



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 26, NO.9
JAN-MAR 2020

ANMF'S 14TH BIENNIAL NATIONAL CONFERENCE

*Fairer, stronger, healthier ...
nurses and midwives make it happen*

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conference in pictures
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unite in Melbourne

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agenda for 2020?

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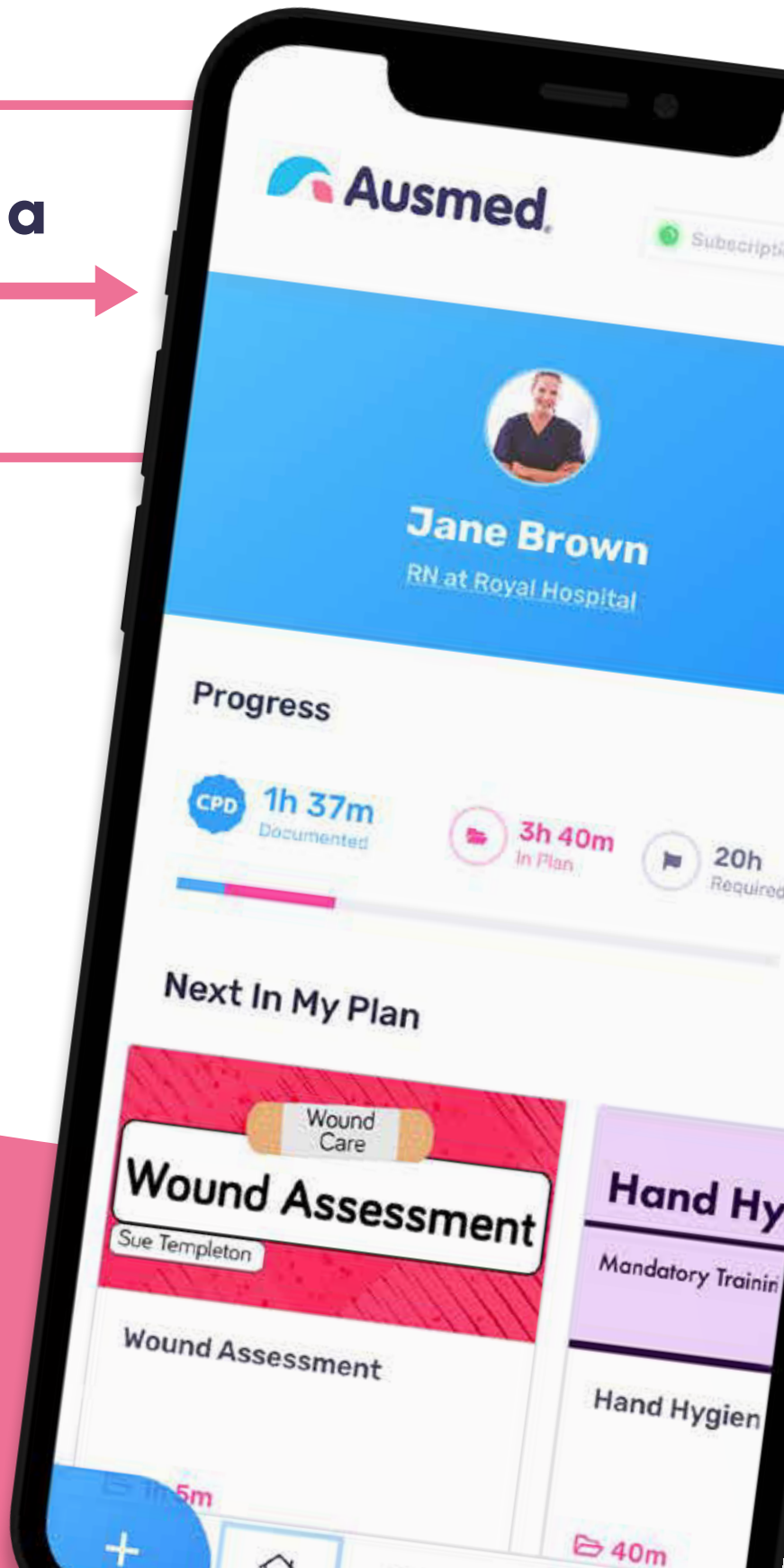
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If ever there is a year for us to shine then 2020 is it.

Annie Butler

ANMF Federal Secretary

As declared by the World Health Organization, 2020 has been designated as International Year of the Nurse and Midwife. The year coincides with the final phase of the International *Nursing Now* Campaign which aims to improve the status and profile of nursing and midwifery so as to create better health equity and access worldwide.

This premise truly epitomises what the ANMF and its members stand for as together, we can, and do make it happen.

Reflecting on our achievements over the past 12 months, we can be proud of the significant inroads we've made. We have been working to improve access to care for older Australians through our national campaign for mandated staffing ratios and skill mix ratios in aged care. Not only have we gained support of the broader community but we are strongly and convincingly participating in the Royal Commission into Aged Care Quality and Safety.

The ongoing influence of our campaign is evident as we continue to expose some of the most dire conditions in aged care. This increasing scrutiny in the sector is revealing the worst failures such as the closure of Gold Coast's Earle Haven aged care facility which literally left residents in the cold, and prompted the Queensland government to legislate staff ratios in public aged care.

With this drive behind us, we have no plans to slow down and will continue to fight for a better aged care system for our elderly across the country.

Also to be proud of was the ANMF's participation in lobbying crossbench senators to block the Ensuring Integrity Bill passing through the Senate. The defeat was a momentous victory given the real threat this anti-union legislation would have had on unions and workers, including nurses', midwives' and care workers' rights if it had passed.

These are a few examples of our achievements during 2019, but we don't plan to stop here.

The Year of The Nurse and Midwife is our time. This is the year for our voices to be heard and for our politicians to recognise our value and to invest

properly in the nursing and midwifery workforce. This includes investment into the use of nurse practitioners and nursing programs for our most vulnerable populations.

As mentioned, we plan to ramp up pressure to legislate ratios in aged care across the country and continue the fight to make aged care providers more accountable and transparent around funding.

We also need to make sure strategies are in place to ensure our nursing and midwifery workforce is safe against rising occupational violence.

Additionally, the ANMF will continue to pressure governments to recognise the impact of climate change through focusing on a genuine emissions reduction scheme as well as to expand measures to protect communities from its effects.

More detail on all of these priorities for 2020 can be found on page 10 of the Journal.

As we come to the end of 2019 and launch into a fresh new year, I want to take this opportunity to thank delegates from across the country who recently attended ANMF's highly successful 14th National Biennial Conference in Melbourne. It is their determination and passion to improve health in their communities and advance the nursing and midwifery professions that helps set up the framework to guide the work of the federation nationally.

Additionally, I sincerely thank all of you who are the ANMF for the great work you have done throughout 2019.

The outlook for 2020 looks promising and together we will make Year of the Nurse and Midwife one to remember.

Annie

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Moving state?

Transfer your ANMF membership

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

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A third of Advance Care Directives found to be invalid

Almost a third of Advanced Care Directives (ACDs) audited in Australian residential aged care facilities were found to be invalid, according to a nation-wide study.

The research, led by Advance Care Planning Australia (ACPA), revealed 30% of ACDs in residential aged care had been completed by someone else (usually family members) on behalf of a non-competent person. Unsettlingly, 68% of those documents included instructions for withholding life-sustaining treatment such as tube feeding or intravenous antibiotics.

An ACD is a legal document outlining a person's preferences and instructions for their future healthcare. The document comes into effect when a person is no longer capable of making their own medical decisions. However, ACDs are only legal when completed and signed by a person with decision-making capacity.

This oversight potentially leaves aged care residents at risk of being denied access to medical treatment they would have wanted, or given treatment they would have preferred to avoid. The ambiguity also creates risk and confusion for aged care staff, families and healthcare providers.

"These findings underscore a broader societal issue that advance care planning needs to start earlier, before people enter care and ideally when they're well enough to make their own decisions. For many aged care residents entering care, it's too late to start advance care planning. We urge Australians to plan well, plan early and involve those closest to you," said Program Director of ACPA Linda Nolte.

Government defunds Indigenous domestic violence body



The only national peak body for Aboriginal and Torres Strait Islander victims/survivors of family violence and sexual assault will be cut June 2020.

The federal government's decision to axe the National Family Violence Prevention and Legal Services Forum (National FVPLS) will

remove Aboriginal and Torres Strait Islander women's voices from the national stage, the organisation said.

The National FVPLS Forum supports and advocates on behalf of the 13 member organisations who work on the frontline of family violence against Aboriginal and Torres Strait Islander women and their children.

Rosie Batty, AO, a prominent campaigner on domestic and family violence said the voices of women and children have never needed to be heard more than now. She said the government's decision to cut funding to the National FVPLS Forum says 'we don't want to hear you'.

"I am completely astounded when you look at the shocking statistics relating to Aboriginal women and family violence," said the first Aboriginal woman to be elected to the Australian House of Representatives Labor MP Linda Burney. "It beggars belief that this would happen."

Aboriginal and Torres Strait Islander women nationally are 34 times more likely to be hospitalised for family violence and 10 times more likely to die from a violent assault than other women in Australia.

DEADLY MEASLES EPIDEMIC GRIPS SAMOA

The tiny Pacific Island nation of Samoa carried out a two-day government shutdown early last month in a bid to stem an unprecedented measles outbreak that has already claimed the lives of more than 60 people, most of them children aged four or younger.

The shutdown was triggered to enable more than 150 mobile vaccination teams to go door-to-door to administer vaccines.

Samoa, with 4,200 reported cases of measles out of a population of 200,000, was declared a



one-month State of Emergency last November as deaths began mounting.

Responding to a request from Samoa, Australia deployed a specialist team of nurses, doctors and public health experts, along with urgently needed medical equipment and supplies.

An Australian Medical Assistance Team (AUSMAT) established an eight-bed critical

care unit and has been working alongside local health professionals to provide urgent care to critically ill patients, help administer vaccinations and spread public health messages.

Announcing the shutdown, Samoan Prime Minister Tuilaepa Sailele Malielegaoi said a lot of the population had not heeded warnings about the importance of getting vaccinated (just 31% have immunity) and that some even turned to traditional healers for help.

Samoa's measles outbreak mirrored new data released by the World Health Organization last month warning that global measles death and infections in 2019 are set to skyrocket past last year's toll, when more than 142,000 people died from the preventable disease, amid a growing health crisis caused by low vaccination levels.

Air pollution hazardous as climate emergency heightens

The nation's leading academics have been amongst a chorus of Australians declaring a climate emergency and demanding action from the federal government.

It comes as air pollution levels across parts of NSW hit the worst in the world with the large parts of the state ablaze with bushfire.

Climate Council health expert Professor Hilary Bambrick said air quality in parts of Sydney was more than 12 times the threshold deemed "hazardous".

"These are the health consequences of a changing climate that health professionals have been warning us about. Climate change is supercharging bushfires and that is what we are seeing now with massive, unprecedented fires producing unbreathable air."

The Board of The University of Sydney Law School voted unanimously to declare a climate emergency in mid-December.

"In passing this motion, the members of Sydney Law School recognise that as legal academics we have a moral duty to stand up, speak out and express our concern, from a justice perspective, for all of the people, ecosystems and species across the world facing an existential threat," University of Sydney Professor of Climate and Environmental Law Rosemary Lyster said.

NSW was currently experiencing two climate-induced disasters, she said.

"Bushfires that have burnt through 2.7m hectares since the start of the 2019 fire season, causing suffocating and hazardous smoke for weeks on end, while drought cripples more than 98% of the state."

"This is a crisis for people's health, for communities and the environment. Our leaders need to acknowledge that this is climate change and do far more to swiftly and urgently lower our greenhouse gas emissions, in order to protect Australians' health today, and into the future," Professor Bambrick said.



Ensuring Integrity Bill defeated

The Morrison government's union-busting Ensuring Integrity Bill that would have made it easier to deregister unions and threatened their ability to represent members failed to pass the Senate last November.

First introduced in 2017, the Fair Work (Registered Organisations) Amendment (Ensuring Integrity) Bill outlined a range of powers that could be exercised against unions and officials, including harsh penalties for minor procedural errors such as filing paperwork late.

Under the Bill, the Minister or a 'person with sufficient interest', such as an employer or lobby group, could apply to deregister a union, disqualify elected officials or put a union into administration.

The ANMF and its members, along with the ACTU and fellow unions, lobbied politicians for several months and ventured to Canberra during Parliament in the lead up to the vote to persuade Senators to block the Bill.

ANMF Federal Secretary Annie Butler said the politically motivated attack on workers and unions would have jeopardised members' ability to take industrial action to protect patient safety.

"This Bill posed a significant threat to members' rights and our ability to represent them," Ms Butler said.

"The trade union movement stood together in solidarity to stop this anti-worker Bill designed to erode worker's democratic rights to be represented by elected officials and to determine how their union is run."

A week after it was squashed, Attorney-General Christian Porter re-introduced the Bill in the House of Representatives and it will likely go to another vote when Parliament resumes in February.



Lori-Anne Sharp
ANMF Assistant
Federal Secretary

The remarkable work of one nurse to improve access to healthcare globally

It's very exciting that 2020 is the year of the nurse and midwife, declared by the World Health Organization (WHO).

