effects on the profession.

“The single biggest issue is that in a lot of TV dramas like *ER* it seems as though doctors are part of nursing hierarchy, that they have input into hiring and firing and discipline, and that’s certainly not the case but it does reinforce that idea that nurses are there to serve doctors, not as independent professionals who work with and in close conjunction with doctors but are not answerable to them.

“Probably the most dominant image [of nursing] is the compassionate, kind nurse and that can be both a benefit and a disadvantage to the profession,” Ms Nipe adds.

“The benefit is that we are trusted and we’re seen as caring and listening and compassionate and all of those things are good and accurate. But I think it also undercuts the professional aspect, the technological aspect of what we do.”

During her clinical career, Ms Nipe confronted numerous misconceptions from patients about the profession.

This included patients and family members showing surprise at what nurses detect and the interventions they lead, their peer to peer relationship with doctors and the general view of what healthcare entails.

In one case, a family member asked her when the doctor would be visiting their home, delivering care and handing out medication, because that’s what they do on *House*.

“I think there is a misconception from some people in the community about what it is that we do and what we’re about,” she suggests.

“That said, I would like to think the majority of people realise that what you see on TV dramas are the things that are dramatic and there isn’t anything dramatic about routine care. Also, having that contact with the healthcare system in general and nursing in particular helps correct a lot of that.”

Ms Nipe acknowledges more well-rounded portrayals of nurses in pop culture are emerging, with *Scrubs* a standout.

“The nurses who were portrayed [in *Scrubs*] were shown as experienced and knowledgeable professionals who not only knew what they’re talking about but guided emerging medical practitioners. You didn’t see any nursing students, or early career nurses, but the nurses you did see, the doctors listened to them.”

CQUniversity academics Margaret McAllister, a Professor of Nursing, and Donna Lee Brien, a Professor of Creative Industries, teamed up to study the portrayal of nurses across all types of creative media in 2011.

This month, the pair will publish a book *Paradoxes in nurses’ identity, culture and image: The shadow side of nursing* examining the darker side of the profession’s portrayal across pop culture, which they believe has been largely overlooked in literature.

Their goal was to present a truer picture of the profession, warts and all, in the hope of enhancing its identity and resilience and shining a light on the complex factors that can cause failures within the health system.

The book delves into topics including nursing’s dark past, the sexualisation of nursing’s image, mean and monstrous

depictions of nursing, murdering nurses and the concept of abjection.

Media explored includes films such as *One Flew Over the Cuckoos’ Nest*, which featured the iconic, cruel and callous Nurse Ratched, and TV series such as *Nurse Jackie*.

“Our book is about the shadow side of nursing, those stories in pop culture that are out there but which get rarely examined and if we did examine them we might learn something about nursing,” Professor McAllister explains.

“I’m a mental health nurse and I’m interested in the unconscious and what kind of ideas get perpetuated in society unconsciously either about nursing or about what we really think about being in hospital as a vulnerable person and what happens when power gets out of control.”

Professor McAllister lists the film *Fog in August*, which features nurses in Nazi Germany who sterilised people with disabilities and even assisted with their gassing and murder, as an intriguing example of a taboo topic uncovered through the analysis.

Ultimately, she says the aim of the book is to advance nursing and improve understanding of its identity and future challenges.

“For nurses it’s acknowledging that you do have power, you do have the ability to harm as well as heal and what are the safeguards you need to put in place to prevent bad things ever occurring. It’s about nurses knowing their history, their capabilities and using fiction and sometimes true stories to learn from mistakes.”

On the broader portrayal of nurses in pop culture, Professor McAllister believes misconceptions contribute to three main damaging effects – patients not knowing what to expect when it comes to nursing care and potentially not trusting nurses with complex information, increased difficulty in recruiting appropriate students to nursing, and society viewing nurses as



Robbie Bedbrook



Margaret McAllister



Tara Nipe

“The single biggest issue is that in a lot of TV dramas like ER it seems as though doctors are part of nursing hierarchy, that they have input into hiring and firing and discipline, and that’s certainly not the case but it does reinforce that idea that nurses are there to serve doctors, not as independent professionals who work with and in close conjunction with doctors but are not answerable to them.”

TARA NIPE



Credit: Art by Madie Palmieri

just assistants and excluding them from healthcare planning and decision-making.

Despite stereotypes persisting, she too believes more balanced depictions of nurses with greater depth are emerging.

She points to a recent film, *Chronic*, that features a cunning home-based palliative care nurse whose actions cross between kindness and evil and create intrigue, and the critically acclaimed *Nurse Jackie*, which charts a strong-willed hospital nurse with a drug dependence.

“If we think about *Nurse Jackie* it’s part of a sub-genre of bad people,” Professor McAllister says.

“*Breaking Bad*, *Dexter*, shows like that have an antihero and she’s the same. I think it’s because the viewing public is becoming more discerning and wants to see more complex characters.”

Critically, Professor McAllister says nursing must own its portrayal within pop culture

and attempt to shift and shape the narrative by becoming storytellers.

“Sometimes we trivialise pop culture and say it’s just trash TV or it’s just entertainment but in fact, it’s mass media, and we know mass media is deeply influential,” she says.

“The stories about nursing might be the only time a little girl or boy sees a nurse and it could plant the seed for that person to become a nurse in the future.”

Registered nurse Robert Bedbrook, aka Nurse Robbie, is one emerging storyteller trying to improve realism when it comes to nursing’s portrayal in pop culture.

The 28-year-old from Sydney works in primary healthcare within general practice, including a focus on sexual health, and rose to prominence after creating YouTube videos on diverse health topics such as nurse advocacy, sexual health and burnout, and circulating them via social media.

His mission was to increase the quality of evidence based online health content and promote the profession in an entertaining way.

“What I’m passionate about is primary healthcare and preventative health and the reason I try to be such a loud advocate is because I think in order to achieve the healthcare goals that we’re working towards as a country nursing will be really vital,” Robbie says.

“The reason I do what I do is to empower the nurses who listen to me, whether through talks, workshops or seeing my videos, and challenge their own perceptions of themselves and their scope of practice a bit more as well as try and teach the general public what a nurse can actually do.”

Last year, Robbie delivered a keynote speech at the Australian Primary Health Care Nurses Association (APNA) Conference on nursing’s limited representation in pop culture.

“If you look at a show like *Nurse Jackie* it’s quite accurate. They [nurses] have quite a large scope of practice and you see them doing a lot. But I think that’s an exception. I think often medical dramas will take a lot of licence with what they get their medical characters to do because what’s really compelling in pop culture is human conflict and drama and that often comes at the moment of face to face interaction with patients and the bulk of people that do that are nurses.”

Robbie claims inaccurate portrayals can be damaging to all health professions.

“It’s negative for the nursing profession but also for the medical profession because you disempower nurses by taking that visibility away from them but at the same time you overpromise to the general public what it is that their medical professional is going to be able to do for them.”

With TV shows like *Nurse Jackie* bringing more three-dimensional characters to light, Robbie says the perception of nursing can be vastly improved.

During his talk at APNA last year, he proposed strategies to improve nurses’ portrayal in pop culture, including encouraging the workforce to engage in more content creation such as his own, promoting the profession through unique stories.

In the long run, Robbie hopes the increased visibility of nurses and their work will encourage TV producers and writers to create more truthful portrayals.

His own contribution is currently in the pipeline and involves writing a TV pilot based around a nurse-led primary healthcare facility.

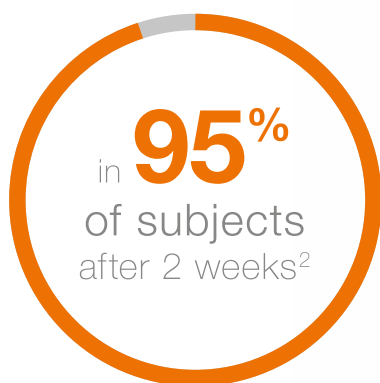
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An historic Partnership Agreement on Closing the Gap has been committed to by federal, state and territory governments and a Coalition of Aboriginal and Torres Strait Islander Peak Bodies. For the first time, Aboriginal and Torres Strait Islander people will have an equal voice and full ownership. *Natalie Dragon reports.*

CLOSING THE GAP:

A NEW PARTNERSHIP



Staff at Monash Health (Tracey Stephens centre)

“Having Aboriginal midwives working with Aboriginal women, babies and families is vital,” says midwife Tracey Stephens, a Kurnai woman from Gippsland.

For the past 16 months, Tracey has been working as an Aboriginal health midwife in the Aboriginal health team at Monash Health in Melbourne.

She liaises with the community and acute hospital services to ensure Aboriginal and Torres Strait Islander women and their babies have access to appointments and adequate healthcare.

Tracey was recently recognised as HESTA’s 2019 Midwife of the Year for her work in improving maternity and healthcare outcomes for Aboriginal and Torres Strait Islander women and babies by implementing culturally appropriate and safe maternity healthcare services.

Since her appointment to the role, the number of Aboriginal babies born at Monash Health has doubled and the hospital has seen a decrease in no shows for prenatal appointments.

There has also been a reduction in the number of women smoking during pregnancy and fewer babies born under 2.5kg, while breastfeeding rates have skyrocketed, Tracey says.

“Aboriginal-led care is crucial to promoting the best possible health outcomes for these women and their babies. I am proud that the number of Aboriginal women accessing the service has increased and through this, we have implemented so many great improvements across our healthcare system.”

Aboriginal-led care and Aboriginal people growing their own workforce is crucial to closing the gap in health outcomes and mortality rates experienced by Aboriginal and Torres Strait Islander peoples, Tracey adds.

“Mainstream services need to embrace and embed Aboriginal and Torres Strait Islander

health professionals in their services to help close the gap. It’s not about Aboriginal people closing the gap; it’s about everybody closing the gap.”

The original Closing the Gap (CTG) policy was agreed to by the Council of Australian Governments (COAG), with the signing of the CTG Statement of Intent in March 2008.

Despite work to improve health, housing, education and early childhood development over the past decade, just two of the seven CTG targets are on track to be met: halving the gap in year 12 attainment rate; and enrolling 95% of four-year-old Aboriginal and Torres Strait Islander peoples in early childhood education by 2025.

In December 2016, COAG announced a ‘refresh’ of Closing the Gap ahead of the 10-year anniversary of the agreement and with four of the seven targets having expired in 2018.

Many consider CTG an initiative of governments that has lacked ownership from Aboriginal and Torres Strait Islander peoples.

In 2017, COAG agreed to a strengths-based approach and to ensure Aboriginal and Torres Strait Islander peoples were “at the heart of the development and implementation of the next phase of CTG”.

In 2018, Aboriginal and Torres Strait Islander peak bodies raised concerns the ‘refresh’ was not being carried out as promised.

A Special Gathering of prominent Aboriginal and Torres Strait Islander Australians presented COAG with a statement setting out priorities for a new CTG agenda.

The statement called for the next phase of CTG to be guided by the principles of empowerment and self-determination and to deliver a community-led, strengths-based strategy that enabled Aboriginal and Torres Strait Islander peoples to move beyond surviving to thriving.

The 13 peak bodies proposed an urgent meeting with COAG representatives. With mounting pressure and little progress, Prime Minister Scott Morrison met with the peaks; which culminated in the historic Partnership Agreement with COAG late last year.

COAG'S COMMITMENT

The COAG Statement on the CTG Refresh in December 2018 declares:

“COAG recognises that in order to effect real change, governments must work collaboratively and in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples as they were the essential agents of change.”

“Aboriginal and Torres Strait Islander peoples must play an integral part in the making of the decisions that affect their lives – this is critical to closing the gap.”

The Partnership Agreement means that for the first time Aboriginal and Torres Strait Islander people, through their peak body representatives, will share decision-making with governments on Closing the Gap; and will have an equal voice and full ownership of the CTG framework.

The top-down approach of CTG was never going to yield the outcomes we all hoped to see, National Aboriginal Community Controlled Health Organisation (NACCHO) CEO Pat Turner says.

“For the Peaks [Peak Bodies], the most important part of Closing the Gap going forward is not the targets but reviewing how we go about achieving them. We firmly believe that changing the way governments work so that Aboriginal and Torres Strait Islander peoples across Australia have shared decision making on Closing the Gap will result in positive outcomes across the board.”

The partnership really does have the potential to be a game changer, according to Close the Gap Campaign Co-Chair and Aboriginal and Torres Strait Islander Social Justice Commissioner June Oscar.

“It will allow our voices, from the ground up to be heard and responded to. This is what we must be insisting when we talk about a refreshed Closing the Gap framework – that we are always at the decision-making table, and that we are self-determining, when it comes to matters that affect us.”

The 2019 Australian Human Rights Commission CTG report “Our Choices, Our Voice” released in March, took a different approach this year, Commissioner Oscar says.

“It has turned away from the deficit story to focus instead on our successes and the cultural determinants of health such as our

FEATURE

resilience, identity and self-determination. By recognising and supporting the work on the ground that strengthens our cultural determinants of health, we will close the gap.”

Communities on the ground had solutions and were already doing the much needed work, Commissioner Oscar says.

“We know that when Aboriginal and Torres Strait Islander peoples are included in the design and delivery of services that impact their lives, the outcomes are far better.

“We need to be front and centre of health policy design and implementation so our knowledge informs the work that needs to be done. We need to invest in and support on the ground voices and solutions.”

Governments and Aboriginal and Torres Strait Islander people will share ownership of and responsibility for a jointly agreed framework as well as targets and ongoing monitoring of the CTG agenda.

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) CEO Melanie Robinson says the Partnership Agreement is a huge step forward in the planning and self-determination of Aboriginal and Torres Strait Islander peoples.

“Aboriginal culture comes from a strengths based approach. We see the CTG targets as measuring deficit. There are a lot of strengths and resilience in Aboriginal people and we need to leverage off that.

“The life expectancy gaps are staying the same or getting worse than non-Indigenous Australians. Most improvements have been in child and maternal health and education but if compared to mainstream the gaps are widening – mainstream is getting better while Aboriginal and Torres Strait Islanders are moving further behind.