The designated year coincides with the final year of the global *Nursing Now* campaign, which seeks to improve health globally by increasing the number, status and profile of nurses.

As we reflect and celebrate the critical work nurses and midwives achieve on both a national and global scale it was timely that at a recent fundraising dinner for Union Aid Abroad- APHEDA I was reminded of the extraordinary work of one particular nurse, Dr Helen McCue.

In 1983, Dr Helen McCue worked in a Middle Eastern refugee camp as a nurse educator for WHO and later as a volunteer nurse in a refugee camp in Beirut. Confronted by horrific massacres, war crimes and shattered communities, Helen recognised that while the international community provided some immediate humanitarian relief, no aid organisation was helping to skill or re-skill nurses and other healthcare workers.

Inspired by this experience Helen returned to Australia with a proposal to the Australian Council of Trade Unions (ACTU) to set up an international solidarity organisation in Australia; with the intention to support humanitarian efforts and mobilise workers who were fighting for basic rights of freedom, peace, safety, health and education.

With ACTU support by then ACTU President Cliff Dolan, Union Aid Abroad – APHEDA, the global justice organisation of the Australian union movement was established. Since then Union Aid Abroad-APHEDA has had the financial support of 23 unions and operates in over 13 countries across South East Asia, the Pacific, the Middle East and Southern Africa.

Union Aid Abroad – APHEDA directly supports unions playing a leadership role in a democratic civil society, supporting local unions and partner organisations to build trade union skills and promote labour rights. Union Aid Abroad – APHEDA achieve this by establishing programs that seek to empower local communities to advance and improve access to education, advocating on health issues affecting communities, offering support in times of crisis and supporting groups that address gender violence. Union Aid Abroad – APHEDA have also continued their global campaign for bans on asbestos, landmines and cluster munitions. Many ANMF members may be familiar with the campaign **Asbestos. Not here. Not anywhere.** seeking to eradicate asbestos use globally.

Two current projects that are worth highlighting include, Union Aid Abroad- APHEDA's **Promoting**

Gender Equality in Political Decision Making

project in Vietnam which has overseen the training of 677 women in leadership at the district, commune and province levels. This project has successfully supported women to run for elected positions, vote for women candidates, and raise gender related issues in political forums, particularly the People's Council, to ensure women's voices are taken into consideration in the development and implementation of policies.

The second project is the **Mae Tao Clinic**, which, with continued support from Union Aid Abroad-APHEDA, was established in 1989 as a single doctor clinic for refugees from the military crackdown on ethnic minorities living on the Thai-Burma border. Today the Mae Tao Clinic has grown into a comprehensive community health centre providing essential healthcare and medical services to migrant worker communities, and a hub for regional health training with more than 3,000 graduates serving clinics, schools, villages, factories, camps and peri-urban slums along both sides of the border. The clinic has an annual caseload of over 100,000 patients.

There will be many nurses' and midwives' stories to celebrate in 2020, the creation of Union Aid Abroad-APHEDA is a great example of one nurse's extraordinary vision, effort and commitment to make an enormous impact to humanitarian assistance abroad. A legacy that remains today, as Union Aid Abroad-APHEDA continues to improve lives by working to defend human rights, advance equality and prevent exploitation.

To learn more about Union Aid Abroad – APHEDA, become a member or if you wish to donate go to: APHEDA.ORG.AU

Union Aid Abroad- APHEDA is currently working on 32 projects, across these 13 locations:

- Palestine
- Lebanon
- Samoa
- Thai Myanmar border
- Myanmar
- Timor Leste
- Vietnam
- Laos
- Cambodia
- Philippines
- Indonesia
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Union Aid Abroad- APHEDA is affiliated with 23 unions and currently has over 2.5K individual members.

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Nurses and Midwives making it happen: ANMF's 14th Biennial National Conference

Over 150 nurse and midwife delegates from across the country converged in Melbourne to attend the Australian Nursing and Midwifery Federation's (ANMF) 14th Biennial National Conference in October 2019.

The conference, themed *Fairer, Stronger and Healthier ... Nurses and Midwives make it happen*, linked into the global campaign *Nursing Now*, which aims to improve the status and profile of nursing and midwifery worldwide. The campaign will culminate in the International Year of the Nurse and Midwife next year.

ANMF Federal President Sally-Anne Jones opened the conference inspiring delegates 'to make it happen'.

"We need to look forward with lessons of wisdom learnt and with a clearer vision of what we want, collaborate and celebrate our connection with each other, and to make occasion to forge new partnerships not only within our workplaces, in our union, in our country but all over the world," she said.

During the conference delegates put forward and debated a range of issues facing the professions, including concerns relating to our workforce, aged care, social justice, political issues, work health and safety and professional issues. The key decisions stemming from these debates will now shape the work of the ANMF nationally for the next two years.

Over the two day-event, delegates heard from an array of speakers, including Australia's *Nursing Now* Campaign Board Member, Professor Jill White, who explained the Campaign and how nurses and midwives can be involved. Other topics discussed included vicarious trauma, the role of Indigenous nurses and midwives, aged care and the impact nurses and midwives have in their communities.

Additionally, the delegates had the chance to hear from and ask questions of politicians such as MPs Ged Kearney and Helen Haines who had originally begun their careers as nurses.

The Premier of Victoria the Hon Daniel Andrews also addressed the delegates as did the Federal Leader of the Opposition Anthony Albanese who faced a barrage of questions on aged care, specifically about legislating ratios, from the floor.

ANMF Federal Secretary Annie Butler said the enthusiasm and determination of delegates shown at the conference was nothing short of inspirational. "It is never more evident to me than at the Biennial Conference how nurses and midwives can make the difference. They are leaders and influencers who want the very best for their communities and for each other. Their determination to fight for what is right is what keeps us strong as a collective and what creates positive change."

To read more from the conference go to the ANMJ website: anmj.org.au



ANMF Federal Office leadership team



Voting on resolutions



Archie Roach entertained the delegates



Delegates debate issues important to the professions



Delegates pose together for a group shot



Nursing Now Campaign Board
Member Professor Jill White



Nurse politicians MP Ged
Kearney and MP Helen Haines



Photography: Chris Hopkins



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A close-up portrait of a woman with dark hair pulled back, smiling warmly at the camera. She is wearing blue medical scrubs. The background is a bright, out-of-focus indoor setting, likely a hospital or clinic.

ANMF PRIORITIES 2020:

EMPOWERING NURSES AND MIDWIVES TO ACT

For the first time in history, the nations of the world will unite in celebration of the benefits that nursing and midwifery bring to the health of the global population.

The World Health Organization (WHO) designation of 2020 as the International Year of the Nurse and Midwife is aimed to raise the status and profile of nurses and midwives and recognise their work. It's a time to celebrate, a time to be heard and a time to make it count!

Australia's contribution to the campaign is focused on access and equity when it comes to health, especially for vulnerable communities.

On the home front in Australia, those in aged care remain amongst our most vulnerable. We have heard of the devastating neglect in aged care in Australia this year with the Royal Commission into Aged Care Quality and Safety. The valiant efforts of a dedicated aged care workforce have held the system together for far too long. These workers can't sustain their efforts much longer; the sector is in crisis.

The ANMF is calling on the government to take urgent measures to improve the situation in aged care before the Royal Commission hands down its final report later this year. Let us continue to advocate for those in aged care this year – to be loud and ensure our voices are heard.

Workplace health and safety featured heavily at the ANMF Biennial National Conference. No nurse or midwife should feel unsafe at work and the ANMF will continue its work to ensure government policies and procedures and workplace conditions support you at work.

The recent bushfires raging along the East Coast have brought climate change right to the fore. Firefighters have reported they have never seen conditions so early and so severe. We need immediate leadership and action from our federal government on this issue.

2020 promises to be a year on which we can deliver change – for our patients, our communities and ourselves – for a better Australia. Let's make our year a memorable one!

INTERNATIONAL YEAR OF THE NURSE AND MIDWIFE

Governments from around the world endorsed 2020 as the Year of the Nurse and Midwife at the 72nd World Health Assembly in May 2019 in Geneva, Switzerland because

of the vital contribution of nurses and midwives toward achieving universal health coverage.

The year 2020 is significant for WHO in the context of nursing and midwifery strengthening for Universal Health Coverage. WHO is leading the development of the first-ever *State of the World's Nursing* report which will be launched in 2020, prior to the 73rd World Health Assembly. The report will describe the nursing workforce in WHO Member States. A *State of the World's Midwifery 2020* report will also be launched around the same time. Nurses and midwives constitute more than 50% of the health workforce in many countries, and also more than 50% of the shortfall in the global health workforce to 2030.

"These two health professions are invaluable to the health of people everywhere. Without nurses and midwives, we will not achieve the sustainable development goals or universal health coverage," World Health Organization Director General Dr Tedros Adhanom Ghebreyesus said.

"While WHO recognises their crucial role on a daily basis, 2020 will be dedicated to highlighting the enormous sacrifices and contributions of nurses and midwives, and to ensuring that we address the shortage of these vital professions."

The idea of 2020 as Year of the Nurse and Midwife was initially suggested by the global, three year *Nursing Now* campaign, which runs until 2020 in collaboration with the International Council of Nurses and WHO. The ICN and the *Nursing Now* campaign believe that 2020's designation will reveal the benefits of having a properly trained and resourced nursing workforce in every country in the world.

The ANMF had been actively working together with key national nursing organisations to formulate Australia's contribution, ANMF Federal Secretary Annie Butler said.

"We want to take this opportunity to get politicians to recognise the value of the Australian nursing and midwifery workforce and invest in us properly. We want to see the expansion of nurse and midwifery-led models of care that are innovative, increase access and lead to better health outcomes for communities. This includes increased



use of nurse practitioners in proper jobs.

"Real investment will enable the delivery of nursing and midwifery programs for our most vulnerable populations – people with mental illness, Indigenous Australians, those living in rural and remote areas and the marginalised including the homeless and our prison population.

"Let's invest in our nursing and midwifery workforce so that we can truly realise equal access and universal health coverage for all Australians."

While the designation of 2020 as the International Year of the Nurse and Midwife coincides with the 200th birth anniversary of Florence Nightingale, Ms Butler said it was a good opportunity for Australia to reflect on its own nursing and midwifery history.

"We have 50,000 years of cultural healing practices through Australia's first Nations peoples. We are a nation that is culturally rich, we need to learn from the past as we go forward and build our future."

AGED CARE

The ANMF will continue to actively participate with the Royal Commission into Aged Care Quality and Safety. The union has called on the federal government not to wait until the conclusion of the Commission in late 2020 to deliver much-needed new funding and reforms.

"Older Australians in aged care, and their families and loved ones, cannot wait another year for government action to fix aged care," Ms Butler said.

Nurses and aged care workers had been working under the burgeoning strain of an under-resourced and under-staffed sector to provide quality care to residents and families for many years, she said.

ANMF PRIORITIES

"We need to acknowledge the best efforts of our nurses and aged care workers who have not only stayed working in the sector but continued to provide the best care they can for our frail elderly under the most difficult conditions."

The Royal Commission's Interim Report had laid out the extent of the problems in aged care and the work that needed to be done, Ms Butler said.

"It provides a recap of alarmingly widespread failures in care across the system, providing detail into some of the causes and starts to provide some direction for government and industry on solutions and outlines three areas where action should start immediately. A focus on extra Home Care Packages for over 100,000 Australians on waiting lists; reducing the use of physical and chemical restraints on nursing home residents and stopping younger people with a disability going into aged care facilities.

"The ANMF agrees those areas need urgent attention and action, but we don't think the government should stop there – we can't wait another year for action on other critical areas desperately needing reform."

The Commission's Interim Report recognised workforce issues were relevant to every aspect of the Commission's Inquiry. The government must act on the need to introduce mandated minimum staffing levels and skills mixes, Ms Butler said.

"Mandated minimum staffing levels and skills mixes in residential aged care are not the only solution required to fix the crisis in aged care but it is the centre piece – many other solutions and improvements required are dependent on proper, safe and quality staffing in order to be effective."

Nurses and midwives are frontline care providers for the public and have the right to return home from work safely – just like everyone else.

The ANMF will continue to call for an increase in funding for aged care and increased accountability and transparency around funding.

"We cannot fix the funding issues in aged care if we cannot see where the money is going. The aged care sector will need additional public funding, but there needs to be greater accountability to ensure that funding is spent on quality care."

The government could immediately start on this by requiring aged care providers to transparently report on their use of publicly-funded subsidies, Ms Butler said. The government could then determine where additional funding is needed and ensure that it is provided.

The ANMF will also continue its work in investigating financial and tax practices around the largest not-for-profit aged care providers.

"We need to guarantee that taxpayer-funded subsidies received by aged care providers go directly to the provision of care to ensure safe and best practice care for every elderly Australian living in nursing homes," Ms Butler said.

WORKPLACE HEALTH AND SAFETY

Incidents of occupational violence against nurses, midwives and other health workers

in hospitals and healthcare facilities in Australia continue to increase, however the protections for nurses, midwives and other health professionals remain weak.

In 2015, the NSW Bureau of Crime Statistics and Research recorded 361 violent incidents in hospitals. In 2018, that figure had grown to 521. Similarly, the Victorian Crime Statistics Agency recorded 335 assaults on healthcare premises in 2015; this figure increased to 539 in 2018.

"The growing trend of occupational violence against healthcare workers shows no sign of decelerating, with the prevalence of the issue widely reported by the Australian media in 2019," ANMF ACT Branch member Carol Sandland said at the recent ANMF Biennial National Conference held in Melbourne.

"The psychological and physical impacts of occupational violence are well documented and can result in tragic outcomes. Nurses and midwives are frontline care providers for the public and have the right to return home from work safely – just like everyone else."

Federal ANMF has been charged with beginning discussions with the Federal government about the increased exposure that nurses and midwives are experiencing of violence and aggression in their workplace, causing untold physical, psychological and economic harm.





“The world needs to move to zero net carbon emissions by about 2050 and halve carbon emissions each decade. Yet, emissions in Australia and globally continue to increase.”

“Action is urgently required to develop an effective integrated approach to the prevention and elimination of violence towards nurses and midwives,” NSWNMA, (ANMF NSW Branch) member Lyn Hopper told fellow delegates at the ANMF’s National Biennial.

This must include:

- Appropriate staffing and skills mix to enable safe care for patients and safety of staff and to ensure that no nurse or midwife works in isolation.
- Improved reporting systems and transparent reporting of violence.
- Proper implementation of policies designed to provide protection from violence.
- Funding pool for anti-violence measures.

“We call on the ANMF to actively campaign against the excessively high levels of occupational violence that are occurring against nurses and midwives across all aspects of health in Australia, with a view to secure adequate and appropriate legislative changes throughout the entire country to keep nurses and midwives safe from occupational violence within their workplaces,” Ms Sandland said.

Sexual harassment of nurses and midwives by patients has also been highlighted as a major issue. In recent research conducted by Dr Jacqui Pich of the University of Technology Sydney, 805 of 3,416 participants reported inappropriate physical or sexual contact in the previous six months.

“Sexual harassment is not part of a nurse or midwife’s job description. Every medical facility should have an official policy and procedures addressing sexual harassment and should take all reports seriously,” NSWNMA, member Liz McCall said.

CLIMATE EMERGENCY

The World Health Organization and United Nations scientists warn that without stronger action to curb greenhouse gas emissions, climate change will have dire consequences for the health of humans and the planet.

A global movement which has inspired the next generation of youth have called on governments to act immediately. Students around the world have gone on strike urging world leaders to act. Nurses and midwives have joined the movement fuelled by their own concerns about health for their communities.

“We note with anger that the climate crisis is already affecting millions in Australia and around the world”, ANMF Tasmanian Branch member Monica Werner said at the 2019 ANMF Biennial National Conference.

“Science tells us that further global warming must be kept to 1.5 degrees C in order to avoid catastrophic climate change. Average temperatures have already increased by 1 degree C in the past century and the world is on track for a further 3.7 to 5 degrees C increase.

“The world needs to move to zero net carbon emissions by about 2050 and halve carbon emissions each decade. Yet, emissions in Australia and globally continue to increase.”

The 2019 ANMF Biennial National Conference called on the ANMF to support the School Strike for Climate movement and to encourage its members to join in global action to combat climate change.

“We further call on the ANMF and its members to support action and campaign for stoppages across the global union movement,” Ms Werner said.

“We understand the enormous work to be done to lower emissions across a number of sectors. We want this work to be done. We demand an enormous and immediate government investment in new low emissions systems.”

ANMF Federal Secretary Annie Butler said as frontline health professionals, nurses and midwives and carers were increasingly concerned and angry about health implications of climate change.

“Adverse climatic conditions continue to pose significant risk to the health and wellbeing of the community, particularly in those who are most vulnerable.”

The ANMF called on the government to focus on a “genuine emissions reduction scheme” through the greater use of renewables, Ms Butler said.

“We need to transition to zero emissions energy sources urgently to avoid dangerous and irreversible impact to the environment and health and to advocate for a renewable energy target.”

The ANMF would pressure all levels of government to rapidly expand measures to protect communities from climate change and develop mitigation efforts that include rapidly reducing Australia’s carbon emissions, Ms Butler said.

The development and implementation of a paediatric pain protocol within the recovery room environment

By Lisa Wilson and Claire Tisdall

INTRODUCTION

Treating paediatric postoperative pain requires the effective use of pharmacological intervention. Applying suitable pain management interventions is vital in improving patient care. Research suggests paediatric medication errors frequently include the overdose or underdose of pain medications, often due to inattention to a child's body weight.

CONTEXT

Current practice in paediatric anaesthesia involves weight related dosing (The Royal Children's Hospital 2018). As recovery room nurses, we noticed general prescription orders for many paediatric patients regularly consisted of 5mcg boluses of Fentanyl, regardless of weight.

We undertook a scoping literature review which led to a retrospective random data audit. The audit was done using data from a recovery room in a tertiary hospital between March and December 2018.

From this we discovered approximately 57% of the targeted population ($n=120$ paediatric patients with a weight variance of $>11\text{kg}$ and $<51\text{kg}$) were prescribed 5mcg boluses in the recovery room setting regardless of weight. This practice stood out as being inconsistent with the weight related drug dosing of paediatric patients and was inconsistent with pharmacological guidelines for weight related dosing (The Royal Children's Hospital 2018).

An example of a prescription order (found on audit) would typically include 1.5mg of morphine, made up to 10mls (0.15mg per ml) and given 1 ml for a 28.5kg child. Using this prescription the child would be under

analgesia. Our newly developed current protocol, supported by existing guidelines, would give 0.6mg morphine per ml (this is based on 0.2mg/kg for a 28.5kg child) to optimise pain relief.

A further difficulty of analgesia orders can rely on the recovery nurse mathematically working out, and double handling the medication prior to transferring the medication into a second syringe for administration. When clinicians are dealing with a distressed child and/or an anxious parent, this may impact on the pressures of the staff member, heightening the risk for errors to occur (Manias 2019).

This study by Manias (2019) found that communication processes accounted for over half of the medication errors ($n=3,340$) reported. It is hoped that by producing a simplistic and user friendly paediatric pain protocol, the risk of poor communication processes and misinterpreted/miscalculated drug orders can be reduced and/or eliminated.

As there is a lack of published studies into existing pain management protocols and their effectiveness, it is therefore the responsibility of "each institution to establish a[n] effective pain management strategy and monitor its effectiveness" (Trudeau et al. 2009 p.531).

This presents an obvious issue, being that it is then the responsibility of each anaesthetist to prescribe the accompanying analgesia for each individual paediatric patient. Due to the inconsistencies in this approach, the potential for drug error is heightened due to the lack of standardisation and administration of opioids within the recovery room environment.

Proactive pain management in children is essential in overcoming the historical issue of ineffective paediatric pain management (Taylor 2008 p.25).

By adopting a standardised approach to paediatric pain management, negative consequences including both physiological and emotional may be reduced. It is important to note however, that the causes of sub optimal pain management in this client group are multi-factorial and are beyond the scope of this clinical update.

The risks to this target group are well documented in the literature, highlighting sub optimal care (Twucross et al. 2015; American Society of Anesthesiologists 2004; Renee et al. 2016; Staveski et al. 2017;



Davidson et al. 2016; Taylor 2008) and medication errors (Manias et al. 2018).

The American Society of Anesthesiologists (2004) suggests the delivery of analgesia in paediatric patients may be underutilised due to a fear of opioid induced respiratory depression.

Furthermore, that “longer stays in the Post-Anesthesia Care Unit (PACU) may result in prolonged discomfort for the child, unit crowding, and increased costs” (Smith et al. 2009, p.86). This is supported by Gandhi et al. (2012) identifying that pain in recovery is a significant contributor to prolonged recovery stays which may add to the distress of the child and accompanying care giver as well as the financial costs associated with

prolonged length of stays (Gandhi et al. 2012). Austin Health (2016) states that the minimum length of stay after a General Anesthetic (both relaxant and spontaneous ventilation) is 30 minutes and sedation is 20 minutes. Our retrospective audit of approximately 160 children in various age and weight groups identified that the average length of stay was approximately 43 minutes. Interestingly, the length of stay increased by approximately 10 minutes in the 14–16 year age groups with variance in weight from 50–100kg. Presently, no protocol is prescribed in this paediatric weight group.

Anxiety is indicated as a predictor of post-operative pain (Ferland et al. 2017).

There are a number of factors that can be seen to impact on a child's anxiety in the post-operative setting. These include difficulties during initial paediatric pain assessment, the subjectivity of pain and the child's, parent or caregiver's expectations (Manworren 2016; Davidson et al. 2016; Trudeau 2009). Strategies to reduce anxiety may include, having the child's parent or caregiver in the recovery room (Lee et al. 1997). This is something that needs to be assessed pre-operatively on an individual basis and allowed only when the airway of the child is deemed safe. This is a current practice in our own recovery room. The use of icy poles on waking has also shown to have advantages to the reduction of

CLINICAL UPDATE

pain and general wellbeing on waking in the PACU (Austin Health 2018). This may also act as a distraction to the child and provide diversion therapy. (Icy Pole use post operatively for the Paediatric Patient, Austin Health Policy, 2018)

METHOD

Our team initially attempted to seek out existing Paediatric Analgesic Pain protocols (PAPPs) and policies used by other hospitals within Australia as benchmarks. We identified that the use of multimodal analgesia (Gandhi et al. 2012), local anaesthetics and blocks were used (and identified as the gold standard), but no specific PAPP for recovery room use through these lines was found. As a result, we set about to develop a paediatric pain protocol specific to the recovery room environment.

The focus then turned to the development of a unique PAPP, to be streamlined and implemented in the recovery room setting by using opioid analgesia which is the basis of pharmacological management of postoperative pain, especially in moderate to severe pain (Carr et al. 1999). The protocol was formulated through consultation with peers, senior anaesthetists and pharmacists from Austin Health, and guided by the dosing recommendations of The Royal Children's Hospital Melbourne, clinical practice guidelines: Morphine/Oxynorm 0.1-0.2 mg/kg and Fentanyl 1-2mcg/kg (The Royal Children's Hospital, 2018).

This was calculated based on 0.2mg/kg of Morphine and Oxynorm, and 2mcg/kg of Fentanyl per individual body weight category. This would equate to dosing of approximately 10% of the total recommended dose, for individual weight categories for paediatric patients. It is then titrated 1 ml at a time to effect.

Standard adult dilution syringes are prepared using: 10mg Morphine/Oxynorm plus 9ml NS or Fentanyl 100mcg plus 8ml Normal Saline (NS).

Excess drug for weight category is discarded, then diluted back to 10ml with NS. 1ml doses are then titrated to effect.

Our protocol is calculated on the higher end of the recommended scale dosing at 0.2 mg/kg or 2mcg/kg for Fentanyl.

This formula is simply demonstrated in our table: **Table 1.** TSC Recovery Paediatric Analgesia Pain Protocol

TABLE 1

TSC RECOVERY PAEDIATRIC ANALGESIA PAIN PROTOCOL

- STEP 1** Start with 100 microg Fentanyl or 10 mg Morphine or 10 mg Oxycodone
- STEP 2** Dilute with 0.9% NaCl to 10mL
- STEP 3** Discard according to weight and make up to 10 mL with 0.9% NaCl.
- STEP 4** Give 1 mL doses 5 minutely and titrate to effect

NB: Each dose (=1 mL) equates to 10% of the total recommended maximum dose.

Kg Range	Discard	Add NaCl (mL)	Final Concentration	Dose per 1 mL
11 - <16 kg	7 mL	7 mL	Fentanyl 3 microg/mL Morphine 0.3 mg/mL Oxycodone 0.3 mg/mL	3 microg dose 0.3 mg dose 0.3 mg dose
16 - <21 kg	6 mL	6 mL	Fentanyl 4 microg/mL Morphine 0.4 mg/mL Oxycodone 0.4 mg/mL	4 microg dose 0.4 mg dose 0.4 mg dose
21 - <26 kg	5 mL	5 mL	Fentanyl 5 microg/mL Morphine 0.5 mg/mL Oxycodone 0.5 mg/mL	5 microg dose 0.5 mg dose 0.5 mg dose
26 - <31 kg	4 mL	4 mL	Fentanyl 6 microg/mL Morphine 0.6 mg/mL Oxycodone 0.6 mg/mL	6 microg dose 0.6 mg dose 0.6 mg dose
31 - <36 kg	3 mL	3 mL	Fentanyl 7 microg/mL Morphine 0.7mg/mL Oxycodone 0.7mg/mL	7 microg dose 0.7 mg dose 0.7 mg dose
36 - <41 kg	2 mL	2 mL	Fentanyl 8 microg/mL Morphine 0.8 mg/mL Oxycodone 0.8 mg/mL	8 microg dose 0.8 mg dose 0.8 mg dose
41 - <46 kg	1 mL	1 mL	Fentanyl 9 microg/mL Morphine 0.9 mg/mL Oxycodone 0.9 mg/mL	9 microg dose 0.9 mg dose 0.9 mg dose
46 - 50 kg	NO DISCARD		Fentanyl 10 microg/mL Morphine 1 mg/mL Oxycodone 1 mg/mL	10 microg dose 1 mg dose 1 mg dose

Reference: TheRoyal Childrens Hospital, Melbourne. Clinical practice guidelines. rch.org.au/clinicalguide/forms/drugDoses.cfm



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This protocol is intended to be efficient and uniformed to address any inconsistencies in the approach and management of pain (Staveski et al. 2017). Prior to the clinician commencing the protocol, it is expected that multi modal analgesia has been optimised both intra-operatively and pre-operatively, taking into consideration that regional and local anesthesia have a clear role in the reduction of postoperative pain and time spent in recovery after surgery (Gandhi et al. 2012).