“We need to try to get better outcomes and better engagement with Aboriginal communities.”

A 10-year review of CTG by the Australian Human Rights Commission, found there had been a lack of focus on the social determinants of health inequality (income, education, racism) which needed to be addressed at a fundamental level.

“Good housing helps the social and cultural determinants of health – clean drinking water, food security and appropriate shelter lead to better health outcomes,” says Ms Robinson.

Issues of family violence, social justice, and high rates of incarceration also need to be addressed, she argues.

“People are on the revolving door – it’s really about getting them off that treadmill.”

A key element of CATSINaM’s 2018-2023 strategic plan and one which has been identified as crucial to CTG is growing the Aboriginal and Torres Strait Islander workforce.

Ms Robinson acknowledges this as a priority across the board – in education, justice, health, disability, and aged care – as well as the health workforce.

“We need to develop and support recruitment and retention of the Aboriginal and Torres Strait Islander workforce. What is the best practice for recruiting students and keeping them to completion to the end? With ATSI nursing and midwifery students how can we share strategies and models to keep them? There are lots of enrolments but we are not keeping them to the end.

“Then, how can we embed them in the workforce? There are issues about competing for jobs with people who have more experience and more skills; and there are issues of cultural bias.”

The Birthing on Country (BoC) Project was identified in the 2019 CTG report as a successful model of Aboriginal designed and delivered services.

BoC was established by CATSINaM, the Australian College of Midwives (ACM) and members of the University of Sydney and University of Queensland.

Currently piloted across two sites; in South East Queensland and Nowra, NSW, BoC provides women access to culturally and clinically safe, inclusive care that incorporates cultural birthing traditions within mainstream maternity services.

“Our focus is improving maternity care delivery to Aboriginal and Torres Strait Islander mothers and babies, working in collaboration with Aboriginal women to ensure the provision of culturally safe care

to their women and families,” says ACM’s Project Officer for BoC Project, Cherrise Buzzacott.

BoC develops the Aboriginal and Torres Strait Islander workforce by offering a culturally safe workplace with opportunities for growth.

Aboriginal and Torres Strait Islander Health Workers in support roles have options to upskill at the first Aboriginal and Torres Strait Islander Birthing Centre in Nowra – set to start construction in 2020.

The opening of the Nowra Birthing Centre is set to be ground-breaking, says Ms Buzzacott.

“It will create opportunities for Aboriginal and Torres Strait Islander mothers to experience holistic care outside mainstream services; it will expand the Aboriginal and Torres Strait Islander workforce; and will utilise the skills and leadership found in Aboriginal community controlled health services.”

Improved outcomes at the BoC pilot sites already include a decrease in smoking during pregnancy rates and a reduction in preterm birth weights. Success of the birthing programs have been attributed to the leadership and ongoing development by Aboriginal and Torres Strait Islander people.

“They needed a hub where women could come together – keeping it safe. Women designed and had governance and self-determination for their own health and control of what they need,” Ms Buzzacott says.

Closing the Gap is at every aspect of health, argues Ms Buzzacott.

“Closing the Gap at the beginning of life gives these babies a good start with healthy mothers and helps with good outcomes before birth – and that continues on.”



Group shot at the Close the Gap event at the Tharawal Aboriginal Corporation and launch of the “Our Choices, Our Voices” report (Melanie Robinson 3rd left)



Kristen Wischer
ANMF Senior Federal
Industrial Officer

Ensuring Integrity Bill 2019: The real threat to unions and workers' rights

The Morrison government recently reintroduced *The Fair Work (Registered Organisations) Amendment (Ensuring Integrity) Bill 2019* into Parliament.

The Bill has passed in the House of Representatives and been referred to a Senate Inquiry, which is due to report later this month.

The Bill was first introduced in 2017 but was not passed because at the time it did not obtain a majority in the Senate. This time, however, there is a real risk that cross bench senators will allow the Bill to pass.

The ANMF remains extremely concerned about this piece of proposed legislation because of the threat it poses to all unions to campaign and act on behalf of members.

The Ensuring Integrity Bill gives broad powers to authorities to make applications to intervene in the operation of unions. It provides:

- The Federal Court must make orders on application to disqualify a union official convicted of an offence that is punishable by imprisonment for five years or more.
- The Federal Court can disqualify a person from holding office on a wide range of grounds, including the person is not a 'fit and proper' person or has breached certain industrial laws.
- Allows the Registered Organisation Commission (ROC), the Minister or a 'person with sufficient interest' to apply for orders deregistering unions, altering union rules or controlling the use of union funds and property, including appointing an administrator.
- Allows third parties to intervene in the process of unions applying to amalgamate and imposes significant hurdles for amalgamation, even where members are in favour of the amalgamation.

Above is only a brief summary of the range of powers that can be exercised against unions and officials. The concern is that this legislation goes too far, is too broad and does substantially more than is necessary to ensure proper union governance and regulated activity.

Australian unions are already one of the most highly regulated in the world. A range of academics and human rights organisations have pointed out the legislation is not compatible with the ILO Convention protecting the democratic rights of freedom of association and the protection of the right of workers to organise through their union.

Industrial relations minister Christian Porter said that 'law abiding unions' have nothing to fear from this legislation. But the ANMF is worried that the Bill is so broad in its application that it could capture some of the campaign activities of the ANMF.

For example, the ANMF has and continues to campaign extensively for ratios and skills mix in aged care and in the public sector to improve quality of care.

Campaigns have involved members taking part in activities such as wearing t-shirts and badges and even changing work patterns for short periods to highlight the risks inadequate staffing levels pose to aged care residents.

Under the Bill, these activities could be considered illegal industrial activity and would be grounds for an interested party, such as an employer, to make an application for orders against a union or union officials.

At the extreme, an application could be made to cancel the registration of the ANMF. If such an application was made, the ANMF would be forced into costly and time consuming legal proceedings and the ability to campaign for just causes that benefit the community would be seriously threatened.

Current legislation already provides that a person convicted of certain serious criminal offences is ineligible to be a union official. In conjunction with criminal law, this is an appropriate protection for union integrity.

Yet the Bill seeks to expand the sorts of offences that could result in ineligibility and includes non-criminal activity – for example a breach of work health and safety law.

Another significant concern with the Bill is that it provides grounds for disqualification of officials or cancellation of registration for relatively minor procedural errors, such as late filing of reporting documents. The current legislation already has serious deterrents for breaches. Thus, the ANMF believes there is no justification for harsher laws.

The ANMF in no way suggests that the law should be disregarded. The problem with this Bill is that it will impose disproportionate penalties, is harsher than other comparable legislation and seeks to prevent unions from pursuing rights on behalf of members and the community.

If passed, the Bill will result in a serious erosion of workers' democratic rights to be represented by elected officials and to determine how their union is run. The ANMF is wholeheartedly opposed to the Ensuring Integrity Bill.

The use of safety engineered medical devices to prevent needle stick injuries in the clinical setting

By Michelle McAlister and Clare Gartland

Needle stick injuries are the greatest occupational health and safety hazard for healthcare professionals with nurses being the largest group experiencing this occupational injury. Yet needle stick injuries can be prevented.



Needle stick injuries (NSI) are defined as 'any percutaneous injury that results in piercing of the skin by a needle or other sharp object or device' (MTAA 2013, p.1). Healthcare Professionals (HCP) administer subcutaneous insulin injections to patients which presents a risk of needle stick injuries.

MTAA (2013 p.3) stated that 'one in nine nurses in Australia has had at least one NSI in the past 12 months', with nurses being the largest HCP group experiencing this occupational injury.

According to the International Safety Centre's Exposure Prevention Information Network (EPINet) data, injuries from disposable syringes make up the majority of NSI (28.1%) and 19.5% are from insulin syringes.

EPINet data indicates that although 35.3% of devices with safety mechanisms were used in the last five years, only 34.6% were activated (Mitchell & Parker 2014). Insulin needles are particularly problematic due to the increase in insulin administration in the hospital population.

There is a dual risk when using insulin pens and pen needles. The needle on the non-patient end (back-end) also may have been exposed to a biological hazard in the needles or the insulin cartilage (Herdman, Larck, Schliesser & Jelic 2013; Mitchell & Parker 2017).

CLINICAL BACKGROUND OF DIABETES PREVALENCE AND INSULIN USE

Diabetes Australia (2019) states that 1.7 million Australians have diabetes.

The AusDiab study (Tanamas et al. 2012) is the most extensive Australian longitudinal study conducted into diabetes and associated complications.

The study demonstrated that 280 people are diagnosed with diabetes per day.

The burden on the Australian healthcare system is substantial with 33% of all patients that are admitted with a medical condition to hospital having diabetes. People with diabetes have an increased length of hospital stay of 1.4 days, increased

cost of stay, more admissions annually and complications whilst hospitalised (Karahalios 2017).

Poor glycaemic control is the major cause of diabetes complications. The principles of diabetes management are a healthy diet, exercise, blood glucose monitoring and oral and/or injectable diabetes medications.

These aim to regulate blood glucose levels into target range with the RACGP guidelines (2016) advising glycaemic levels be maintained between 6-8mmol/L in the fasting and pre-prandial state 8-10mmol/L.

Currently 414,640 people living with diabetes are self-administering insulin (National Diabetes Services Scheme 2019) to assist achievement of these glycaemic targets. The number of inpatients that have their diabetes managed with either oral diabetes medication and insulin or insulin exclusively was collectively 53.8% (Bach et al. 2014). When HCP administer insulin in the clinical setting they are of a high risk of obtaining a NSI (MTAA 2013).

OCCUPATIONAL RISK OF NSI TO HEALTHCARE PROFESSIONALS

The Occupational Health and Safety (OHS) issue of NSI has been largely ignored in Australia. This is in contrast to the United States of America that have legislated with the Needlestick Safety and Prevention Act (modified 2000) which requires healthcare facilities to utilise engineered needle safety devices and the maintenance of a NSI record (Mitchell & Parker 2017).

This is in contrast to hand hygiene which has attracted government funding for policy development, research and subsequent education (Grayson & Russo 2009; Grayson et al. 2011; Murphy 2014).

This is remarkable given economic impact of NSI and health and wellbeing repercussions for HCPs.

Mannocci et al. (2016 p. 644) stated that 'NSI generate significant direct, indirect, potential and intangible costs which may increase with time'. The direct cost relates to the post NSI pathology screening, review of results, subsequent medical management if required and financial reimbursement to the individual if deemed not fit for work.

The indirect costs are associated with replacement of man hours, debriefing of the effected HCP and potential long term psychological repercussions. The psychiatric impact of NSI extends from excessive concern to post traumatic stress disorder (Cooke and Stephens 2017).

NSI occupational exposure places the HCPs at risk of viral infections such as hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) (Adefolalu 2014; Matsubara 2017). HCP's health and wellbeing is placed at risk when they could be protected through the use of available Safety Engineered Medical Devices (SEMD) (Murphy 2014).

OPPORTUNITY TO PREVENT NSIs

This issue of NSI across two private hospitals in metropolitan Melbourne was identified as a concern.

Both hospitals used a combination of traditional insulin needles and syringes for the administration of insulin.

Hospital A is a 359 patient-bed healthcare facility which provides a large range of acute medical and surgical services including 12 theatres, 24 hour emergency department, intensive care and coronary units together with a day procedure unit.

Hospital B is a 30 bed rehabilitation centre that provides both inpatient and outpatient rehabilitation programs.

The hospital has specialty programs for cardiac, orthopaedic, trauma and pain management rehabilitation.

The Diabetes Educators (DE) were introduced to a SEMD at the Australian National Diabetes Scientific Meeting.

The selection criteria for the SEMD was related to evidence based practice and clinical need:

1. 5mm needle length: According to the current Australian Diabetes Educators Association needle length recommendations (ADEA 2015) smaller needles reduce the tissue damage caused by repetitive injections into the same sites. Tissue damage, known as lipohypertrophies are hard fatty lumps that form under the skin and effect insulin absorption and therefore stability of a person with diabetes' glycaemic control. The smaller needles reduce the risk of insulin being injected intramuscularly which affects the action profile of the absorption rate of the insulin (ADEA 2015).
2. Dual end retraction and passive safety activation as opposed to active activation. When administering insulin with a pen device, the HCP are at risk of a NSI from both ends of the pen needle (injection and cartridge ends) (MTAA 2013). The SEMD selected shields both ends of the needle as a component of the injection technique. There are no additional steps to be undertaken by the HCP to shield the needles at either end of the insulin needles.
3. The recent introduction of Toujeo into the Australian market. Toujeo is a basal insulin that is the first insulin in Australia with a duration of up to 36 hours. It contains the same active ingredient as Lantus which like all other insulin types on the Australian market are 100 units/ml but with a more concentrated formulation of 300 units/ml and therefore cannot ever be given with an insulin needle. Insulin syringes are designed for U-100 and without proper calculation a substantial insulin overdose can occur. For this reason, U-300 insulin should only be administered using an insulin pen and pen needle (Sanofi 2018). There are plans for further insulin types of a variety of concentrations not consistent with the 100 units/ml to be launched onto the Australian market in the near future.
4. Provision of supportive education from the manufacturer. The company representative from the manufacturer was involved in the initial and the ongoing education provided at both of the sites. This reduced the hospital

man hours required to introduce the product and follow up when difficulties or questions arose.

5. Ease of use of the SEMD. The technique to using the selected SEMD was simplistic. The HCP is taught to listen for an initial 'click' on injection, indicating that the needle has pierced the skin and ensure the white sleeve is flush on the skin. Then to listen for a second 'click' when releasing the needle from skin contact. This indicates that the injecting side of the needle has been shielded. When shielded, a red band appears at the tip of the needle. When the SEMD is removed from the insulin pen, the second side of the needle connected to the insulin pen is shielded automatically.

The SEMD was introduced as both a diabetes education and infection control initiative initially in one of the sites. The product was rolled-out by the clinical diabetes nurse consultant and diabetes resources nurses associated with the two departments together with the support of the manufacturer. Lewin's change management theory (Mitchell 2013) was applied to the scenario.