RESULTS

To date, there has been no known adverse events reported on Riskman specific to the administration of opioids among paediatric patients at our hospital since the implementation of the PAPP. Compliance within medical groups (in prescribing the protocol) has been excellent. Constant liaising with anaesthetists has been significant in assessing the usefulness and pharmacological safety of the protocol, and both nursing and medical staff feedback have described the ease and efficiency of this user-friendly protocol.

OPPORTUNITIES TO ADDRESS FUTURE RESEARCH

Given the "ever-increasing body mass index (BMI) phenomenon in current society" (Baines, 2011 p.144), our protocol could in the future be extended to include and accommodate the 50kg plus categories. However, currently there is a lack of available research on the effects of anesthetic and opioid drugs in obese children (Baines, 2011 p. 145, Philippi-Höhne, 2011, p.56). Clearly, further research is needed in this area to also include the optimisation of multi modal analgesia in

this age group. This finding was incidentally supported during our retrospective audit. We found that in the 14+ years' category a significant weight variance of 50-100kg was present. This group had an increased average length of stay by 10 minutes. A speculative reason for this may be in the length of time taken to manage pain. Therefore further research as above would be useful, and also may consequently reduce length of stay in the recovery unit and negate the consequences of this, such as "prolonged discomfort for the child, unit crowding and increased costs" (Smith et al. 2009, p.86). The choice of opioid used to manage paediatric pain postoperatively may be a further area of opportunity for research, as there is little research identifying the most effective opioid for paediatric patients (Manworren 2016).

CONCLUSION

The implementation of a successfully developed paediatric analgesia pain protocol for use within the recovery room environment has been the basis of this paper/clinical update. This was developed as a new concept, with literature review assistance, as precedence was hard to find. No known published paediatric pain protocols (or reviews of) could be found at the time of research, development and implementation.

The protocol has been successfully implemented with no known adverse events reported on Riskman to date. Pain assessment, treatment and management in the paediatric population is particularly subjective and challenging. Our protocol has focused on the pharmacological aspects of this by encouraging unique and individual dosing, standardised to reduce some of the risk associated with drug errors.



TAKING A STAND AGAINST OCCUPATIONAL VIOLENCE

In the past year, nurses and midwives were punched, stabbed, threatened with weapons and assaulted all too frequently. Escalating occupational violence within the health professions is causing untold physical and psychological harm and urgent action is required so nurses and midwives working across all settings can feel safe on the job. **Robert Fedele** investigates.

New South Wales mental health nurse Erin Francis still carries the scars of occupational violence.

Across six years working in acute mental health at a hospital in NSW, verbal and physical abuse was common.

It intensified in October 2017, when a male patient threw her from her shoulders and neck, the jolt triggering a whiplash injury that left her unable to work for a month.

Erin had simply been the bearer of bad news.

"I said sorry you don't have any leave but we'll continue working with the doctors and hope to get you some leave from the ward. Then probably a good half hour or so later, that's when he must have just snapped."

Erin suffered another serious assault just a month later, this time at the hands of a complex female patient who grabbed her head and threw it around like a rag doll.

Erin could not move for weeks afterwards and required frequent physiotherapy for her now long-term whiplash.

Sidelined on WorkCover, Erin struggled with the mental burden of dealing with insurance companies, visiting independent doctors and having to repeatedly prove her ongoing injuries.

She eventually returned to work after three months and for a short period was placed on light duties.

Leaving mental health never crossed her mind but coming back was confronting.

"I became very anxious when I was sent back to that ward and I actually refused to go back and work there after that because I just didn't feel that I was able to function in that workplace anymore."

Erin experienced stigma from management and some colleagues following the incidents.

"A lot of people just get on with it and if you're seen to be someone making a fuss about not putting up with it or trying to take a stand against it, I think people think you're trying to shake up the work environment and your role."

A NSWMA Branch Councillor, Erin believes occupational violence occurs due to a range of factors.

"For us in NSW, we don't have nurse-to-patient ratios so that's a big thing we've been fighting for. When you've got enough staff on the floor in a mental health unit you can put things in place where you're able to distract people and provide a more therapeutic environment and we've seen rates of violence go down in that scenario.



We also need occupational health and safety laws that protect the employee and not just the employer."

Erin says nurses and midwives "shouldn't just cop it and get on with the job" and must take a united stand against occupational violence.

VIOLENCE ON THE RISE

Violence in nursing and midwifery is on the rise. A study by the University of Technology Sydney (UTS) and NSWMA, *Violence in Nursing and Midwifery in NSW: Study Report*, surveyed over 3,500 branch members about the issue.

Led by UTS researcher Dr Jacqui Pich, the study found almost one in two nurses and midwives had firsthand experience of violence in their workplace, while four in five nurses and midwives were on the receiving end of violence in the past six months.

Verbal abuse, physical violence, sexual harassment and death threats emerged as common daily occurrences, with violence

rife across all sectors members worked in.

Physical violence included grabbing, hitting, spitting and pushing, and the most common type of impact was psychological, such as flashbacks and nightmares.

Almost 80% of nurses and midwives who experienced physical injury said they could not do their job anymore or had to change workplaces.

National media coverage in the past year echoes the study's findings.

In early 2019, a series of violent assaults took place at Sydney's Blacktown Hospital, with one nurse left with facial fractures and another punched and choked.

In South Australia, a Port Lincoln Hospital nurse was punched by a member of the public while working in the ED, leaving her bruised and battered.

In Western Australia, a nurse was stabbed in the neck by a patient.

More recently a community mental health nurse in NSW was murdered by one of his clients at the client's home.

Worryingly, the study found dissatisfaction with the immediate response from management following an act of violence, with little access to counselling and 87% reporting no change to the workplace.

Nurses and midwives who felt safe in their workplace were influenced by a positive safety culture, supportive management and working together in teams or pairs, while those who felt somewhat safe or unsafe reported not having enough staff or a poor skills mix.

CALLS FOR ACTION

At the ANMF's 14th National Biennial Conference in Melbourne last October, nursing and midwifery delegates tabled several notices of motion aimed at preventing and curbing occupational violence.

They included that the ANMF campaign to tackle the issue across all health settings and drive legislative changes to keep nurses and midwives safe.

"It's just getting worse. It's not acceptable. It has to be zero tolerance," ACT delegate Carol Sandland declared.

One delegate portrayed occupational violence as a daily occurrence being fuelled by growing levels of drug and alcohol abuse and mental illness among the population.

Another motion called on the ANMF to develop a policy position statement to help trigger systems that identify and manage the risk of occupational violence and aggression in aged care, proposing violence risk assessments and putting controls in place to minimise risk, such as appropriate staffing levels.

"The aged care workforce faces verbal abuse, intimidating physical behaviour, physical assault and extreme acts of aggression from residents and family members in our jobs every day," NSW delegate Jocelyn Hofman said.

NSW delegate Lyn Hopper moved a motion calling on the ANMF to lobby the federal government to take urgent action, outlining potential strategies such as adequate staffing and skills mix, improved reporting systems and a funding-pool for anti-violence measures.

"Violence against nurses and midwives, from patients and relatives, has become the norm," Ms Hopper said.

"It should not be accepted. It's not unusual these days for nurses to go to work and get spat at, beaten, and be inappropriately touched."



Nurses in South Australia stand in solidarity against occupational violence.

DRIVING CHANGE

Efforts to reduce occupational violence include the ANMF (SA Branch's) ongoing anti-violence campaign and its adoption of a 10 Point Plan to Address Violence and Aggression.

The union tabled the plan to the SA government as part of its log of claims during the latest public sector Enterprise Agreement negotiations.

Modelled on a successful blueprint developed by ANMF (Vic Branch), the plan covers:



Victoria's pioneering *10 Point Plan to End Violence and Aggression – A Guide for Health Services*, was sent to all its public health services in 2017 and advocates for safe workplaces driven by hospital executives that must include a combined clinical, security and health and safety approach.

It mirrors *WorkSafe Victoria's 'It's Never OK'* campaign to prevent occupational

violence and aggression, backed by the state government funding to make hospitals and mental health services safer through projects such as installing alarms, CCTV, lighting and security systems and redesigning waiting areas.

PREVENTION IS KEY

ANMF Federal Industrial Officer Daniel Crute suggests provisions to help address occupational violence exist within current work health and safety (WHS) laws but are not being utilised.

"We have work groups and health and safety representatives (HSRs) within workplaces now and we need to be actively training them on these issues to make sure that when a violent incident occurs or if they believe a particular layout in a health facility will lead to increased violence then action is taken."

HSRs are elected volunteers that represent work groups on WHS issues and have powers to enforce compliance under the Work Health and Safety Act or equivalent.

Notably, trained HSRs can issue Provisional Improvement Notices (PINs) that identify WHS laws have been contravened and require the employer to fix the problem.

HSRs can investigate health and safety complaints, monitor compliance measures, and instruct a work group member to cease unsafe work.

Mr Crute says employers hold responsibility for complying with WHS laws but not all employers conform and penalties for infringement are often inconsistently applied across the nation.

He says HSRs can make a real difference in achieving better health and safety outcomes through proactive prevention.

He cites one example from the ACT, where a PIN was issued in response to violence that threatened bed closures unless more staff were added, which resulted in the government agreeing to the demand.

Ultimately, Mr Crute says it will take government will at a national level to enhance legislation for better protections.

"The idea within WHS laws is to a large extent making sure that violence doesn't happen in the first place. It's not about being reactive. It's about actually having the systems and processes in place to identify risk and force employers to take action. No one is going to be perfect but employers must do what is 'reasonably practicable' to ensure health and safety."

IT'S JUST NOT PART OF OUR JOB

In 2017, South Australian RN Lynsey had a chunk bitten out of her arm by an agitated patient she was caring for in the Intensive Care Unit (ICU).

In the aftermath, she reported the incident to police despite being discouraged to do so and took the perpetrator to court.

The violent attack unfolded after the patient, in hospital to have a procedure, woke up from sedation, became aggressive and needed to be restrained.

Lynsey had been attempting to facilitate the woman's request to phone a loved one.

ICU is a challenging environment where disoriented patients waking up from sedation can lash out and commonly

develop ICU delirium, she explains, but it wasn't the case for this patient.

The patient had been restrained several times that day, triggering code blacks activating security backup.

Concerned for the patient's safety, Lynsey attempted to restrain the woman as she kicked out and tried to exit her bed.

A colleague had to pull Lynsey's arm away as the woman bit her, as she wouldn't let go.

"I honestly didn't feel it when she was doing it," Lynsey tells the *ANMJ* of the large wound to her forearm.

"I stepped away, started shaking immediately and began crying. The disbelief hit me of what had just happened. I felt like I was going to faint."

Post incident, Lynsey developed cellulitis in her arm, an infection which caused permanent damage and nerve pain from her neck, down to her arm.

She was admitted to hospital for surgery and IV antibiotics and was discharged after four days.

She says she felt compelled to contact police.

"I said I want to because it's wrong and it's assault and whether it happens at work or it happens on the beach or wherever, it's wrong. It's assault."

In her three-page victim impact statement, read out in court in front of supportive colleagues, Lynsey revealed the incident had taken an emotional and physical toll and kept her off work for six months.

She told the court she still had a dint in her arm, weakness, tingling in the fingers and reduced grip strength.

Lynsey said she was determined to return to ICU but that the lasting injuries, including psychological impacts and panic attacks, forced her to switch settings.

"It has changed my life dramatically, ruined my career, reduced my earnings and potential earnings, given me chronic pain to deal with for the rest of my life and possibly more surgery in the future, something that I am not ready to undertake due to the length of time it has taken me to get back to being able to work," Lynsey told the court.

"I just want to be able to feel normal again and work in the job I love."

The lengthy two-year court process concluded with the perpetrator found not guilty due to a mental health impairment, escaping jail time.

Instead, she was placed on a license where she must abide by certain conditions for three and a half years and the incident will remain on her permanent police record.

She will be summoned to court if she fails to abide by the terms of her license and will face the full 19-year prison term.

"I wanted her to be held responsible and accountable for her actions," Lynsey says.

Ultimately, Lynsey says nurses and midwives should not have to put up with occupational violence and need to rally together for change.

"The more people that speak up about it, the more people that stand up and say this has to stop, the better. Otherwise, it's just going to continue happening."



NSW nurses rally outside Blacktown Hospital in the wake of violence.



NSW nurses taking a stand against workplace violence during last October's national Safe Work Month.



James Lloyd
ANMF Federal
Vice President

Understanding vicarious trauma

Nursing and midwifery are professions that involve giving part of ourselves at work.