The unfreezing, moving and refreezing process was undertaken.

These steps were taken to ensure behavioural change and reinforce the behaviour following the introductory phase. Lewin's model was utilised in this circumstance to plan and bring about the desired change. To ensure the success of the clinical initiative, clear steps to the process were developed in the phases of Unfreeze, Moving and Freezing (Mitchell 2013).

The elements integral to these steps were flexible as challenges of the change become apparent.

The nursing staff on one ward were provided with education on the correct technique used to administer insulin using the SEMD.

This was initially undertaken as a group and then one-on-one observation of technique was undertaken. The Diabetes Educators Service and Education Team were instrumental in this process. Education was paramount to change the behaviour of the nurses in the hospitals (Johnson & May 2015).

SEMD were designated for HCP use only in this setting. In the United States of America the SEMD is cleared for patient self-injection.

In theory the patient can be trained to use SEMD when in the hospital.

The SEMD was utilised by the HCP when the patient was unable to self-administer insulin during their hospital stay.

UNFREEZE

MOVING

REFREEZING

- Need to prevent needlestick injuries
 - Management support
 - Ward by ward
 - Introduced Safety Engineered Medical Device (SEMD)
 - Initial group education with one on one competency completion
 - Evaluation form providing feedback on use of the SEMD completed by nursing staff.
-
- The launch of the product facility wide
 - Hospital wide transition to the SEMD – all nurses educated and assessed using competency tool developed
 - The launch of the product across the additional site.
-
- All undergraduate staff who undertake clinical experience at Hospital A have a 30 minute practical session on the SEMD
 - All new staff undertake a practical session and then complete a competency on the use of the SEMD
 - SEMD included in the diabetes workshops and resource nurse programs
 - Provide the staff with statistics and benefits of the change and compliance with practice.



Injecting insulin using SEMD

If a patient requested to self-inject then the patient was assessed for their ability to safely self-inject insulin using their own needle.

The patients need to be cognitively aware and oriented, able to remove their own needle after injection and safely dispose of it in a sharps container.

OUTCOME OF THE INITIATIVE

Both sites reported a reduction in NSIs from insulin pens needles.

Hospital A reported a 66.6% decrease in NSI.

NSI recorded after the introduction of the SEMD occurred when the patient was self-administering insulin using standard insulin needles.

The incidents were at the point of the checking of the dose process, when the patient did not recap the needle after use or when a used needle was left attached to the insulin pen. No NSI have been reported involving the SEMD.

These events have formed the basis of ongoing insulin device handling education.

It has reinforced the importance of the self-administration assessment process and the need to stress that the patient can only self-inject if they are prepared to discard their own needle every time after use.

Hospital B reported no further NSI. This represents a 100% reduction in relation to insulin pen needle usage for the five years since the introduction of the SEMD.

THE PATIENT EXPERIENCE

Comments by patients specific to this device are the size of the needle device compared to their regular needle. The look of the device gives the perception that the needle is larger. This size of the device is to enable the passive shielding at the dual ends (BD 2018). In many cases the actual needle is smaller and the patients state they have not felt the piecing of the needle on the skin. Encouraging the patient to listen for the clicks as the insulin is injected reassures them of the functionality of the SEMD.

ONGOING ROLE IN THE EDUCATION OF HCP REGARDING SEMDs

1. Correct technique is the most important learned element for these types of devices (BD 2018). The two hospitals have introduced key measures to ensure the smooth continuation of the correct technique by all staff.

2. HCP need the hands-on experience with the device to develop the manual dexterity and familiarisation with the device. This can occur at orientation or during the first few days in the ward area. This is followed by completion of a SEMD competency by a senior nursing staff member or a Diabetes Resource Nurse.
3. eLearning SEMD technique instruction guide has been developed and has been uploaded onto the hospital learning platform for all nursing staff in Hospital A to complete annually. There is a proposal for this instruction guide to be available across the network to enable new employees at hospital sites without Diabetes Educators to learn correct technique with minimal difficulty.
4. Continue the education process from the undergraduate and beyond to ensure new staff are protected from NSI. A proposal has been submitted for the SEMD product technique to be incorporated into orientation programs across this specific private hospital network.

DISCUSSION

In order to protect HCPs, SEMD devices need to be introduced throughout the Australian healthcare system to prevent NSI. This is a preventable injury that has substantial financial and health ramifications. The introduction of SEMD that protects both ends of the needle in two metropolitan Melbourne private hospitals significantly reduced the incidence of NSI to HCPs. The ongoing education underpins the continued correct usage of the product. This aims to ensure that the HCP that provide care for the community are given the occupational health and safety protection they deserve.



SEMDs

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James Lloyd
ANMF Federal
Vice President

Super in an ethical fund can drive action on climate change

Concerned about the lack of action on climate change by our leaders? Some Australian politicians are dithering to decarbonise our economy. Some haven't even removed their collective heads from the sand, exploiting wilful ignorance as a policy.

As rational citizens, it is easy to believe that individuals can't create significant change. But you have a powerful and easy tool to create meaningful change in the world, and it involves your super. Every investment choice has consequences. Ethical super funds allow you to invest into issues that you care about and that reflect your personal values. It gives you the peace of mind that your money is making a positive contribution toward driving change.

Australian superannuation funds hold 2.7 trillion dollars, or 30 trillion dollars worldwide. This is a considerable sum, so even a modest proportion directed into ethical or sustainable investments could generate massive positive changes on animal, human and planetary health.

All major industry funds have ESG (environmental, social and governance) options. According to ASIC, ethical funds are designed to screen out companies that don't meet standards determined by an investment manager. Various ESG funds also cater to your personal comfort level of risk from conservative to high growth options and your screening preferences ranging from 'dark-green' to 'light green'.

ESG funds deliver comparable to above-average returns when compared to benchmark returns. However, many of these ethical funds are less than 10 years old, so longer-term performance is unknown.

The ANMF Federal Office has a position on climate change (anmf.org.au/pages/climate-change, anmf.org.au/pages/climate-change), recognising that climate change is largely occurring due to human activity and carbon emissions from the burning of fossil fuels. As nurses who are grounded in both science and ethics, we know that a clean environment is crucial to health and wellbeing.

Humans depend on an unpolluted and stable planet for healthy food production, adequate water supply, suitable living conditions and psychological wellbeing. Major industry super funds in Australia (including HESTA) recognise that climate change requires a collective and collaborative response so critical changes in our climate policy are made to protect the long term interests of members and the community (bit.ly/2Kaupc6). There is some positive movements in the global business community. At the Paris 2015 agreement, the investment community

made several significant pledges directing capital toward decarbonising our economy.

This included the RE100 Pledge – the world's most influential companies committing to using 100% renewable power (there100.org/re100), and the Portfolio Decarbonization Coalition (unepfi.org/pdc/) which involves the commitment of 32 funds (with \$800 billion in management) to slowly decarbonise their investment portfolio through mobilising intuitional investors.

Similarly, through the action of individuals and pressure from members, major super funds have disinvested from tobacco-related companies and firms. In 2010, radiation oncologist Dr Bronwyn King realised her industry fund had stocks in tobacco companies. Understanding the devastating effects of smoking on her patients, she began campaigning for super funds and the finance sector to move their members' money out of tobacco companies.

In 2012 she persuaded her first industry fund, First State Super, to disinvest in tobacco related investments and more than 30 industry super funds have since followed suit. I believe it is critical all citizens play a role in decarbonising our environment. If we wait for a political solution it may be too late.

But if a mass of people put their money into ethical investments (including those that effect climate change), then momentum can build and we can achieve a future where the effects of climate change are reduced.

Money can play a significant role in influencing companies and governments to act on climate change. I am mindful of our collective footprint on the Earth.

I want my money invested in clean energy, sustainable products, innovative technologies, healthcare and medical solutions, recycling and education.

Like all investments, switching to an ethical/sustainable fund is no guarantee of future wealth, but it does empower you to create change with a clean conscience. There doesn't need to be a conflict between ethical investing and sound financial returns – put your money where your values are.

By investing ethically, you become part of the solution, not the problem.



Dr Micah D J Peters

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

* Note

In this column I have used the National Aboriginal Community Controlled Organisation's (NACCHO) definition of Aboriginal people which is inclusive of both Aboriginal and Torres Strait Islander peoples

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Aboriginal and Torres Strait Islander nurse and midwife research

Increasing the number of Aboriginal and Torres Strait Islander nurses, midwives, and carers in the workforce is important, along with supporting Aboriginal and Torres Strait Islander research and leadership.

As the largest group of direct healthcare occupations, nurses and midwives play a critical role in promoting and improving the health and wellbeing of the Australian community.

As holders of a unique blend of cultural and clinical wisdom, it is vital that Aboriginal nurses and midwives are recruited, supported and retained in Australia's health workforce as a key element of closing the persistent gaps between Aboriginal peoples' health, wellbeing, and cultural understanding to that of other Australians*.

Aboriginal nurses and midwives must be supported in their roles as leaders in the professions for the provision of effective, high-quality, and culturally safe care, and to be leaders in research and the implementation of evidence to improve the health status and life opportunities for other Aboriginal and non-Aboriginal people.

I have written elsewhere on the importance of enabling and sustaining nurses' and midwives' engagement with and in research training, activities and outputs and here I focus more precisely upon the need to specifically extend this ambition to ensuring Aboriginal people are central in this endeavour.

In 2020, the Rosemary Bryant AO Research Centre (RBRC) will offer the first grant for Aboriginal nurses and midwives to undertake a Master of Research focusing on a topic of key importance for low-resource communities.

A range of factors has been found to improve retention of Aboriginal nurses and midwives in study and work including feeling culturally safe, access to personal and financial support, and access to local support from families and communities (CATSINaM).

The Grant concept, developed from discussions between the RBRC, ANMF (Federal Office), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the World Health Organization, and the International Council of Nurses (ICN), is funded by the Rosemary Bryant Foundation and has been designed to allow the awardee to undertake the degree via distance learning, so it doesn't require people to leave their home community to progress this degree.

It is hoped that this will enable improved local application of the research findings to support and where possible improve the health and wellbeing of community members and to grow local leadership and research capacity in the Aboriginal nursing and midwifery workforce.

The RBRC was established in 2016 as a partnership between the South Australian Branch of the Australian Nursing and Midwifery Federation (ANMF) and the University of South Australia (UniSA).

Along with establishing local and national partnerships to build research capacity and leadership in nursing and midwifery, the RBRC aims to strengthen the nursing and midwifery workforce across health systems and advance evidence-based healthcare through high quality education and training and nurse and midwife-led research (Rosemary Bryant AO Research Centre Strategic Plan 2018-2022).

Aboriginal people, who make up around 2.8% of the total Australian population, represent around 1.1% of the total number of employed nurses and midwives in Australia.

Along with ensuring that nurse, midwife, and carer work is recognised as a key part of closing the gaps between Aboriginal peoples' and other Australians' health and wellbeing, the ANMF also supports increasing the Aboriginal nursing, midwifery, and carer workforce to be proportional with the overall Aboriginal population (ANMF Strategic Plan 2018-2023).

By enhancing the engagement of Aboriginal people in nurse and midwife-led research through training opportunities that enable awardees to become leaders that will bring positive impact for their own communities, this new program will support work in-line with the holistic concept of Aboriginal health:

'... not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life'

National Aboriginal Health Strategy Working Party 1989

Health recruitment learning from challenges and success

By Suzanne Kelpsa

Applying for a health position seemed like a simple process – find the role, meet the criteria and attach a resume. However, after several attempts at applying for roles with some successes but many more disappointments, it was clear that this simple process was much more complicated.

As a registered nurse and midwife of 17 years, there has been no educational sessions, professional career advice and support on how to apply for a health role. Even greater uncertainty has been the interview process including how to manage the nerves, fear and sometimes embarrassment of 'selling yourself'.

When applying for jobs it became increasingly apparent that, despite nursing experience, education and knowledge, there was a need to have extended skills in writing

job applications and understanding and excelling in interviews.

With many returned emails of 'thanks for taking the time to apply, however on this occasion your application has been unsuccessful' and greater critical review of personal attempts and errors, I have had opportunities for greater reflection upon the entire process.

Indeed, it can be incredibly disappointing to 'miss the mark' during an application or interview, the entire activity takes

considerable time and energy and the repeated 'unsuccessful' emails and at times vague and often odd feedback from the convenor, has now offered a compilation of learning opportunities.

This personal critical reflection and deeper understanding has been explored with a series of steps to assist in any future applications for myself and for others in a similar situation.

Therefore, as many leaders have advised 'no unsuccessful application or interview is wasted time, and they all offer considerable opportunities to personally learn and professionally grow', it has been essential to not give up and to keep moving forward.

Personally, in each and every application for expressions of interests, secondments and new roles; in success and in disappointments there has been a gradual improvement in each attempt. Consequently it is essential to gain strength and learn from the challenges and keep applying.

CRITICAL REFLECTION ON FINDING JOB SUCCESS

During job searches, a position description or information pack became essential reading. If the skills and attributes matched,



it became clear to always call the contact person.

At times calling seemed difficult and confrontational so an email was sent instead. However emailing proved to be detrimental in addressing the criteria effectively compared to making a personal connection via a call or face-to-face meeting; the latter providing a greater understanding on how to address the criteria and opportunity for the contact person to connect.

Additionally, at times, the contact person gave more flexibility when meeting the criteria and offered opportunity to flesh out specific personal suitability to meet each criteria.

Therefore, always call the contact person, gain a greater understanding of the role and begin the process of 'selling yourself'.

When writing the application, or answering questions at interviews the position description is a fantastic resource to offer key words along with individual personal skills and experience to specifically meet this position.

Furthermore, the position description, capabilities, challenges, expectations along with direction of the role greatly assisted with writing to the criteria and during the interview by using personal professional

and academic specific examples that would be easily transferable.

During a recent missed opportunity of a high grade role, the contact person suggested having a greater indepth look at each point in each question. The responses should use specific examples, identifying each and every aspect of the question to provide greater demonstration on how the applicant exactly meets the criteria/question.

Unfortunately, my previous applications only provided a broad sentence and addressed some but not all of the entire criteria. Now on reflection these applications missed all specific elements of the question.

Open discussion with management about looking for other roles was personally challenging for me in terms of privacy and worry of disharmony in my current role.

However, during another opportunity for feedback, after disappointingly being unsuccessful in a different role, the convenor stated omitting a direct line manager as a referee was seen as very concerning and 'appeared to be hiding something'.

The convenor suggested that offering referees who were friends or in similar

roles were not suitable. Alternatively the convenor suggested that to protect privacy an 'upon request or following the interview' referee detail would be appropriate.

Interestingly using this advice and having an open and frank conversation with the line manager about opportunities in the division or elsewhere was not as difficult as expected and in actual fact was welcomed and encouraged.

Management has now offered individualised support and assistance along with offering to be a referee.

Finally, always seek feedback, despite the humiliation or frustration, it demonstrates enthusiasm, greater understanding of your own application and how to improve and have greater success at the next role.

Author

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Assessing pain in residents experiencing dementia in residential aged care

By Amy Licheni and Cylo Hercelinskyj



The purpose of this study was to identify if nurses and personal care assistants were instigating best practice in pain assessment in a low-level residential aged care service.

The researcher compared pain assessment practices of nursing and care staff, to a retrospective audit consisting of 11 standards, designed by the researcher based on The Australian Pain Standards (Australian Pain Society 2005).

A three month review of each resident's medical records was conducted by the researcher, to observe for pain assessment behaviour of the nursing and care staff that complied or did not comply with the retrospective audit based on The Australian Pain Standards (Australian Pain Society 2005).

From standard four from the 11 standards in the audit; is new acute pain diagnosed promptly and treated appropriately, nine residents with dementia did not meet this standard compared with 22 residents with good cognition that complied with this standard.

Standard five: Was resident's chronic pain diagnosed promptly and treated appropriately. Nine residents with dementia did not comply, and 50% of these residents displayed non-verbal cues of pain that were not assessed and identified.

Six of the nine residents who had dementia also had a pain diagnosis. Only three residents were assessed with the Abbey Pain Assessment tool by the allied health team, which was identified by The Australian Pain Society (2005) as the gold standard for assessing pain for residents with dementia.

It was evident from this retrospective audit that nursing pain assessment of residents experiencing dementia did not meet The Australian Pain Society (2005) standards for pain assessment, compared to residents that were more cognitively able.

This study found that pain assessment for residents with dementia was less likely to be practiced by nursing and care staff. Whilst it was evidenced in the progress notes that non-verbal cues and behaviours of pain were present in some residents with dementia, it was doubtful that a pain assessment or pain intervention would occur. Barry et al. (2012) similarly found when exploring managers' beliefs and attitudes towards pain assessment and management of dementia residents that no guidelines or structured procedures for pain assessment were in place for the staff.

In addition, managers had limited knowledge of opioid use and non-pharmacological treatment for residents with dementia (Barry et al. 2012). Barreto et al. (2013) similarly argued that the lack of pain guidelines and protocols could lead to underuse of analgesia for persons with dementia.

It may be lack of knowledge and poor implementation of structured guidelines for pain assessment for dementia residents that may have resulted in the poor compliance with the standards for this research. Further research is required to understand why residents with dementia are more disadvantaged when nurses conduct pain assessments, and/or why nurses don't complete pain assessments at all.

It was also more likely if a GP was contacted about non-verbal cues of pain, that it was managed as a disruptive behaviour that sometimes required antipsychotics.

The reason for this may be lack of education and knowledge from the nurses and carers of what non-verbal cues of pain means.

There may be a pain culture in the facility that does not recognise and understand non-verbal behaviours of pain. Further research may be required into the GPs knowledge of dementia residents experiencing pain, and the impact this has on pain assessment.

Other researchers have identified that more research is required into GPs knowledge of pain for residents with dementia (Barry et al. 2012; Barreto et al. 2013).

Barreto et al. (2013) stated that GPs are responsible for the residents that they care for and questioned if GPs were aware of the pain status of the residents, why residents with dementia were not prescribed analgesia, and argued that a poor relationship between residential aged care and GPs impacts on pain management outcomes for residents.

Moreover Barry et al. (2012) discovered that nursing home managers found GPs as an obstacle for pain management and were reluctant to prescribe alternative analgesia schedules, and recommended further research into this area.

Guidelines and protocols around pain assessment and pain management need to be embedded into the pain culture of a facility. Nurses and care staff need a structured process they can follow when confronted with challenges of residents experiencing pain.

With regulatory requirements and cumbersome documentation in aged care it is important that pain assessment does not create extra documentation for staff. Pain assessment is required as a method to understand what the resident is experiencing, and to justify decision making around pain management and intervention.



Amy Licheni

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Elizabeth Foley
Federal Professional
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Reflections of my nursing career

I'm a reflective person. As I step into retirement, I've found myself looking back over my almost half-century career in nursing.

I never set out to have a 'career' – it just seemed to happen.

As a young student nurse I would never have believed the breadth and depth of experiences nursing would give me, the travel opportunities I'd get, or the people I'd meet and the wonderful friends I'd make within this profession.

From about age seven I wanted to be a nurse.

Back then, 'Cherry Ames' nursing novels gave me an idealised view of the profession which was somewhat shattered on entering PTS (preliminary training school) at 18.

"Explain and screen, offer a bedpan or urinal", was the catchcry that prefaced all our procedures.

I've remained friends with some of the girls I trained with as well as our dear Matron who still thinks of us as 'her girls'. She seemed fearsome in those days, but did let me have the Friday off the day before I got married while still a student nurse (rarely done then).

While our training was appropriate for the time, nursing education needed to expand to meet a rapidly changing healthcare system, and I staunchly supported the move to tertiary education.

When I later completed a bridging degree in nursing at the then Lincoln Institute of Health Sciences, I was fascinated with the new learnings in anatomy and physiology younger nurses were exposed to, as well as models of care.

On graduating as 'Sister Foley', I lived and worked in a small country town. The hospital is the hub of those communities and you get to know people well as they pass through for care or to support family members.

This level of involvement in people's lives means you share the excitement of a birth, the pain of traumatic and premature deaths, and the sorrow of an elderly family member's passing.

I learnt to work with little support; but there were fun times, and we'd think nothing of travelling for miles to attend regional RANF education and networking forums.

I feel privileged to have experienced both hospital-based training and tertiary nursing studies, then a Masters degree of Education because there were no available nursing Masters programs; to have practiced in regional, rural and city hospitals; to have studied and specialised in coronary care; to have held research officer and nurse educator positions; to have held senior nursing management positions - Assistant Director of Nursing Resource Management (coordinating a \$55m budget

for the nursing services) as well as Acting Executive Director, on several occasions, of a 600 bed hospital; for an incredibly busy seven months Acting as Executive Director of the former Royal College of Nursing, Australia (RCNA); and, to have actively contributed to nursing and midwifery policy development and analysis at international and national levels over the past 25 years.

I've trodden the halls of power in Canberra advocating for nursing to politicians from both sides of the House; I've known nurse and midwifery leaders in practice, academia and professional organisations from across the globe and within Australia, making firm friends of many over the years.

While at RCNA, I worked closely with colleagues at the International Council of Nurses (ICN). It was exciting when Australia was readmitted to ICN in 1997 in Vancouver – but daunting when we had two weeks to organise travel, accommodation and the merchandise to run a trade booth at the week-long conference.

I travelled extensively while at the College to showcase Australian nursing at ICN conferences, particularly educational offerings, as we were generously supported by many universities.

At some I presented papers, but always we worked hard with the trade booth activities (ours was the busiest booth as everyone wanted to travel, work and study in Australia), attending endless meetings and networking – invigorating days of working in the international nursing scene, contributing to advancing nursing globally.

My love of writing about nursing possibly started with being published in the ANJ April 1984 edition, with even the cover taking up the theme of my article!

Over the years at the College and then ANMF I've been a prolific writer with articles in national and international nursing and health journals, co-authored a book chapter, penned hundreds of submissions, reports, papers, annual reports, conference presentations (national and international) and speeches (many of these I was the ghost writer for others to deliver), and journal columns.

In a recent conference paper I highlighted the fact that nurses make a positive difference in people's lives. I firmly believe that.

My faith, family and friends have made my nursing 'career' possible.

I'm leaving the workforce. But I'll always be a nurse! And, the 'RN Foley' legacy is being carried on by my son.



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Best Practice Guidelines: Integrating person and family centred care and client centred learning into practice in a nurse-led eczema clinic

By Deryn Thompson

BACKGROUND

The Women's and Children's Health Network (WCHN), South Australia (SA), became a designated Best Practice Spotlight Organisation (BPSO) site in 2019 following a three year candidature, through the Registered Nurses Association of Ontario (RNAO) with host organisation, the Australian Nursing and Midwifery Federation (ANMF) SA Branch.

Implementing the Best Practice Guidelines of Care Transitions (2014) and the Person-and Family-Centred Care (2015) aimed to improve core staff capabilities to deliver best practice care to healthcare consumers by fostering optimal provider-client-parent relationships and client-led decisions in their healthcare (SA government 2018; ANMF SA Branch 2019). The ANMF SA Branch and the University of South Australia School of Nursing and Midwifery, partnered to create the Rosemary Bryant AO Research Centre (2017), which is committed to optimising best practice through robust, translational research.

Care Transitions are the activities undertaken by healthcare professionals and

healthcare providers to ensure safe, effective coordination and continuity of care across or between healthcare settings, and between providers, when people experience changes in health needs (RNAO 2014).

Person- and family-centred care (PFCC) enables safe, effective care encompassing the psychosocial, holistic and physiological aspects of shared care and the implementation of evidence based information. Person-centred care is a right of all healthcare consumers and a key responsibility of nurses (International Council of Nurses 2015).

LEARNING FACILITATION BY NURSES

Optimal provider-client-parent relationships and informed client/parent-led decisions in their healthcare are vital as 37% of children in Australia have at least one long term/ chronic condition requiring long-term care (Australian Institute of Health and Welfare 2012). Parents/carers often provide such care, until the child can participate in making their own decisions (United Nations Rights of the Child 1989). Parents/carers must learn the required care/treatment strategies and develop the problem-solving skills to adapt care when required. This optimally occurs

through parent education, with the learning process facilitated by nurses (Thompson & Thompson 2014). This is a key aim of the nurse-led eczema outpatient clinic at the WCHN which integrates PFCC and the Facilitating Client Centred Learning [FCCL] (2012) guidelines into the education sessions provided by the eczema nurse.

HOW THE NURSE-LED ECZEMA EDUCATION CLINIC INTEGRATES THE PFCC GUIDELINES

The PFCC guideline (2015), includes significant aspects of client education: listening, identifying cultural and personal beliefs, life circumstances, taking adequate time to establish and respect people's perceptions of their health and previous experiences. Each person's health literacy is considered. Nurses must recognise that health literacy relates not only to the reading and writing skills needed to understand information provided, but also to the cognitive (learning) aspects of health literacy, whereby people interpret and apply the information provided (Wolf 2009; Australian Commission on Safety and Quality in Health Care 2017; RNAO 2015).

Nurses facilitate this through a learning process, which Braungart et al. (2011), building on the robust research from educational psychology (Gagne 1985; 2005), describe as a:

planned, multi-layered, logical, evaluated set of opportunities in which health professionals facilitate patients, carers and parents to interpret information, develop analytical thinking and reasoning skills, reorganise information, develop problem solving capabilities and become motivated to change their behaviours in not only their thinking, but how they provide care.

A multitude of studies exemplify the determinants of learning (Kitchie 2011), including learning needs, information preferences, styles and readiness which influence how people learn (Jackson et al. 2007; Ramsay et al. 2017).

A plethora of literature also describes teaching strategies; the activities that help nurses communicate information required in the learning process, once learning needs are identified (Fitzgerald 2011). The strategies support the required behavioural outcomes for parents'/carers' autonomous care, but are not the learning process itself (Braungart et al. 2011). Tools which help nurses identify patient learning needs (Nightingale et al. 2017) and health literacy abilities (Kim & Xie 2017) are useful, but may distract nurses from developing their understanding of how to activate and

facilitate the cognitive aspects of learning (Thompson 2017).

For this, nurses must help parents to process the information given, link it to what they already know, store and retrieve the information, build practical and factual knowledge, and understand the practical skills needed to apply their knowledge meaningfully, to care for their child, eventually mastering the required care (Thompson 2017). Kitchie (2011), Friberg et al. (2012) and RNAO (2015) suggest many nurses may not really understand how people learn. In the PFCC guideline, 'learning' facilitation is not expanded to provide additional guidance nurses need to optimise clients' cognitive learning processes.

INTEGRATING FACILITATING CLIENT CENTRED LEARNING

The RNAO, BPSO document, 'Facilitating Client Centred Learning (2012)', does incorporate many key aspects of the learning process as described earlier, to guide nurses. As FCCL guideline focusses on the care of people 18 years and over, the concepts can be applied to parents/carers of children (RNAO 2015 p. 5).

Optimal patient/parent education practice requires simultaneous use of both PFCC (2015) and the FCCL (2012) guidelines.