By default, we are attracted to the profession because we are natural empaths. In our day-to-day caring, we engage emotionally with our patients and clients. Sometimes this engagement is positive- for example, when a mother gives birth to her first child and her midwife shares her joy. Other times it is negative- for example, a patient retelling their trauma to an ED nurse.

For nurses and midwives, empathy is a powerful tool to relate to our patients. But this empathy has a cost, especially from a negative experience. This cost is called compassion fatigue or burnout; in some scenarios it is called vicarious trauma. Vicarious trauma appears when we empathically engage with our patients - we bear witness to our clients' trauma through their recounting of their story.

Over time, the compensatory mechanism to cope with these experiences grinds us down, leading the carer to experience vicarious trauma. This suffering leaves the carers fatigued and the inevitable sequel to repeated exposure to trauma-focused interactions.

Symptoms may include:

- Decreased concentration span
- Anxiety, numbness, depression
- Hypersensitivity, hypervigilance
- Powerlessness, feeling overwhelmed
- Impacts in personal relationships
- Changes in appetite, sleep disturbances
- Arousal of nervous system
- Career fatigue

As nurses and midwives, we must recognise that during stressful encounters with our patients we are at risk of vicarious trauma. Well developed self-care strategies are therefore required.

As carers and empaths, this risk of distress from vicarious trauma is very real. If you have had prior or unresolved traumas, your risk is increased. Your own personal capacity to deal with stress, your current personal life circumstances, your support system and your professional history can all affect your risk.

So how do we withstand the buffeting by secondhand trauma, these cumulative effects of the myriad of psychological wounds inflicted on us while at work? How do we find balance and healing?

All nurses, midwives and carers need an appropriate work/life balance - the ideal equilibrium between career and personal life. We need downtime to rest, rejuvenate, interact with our families and practice self-care.

This is one of the most vital strategies to minimise risk of vicarious trauma; it is imperative to look after our psychological, spiritual and physical health. A good foundation of self-care provides a buffer of resilience, so when stressors shock us, we have enough internal resources to absorb and recover.

Some self-care tactics include:

SUPPORT GROUPS/DEBRIEFING

After stressful shifts, one of the most important strategies is to sit down and debrief with your colleagues or a significant person in your work life.

EXERCISE

Exercise improves mental health by reducing anxiety, depression, and negative mood and by improving self-esteem and cognitive function. Physical activity prompts the release of feel good chemicals like endorphins and serotonin in the brain.

GOOD DIET

A healthy, well-balanced diet improves physical health. It also improves sleep, energy levels and decreases our chance of illness

GOOD SLEEP

After a good night's sleep, the world appears fresh and optimistic. Sleeping well increases your mental capacity to deal with daily stressors.

MAINTAINING GOOD RELATIONSHIPS

These relationships help maintain a good life/work balance. A fulfilling social life allows for debriefing, relaxing, and smoothing the rough edges of a disturbing day.

REFLECTIVE PRACTICE AND AWARENESS

Awareness of vicarious trauma reduces its potential harm. Mindfulness of our behaviours provides us with the opportunity to change our technique and then employ self-care strategies.

Vicarious trauma is a condition that is not well known among nurses and midwives. It may sound similar to signs and symptoms of carer's fatigue (ie. burnout), but vicarious trauma is the profound shift in world view that occurs when we work with clients who have experienced trauma or we experience the repeated exposure to traumatic material. As nurses and midwives, we need to be aware that vicarious trauma exists, recognise its signs and practice self-care techniques to help us heal and build resilience.

Extra resources

Beyond blue
beyondblue.org.au
p: 1300 22 4636

Life line
lifeline.org.au
p: 13 11 44

Nurse and Midwife Support
nmsupport.org.au
p: 1800 667 877



Dr Micah D J Peters

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Equity of access and outcomes – Prioritising rural and remote health and wellbeing

With the holiday season approaching think of those who may be less fortunate.

As we enter the warmer months, people who live and work in rural and remote Australia - those who are worst-affected by the ongoing droughts, and the increasing number and severity of environmental and climate emergencies, while contending with failures of politicians to deliver effectively on real action and support, come to the forefront of my mind.

'Rural and remote' refers to all areas outside Australia's major cities. Within rural and remote areas, there are zones classified as 'inner regional', 'outer regional', 'remote' or 'very remote'. Within each of these areas, individual communities are very different and can have diverse profiles and needs.

These communities are however, often disproportionately impacted upon by factors that lead to worse physical and mental health and wellbeing. Around one in three people (7 million people) in Australia live in rural and remote areas. This population is cared for by over 70,000 ANMF members who live and/or work there.

People living in rural and remote areas have different experiences and needs regarding healthcare from people living in metropolitan areas. However, despite knowing that these differences exist, there is ongoing uncertainty regarding the exact nature and impact that distance has upon health and wellbeing.

A few reasons for this are the complex interactions between multiple factors, including; socioeconomic position, social determinants of health (eg. differences in education and employment opportunities), demographics (particularly Aboriginal and/or Torres Strait Islander and older people who make up a larger proportion of people in rural and remote areas), and the relative paucity of health data in these areas. Additionally, establishing the adequacy of health services in rural and remote regions can also be challenging due to differences in health-seeking behaviours, workforce composition and integration, and health system efficiencies.

These and other differences between rural/remote and metropolitan populations have led to inequities in healthcare access and an increasing disparity between health and wellbeing outcomes.

In comparison to those living in metropolitan areas, Australians living in rural and remote areas die younger (1.9 times the rate of premature death), experience higher rates of injury and illness (1.7 times the burden of disease people in remote areas), are

more likely to experience a chronic health condition (eg. arthritis, asthma, back problems, deafness, diabetes, heart, stroke and vascular disease), and face more limited access to health services.

The differences between regional and remote populations and their metropolitan counterparts have resulted in an understanding that different approaches and interventions are necessary to deliver healthcare and support outside cities.

There are, of course, considerable challenges to the provision of healthcare in these areas; low population density, limited health infrastructure, difficulties attracting and retaining members of the health workforce, and greater costs.

As a member of the National Rural Health Alliance (NRHA), the ANMF is active on several fronts to positively drive and influence policy in relation to the nursing and midwifery workforce, and health, maternity, and aged care in rural and remote areas. The health and wellbeing of Aboriginal and Torres Strait Islander people is a key priority in improving the overall wellness of people in regional and remote areas. By focusing on closing the gaps between Indigenous and non-Indigenous Australians, a significant proportion of the differences between rural/remote and metropolitan health outcomes could be resolved.

To work towards improving rural and remote health and wellbeing outcomes, considerable action is required which necessitates funding and policy and political support. Currently, below 3% of the funding granted through the National Health and Medical Research Centre is directed toward research that is specifically designed to generate health benefits rural and remote-dwelling Australians.

In 2020, the ANMF will continue its work with the NRHA and explore new opportunities through our existing involvement with other groups and organisations to support further efforts to improve the health and wellbeing of Australia's rural and remote communities and to protect and back our members and the wider health workforce.

Key areas will include Aboriginal and Torres Strait Islander peoples' health and wellbeing, equity and access to health services, building health workforce capacity, and the impact of environmental emergencies and climate change.



Group 792 reunion: *training by ordeal, living up to the ideal*

It was our 'Ruby Anniversary', 40 years since 'Group 792' from St Andrews Private Hospital, Adelaide, commenced our nursing training. We were a small group of 11, but eight of us had made it to our 2019 reunion in Canberra.

By Kate Davis

Half a lifetime ago, we were sheltered 17-year-old girls who together, over three years, learnt the formative, professional, and personal lessons of our young lives. Then, we mostly went our own ways. Now, 37 years later, as 'middle-aged' women, we reunited to share our life experiences. How would it go?

Six of the reunion group are still registered nurses (RNs):

Amanda works in palliative care, and Karena in recovery.

Sue is a dermatology nurse.

Nicole is a midwife who has worked nights for the past 20 years, and Anne-Marie is a health informatics professional.

I am a PhD candidate undertaking research on the feasibility of nurse-led clinics for people with multimorbidity.

Only one of us is no longer nursing – Wendy is a tomato farmer.

All of us had enjoyed our many years in nursing. Nicole reflected:

"I get most of my rewards from the mothers I have helped in overcoming their initial fears with baby and breastfeeding, and have received lovely letters sent to me, months later, that has given me my greatest buzz".

Sue recalled her time coordinating an IVF clinic:

"I spent the following month following up on all the women, enjoying the highs of those who were successful and providing a shoulder to cry on for those who were not. I loved every minute of it".

It was universally agreed that now there is no such thing as an empty bed and that for nursing and midwifery high patient turnover is a common stressor.

As older nurses, we spoke about fast-paced workdays and the shifting perceptions of younger colleagues. Nicole observed:

"I feel that some staff resent the older person as we don't practice the same way that they do and we are slow, and our priorities are often different. But, on the other hand, some younger nurses recognise our knowledge levels and respect us. I often question myself as to why the younger nurses seem to finish their rounds hours before me or do their feeds quicker. Are my time management skills lacking or do I just do more? I feel the latter but feel they don't see it that way."

Some of us felt occasionally ignored; our experience and knowledge overlooked and undervalued by younger staff. Others noticed they were sometimes sought out and valued *because* of their experience.



"Although the fundamentals of nursing have not changed, the pace at which we're expected to deliver care, patient throughput and technology has escalated."

Nicole summed up the challenges we experience:

"Although the fundamentals of nursing have not changed, the pace at which we're expected to deliver care, patient throughput and technology has escalated."

Of course it wasn't all serious! We relived past antics from our training and Amanda recalled the glamorous Matron, Miss Pitcher.

Big cheese in nursing administration, Miss Pitcher was a cross between sultry Lauren Bacall and innocent Sally Field as the 'Flying Nun'. Standing six feet tall, with a slash of red lipstick, she cut a striking figure with her oversized aeronautical headwear!

I can't really say 'professional engagement' with the student nurses was Matron Pitcher's forte, but it certainly was for our clinical tutor Sister Voveris (or 'Iced Vovo' as we affectionately nicknamed her) who was a kindly, yet stern woman of Latvian heritage with a razor-sharp intellect lurking behind an imperious forehead. Wendy remembered that 'Iced Vovo' would find her skulking in 'the backs'. Wendy would then be dragged out for random aseptic technique testing; was it up to scratch? Following the aseptic

technique interrogation, she would be on a roll. Did the pillow cases open towards the windows? If not, on the spot bed re-making would be required. Were the commodes clean? Wheels and dressing trolleys thoroughly scrubbed? Were bins empty; jugs full; and bowel and pressure area books up to date? Were patients sitting upright and comfortable in bed- with their covers pristine- and all hygiene completed, *by 10 am*?

Then came the *piece de resistance*: Deputy Matron, Sister Le Poidevan (or 'Le Poison' as she was known). 'Le Poison' found me one Christmas morning, only to ask; "Nurse Bishop, have you ever seen a dead body"? My jaw dropped, clearly signaling that I hadn't. I was then ushered respectfully into a room to lay out the body of an elderly gentleman with the good Sister. Why was she even working on Christmas morning?

Then, of course, we remembered the humiliations. Like the time third-year scout nurse Margaret was 'playing' with an elastic band whilst in theatre. Of course, she pinged it, dead centre, into the middle of the sterile field, mid-operation. The operating room team's response? NOT HAPPY JAN, to put it mildly.

REFLECTIONS

Margaret was relegated to tea duties for the doctors after that: “two for tea in theatre three” would be heard over the intercom, or was that “tea for three in theatre two”?

Nursing did have its positives though – like going on a ward round with Mr. Plowczkieczi, that young, hot-blooded Hungarian hunk (also known as Mr. ‘please kiss me’).

Looking back, we were nothing if not young and naïve, intimidated into politeness on those early ward rounds. The heady thrill of ‘charging’ the ward in our third years, along with the joy of passing each procedure test and slowly inching towards our collective dream of becoming Registered Nurses. We experienced appreciation and chocolates from patients and their grateful families, mixed with bullying and terror from the ward sisters. Despite this and our youthful inexperience, a gradual building of competence was evident.

Of course, those of us who didn’t continue with nursing have had full and interesting journeys. Ann says:

“I found my experience in nursing has helped in some respects with farming life, I have helped our sheep with births, wound healing, and general first aid on the farm”.

Ann is glad that she nursed so many years ago, but wouldn’t return to it. Wendy talked about her life on a Northern NSW farm, where she reluctantly gave up nursing when it became too difficult to manage the farm, sell organic produce locally and raise six children. More recently, she has faced extreme drought and devastating bush

fires, an experience resonating throughout Australia.

On a personal level, we have all been through the ups and downs of life; confronted with the death of partners and, devastatingly, children.

We had weathered separation and divorce, children’s mental and physical health issues, children longed for and never born, as well as the joys of our own, partners, children’s and even grandchildren’s achievements.

Despite our disparate personal and professional experiences, we rediscovered a shared love of nursing and enduring close bonds based on our earlier formative

experiences together. We still love to care for people; to make them comfortable; relieve their pain and most of all, provide them with dignity.

Despite being challenged with a progressively complex health system we continue to find satisfaction in educating and empowering our patients.