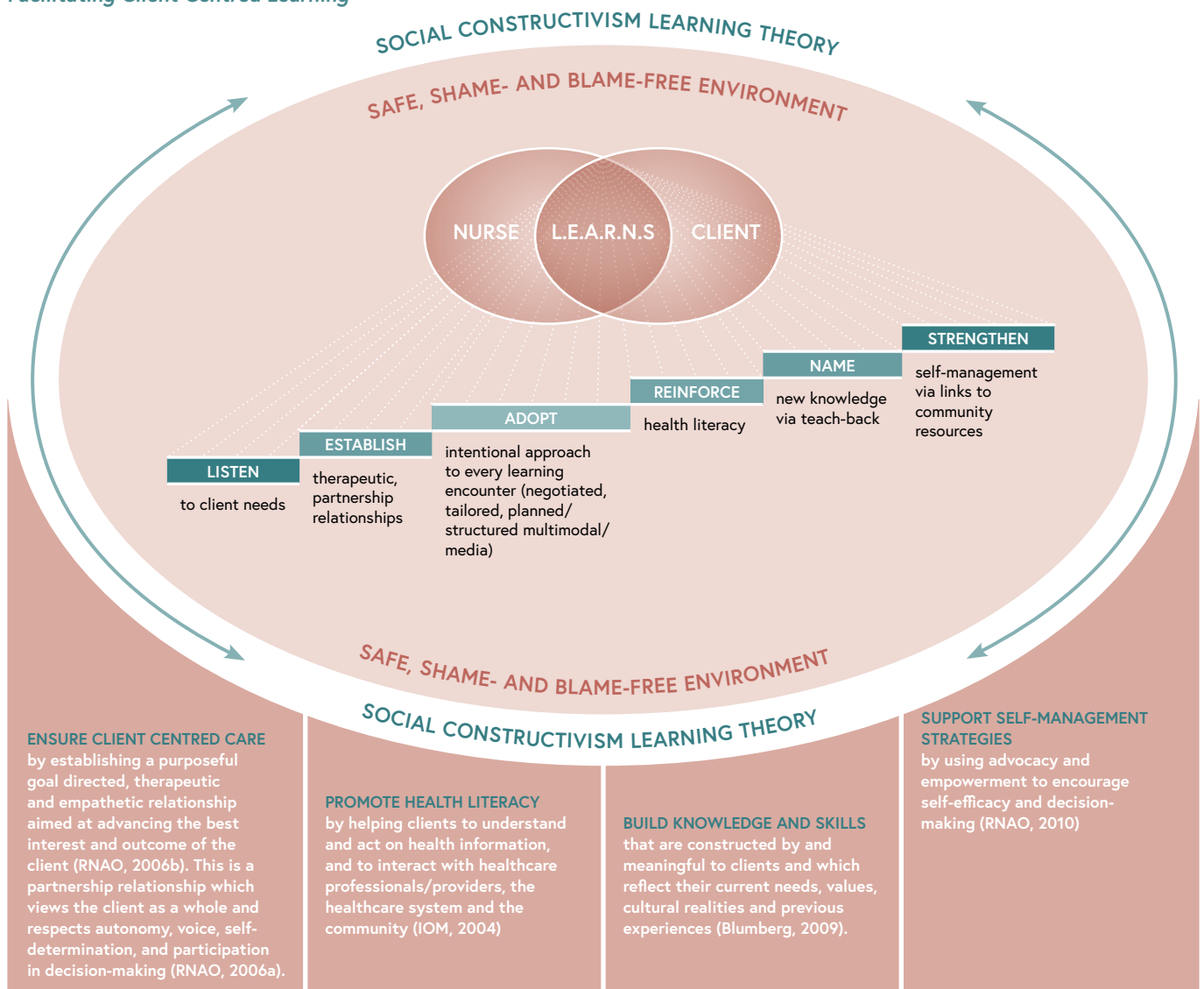
The FCCL (2012) guideline is underpinned by the theory of social constructivism. A central tenet of FCCL is the model with

the acronym L.E.A.R.N.S. (listen, establish, adopt, reinforce, name and strengthen), shown in **Figure 1**.

The model contends that in a learning process clients (and parents when the client is a child) link new and existing knowledge, in their life and social context, to create their own understanding, guided by support from the nurse/health professional (Beck & Kosnik 2006, cited in RNAO 2012 p. 15).

Each person's learning needs and understanding must be evaluated, to help the nurse identify gaps in the clients'/parents' learning or the nurses' own practice, to allow adjustments to be made as the learning process progresses towards autonomous care (Thompson & Thompson 2014).

FIGURE 1:
 'L.E.A.R.N.S.' model from Registered Nurses' Association of Ontario, 2012
 Facilitating Client Centred Learning



The chronic, fluctuating and incurable nature of eczema, affecting one in three of Australian children (Martin et al. 2013), requires nurses to provide comprehensive, face-to-face, interactive eczema education and ongoing support to parents and children to reach their goal of learning how to apply their knowledge to manage the condition (Thompson & Thompson 2014). The eczema nurse is mindful that the significant, often under-recognised psychosocial impact of eczema on these families, influences parent/carer learning capabilities (Santer et al. 2014).

USING PFCC AND CCL BEST PRACTICE GUIDELINES TO ACTIVATE THE LEARNING PROCESS

At the first appointment, the eczema nurse **LISTENS** to the parents (and child) relate information about their eczema journey, including previous interactions with health professionals, as these all influence the learning process (Thompson 2017). The nurse identifies parents' existing knowledge of eczema, management experiences and effective strategies parents are using. Listening also helps the nurse to establish health literacy levels, learning styles, learning needs and readiness to learn (Wolf et al. 2009) and identify where adaptations to the teaching strategies are needed. This information is consolidated with information provided in the doctor's referral letter. This approach helps the eczema nurse **ESTABLISH** a therapeutic relationship, foundational to the necessary learning (Thompson 2017).

In partnership with the child and family, integrating the PFCC approach (RNO 2016), the eczema nurse helps the child and parents/carers to distinguish between the factual (declarative) knowledge about eczema and the practical (procedural) knowledge (Thompson & Thompson 2014). Using the brick wall analogy (Figure 2), described in detail elsewhere (Thompson and Thompson 2014), the nurse explains what causes eczema, helping the child and parents to learn why they must use thicker moisturisers several times daily and the correct way to apply moisturiser.

The child and parent/carers can connect to previous experiences and knowledge, understanding better why the runnier moisturisers used previously, were unsuccessful. This pictorial analogy also helps the eczema nurse explain the rationale for the prescribed topical corticosteroid preparations lessening the reddened, itchy areas (Thompson & Thompson 2014).

Understanding the rationale potentially reduces parents' fear of topical corticosteroids that commonly limits their application when needed (Smith et al. 2013). This approach aligns with the FCCL guideline (2012). See Figure 2.

Goals of management are established, linked to what the doctor prescribed, what strategies can work for the family's life and financial circumstances discussed and **ADOPTED**. Information is broken into small achievable steps, to seem less overwhelming. The nurse demonstrates the practical skills required and provides the opportunity for parents/carers to practise skills under supervision (Thompson & Thompson 2014).

Having too much information to learn at one time is a well described barrier to effective learning (Thompson & Thompson 2014). By creating a metaphorical 'eczema toolbox', the child and parents can put into the 'toolbox' any strategies that may not be appropriate to use at that timepoint. Parents also learn that eczema flares are common when a child develops an illness, or cuts teeth. Most importantly, armed with this knowledge, parents recognise that treatments did not 'fail'; they adjust care as necessary (Thompson & Thompson 2014).

It is crucial that the eczema nurse explains these phenomena. A simple explanation for learning is: The links between the skin and the immune system mean that when

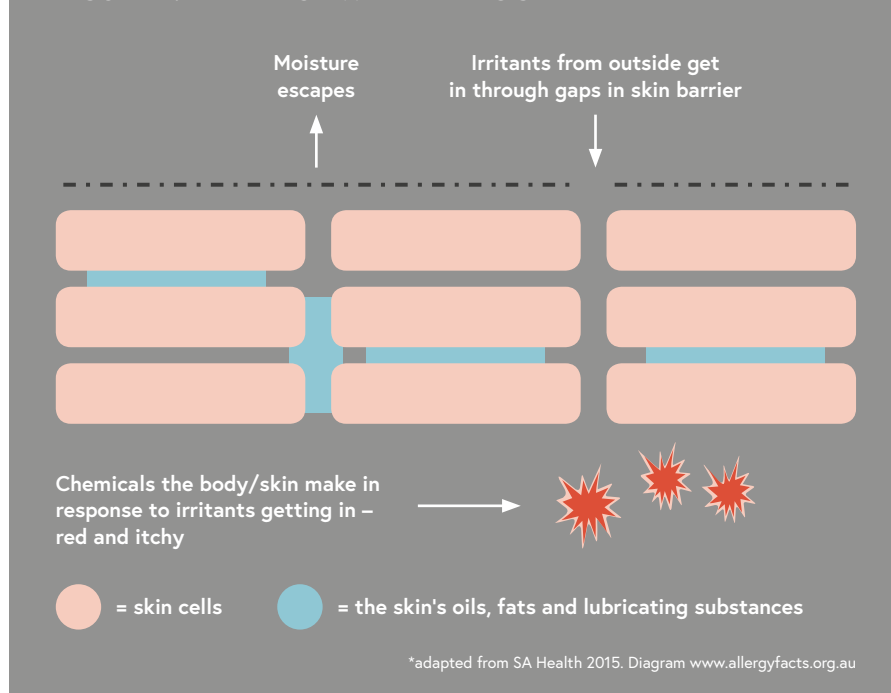
a child is fighting an infection the skin becomes involved causing the eczema to flare (WCHN 2015).

Parents recognise the need to adjust treatments as recommended on the eczema care plan. Providing a rationale for the flare reduces the likelihood that parents will abandon recommended treatments (Thompson 2017).

The nurse is **REINFORCING** important learning points helping parents to apply their knowledge and skills, building confidence, acting as a motivator as the child and parents/carers develop and practise the skills, moving towards mastering the complexities of effective care.

NAME, involves using 'teach-back', whereby clients repeat back, in their own words, what they have understood from the nurse's explanation (Schillinger et al. 2003). However, some researchers propose many nurses still struggle to evaluate effective communication in teach-back (Ha Dinh et al. 2016). Ideally, nurses should not reply upon one consultation to assume 'teach-back' demonstrates an effective learning process or long-term understanding of what transpired (Braungart et al. 2011; Thompson & Thompson 2014). Research suggests that teach-back alone, does not identify longer-term learning and understanding, as many 'teach-back' studies are of short duration (Griffey et al. 2015; Ha Dinh et al. 2016).

FIGURE 2: THE BRICK WALL ANALOGY*



Effective learning is best demonstrated when nurses provide parents/carers with scenarios related to their situation, with parents'/carers' validating understanding by answering the nurse's questions, explaining their actions, should situations develop (problem solving) that would affect the eczema trajectory (Wolf 2009; Battista 2017). Communication with parents/carers at a subsequent visit or via a follow-up telephone call, many weeks or even months later, to see if they have applied their learning in various situations at home (Mason et al. 2013; Thompson & Thompson 2014) can enable any misconceptions to be corrected and any care parents/carers found challenging or unsuccessful, revisited and adjusted with the nurse.

STRENGTHEN is the stage where the nurse evaluates if the learning process has been effective. Once parents can answer the scenario questions confidently, are less anxious about fluctuations in the condition and make decisions to adapt treatment strategies when needed, the nurse's role as a facilitator and motivator decreases significantly. Successful 'self-management' is shown when parents/carers have developed skills of autonomy, empowerment, problem solving and decision-making as the result of a successful learning process within FCCL (2012) and PFCC (2015). Critical to this stage of the learning process, is that the nurse provides additional resources for parents to access eczema support if needed, following discharge. Correspondence is sent to the child's general practitioner and/or other healthcare professionals involved with their care.

CONCLUSION

This article outlines how the RNAO FCCL (2012) and PFCC (2015) guidelines have been implemented into the eczema nurse's practice at WCHN to facilitate learning in parents of children with eczema. It can help nurses see how they can activate a successful learning process integrating two Best Practice Guidelines into their practice to become effective educators.

The FCCL (2012 p. 49) guidelines development panel suggest important gaps still exist in the skills nurses require to enact the learning process, the opportunities for nurses' education to implement FCCL in various settings and the effectiveness of the LEARNS model. ANMF SA Branch (2019) conduct training workshops.

A research project, involving the WCHN is also underway to identify how paediatric and child health nurses use the Principles of Learning to activate and facilitate the learning process in nurses' clinical practice.

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Conflicts of interest

DT has no conflicts of interest to declare and did not receive any form of payment from any source or funding for writing this article.

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Anxiety disorders tutorial

By ANMF Federal Education Team

The following excerpt is from the ANMF's Anxiety disorders tutorial on the Continuing Professional Education (CPE) website.

Anxiety is a normal part of life and mild anxiety can be productive, such as the anxiety experienced prior to taking an exam or when faced with a threat.

This type of anxiety works to increase our level of alertness and cope with the stress of the exam. If we are faced with danger, anxiety will stimulate physiological responses that trigger the 'fight' or 'flight' response, allowing us to fight the danger or run from it.

When anxiety is irrational or becomes unmanageable it is likely due to an anxiety disorder, of which there are several types.

Anxiety disorders are classified as a mental illness, and comprise of consistent fear and worry which affects most aspects of daily living. Anxiety disorders can lead to depression.

- **One quarter of Australians will experience an anxiety condition in their lifetime.**

Breakdown: 26.3% of Australians aged 16 to 85 have experienced an anxiety disorder. This is equivalent to 4.96 million people today.

- **One in seven Australians is currently experiencing an anxiety condition.**

Breakdown: 14.4% of Australians aged 16 to 85 have experienced an anxiety disorder in the last 12 months. This is equivalent to 2.71 million people today.

- **One in six Australians is currently experiencing depression or anxiety or both.**

Breakdown: 17% of Australians aged 16 to 85 have experienced an anxiety and/or affective disorder in the past 12 months. This is equivalent to 3.2 million people today. Note: the percentage of Australians who have lifetime experience of anxiety and/or an affective disorder is unknown.

- **Females are more likely than males to experience depression and anxiety.**

One in six females will experience depression in their lifetime compared to one in eight men. One in three females will experience an anxiety condition in their lifetime compared to one in five men.

Breakdown: 17.8% of females aged 16 to 85 will experience an affective disorder in their lifetime compared to 12.2% of men. Thirty two percent of females aged 16 to 85 will experience an anxiety disorder in their lifetime compared to 20.4% of men (ABS 2016).

Anxiety disorders are believed to be caused by combinations of factors, these include:

- The first consideration is the possibility that anxiety is due to a known or unrecognised medical condition. Substance-induced anxiety disorder (over-the-counter medications, herbal medications, substances of abuse) is a diagnosis that often is missed.
- Genetic factors significantly influence risk for many anxiety disorders.
- Environmental factors such as early childhood trauma can also contribute



to risk for later anxiety disorders. The debate whether gene or environment is primary in anxiety disorders has evolved to a better understanding of the important role of the interaction between genes and environment.

- Some individuals appear resilient to stress, while others are vulnerable to stress, which precipitates an anxiety disorder (Mayo Clinic 2018).

All anxiety disorders have specific symptoms and essential criteria they must meet to reach diagnosis, but the central features of severe anxiety are:

- Feeling nervous, restless or tense
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation)
- Sweating
- Trembling



- Feeling weak or tired
- Trouble concentrating or thinking about anything other than the present worry
- Having trouble sleeping
- Experiencing gastrointestinal (GI) problems
- Having difficulty controlling worry
- Having the urge to avoid things that trigger anxiety (Mayo Clinic 2018).

Individuals with anxiety disorders may experience some or all of the symptoms mentioned, and different anxiety disorders stipulate a minimum number of symptoms that must be experienced within a given timeframe in order to establish a diagnosis.

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) describes anxiety as 'anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioural disturbances'. Fear is the

emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviours, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviours. Sometimes the level of fear or anxiety is reduced by pervasive avoidance behaviours. Panic attacks feature prominently within the anxiety disorders as a particular type of fear response. Panic attacks are not limited to anxiety disorders but rather can be seen in other mental disorders as well (Psychiatry Online).

The manual identifies the following disorders as anxiety disorders and the anxiety must be to such an extent that it

interferes with the individual's ability to carry out normal activities of daily living, such as attending work or school.

1. Separation anxiety disorder
2. Selective mutism
3. Specific phobia
4. Social anxiety disorders (social phobia)
5. Panic disorder
6. Panic attack specifier
7. Agoraphobia
8. Generalised Anxiety Disorder (GAD)
9. Substance/medication induced anxiety disorder
10. Anxiety disorder due to another medical condition
11. Other specified anxiety disorder
12. Unspecified anxiety disorder (Psychiatry Online).

Anxiety disorders can be distressing and debilitating. They may contribute to loss

EDUCATION

of educational and employment opportunities and difficulties in family and social relationships. Recovery is possible with appropriate treatment such as exposure therapy, attention training, and a range of anxiety management techniques that can help you manage your symptoms (Better Health Channel 2017).

Treatment for anxiety disorders may include cognitive therapy, exposure therapy, attention training, counselling, diet and exercise and the use of techniques including relaxation and assertiveness training.

Medication can help to alleviate anxiety symptoms, but is not a long-term solution. SSRI's are anti-depressants and are currently the most popular anti-depression/anti-anxiety drugs as they have fewer side effects than Monoamine Oxidase Inhibitors (MAOI's).

Psychotherapy involves talking with a trained mental health professional, such as a psychiatrist, psychologist, social worker, or counsellor, to discover what caused an anxiety disorder and how to deal with its symptoms. Cognitive-behavioural therapy (CBT) is very useful in treating anxiety disorders. The cognitive part helps people change the thinking patterns that support their fears, and the behavioural part helps people change the way they react to anxiety-provoking situations (National Institute of Mental Health 2018; Better Health Channel 2017).

In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both. Treatment choices depend on the problem and the person's preference.

Before treatment begins, a careful diagnostic evaluation must be conducted to determine whether a person's symptoms are caused by an anxiety disorder or a physical problem.



If an anxiety disorder is diagnosed, the type of disorder or the combination of disorders that are present must be identified, as well as any coexisting conditions, such as depression or substance abuse.

Sometimes alcoholism, depression, or other coexisting conditions have such a strong effect on the individual that treating the anxiety disorder must wait until the coexisting conditions are brought under control (National Institute of Mental Health 2018; Better Health Channel 2017).

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**30 minutes
CPD**

The following excerpt is from the ANMF's Anxiety Disorders Tutorial on the Continuing Professional Education (CPE) website. The complete tutorial is allocated two hours of CPD, the reading of this excerpt will give you 30 minutes of CPD towards ongoing registration requirements.

The complete tutorial covers: causes in detail, types of anxiety disorders and phobias in detail, treatment options in detail including medications, suggested readings.

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

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

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FOCUS

**MEDICAL / SURGICAL
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**MATERNAL HEALTH
& MIDWIFERY**

**EDUCATION
PART 1**

Graduate nurses' experiences of reporting clinical incidents: What we don't know

By *Asiye Kopan, Stephen McNally, Antoinette Cotton and Peter Lewis*

A clinical incident is defined as any unplanned event which causes or has the potential to cause harm to a patient (Clinical Excellence Commission (CEC) 2019).

In NSW, healthcare providers are required to manage the notification of incidents by being open about failures and while there is an upward trend of reporting by nurses, the Clinical Excellence Commission have indicated incident reports are fragmented and incomplete.

Therefore, known failure mechanisms may go undetected and the gravity of not knowing how and why incidents occur has led to harmful outcomes for patients (CEC 2019).

Although it has long been established that reviewing and investigating the cause of clinical incidents greatly improves a health system to maintain quality and address patient safety, (CEC 2019) nurses are known to experience barriers to reporting clinical incidents, such as difficulty admitting to mistakes, reluctance to appear incompetent and the fear of litigation.

They also experience knowledge deficits in reporting systems, time constraints, and inadequate feedback from management, unsatisfactory processes and perceived lack of confidence in the patient safety reporting systems (Harrison et al. 2014).

New graduate nurses are known to experience difficulties coping within unsupportive and disruptive workplace environments (Sahay, Hutchinson & East 2015).

However, there is little evidence exploring the issues related to new graduate nurses and reporting clinical incidents. In order to maintain quality and safety for consumers within healthcare organisations, it is vital that an Inquiry is conducted to understand how graduate nurses experience incident reporting at the start of their careers.

A qualitative study using Interpretative Phenomenological Analysis is being conducted to understand the experiences of eight new graduate nurses in reporting clinical incidents.

A semi-structured interview schedule was used and an in-depth analysis is currently underway. The findings from this study will inform clinicians and educators about the practices of incident reporting by new graduate nurses. Increased awareness related to how undergraduate students can be taught to define, identify and understand the processes involved in navigating reporting systems in order to maintain quality and safety for consumers within healthcare organisations.

Understanding work related pressures associated with clinical incident reporting may also lead to new graduate retention.

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Chronic Obstructive Pulmonary Disease (COPD), is it more than smoking related disease?

By Jody Hook and Sheree Smith

Nearly every nurse, at some stage of their career, will care for a patient with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

More often than not, these patients are described to colleagues as a 'typical COPD patient'. This raises an important clinical question, what is a typical COPD patient. Our clinical experience suggests that they are smokers, possibly overweight and may be thought to be non-compliant and a challenge to provide ongoing care.

Smoking is currently the prevailing cause of COPD and smoking cessation is considered the most effective preventative intervention (COPDX 2018).

Whilst this remains true, with the increasing concept of personal responsibility for one's health, adults with COPD often experience shame and regret for smoking in the past or for being unsuccessful in their attempt to quit (O'Connor et al. 2017). Patients experience stigma that the disease is self-inflicted, a moral weakness or character flaw (Halting et al. 2011).

This may lead patients to feel they are of less value and less deserving of care from health professionals (Johnson et al. 2007).

In 2017, international COPD experts, Dr Celli Bartolome and Dr Alvar Augusti, published *COPD: time to improve its taxonomy* challenging the traditional understanding of COPD (Bartolomé & Alvar 2018).

They proposed COPD could be considered more as a syndrome than a disease and this syndrome may have up to eight different classifications based on the patient aetiology (Bartolomé & Alvar 2018).

These classifications include 'pre-COPD' for patients that have evidence of abnormal lung structure and normal airflow values, genetic COPD (COPDg), biomass exposure COPD (COPDb), COPD due to infections (COPDi), pre-existing uncontrolled asthma leading to COPD (COPDa), COPD due to abnormal lung development (COPDd), COPD of unknown cause (COPDu) and finally, cigarette smoking leading to COPD (COPDc).

This proposed classification has been the genesis of numerous studies around the world including epigenetics and genomic research along with the addition of new biologic and immunotherapies for these patients.

While our understanding of different COPD classifications is in its infancy and not yet ratified by the wider COPD health professional community, it demonstrates that there may not be a 'typical COPD patient'.

As health professionals, nurses may ask 'are we doing our patients a disservice by assuming they are all the same and is it time to reconsider our respiratory nursing practice based on new and current evidence'.

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Accuracy of PRE-DELIRIC (PREdiction of DELIRium in ICU patients) delirium prediction model: A systematic review and meta-analysis

By Mu-Hsing Ho, Megan F Liu, Kevin Shu Leung Lai, Kee-Hsin Chen, Hui-Chen Chang and Victoria Traynor

ABSTRACT

Background: Delirium is hard to be detected and diagnosed in the intensive care unit (ICU) settings. Delirium prediction model (PREdiction of DELIRium in ICU patients, PRE-DELIRIC) was developed to assist critical healthcare professionals to predict delirium effectively. This study aimed to evaluate the predictive accuracy of the PRE-DELIRIC model.

Methods: A systematic literature search was performed using the Cochrane Library, PubMed, CINAHL, Embase, and Scopus. Studies evaluated the diagnostic performance of PRE-DELIRIC and published in English or Mandarin from inception until December 2018 were included.

The revised quality assessment of diagnostic accuracy studies (QUADAS-2) was used to assess the methodological quality of the included studies by two review authors independently.

The moderate risk (20-40%) group of PRE-DELIRIC was used as a cut-off point to be evaluated. Data were pooled on the basis of sensitivity, specificity, and diagnostic odds ratio (DOR) by the bivariate random effects model. Overall test performance was summarised using a hierarchical summary receiver operating characteristic (HSROC) curve and the area under the curve (AUC).

The univariate meta-regression analysis was adopted for identifying potential source of heterogeneity in the diagnostic performance.

Results: We identified eight studies with a total of 5,817 critical ill patients. When predicting delirium in the meta-analysis, the result revealed pooled sensitivities and specificities of 0.58 (95% confidence interval [CI] 0.40-0.73), 0.86 (95% CI 0.73-0.93) for a moderate risk level of PRE-DELIRIC score respectively, with a DOR of 8.00 (95% CI 6.00-12.00) and the AUC was 0.80 (95% CI 0.76-0.83).

In meta-regression, an average length of ICU stays, on mechanical ventilation and percentage of male patients were associated with study heterogeneity.

Conclusion: PRE-DELIRIC yield good discrimination in predicting delirium among moderate risk group of critical ill patients, but the results must be interpreted with caution due to the between-study heterogeneity.

Keywords: Delirium, PRE-DELIRIC, Critical Care, Intensive Care Unit



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Make way for the weigh chair

By Venicia Espiritu and Kelly Percy

Fluid balance describes the balance of fluid input and output in the body (Welch 2010). Losing the balance between input and output may cause significant problems, especially for patients whose health is already compromised (Masaki & Mahendiran 2016).

Patient history, assessment, observations, blood and urine tests along with daily weights and fluid balance charts (FBCs), are tools clinicians use to assess patients' hydration status. However, FBCs are limited by omission or duplication of data, mathematical errors, incompleteness and difficulties associated with estimating insensible losses, which vary according to the environment and patient's disease process (Eastwood 2006; El-Sharkawy et al. 2014; Shepherd 2011).

Currently, there is no gold standard to measure a patient's hydration status (Fortes et al. 2015). This project set out to find the best available evidence to measure a patient's hydration status.

LITERATURE SEARCH STRATEGY

The following databases were searched- Ovid MEDLINE @ ALL, JBI ConNECT+ and CINAHL Complete. Search terms were – “hydration status”, “measur* or assess*”, “fluid status”, “body water”, “water-electrolyte balance”, “dehydration”, “diagnosis”, “fluid balance”. The search was limited to published articles only, those in English language and dated back to the last fifteen years. The reference lists of selected articles were also hand-searched. Joanna Briggs hierarchy of evidence has been used to evaluate the strength of the evidence.

RESULTS

A prospective, observational study of 147 ICU patients (cardiac, cerebral, septic and others), found the correlation agreement between body weight changes (measured on admission and discharge), net cumulative and adjusted cumulative FBCs to be poor. The reliability and validity of cumulative FBCs and their use in both the clinical and research environment cannot be justified as a standard of care (Perren et al. 2011) – Level 3

A prospective, observational study of 106 critically ill patients, confirms daily standardised weighing is a more accurate way of estimating fluid balance when compared with cumulative FBCs (Koster et al. 2017) – Level 3

Evaluating measurement resolution, accuracy and validity of 13 hydration assessment techniques,

found body weight changes were the most accurate measure of hydration status in real time. They were associated with little cost and time, required small technical expertise, portable and had a low likelihood of adverse events (Armstrong 2007) – Level 5

Serum and plasma osmolality are the most commonly used reference standards for measuring water-loss dehydration, in the absence of data trends over time. Fluid intake, urine specific gravity, urine output, urine volume, heart rate, dry mouth and reports of feeling thirsty are tests that should not be used individually to assess for dehydration in patients >65 years of age (Hooper et al. 2015) – Level 2

It is recommended clinical observations, in conjunction with patient history, physical examination, laboratory results and clinical experience should be used to diagnose dehydration (Armstrong et al. 2016) – Level 5

RECOMMENDATIONS FOR PRACTICE

A standardised daily weigh is the simplest and most accurate measurement of fluid hydration status (Armstrong 2007).

Weights should be recorded at the same time each day, using the same calibrated scale and baseline clothing (Vivanti et al. 2013). Weighs should be performed after the first void and before breakfast (Bak, Tsiami & Greene 2017).

In the absence of data trends over time serum and plasma osmolality may be used to assess hydration (Hooper et al. 2015).

There is no single gold standard for measuring fluid hydration. Assessment is multi-factorial and should include observations, patient history, physical examination, blood results and clinical expertise (Armstrong et al. 2016).