Our 40 year anniversary, much like the ruby that represents the passing of this significant period of time, celebrates these nurses, educated in a very different era and way; and how they brought passion and commitment for nursing into their patients’ lives. Given the ruby’s hue is so close to the colour of blood, which carries life-giving oxygen, the gemstone, much like these nurses, is also said to represent vitality and vigour. In their own unique way this group of skilled and caring practitioners, even after 40 years, remain an integral part of the professional cornerstone of the health workforce.

* The author wishes to acknowledge the nurses mentioned for sharing their lives and thoughts in this story.

1 The real names of people have not always been used.

Kate Davis, RN, BNsg, MScIsc. is a third year PhD candidate (Rosemary Bryant AO Research Centre, School of Nursing and Midwifery, University of South Australia). Kate’s research focusses on the feasibility of implementing a nurse-led care coordination service for people living with multimorbidity, and provision of continuity of care across the tertiary and primary healthcare sectors.



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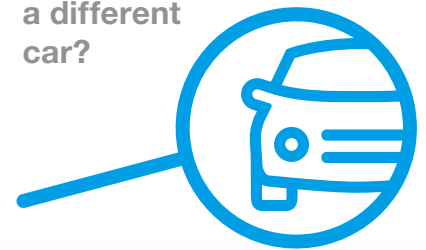
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†Negotiated Smartleasing buying power discount on chosen vehicle may vary.



Julie Reeves

Federal Professional Officer

Nursing education under review

Recently the government undertook an independent review of nursing education. The ANMF's submission to this review was a comprehensive and considered response (Australian Nursing and Midwifery Federation, 2019).

The review, titled '*Educating the Nurse of the Future – Report of the Independent Review into Nursing Education*', was announced as a measure within the 2018/19 Federal Budget and was conducted by Professor Steven Schwartz.

The Terms of Reference were broad and included:

- the effectiveness of current educational preparation and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery;
- factors that affect the choice of nursing as an occupation, including for men;
- the role and appropriateness of transition to practice programs however named; and
- the competitiveness and attractiveness of Australian nursing qualifications across international contexts.

Consultation opened in February, closed in June and included a number of face to face consultations held across the country. Eighty four submissions were made to the review including responses from other professional nursing organisations, health services, education providers and individuals.

Overall the ANMF's response to the review outlined that nursing education in Australia is in good shape.

Both the Bachelor of Nursing, leading to registration as a registered nurse, and the Diploma of Nursing, leading to registration as an enrolled nurse, provide a comprehensive generalist foundation for nursing practice, the backbone of healthcare delivery in Australia.

Our submission included four sections that responded to the Terms of Reference. Each section outlined the current situation, what makes it effective, and any areas that are problematic or missing. Solutions to these matters were then discussed along with clear recommendations going forward.

The 17 recommendations made focused on a number of key areas in nursing education that need attention. Further support for newly qualified nurses in their consolidation year and the need for the implementation of clinical supervision were raised. Additional opportunities for nurses to complete a Master's degree leading to endorsement as a nurse practitioner were explored in depth.

With reference to undergraduate programs, the ANMF recommended the theory and practice experience of nursing students be re-evaluated in relation to

the importance of educating students about the provision of aged care. We emphasised the skill and expertise needed to provide safe, quality care to older people. This is essential considering the growth of our ageing population, the increasing complexity of care requirements for older people, and the increasing prevalence of dementia.

The quality of clinical placement experiences in undergraduate programs was identified as a key issue requiring improvement. Six recommendations were made with the aim of improving the student experience. These recommendations related to students being able to access placements in a range of contexts of practice, sufficient placement hours, and support for both the student and the supervising registered nurse.

When done well, clinical placements can effectively prepare students to meet the Nursing and Midwifery Board of Australia's standards for practice, and to gain future employment. However, achieving quality clinical placement can be difficult. ANMF members tell us regularly about the challenges of clinical placement. Many nurses report that when their health service accepts students for placement, the responsibility for facilitation impacts upon the quality of care being delivered. They feel they are not adequately resourced to both support the student and provide quality care.

One of the recommendations made in the submission is that all education providers be required by the Australian Nursing and Midwifery Accreditation Council to use an evidence-based framework, such as the Best Practice Clinical Learning Environment Framework (Victoria. State Government 2018) to support students on placement. If this framework were adopted, all stakeholders engaged in clinical placements, including registered nurses providing support, the student, the health service and the education provider, would be required to work together to support one another to offer quality clinical placement to students.

The final report of the review has been submitted to the Federal Minister for Health, Greg Hunt. We look forward to the government providing a comprehensive response in a timely manner.

The ANMF's submission to the review is available at the following link: anmf.org.au/documents/submissions/ANMF_Submission_Nursing_education_review_4July19.pdf

References

- Australian Nursing and Midwifery Federation (2019) Submission Educating the nurse of the future – independent review of nursing education anmf.org.au/documents/submissions/ANMF_Submission_Nursing_education_review_4July19.pdf
- Victoria. State Government (2018) Best Practice Clinical Learning Environment (BPCLE) Framework. Online at health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework



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

Taking an unfair advantage – breaching professional boundaries for personal gain

Mr Cox was a 92 year old man who lived alone and had no family. He did however, have good neighbours and a case manager from the Brotherhood of St Laurence and with their assistance he was able to remain in his own home despite some ill health.

In July 2015 Mr Cox was admitted to an aged care facility for respite care where he told the nurses he was only staying for the colder months and would be returning home. This is where Kumar, the nurse unit manager (NUM), met Mr Cox for the first time and discovered that he lived alone in his own home, had no family – and had not made a will.

Shortly after his admission Kumar accompanied Mr Cox home in a taxi to collect some of his belongings and \$4,500 cash. After doing some research Kumar took it upon herself to buy a will kit from the local post office and gave it to Mr Cox to write his will. She insisted that a nurse and another staff member witness the signing of the will despite the distress this caused the staff member who complied with the request only because she viewed it as a direct order from her NUM.

The tribunal noted that the NUM had a position of power and trust and manipulating the staff in this way was an abuse of this position. Furthermore, witnessing this document was in breach of the organisation's policy that did not allow staff to witness legal documents on behalf of patients, especially wills.

The will named Kumar as the executor and sole beneficiary of Mr Cox's estate with an estimated value exceeding \$1,000,000. The witnesses did not know that Kumar had been named as the sole beneficiary, in fact Kumar told them that Mr Cox had named two nephews in Ireland as benefactors to the will and later advised that the will had been torn up.

Mr Cox died in August 2015. Although not at work at the time of his death, Kumar insisted that the nurse immediately search his room and belongings for his house key causing distress to the staff member who felt this to be disrespectful while the deceased's body remained in the room as the search took place. A grant of probate was made in 2015 and the title and ownership of Mr Cox's property was transferred to Ms Kumar. The will was not contested. In 2016 Kumar sold the house for \$1,117,000.00. The notification regarding Kumar's conduct was raised by six concerned neighbours (on behalf of a much larger group of friends and neighbours) regarding the circumstances that led to the deceased making a will in favour of the

NUM whom he had only recently met and whether other vulnerable residents could be at similar risk.

It was established that the actions of escorting Mr Cox home, securing a blank will and organising its execution were beyond the duties of the NUM whose role was being primarily responsible for the overall provision of nursing services rather than being involved in the delivery of day to day care to residents. In fact, this was recognised as a significant departure from her professional responsibilities and more in line with the role of his case manager. An aggravating factor in this case was Kumar's retention of the proceeds of the estate which was viewed as her willingness to profit from her own acknowledged wrongdoing.

The tribunal was clear that this case was not about the circumstances of the patient's death where evidence showed he received a high standard of care, nor was it about the validity of the will. It was about Kumar's conduct and the professional and ethical obligations nurses have towards their patients, colleagues, the profession and the public.

Kumar was found guilty of professional misconduct for transgressing boundaries through over involvement with a patient, failing to manage a conflict of interest where she obtained a benefit in circumstances where she knew or had a reasonable belief that she was going to be named as a beneficiary under the will and her conduct towards her colleagues.

The practitioner was disqualified from applying for registration for a five-year period and prohibited from providing any health service involving provision of care to people in residential aged care or receiving community based aged or disability care in any capacity for the same period.

This case not only highlights how the abuse of power and a failure to follow professional codes and standards impacts upon the practice and confidence of those working in the profession but also the detrimental effect this has on the public's trust in the profession. It is also a further reminder of how important it is to be familiar with organisational policy and to ensure that staff meet their contractual obligations to their employer by adhering to these.



The Power of Calm

By ANMF Federal Education Team

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

This tutorial explains what stress is and why it's important to understand it. It also offers some simple and effective tools to help you start doing something about it both for yourself and for those you care for.

Stress is an unavoidable part of life. In fact, when working as intended, your stress response can be helpful, even lifesaving. It can get you out of a bind with incredible agility, sharpen your awareness or concentration, or even help you complete a worthwhile exercise session.

However, what can be helpful in small doses can be extremely harmful in large or persistent ones.

What we are not designed for is chronic stress – being constantly chased by tigers (or

in our case, deadlines, hostile environments, economic woes, personal conflicts ... the list goes on). In fact, our modern world affords us the opportunity to be stressed on an almost constant basis. Physiologically and psychologically, this is not an outcome we can afford to indulge.

The scientific evidence is abundant and persuasive. Living life in the shadow of persistent stress is not a recipe for either health or happiness.

But there is good news. Persistent stress doesn't have to be accepted as an unavoidable consequence of the 21st century.

Life's stresses are not going away, but engaging with this tutorial can provide the knowledge, the resolve, and the skill to

help you to respond to them in a different way. Changing the way you think about and deal with stress can be life changing. This is an invaluable resource towards achieving this goal.

Stress can be a heavy burden to carry. It has a unique and powerful capacity to affect the way we feel, cope, look, perform, and behave.

Intuitively, we get it. Persistent stress can throw us off balance, make simple challenges seem daunting and cause us to make poor or hasty decisions. It also seems clear that the more stressed we are, the more often we get sick, and the longer it takes us to recover.

Of course, this is not news to you. It's something we all very much understand and relate to.

Curiously, it took medical science quite some time to devote any rigorous attention to the dangers of chronic stress. Perhaps this has made it a little easier for us to ignore as fact, what we have always understood by intuition.

We no longer have the luxury of that excuse. In recent years, doctors and scientists from



the world's most prestigious institutions have applied themselves vigorously to this area of study. Their findings are both clear and concerning.

Persistently high levels of stress are a serious and an immediate challenge to our health and wellbeing.

The statistics are even more remarkable than you may imagine.

Fortunately, the news is not all bad. Research has also shown that relatively simple techniques can be remarkably effective in reducing stress and the way it affects health and wellness outcomes.

This is both comforting and confounding. If stress can quite fairly be described as an epidemic of the 21st century, and clinical studies have shown there are some simple and effective ways of addressing it, why are we failing to rise to the challenge?

STATISTICS

- 75% of all doctor visits are related to stress in some way
- 66% of people believe stress has a visible effect on their physical health

- Hundreds of billions of dollars are lost worldwide due to stress-related illness (Statistics Brain, 2013).

Stress is not just floating around in the air. It is your body's INTERNAL response to a perceived threat.

The stress response is a 'red alert' signal from the brain. A warning that your safety or wellbeing may be at risk.

Whether the danger is immediate and physical:

- Running from an attacker
- Avoiding a falling branch

Or emotional and abstract:

- Speaking in front of people when you're not used to it
- Waiting for your test results

Your body gets the message that your wellbeing may be potentially under threat. As such, the first priority of the stress response is to make sure your body is primed to defend itself.

The stress response is powerful, single-minded and somewhat inflexible.

The capacity of the stress response to change your physical state is impressive.

So is the speed with which it acts.

You can go from relaxing in a chair listening to the rain, to tearing wide-eyed down the hallway before the thunder crack has even subsided.

It is a powerful, yet somewhat an inflexible tool of self-defence.

When the stress alert sounds in your brain, your body gets a clear and immediate message from upstairs.

Prepare for FIGHT or FLIGHT

Our ancestors didn't have to apply for jobs or write exams. The speed and power of our stress response developed to protect us from physical threats and was designed to be implemented in short, intense bursts.

It is only in very recent human history that the nature of threats we face has significantly changed. Aggressive physical responses preparing us for 'battle' are now rarely appropriate or useful.

Today's threats are often better described as challenges. While still very real, they are more emotional, abstract and persistent than those our ancestors faced.

EDUCATION

The prospect of losing your job, for example, is certainly a worthy concern. But starting to sweat, increasing your blood pressure and dilating your pupils is hardly going to help you avoid it.

Passing an exam may be crucial, but halting your digestion, not being able to sleep and directing thoughts from logical to reactive is going to hurt, not help you in your endeavours.

Scientific journals are now littered with detailed studies that link persistent stress with long-term health issues.

Researchers at Penn State University, to pick one, assessed 2,000 individuals over a ten-year period. The team found that subjects who responded in a more stressful way to general daily challenges (high stress responders) were more likely to suffer from serious health problems ten years later (Penn State University News, 2 November 2012).

In short, those subjects who spent more time swimming in a sea of stress hormones were more likely to lose their health in the future.

It's true that some people are generally more prone to 'stress' than others. This can be as a result of our genetic code or the environment we have been exposed to. It is however safe to say that, when it comes to persistent elevated stress levels, 'less is more' is likely to be a reality that applies strongly to us all.