One of the tenets of evidence based practice, is that practice change should add value to what we are doing. It is therefore recommended that we stop adding up the cumulative values on the FBC, a practice which adds no value and replace it with a value-adding daily weigh.

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Venicia Espiritu, RN and Kelly Percy, A/Clinical Nurse/Clinical Facilitator both work at the Rapid Assessment Medical Surgical Unit/Early Assessment Medical Unit/Day Unit of Investigations and Therapies at The Prince Charles Hospital.



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Healthy happy beginnings: A co-designed model of group pregnancy care

By The Healthy Happy Beginnings Partnership

Women from a refugee background are at increased risk of poor maternal and perinatal outcomes.

They are more likely to have a baby that is stillborn or that dies soon after birth compared with Australian-born women (Gibson Helm et al. 2015; Davies-Tuck et al. 2017; Heslehurst et al. 2018).

The Clinical Practice Guidelines: Pregnancy Care identifies antenatal groups as having the potential to meet the needs of populations vulnerable to poor outcomes, including women of refugee background (Department of Health 2018).

Healthy Happy Beginnings was named by and co-designed with Karen community members (women and men predominantly from refugee camps on the Thai/Burma border) and healthcare providers and refugee settlement services. The Karen community said they wanted to:

- access pregnancy care close to home (due to transport barriers);
- access professional interpreters;
- meet other people from the community also having a baby;
- learn about what to do to have a healthy pregnancy; and
- find out what to expect from labour and childbirth in a hospital setting.

A local partnership group was established to enable collaboration between Werribee Mercy Hospital, Wyndham City Council maternal and child health service, VicSEG New Futures and the Karen community.

Using the feedback provided by the Karen community, the group developed an innovative model of community-based antenatal and postnatal care located in Werribee, an outer suburb of Melbourne. The Murdoch Children's Research Institute provides facilitation support and is coordinating an evaluation.

Healthy Happy Beginnings provides culturally appropriate clinical and preventive healthcare, information and support in the women's own language during pregnancy in a group setting, with follow-up after birth.

Reflections from staff:

"... we have noticed that word of mouth travels fast, with the woman attending the group only days after arriving in this country. This supports the idea that our program provides pregnant women of Burma with a safe place to access their maternity care ..."



It is our goal to ensure these women feel as safe as possible and empower them to have a voice. As the saying goes, 'it takes a village to raise a child'. HHB has created a village that provides a pathway to genuine improvements in maternity care for refugee women" (Midwife).

"When a refugee comes to Australia she soon learns that her pregnancy experience will be quite different. She does not have the benefit of family and community living close to her for support... She feels isolated and alone, and she is confused by all the things she is expected to do. The Healthy Happy Beginnings program has been designed to improve these problems by running fortnightly groups to focus on physical, social and emotional issues of refugee mothers and their young children" (Bicultural Refugee Family Resource Mentor).

In an evaluation, Karen women reported that the program made them feel confident and reassured about their pregnancy, labour and birth and going home with a new baby (Riggs et al. 2017).

Further information can be found on the website: mcri.edu.au/search/site/grouppregnancycare

For more information please contact: Dr Elisha Riggs, Senior Research Fellow, Intergenerational Health, Murdoch Children's Research Institute and Senior Fellow, Department of General Practice, The University of Melbourne Murdoch Children's Research Institute, Victoria.

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The Exploring Student Midwives' Experiences (ESME) project – NSW

By Virginia Stulz, Belinda Dewar and Jacqui Cross

The Exploring Student Midwives' Experiences project (ESME) is a body of work to help progress improving the experiences of student midwives.

This work was commissioned by the Nursing and Midwifery Office, NSW Health and is a joint initiative with University of the West of Scotland, School of Nursing and Midwifery, Centre for Nursing and Midwifery Research, Nepean Hospital, Western Sydney University and three other local health districts including South Eastern Sydney (St George Hospital), Western Sydney (Blacktown Hospital) and Hunter New England Health (John Hunter).

The research used an appreciative inquiry approach that enabled the research team to discover what matters and works well at present in the student midwife experience from the perspective of student midwives and midwives and to use this knowledge to create enhanced experiences in the future.

Successful relationships between student midwives and midwives were the key underpinnings of fruitful, learning environments. Relationships enabled and increased the capacity of students' knowledge and

the ability of students' future inquiry into their own clinical decision making skills and feeling comfortable and brave enough to speak up and ask questions about setting their own goals whilst working alongside midwives in the clinical areas.

Other studies (Gray 2018; Pryjmachuk & Richards 2008) have also identified that interpersonal relationships and successful learning experiences contributed to students transitioning into the workforce as confident health practitioners. What this study has identified are the dimensions of these relationships ie. the senses and aspects that enhance these dimensions to happen more of the time.

An Envision Event day was held in December 2018 that enabled the researchers to share and co-create the data with students, midwives, managers and leaders from the four local health districts. The appreciative inquiry methodology enabled all student midwives, midwives, researchers and co-inquirers to take an approach that was curious and focus on the positives of an organisation and the people within and explore further about what was working well and to improve and enhance these experiences. This process enabled all who participated in the study to become aware of assumptions they might make and being open to re-frame how each individual may use language, jargon and respond to others in the workplace.

This appreciative inquiry study has highlighted many challenges in the student midwife and midwife experiences and also gives an indication about what they value. It is important to explore the student midwife experience in collaboration with the midwives themselves and co-create and evaluate strategies to enhance their experiences.

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Researchers at the Envision Event Day in December, 2018.
Back row L to R: Kelley Lennon, Belinda Dewar, Tamsin MacBride, Karen McLaughlin, Louise Connolly, Katie Newport, Nicola Drayton.
Front row L to R: Michael Peregrina, Alexa Buliak, Susan Rebolledo, Virginia Stulz



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Credit: School of Nursing and Midwifery, La Trobe University

Contemporary child, family & community nursing education at La Trobe University

By Catina Adams, Lael Ridgway, Leesa Hooker and Carolyn Westall

Early last century almost 15% of Australian infants died within a year of their birth.

In poorer Melbourne suburbs where families lived and worked in appalling conditions, high rates of infectious disease and poor nutrition were recorded (Flood 1998). In response, an Infant Welfare Service was founded.

One hundred years later, the Maternal and Child Health (MCH) service in Victoria works in partnership with parents and early years' services to promote healthy outcomes for children and their families (Department of Education and Early Childhood Development 2009).

Jointly funded by local government and the Victorian state government, the MCH service is free, and includes a universal service, an enhanced home visiting program which provides additional support for vulnerable families and a 24-hour MCH phone line. The service has almost 100% engagement with families at birth.

The MCH service incorporates family partnership and strength-based models of care (Department of Education and Training 2017). The MCH nurse plays an increasing role in identifying and supporting women

experiencing family violence (State of Victoria 2016). This includes applying a trauma informed lens to the care and support of families.

The Victorian state government has offered scholarships to attract nurse/midwives to the MCH service. At least half of our students live in regional or remote areas, and these areas are keen to recruit local MCH nurses. The rising birth-rate in Victoria has also increased the demand for MCH nurses.

In 2019, La Trobe University introduced a restructured Graduate Diploma in Child, Family and Community Nursing. The accredited study program refines the previous curriculum and enables increased focus on the educational, professional and clinical needs of students. The new program meets Australian Quality Framework standards and qualifies graduates to work in child, family and community health nationally. Offered via flexible delivery, the course is attractive to rural and remote students, as well as students who are combining study with work and family responsibilities.

Lecture content is delivered online and resources are available for students electronically, ensuring students have access to quality, contemporary research. Learning is enhanced by webinar-style discussions (via *Zooms*), and interactive noticeboards. Students undertake a minimum of 310 hours of clinical placement and are supported on their placement by MCH nurse clinical preceptors.

The course can be undertaken full time (over 12 months) or part time over two years, with elective studies including lactation, nurse immuniser, infant mental health, family violence, or family planning and sexual health. Students can apply to articulate from the Graduate Diploma to the Master of Nursing Science program, and potentially PhD or professional doctorate programs.

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Sari Holland, Midwifery Unit Manager (L) and Rhonda Taylor, Clinical Midwifery Consultant (R)

Immersive sensory experience during labour – is it the way forward?

By Sari Holland, Rhonda Taylor, Mariann Hadland, Wendy Smyth and Cate Nagle

It is well established that the environment in which a woman labours has an impact on her experience and behaviour during labour and birth, birth outcomes and breastfeeding (Hammond et al. 2014; Hodnett et al. 2012).

However contemporary birthing rooms in Australia and other high-income countries vary from welcoming homelike settings to those that are medicalised and clinical in appearance. Stenglin & Fourer (2013) proposed that birth spaces that help women to feel safe and secure may reduce the rate of caesarean section. A review of systematic reviews on pain management found some evidence to support the use of sensory distraction to improve the management of labour pain (Jones et al. 2012).

This evidence has led a team of midwives and researchers at Townsville Hospital to design and

evaluate an innovative intervention that aims to provide distraction, relaxation and comfort. The Immersive Sensory Experience is provided in one birthing room where a ceiling mounted projector can be utilised during labour to create an environment that suits the woman's individual needs. The woman has a choice of audio-visual images that are projected onto a wall. Images include scenery, including images of local country, and a variety of visual effects that can be moving or static. There is also a variety of relaxing digitally recorded sound tracks from which the woman can choose.

The Immersive Sensory Experience is currently being trialled with women attending the Midwifery Group Practice at Townsville Hospital. The Midwifery Group Practice provides continuity of care to women across all risk categories. The quasi experimental study is measuring the impact of the intervention on mode of birth, and other outcomes that include pain management, duration of labour and breastfeeding rate at six weeks. Women's experience of using the Immersive Sensory Experience during labour will be explored by interviews, as will the perspectives of midwives.

There is limited amount of evidence on sustainable innovations to promote physiological birth within a conventional hospital birthing environment. The results of this study will translate to practice, education and policy.

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The prevalence and aetiology of distress experienced by women with primary breast cancer upon commencement of neoadjuvant chemotherapy compared to first-line surgical intervention and those commencing adjuvant chemotherapy

By Rebecca Hay and Elizabeth Pascoe

Timely screening and management of distress among women with Primary Breast Cancer (PBC) has been shown to optimise patient outcomes and promote treatment compliance (Lo-Fo-Wong et al. 2016).

In recent times, Neoadjuvant Chemotherapy (NAC) has gained momentum as a key component of the multi-modal treatment trajectory of breast cancer (Vugts et al. 2016; Zdenkowski et al. 2016). Despite the burgeoning use and urgent nature of this treatment modality (Beaver et al. 2016), suggesting the potential for distress, literature addressing the prevalence and aetiological contributors of distress among women commencing NAC is limited. It is important to determine whether women commencing NAC are experiencing distress and the ways that this distress is manifested compared to those undergoing other forms of treatment for PBC to ensure healthcare professionals can initiate timely interventions aimed at optimising treatment outcomes.

My cross-sectional pilot study involved a retrospective review of validated Distress Screening Tools (DSTs)

completed by 58 women upon commencement of either NAC, first-line surgical intervention or adjuvant chemotherapy (AC) for PBC at a large regional hospital, with the aim to compare the prevalence and aetiological contributors of distress namely practical, family, emotional, spiritual/religious and physical problems experienced by women across the three treatment modality groups. (Further details of the study will be presented in a forthcoming Clinical Update).

The results demonstrated that 80% of women self-reported elevated distress upon receipt of NAC, compared to those who underwent first-line surgery (67%) or AC (71%) for PBC. Furthermore, despite baring the youngest mean age of the three modality groups and yet to undergo the other more invasive surgical and chemotherapy treatments, women who underwent NAC also identified a greater number of aetiological contributors of distress.

The types of emotions reported women commencing NAC included fear, nervousness and sadness, which may stem from uncertainty associated with the back-to-front treatment regimen, questioning treatment efficacy, and, owing to their younger age, having more family and lifestyle demands (Beaver et al. 2016; Herrmann et al. 2018).

These findings have implications for nurses suggesting the importance of early assessment of the signs and physical manifestations of distress among women commencing NAC to enable initiation of timely supports, education and resources aimed at optimising emotional wellbeing and ease the burden of distress (Beaver et al. 2016).

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Amy Cattnach
(and her son)

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Exploring infant feeding amongst women in Illawarra and Shoalhaven

By Amy Cattnach and Pippa Burns

Current guidelines recommend that infants are exclusively breastfed (EBF) until six months of age and that breastfeeding is continued until 12 months (NHMRC 2012; WHO 2011).

Exclusive breastfeeding is feeding babies breast milk, directly from the breast or expressed into a bottle, without giving extra water, cow's milk, formula or food (Arora et al. 2017). These guidelines are based on the many benefits breastfeeding provides for both mothers and babies (NHMRC 2012).

Current research demonstrates that Australian breastfeeding rates are below these recommendations (AIHW 2011; HealthStatsNSW 2018; Ayton et al. 2015). Reasons why women do not initiate breastfeeding and cease breastfeeding prematurely are varied and not consistent across studies (Ayton et al. 2015). Further, these reasons seem to be area dependent, with findings from local studies not reflecting reasons found in national studies (Obgo et al. 2017).

With this in mind, we decided to investigate local rates of breastfeeding and the barriers and enablers that affect breastfeeding.

An online survey was developed using questions based on the Australian National Infant Feeding Survey (AIHW 2011). The survey questions covered demographics, location and type of delivery, feeding types and reasons for these choices, and services used. The survey was promoted through Facebook to mothers' groups in the Illawarra and Shoalhaven area. Ethics approval was obtained from the University's Human Research Ethics Committee (HREC 2018/469).

The survey received 304 respondents, of which 273 met inclusion criteria and were included for analysis. Overall, 96% of respondents breastfed their baby, of which 72% EBF, for some period of time. Only 56% of babies were receiving any breast milk at six months old. The most common reasons for stopping breastfeeding included low breast milk supply (n=64, 37%), baby being old enough to stop (n=48, 28%), baby losing interest (n=37, 21%) and mother returning to work (n=31, 18%). Parity and delivery method had the greatest impact on women EBF with women experiencing emergency caesarean sections having the lowest rates of EBF (45%).