When engaged, the stress response is dominant, often at the expense of key



functions related to repair, re-balance and regeneration.

When you're in a calm and relaxed state, your body is designed to respond in a different, yet equally impressive way.

In this state, the body switches its considerable talents to the complex maintenance required to keep your systems thriving. In fact, you would be surprised at how well it can look after itself if given half a chance. When your body is running efficiently, it skillfully regulates countless processes that help keep you calm, healthy and happy.

The Power of Calm tutorial discusses; detailed information on the physiology of stress; recognising symptoms in yourself and others; the impact of stress on performance and how stress contributes to health issues. There is a detailed section on 'how to address stress' which includes looking deeply into the biology of stress and the relatively unknown partner of stress, the relaxation response.

The tutorial is supported by videos throughout and access to the Power of Calm app, which is offered at a discount price to ANMF, NSWNMA and QNMU members.



30 minutes
CPD

The following excerpt is from the ANMF's The Power of Calm on the Continuing Professional Education (CPE) website. The complete tutorial is allocated three hours of CPD, the reading of this excerpt will give you 30 minutes of CPD towards ongoing registration requirements. Be sure to add it to your portfolio on the CPE website

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

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

anmf.org.au/cpe

QNMU and NT members have access to all learning on the CPE website free as part of their member benefits.



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Daniel Crute

ANMF Federal
Industrial Officer

The importance of HSRs in keeping workplaces safe

WHAT ARE HSRs?

Health and Safety Representatives (HSRs) are elected and voluntary roles in your workplace. HSRs make a difference in achieving better health and safety outcomes. Your employer is legally obligated to work with them and support them in this vital role.

HSRs exist within a national framework of work health and safety (WHS) laws. The Commonwealth, states and territories (except Victoria and Western Australia), implemented the 'harmonised' model Work Health and Safety Acts in 2011. Western Australia is also in the process of joining the 'harmonised' laws, hopefully within the next year. These 'harmonised' WHS laws are largely the same in each jurisdiction with some minor differences. All states and territories have HSRs, except Western Australia. Victoria has HSRs but is not currently part of the 'harmonised' WHS laws. Various aspects of the Victorian Occupational Health and Safety Act 2004 are superior to the model laws. Throughout this article reference is made to the practices under the 'harmonised' WHS laws, although the situation in Victoria is very similar.

HOW DO YOU BECOME AN HSR?

If you want an HSR at work then the person conducting a business or undertaking (PCBU) (usually the employer) must start negotiations with workers to determine the number and composition of the work groups in the workplace, the number of HSRs and deputy HSRs in each work group and workplaces to which the work groups apply.

If negotiations fail in establishing a work group any person who is a party to the negotiations can request a government inspector to assist in deciding the matter. After defining the work group, the members then elect their HSR. Despite what your employer may say, they are not appointments by them. All work group members are entitled to vote in the election and the HSR must be a member of the work group. Members of the work group decide how an election will be conducted. The election may be conducted with the assistance of the ANMF or any other person/organisation, if supported by a majority of work group members. Elections for a deputy HSR are carried out in the same way and the term of office for an HSR or deputy is three years.

HSRs and deputy HSRs can be re-elected. In harmonised jurisdictions, employers must notify the relevant government agency of HSR and workgroup details whenever these change.

WHAT ARE THE POWERS OF AN HSR?

HSRs have important powers under WHS legislation. They are entitled to:

- Undertake workplace inspections
- Review the circumstances of workplace incidents
- Accompany a government inspector during an inspection
- Represent the work group in health and safety matters
- Attend an interview about health and safety matters with a worker from the work group (with the worker's consent)
- Participate in a health and safety committee
- Monitor compliance measures
- Investigate WHS complaints from work group members
- Inquire into any risk to the health and safety of workers in the work group
- After being trained, issue Provisional Improvement Notices (PINs) and direct a worker to cease unsafe work
- Whenever necessary, seek the assistance of any person for WHS purposes. This could be a union official.

WHAT IS A PIN?

A PIN is a written notice requiring a contravention against the WHS Act or Regulations to be remedied within a certain period or a likely contravention to be prevented. Only an HSR who has completed approved training can exercise this power, except in Victoria where the HSR does not have to have completed this training. A PIN is a powerful tool that can be used to great effect in achieving positive WHS outcomes for workers. For example, Queensland Nurses and Midwives Union (QNMU ANMF QLD Branch) members used a PIN to achieve better cooling in a major hospital that was often overheated, with members working in temperatures above 35 degrees. The overheated hospital was not just a matter of personal comfort but a WHS issue (QNMU, 2017).

HOW CAN ANMF WORK WITH HSRs?

ANMF branches can help establish work groups and run elections for new HSRs. Additionally, ANMF officials can also be invited onto premises by an HSR. Your ANMF branch can work with you as an HSR to ensure you are trained to use your powers for positive outcomes around health and safety. Your employer must pay for this training and pay you while you attend. In some states, branches run accredited training themselves.

WANT MORE INFORMATION?

Contact your ANMF branch or go to safeworkaustralia.gov.au for information about your jurisdiction's WHS laws, including the role of the HSR.

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EDUCATION

PART 2



Embedding inter-professional education among healthcare groups to deliver best patient care

By Rachel Longhurst

Interprofessional education (IPE) has been defined as those occasions when two or more professionals come together to learn with, from and about each other with the aim of improving collaboration and quality of care (Zwarenstein 1999).

A meta-analysis by Guraya & Bar (2018) shows IPE has a positive impact on collaborative teamwork, and improving knowledge and skills, while Cusack & Donoghue (2012) identify that it reduces the barriers and preconceptions that often exist among healthcare groups.

In a 10 bed non-tertiary metropolitan ICU in the ACT, patients requiring tracheostomy

are an infrequent occurrence (two to three a year). Maintaining the knowledge and skills of the interdisciplinary team that manages these types of patients is therefore essential.

Following the development of an updated procedure for tracheostomy management, an interprofessional education session was developed by leaders in the ICU nursing, speech pathology and physiotherapy teams.

A storyline was developed and each discipline lead applied their teaching to a simulated patient. The training was undertaken in the clinical environment, using a high fidelity simulator with a tracheostomy in place. Each discipline lead presented key information relevant to their specialty.

Physiotherapy presented on inspiratory muscle training and suction techniques, speech pathology on cuff management and achieving speech, and nursing delivered information on emergency management of blocked tracheostomies.

Twenty-two staff from across the three disciplines participated in two sessions, with staff evaluated at the end of the session.

All staff identified the training provided was relevant to them and that the simulation provided a useful learning experience.

Key reasons why, included: an opportunity to revise concepts; an opportunity to learn new concepts; simulation helping them to visualise theoretical learning; and simulation helping them to build their confidence in tracheostomy management.

The multidisciplinary approach was identified as a helpful component with staff highlighting an appreciation for other perspectives.

Overall, most felt it helped them to develop a better understanding of each of the roles and how they can help each other in the delivery of best patient care.

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Clinical competency framework

By Loren Madsen, Phoebe Drioli-Phillips and Jane Cleveland

In busy healthcare settings, it is possible for nurses, particularly newly graduated nurses, to be assigned clinical procedures with which they are unfamiliar, or not yet competent.

This may result in compromised care to patients. At Calvary we are committed to developing a capable, competent, engaged workforce that is able to deliver safe, high quality patient-centred care.

Accordingly, we have developed a Clinical Competency Framework for all nurses and midwives working at Calvary nationally. Nurses are routinely assessed on competencies within this framework, including medication administration, urinary catheterisation and blood glucose measurement. These assessments are referred to as Clinical Competency Assessments (CCA).

Prior to this project, Calvary did not have a formal recording process for completed CCAs. Rather, paper copies of successfully completed CCAs were provided to learning and development (L&D) team members for review.

Importantly, no formal record was kept of instances in which a clinician had not successfully completed their CCAs. As a result, there could be no formal communication to managers informing them of nurses' clinical skill set, nor was there any ability for clinical or managerial groups to access CCA records for purposes such as rostering.

In order to improve Calvary's ability to ensure that clinicians were assigned work that they are competent to complete, Calvary introduced and evaluated an online tool for recording and accessing CCA data. This tool enabled access to a library of online assessment tools via a handheld device, and allowed for on-the-job assessments.

In conjunction with researchers from the University of Adelaide's Nursing School, we designed a robust evaluation of this online CCA tool.

In two separate, successive pilots at two different Calvary network settings, Calvary staff across four work groups (nurses, assessors, clinical managers, and L&D team members) were asked to complete anonymous surveys of their experiences with the CCA tool. Staff were strongly encouraged to provide feedback and suggestions for quality improvements.

This evaluation produced extremely valuable insights. Calvary staff (n=88) across all work groups consistently indicated that the standardisation and centralisation of CCA data was useful, including for purposes such as rostering.

A number of staff emphasised the improved allocation of patients to appropriately skilled nurses as a particular advantage of this tool. Calvary staff also reported experiencing a number of individual professional benefits of the tool, including having the opportunity to reflect on one's own professional practice as well as that of other employees.

Others praised the tool as a positive step toward supporting best practice in nursing. The enthusiastically favourable reception of our tool has in turn provided evidence for its implementation at other settings across the Calvary network.

Our CCA tool, and the evaluation process we undertook in validating this tool additionally received supportive and complimentary feedback at the Catholic Health Australia Nursing and Midwifery Symposium.

It is our hope that other healthcare providers might adopt similar practices in order to support the development of a capable, competent nursing workforce, equipped to deliver safe, high quality, and patient-centred care Australia wide.

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Instructional videos for clinical skill acquisition in undergraduate nursing students

By Krishna Lambert and Evan Plowman

Blended learning is an approach that combines different learning styles and delivery methods (Vidgor & Sela 2017).

Some contemporary methods used in blended learning incorporate technology and platforms that do not require the learner and instructor to be co-located.

Video assisted online resources are an effective approach to teach clinical skills, allowing the learner to link theory to practice and increasing the autonomy of learning for the adult learner (Coyne et al. 2018).

We implemented instructional videos that students viewed online prior to attending clinical laboratory sessions in an effort to improve the learning experience.

Undergraduate nursing education includes clinical skill acquisition. This is traditionally developed through presenting the student with theory behind the skill, evidence to

support best practice, a demonstration by the lecturer, followed by an opportunity to practice the skill in the simulated hospital laboratory, then concluding with a debrief session.

These simulated laboratory sessions may include 20-25 students. We found that large class sizes impeded the opportunity for students to effectively view the demonstration.

Demonstrations also consumed a considerable proportion of the session, reducing practice and debrief time. Additionally, when demonstrations are delivered in real time, the learner is only able to view the demonstration once.

We filmed a series of instructional videos. We made the decision to create our own resources in preference over pre-existing materials as a study of clinical nursing videos on YouTube rated 69% of sites as having poor production quality and 35% of sites as having substandard technique (Duncan, Yarwood-Ross & Haigh 2013). Creating our own allowed us to tailor the content to specific subject learning outcomes and to ensure that the videos were of a high production quality and demonstrated evidence based practice. The videos were then uploaded to Vizia, an online software program. This software enhanced the video from being a passive resource to an active learning tool.

Feedback from students and teaching staff was overwhelmingly positive. Students appreciated the ability to watch the videos several times and that the videos made the expectations of the laboratory classes clearer.

Lecturers noted that students were more engaged in the practice of skills, there was more opportunity for debriefing and feedback, and that the laboratory sessions achieved more 'deep learning' than the traditional method.

This concept has potential for application in any health discipline that involves clinical skills acquisition.

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Snapshot of student view with interactive questions



Sarah Stenson

From the clinic to the classroom: Reflections of an experienced clinician transitioning to a novice academic

After 10 years working as a registered nurse, firstly in a general medical/surgical ward and the latter four years as a child and family health clinical nurse specialist, I accepted the challenge of teaching undergraduate students in a regional university.

It certainly is a whole new world but one that clinicians need to be more engaged with and contribute to so that the bridge between university and clinical work is more easily traversed, making the journey less daunting for newly graduated registered nurses.

It also builds collaborations between industry and the university so that knowledge is shared and possible links are forged to promote research.

Some of the learning I have done whilst developing my skills in teaching are probably very familiar to experienced teachers, but the goal in sharing these experiences is to inform other registered nurses and perhaps encourage them to consider undertaking some teaching in the academy.

Personal experience thus far has been with first year and third year students and understanding the difference in their knowledge and learning styles.

The first year students seemed less prepared for classes than the third years had been, so there was a need to stress the importance of pre-reading, engaging with content and coming to class prepared. Most of the first years also struggle with the requirement to communicate with the mannequins in the laboratories which often resulted in a fair amount of giggling among small groups.

Empathising with students that I understood that they felt "silly", and encouraging them with praise as well as relating personal experiences of transitioning from working with mannequins to working with real people assisted in reinforcing these early skills around developing the therapeutic relationship.

Nursing students value skills they see as directly related to their future practice (Gharaibeh, Hweidi & Al-Smadi 2017; Richardson 2011; Coates 2010).

With a large cohort of online students, I have learned to navigate the online teaching environment, including managing technical difficulties. Online

students attended the live sessions and only a few would participate in the discussion, however, the discussion provided was sufficient to raise most of the key points for the online meetings.