Ninety percent of women who breastfed encountered difficulties during their breastfeeding journey. The most common difficulties encountered whilst breastfeeding were nipple problems (sore nipples n=141, cracked nipples n=99), attachment difficulties (n=96) and low supply (n=86). Women wanted to receive more information on breastfeeding antenatally including realistic views of breastfeeding, challenges associated and information on where to access help. Additionally, women thought there needed to be more services such as lactation consultants and more midwives to help support them whilst breastfeeding.

Breastfeeding rates within the Illawarra and Shoalhaven area were found to be lower than national and international recommendations with only 56% of babies receiving any breastmilk at six months old. There are many reasons why women in this area are not breastfeeding until six months and ways to improve these rates include more education and increased access to support services within the hospital and in the community. Education that women thought to be most beneficial included information on what is involved in breastfeeding including attachment, the realities of breastfeeding and the common problems faced during breastfeeding. Breastfeeding education can be integrated into midwifery and obstetrician appointments, antenatal classes and in the early postpartum period.

Clinical success: A new approach to clinical remediation of under- graduate nursing students

By Fiona McDermid, Leanne Hunt, Debbie Hetherington, Sue Willis, and Kath Peters

The development of clinical competence is essential in undergraduate nursing education (Camp and Legge 2018).

The School of Nursing and Midwifery at Western Sydney University recognised that a small number of undergraduate students were struggling in the clinical environment and implemented an innovative program to assist them.

The program, titled Clinical Remediation and Management (CRAM), involves a three phase approach using blended learning, clinical simulation and reflection.

Previously, when students were identified as 'at risk' or not clinically competent, remediation was implemented in the clinical setting using a learning contract to address individual students' needs.

While this remediation strategy had some success, it placed strain on clinical facilities (Hutton and Krull-Sutherland 2007) and permitted students to continue working in the clinical setting with deficits which may have potentially compromised patient care. Alternatively, students were required

to repeat their clinical placements which impacted on course progression and had significant financial implications for students.

CRAM utilises a combination of online learning and assessment, clinical simulation and reflection. The online approach focuses on numeracy, documentation and incorporates assessable theoretical knowledge. Students are required to attend clinical workshops where they are engaged in low, medium and high fidelity simulation and assessment.

Simulation has been used extensively in nursing education and is shown to significantly improve learning outcomes related to clinical reasoning, namely, critical thinking; clinical skill performance, and knowledge acquisition (Lapkin et al. 2010). The combination of blended learning and simulation also assists in bridging the theory-practice gap that has been reported as an issue with new graduate nurses (Dadgarana, Parvizyc and Peyrovi 2012).

The process is finalised through a reflection process that provides feedback to the student. The student's clinical strengths and areas requiring further development are clearly identified.

This promotes critical self-reflection and enables them to respond in a positive way when the need for improvement is identified. If students successfully complete the CRAM project, they can return to clinical placement with minimal disruption to their course progression.

CRAM is an innovative, intensive program that assists and supports students' learning. The program focuses on student needs within a clinical context and contributes to safer nursing practice and ultimately, quality patient care.

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Improving evidence based policy for national nursing education reform

By Cristina Thompson, Elizabeth Halcomb, Malcolm Masso, Kathryn Williams and Jane Currie

An Independent Review of Nursing Education – *Educating the Nurse of the Future*, (the Review) is currently being undertaken as a measure announced in the 2018–19 Federal Budget as part of the *Stronger Rural Health Strategy – Strengthening the role of the nursing workforce* (Australian Government, Department of Health 2018).

This is the first national Independent Review of Nursing Education to occur since 2002. The aim is to ensure that our future nursing workforce is equipped to meet the evolving population health and service needs of our nation.

It was scheduled for completion in August 2019 under the leadership of the Independent Chair, Emeritus Professor Steven Schwartz and through the support of the Office of the Commonwealth Chief Nursing and Midwifery Officer (Australian Government, Department of Health 2019).

The Department of Health engaged the Australian Health Services Research Institute and School of Nursing at the University of Wollongong to undertake four literature reviews on specific topics, to support the Review.

The research team established a national advisory panel and international advisory panel with experts in nursing education. These reviews have informed the broader national consultation process through translating the published evidence into plain language, synthesising key issues for further consultation and distilling the implications for policy.

TOPIC 1: FIT FOR PURPOSE/WORK READY/TRANSITION TO PRACTICE

At the core of this topic is the concept of the new-graduate nurse (Registered Nurse, Enrolled Nurse or Nurse Practitioner) being ‘fit for purpose’. The focus is on the point at which they take up the role for which they recently qualified, which may or may not include a period of prior work in the nursing workforce. The definition of

the transition period used for the review encompassed the first year of employment for a beginning practitioner (RN, EN or NP) (Masso et al. 2019).

TOPIC 2: NURSING AS A CAREER CHOICE

Australia’s nursing workforce is predominantly female. There may be value in encouraging greater participation by men and people from other under-represented groups (eg. Indigenous people, Culturally and Linguistically Diverse groups) in nursing education in an effort to build a more representative nursing workforce for the future.

Barriers to participation in nursing education were explored and several promising interventions identified, all of which require further evaluation. The review also considered interventions in other tertiary education fields dominated by female students (eg. psychology, social work, primary school teaching) or male students (eg. science, technology, engineering, mathematics) (Williams et al. 2019).

TOPIC 3: CLINICAL SKILL DEVELOPMENT

The third literature review focuses on the period of education prior to qualification and enrolment as an EN, registration as a RN or endorsement as a NP. The evidence gathered and synthesised for this topic came from studies undertaken during the pre-registration training period.

The definition of the training period used for this review was from the point of enrolment into a nursing educational program, to the completion of the program. Clinical skills were defined as the technical and non-technical skills, knowledge and attributes required of an EN, RN and NP (Currie et al. 2019).

TOPIC 4: FUTURE DIRECTIONS IN HEALTHCARE DELIVERY

Topic 4 addresses the current and emerging issues across the healthcare landscape influencing the education and training of healthcare professionals (considering both national and international contexts), and how these trends may influence the key skills and attributes required of RNs, ENs and NPs in the next 15 years.

It is a hybrid between an environment scan and literature review. The grey literature provided the most contemporary material about current and emerging issues. The peer-reviewed literature was essential to explore the implications of these trends for the key skills and attributes required by future Australian nurses and the

implications for the system of nursing education (Thompson et al. 2019). It is anticipated that these literature reviews will be publicly available later in 2019.

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Professor Elizabeth Halcomb – our role was to translate the published evidence into plain language, synthesise key issues for further consultation and distil the implications for policy



Students and staff at IQN Batch12

Contributing to the Australian nursing workforce: One nurse at a time

By Joy Penman and Jose Tighe

The Internationally Qualified Nurse (IQN) Program is a university-based initiative aimed at preparing international nurses for Australian registration.

It utilises contemporary and evidence-based approaches to professional nursing education and practice, and blended learning underpinned by nursing research and evidence-based inquiry. The central focus is on nursing practice in the Australian healthcare context, and on those aspects of the nursing practice that are different from other countries. The program consists of seven modules; the first five are

online, the sixth module is an intensive workshop at the university, and the final module is a full-time clinical placement undertaken at an acute healthcare setting.

A survey was conducted to determine the impact of the program on the internationally qualified nurses. During the ninth IQN offering in 2018, all 27 (n=27) participants were invited to answer five open-ended questions examining their perceptions about the program, the most essential learning gained from participating in the program, the best aspects of the program, the personal and professional impact on participants, and area/s for improvement. Content analysis was then undertaken.

Of the 27 nurses who enrolled in the program and completed the questionnaire, six were male, and 21 were female. They originated from India, Israel, Nepal, Spain, Taiwan and the Philippines. The most important outcomes for the participants were the 'introduction to the Australian healthcare system', 'getting to know the Australian culture and diversity', and 'familiarity with the nursing practice in

Australia'. The participants rated the best aspects of the program to be the 'supportive teachers and staff', 'flexible time to study', 'a well-organised program and resources', and 'a supportive clinical learning environment'. Several popular answers encapsulated the personal impacts such as 'improving in human relationships', 'extending network', and 'gaining confidence in self and practice'. Professionally, the participants commented on 'gaining a basic knowledge of the healthcare system', 'opportunity to gain employment and pursue a career in Australia', 'broadening of skills and realising there is so much more to learn in nursing'. The majority thought the online learning and intensive workshop featuring simulated ward experience was highly satisfactory, as were their clinical placement experiences. These findings resonate with anecdotal accounts and other evaluations of IQN offerings. There were several areas for improvement suggested including 'longer practical sessions' and 'more skills demonstrations'.

Participants must complete the IQN program in order to be recommended for nurse registration in Australia. These IQN nurses could potentially be part of the future nursing workforce; hence, their preparation must be rigorous, appropriate, high quality and comprehensive in order for them to meet the standards of safe, holistic practice. The program presented here showed that the bridging course suitably prepared qualified overseas nurses for registration with the Nursing and Midwifery Board of Australia. More than introducing them to the Australian healthcare system, culture, and nursing practice, the program influenced their personal and professional lives positively.

In order to enhance student experience further, the program, now called Australian Nursing Studies, is offered as two units (NUR5112 and NUR5113) under the Masters of Advanced Nursing program.

Authors

Dr Joy Penman, Senior Lecturer, Monash Nursing and Midwifery, is the incumbent coordinator and principal lecturer of the Australian Nursing Studies (formerly the IQN program); and Ms Josie Tighe, Lecturer, Monash Nursing and Midwifery, taught into the IQN program.

Maintaining clinical currency: A risk management strategy for undergraduate nursing students

By Fiona McDermid, Stephen McNally and Rebecca O'Reilly

Preparing and maintaining a student's clinical skills competency and currency with clinical practice prior to their completion of the Bachelor of Nursing (BN) program is a significant challenge for schools of nursing.

This is largely due to students becoming out of practice due to personal reasons or unit failure preventing them from progressing through the program in the expected pattern.

The concern is related to risk, as students are able to register as a nurse and yet may have experienced a lengthy time without gaining any clinical practice experience. The risk relates to a theory-practice gap that has been reported as an issue with new graduate nurses (Dadgarana, Parvizyc and Peyrovi 2012) and is further exacerbated by extended periods without clinical experience.

Western Sydney University School of Nursing and Midwifery (SoNM) has

developed a model of learning that has combined the use of blended learning, reflective practice and hi fidelity simulation to provide an innovative, unique and engaging experience for students that does not add additional time or costs to their course completion.

Maintaining Clinical Currency (MCC) is an innovative, responsive risk strategy that enables the SoNM to ensure graduates from the BN course are clinically current and competent.

MCC integrates digital technology with face-to-face clinical workshops and self-reflection which assures students are active participants in their learning, and promotes a positive student experience.

These learning strategies have been evaluated to have a significant impact on student learning, enhancing their confidence and ability to commence practice as a registered nurse.

The MCC model offers a dynamic and intensive learning experience for students integrating a range of activities and learning approaches to support different styles of student learning.

The model incorporates online learning and assessments and participation in three compulsory workshops. The workshops are designed to inspire and motivate students through effective face-to-face communication over three days, utilising patient scenarios with medium and high fidelity simulation.

The patient scenarios are based on the theoretical information they had previously

completed online, consolidating the theory to practice link.

Students are required to participate in total patient care, documentation exercises and reflect on their clinical practice development. They are also expected to demonstrate competency and safety in the delivery of nursing clinical skills in a supported, simulated environment.

The flexibility of the workshops allows students to individualise their practice to particular clinical skills that they feel require further development and they are provided feedback on their clinical practice for each clinical skill and patient scenario. Students are then provided with further opportunities to practice, which enhances their confidence and self-esteem within the professional environment.

MCC provides a unique opportunity for students to revise and consolidate their clinical practice learning development.

This model encourages and supports the complex nature of the clinical skills and theoretical nexus developed from the first year of the BN to the final year and in doing so prepares the student for commencing a new graduate position as a Registered Nurse (RN).

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The experience of undergraduate nursing students in patient safety education: A qualitative study

By Lara Johnson, Stephen McNally, Nikki Meller and Jackie Dempsey

Patient safety is a fundamental principle in the attainment of positive health outcomes.

The World Health Organization (2018) defines patient safety as the minimisation of preventable harm to a patient, throughout the process of accessing healthcare. Interestingly, Jha et al. (2013) reported that 42.7 million medical errors occur annually that negatively impact upon patient safety, making medical errors the third leading cause of death across all developed countries.

These episodes of unnecessary harm are significant enough to contribute to a larger annual mortality rate than breast cancer, acquired immunodeficiency disease syndrome and motor vehicle accidents (Chenot and Daniel 2010). Furthermore, these errors contribute to a significant economic burden, costing an estimated \$42 billion USD annually (World Health Organization 2018).

Nurses hold an innate responsibility to comprehensively and critically implement high quality healthcare, in an effort to uphold the highest achievable standard of health for their patients.

To achieve this, it is essential that the principle of patient safety is incorporated into quality improvement strategies throughout both academic and clinical education (World Health Organization 2018).

Educating nursing students about patient safety early within their learning journey has shown to have a compelling positive impact on each individual's knowledge, skills and behaviour growth surrounding the concept of patient safety (World Health Organization 2011).

To date, current literature identified a prevalent disconnect between theoretical knowledge and clinical practice, resulting in an overall lack of readiness to practice in undergraduate nursing students (Montgomery et al. 2014).

The "Patient Safety Education" research project is focused on exploring these research gaps of theoretical knowledge and clinical practice, to gain a greater understanding of the ways that undergraduate nursing students learn about patient safety.

The data collected from this project may present opportunities to highlight patient safety as a practice of key importance for nurses to uphold and lessen the burden of patient safety errors within the healthcare setting.

By identifying such areas of education that promote or negate patient safety competence within Australia, updates in academia, policies and guidelines may occur to better align with the National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care 2017).

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