I tried to use Socratic questioning (Sahamid 2016) to draw out others' thoughts and opinions on the ideas posted by the few students who engaged. This was successful up to a point – it encouraged others who were already participating to expand on the ideas presented and to provide new insights, but was not consistently successful in encouraging other participants to contribute.

On reflection, using tactics such as calling on specific participants to contribute their ideas or using other tools such as polls may help to involve others that were simply watching and listening.

As a sessional staff member, I had previously been involved in teaching in the clinical laboratory situation but I then had to master teaching in tutorials. Teaching in teams assisted with this but I had to be sensitive to what was happening in the tutorials.

About half way through the semester, students were less engaged with the subject content and I suspected they were tired, stressed or worried about assessments so for the subsequent weeks, I modified the content to include some videos, which we discussed, rather than encouraging small group work. This seemed to work quite well and we had a much better discussion with the changes I made, which boosted confidence in my teaching skills.

What I have found is that students appreciate teaching that uses a variety of techniques to engage them with the content, rather than using a "formulaic" approach to tutorial delivery. Students appreciate educators who attempt to relate to their situation (Richardson 2011), and they seem to value reassurance that they are "on the right track".

I think it is important for educators to be responsive to students and to identify when things are not working. We need to be flexible in our delivery and empathetic to what else might be happening for students (eg. workplace learning, assessment tasks, and personal issues).

What I have learnt in making the transition to university teaching is that I really enjoy teaching and am now more confident in my clinical knowledge and skills.

I have learnt to be reflective in my practice of teaching and know I need to be flexible; that teaching relies on feedback from students (both formal and informal) to gauge its effectiveness and the teacher has to be open to that feedback, using it as a chance to continue to develop teaching skills.

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Blog It: Free Open Access to Nursing Education (#FOANed)

By Paul Ross

The internet and social media can equally connect or disrupt with powerful and unpredictable consequences (Rozenblum and Bates 2013).

Social media content is brief and involves communication with the ability to spread rapidly on a global scale (DeCamp et al. 2013).

Online social communities of practice have developed, often within clinical speciality domains. The hashtags of #FOANed (free open access to nursing education) and #FOAMed (free open

access medical education) across varying social media platforms are supplementing traditional knowledge by asynchronously allowing communication and educational opportunities (Carroll et al. 2016).

The impact of social media in nursing is exemplified by campaigns such as #hellomynurse, #proudnurse, #safeHANDS and the #wenurses healthcare communities (Moorley and Chinn 2014).

Nursing Education Network is an educational theory-focused blog aimed at the nurse educator community and with an open access philosophy.

The blog publishes on a weekly basis and utilises social media to increase readership using the #FOANed hashtag. Metrics to demonstrate the number of views and global reach of Nursing Education Network, are presented with analytics from a one-year period from June 2018 to May 2019 where visitors from 166 countries visited the blog (see Figure 1).

The future of nurse training and education must engage with technology and social

media to provide a future ready workforce (Royal College of Nursing 2016).

The opportunities for nurses to engage and discuss latest research and improve the translation of evidence into practice in an online e-community of practice are excellent learning opportunities.

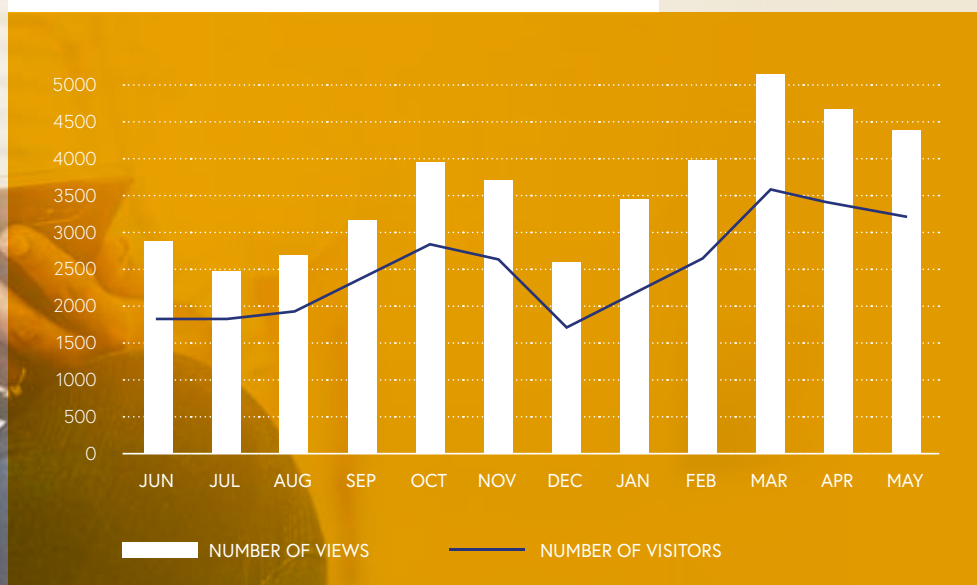
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FIGURE 1: ONE-YEAR ANALYTICS FOR NUMBER OF VIEWS AND VISITORS



There's a person behind the diagnosis! Consumers as experts by experience in mental health nursing education

By Brenda Happell and Shifra Waks

The nursing profession proudly claims the provision of holistic and person-centred care as distinguishing characteristics of its discipline base and unique contribution to health in contrast to other professional groups.

Anyone involved in undergraduate education will surely agree that these are very difficult concepts for students to grasp.

Our highly specialised health system encourages nurses to focus on the specific illness or injury being treated (ie. the chest in bed 5).

Mental health needs are therefore commonly not prioritised in general health environments. Ultimately, this means people do not receive the standard of care they should.

Involving consumers as experts by experience in teaching mental health has

demonstrated positive impacts on the skills and attitudes of nursing students. This initiative has been successful in reducing stigma and encouraging a greater acceptance of patients as people.

The concept of 'understanding the person behind the diagnosis' was a major theme identified by nursing students in a qualitative study, conducted as part of the international: *Coproduced Mental Health Nursing Education* (COMMUNE) project. This project involved the co-production of a unit of study by mental health nurse academics and experts by experience. Experts by experience then delivered the unit.

Focus groups were conducted with nursing students to provide a deep understanding of this learning approach from their perspective. Student participants were extremely positive about the experience, with the input and direction from the expert by experience bringing concepts to life in a way they had not previously experienced through more traditional approaches.

Students described recognising consumers as far more than their psychiatric diagnoses, and felt they had a better grasp of person-centred care and holistic practice.

Understanding the individuality of consumers, their needs and goals, is crucial in all areas of nursing practice, not only in mental health, as eloquently stated by one student:

"We all have something to give... it's not about pinpointing the sickness, it's about being together

and helping people experience the best life they can have for themselves that they're happy with. Looking at the other side of the coin."

These findings demonstrate that involving experts by experience in mental health nursing education is an important component of quality pre-registration nursing education.

If further weight is needed to support the argument, we need only look to the *National Safety and Quality Health Service Standards*, standard 2 – partnerships with consumers (Australian Commission on Quality and Safety in Health Care 2012).

Recognising and valuing the expertise and knowledge consumers develop through their lived experience is essential for this standard to be enacted in practice. Exposure to consumer participation as part of the education process is likely the best place to start in changing the culture of healthcare to embrace genuine and effective consumer participation.

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Mental health nursing education in undergraduate and postgraduate programs: Time for change

By Brenda Happell, Kim Foster (Vice President), Bronwyn Lawman, Lorna Moxham, Mark Powell, Tom Ryan, Scott Trueman (Treasurer), Eimear Muir-Cochrane (President).

Board of Directors, Australian College of Mental Health Nurses

Recent media exposure and anti-stigma campaigns have highlighted the common occurrence and impact of mental illness in the community.

Unfortunately, despite nurses encountering people diagnosed with mental illness and experiencing significant mental health challenges, increased awareness is not reflected in the mental health component of undergraduate nursing programs.

Since the introduction of comprehensive nursing education, mental health nursing has been severely under-represented in undergraduate programs in most Australian universities.

Numerous reports and Inquiries have highlighted the problem and recommended an increase.

To provide the best student experience, innovative teaching strategies have been developed and championed by mental health nurse academics, often in collaboration with clinical colleagues. Despite these efforts, little has changed and mental health nursing content remains unacceptably low.

It is not an issue of quantity alone. Increasingly, authors have become aware of mental health nursing taught by nurses without qualifications, expertise and experience in mental health nursing.

The implication that any nurse academic can teach mental health nursing is a fundamental dismissal of the unique skills, knowledge and attitudes underpinning this specialist practice. It also calls into question the quality of education provided. Statistics demonstrating the prevalence of mental health conditions throughout the healthcare system emphasise the necessity of mental health skills for all nursing graduates, regardless of where they practice.

L to R Lorna Moxham, Bronwyn Lawman, Scott Trueman, Tom Ryan, Kim Foster, Eimear Muir-Cochrane, Mark Powell and Brenda Happell



A quality program taught by specialists with qualifications, expertise in, and passion for mental health is necessary to promote positive attitudes among nursing students. The Australian College of Mental Health Nurses developed an evidence based framework for mental health undergraduate nurse education as a guide and benchmark for universities (Australian College of Mental Health Nurses 2018).

The 'overcrowded curriculum' is a common rationale for not increasing mental health nursing content, given not all specialty areas can be covered in three years.

Mental health nursing is essential for practice. All people have mental health and physical health needs. Mental health skills, expertise and positive attitudes are essential for the message of holistic nursing practice to be embraced by nursing students and practiced in the future regardless of the setting they work in.

Negative attitudes graduate nurses often hold towards people with mental illness, and their perceived lack of knowledge and skill in basic mental health practice, should be a signal to Schools of Nursing that something needs to change. The current situation is broken and needs to be fixed.

Unsurprisingly, negative attitudes can deter nursing students from a career in mental health nursing.

The crisis in the mental health workforce will not improve, and likely deteriorate further, unless we attract sufficient numbers of nursing graduates into this field. Undergraduate nursing education needs to ignite interest in mental health and to

present a clear pathway from undergraduate to postgraduate programs for interested graduates.

It is only by having enough students and graduates of postgraduate specialist programs that we can achieve a nursing workforce with the skills, expertise and motivation to provide high quality mental healthcare.

The quality of postgraduate mental health nursing programs also requires urgent attention.

The Australian College of Mental Health Nursing (2016) has developed a clear framework to guide program development. The necessity of specialist qualifications for postgraduate teaching has also been questioned or ignored in some universities. This begs the question: why would we encourage students to complete postgraduate qualifications in mental health nursing if we do not even consider them necessary to teach?

This is unacceptable and these discriminatory attitudes must change.

We urge those responsible for the development and implementation of nursing curriculum to immediately address the inadequate mental health content in undergraduate programs and implement policies and procedures to ensure only nurses with qualifications and expertise in mental health nursing teach at undergraduate and postgraduate levels.

People using mental health services deserve the same quality service provision as those experiencing physical health issues. They also deserve staff who understand and

are able to attend to mental health needs in the context of physical health conditions.

It is time to address a significant health inequity and ensure people using mental health services are integral to determining the content of nursing curriculums. The future of mental health service delivery, quality of care, and patient outcomes depends in no small part on these decisions.

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Nurses can be leaders in dismantling stigma and discrimination toward people with blood borne viruses

By Shelley Kerr and Melinda Hassall

While Australia has been a global leader in clinical care for HIV and viral hepatitis, people living with blood borne viruses HIV and viral hepatitis continue to experience stigma and discrimination when accessing healthcare (Cama et al. 2018).

Many factors influence the lives of people living with a blood borne virus (BBV) including country of birth, culture, ageing, sexuality and injecting drug use. These factors often contribute to marginalisation in broader society, including healthcare settings. Stigmatising attitudes and discriminatory behaviours can adversely affect a person's access to screening, treatment and monitoring for HIV and viral hepatitis (Cama et al. 2018).

Nurses have a professional and ethical responsibility to provide care that is safe and achieves the best outcomes for individuals, families and the community. This tenet goes beyond clinical care and extends to person-centred care that considers a person in the context of their values, culture and social circumstances.

Recognising the enormous potential nurses hold to positively influence the lives of people living with a BBV, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) collaborated with sector and community partners to develop an online learning module for nurses to combat stigma and discrimination in healthcare settings. The module focuses on areas which research suggests contribute to stigma and discrimination. Lack of knowledge associated with transmission risks, the efficacy of standard precautions and intersectional issues such as drug use and culture, influence how a health professional interacts with people living with a BBV (Richmond et al. 2007).

Stigma and discrimination can manifest in a multitude of ways and may be deliberate, such as refusing service, or unintentional and as subtle as taking a step back when a person shares their diagnosis. The module aims to build knowledge and improve attitudes and behaviours.

Built on adult learning principles the module is short, self-directed, relevant to nurses, flexible and interactive. Information is evidence based with opportunities for further reading and access to resources to support professional development. Nurses are invited to reflect on their own attitudes, culture, values and professional practice through reflective and scenario-based activities. Learning is reinforced with lived experience videos which highlight the positive impact of professional and safe care that is free from stigma and discrimination. Initial feedback reflects high levels of satisfaction and relevance, one participant commenting "great online course- I think all nurses should do it. It really makes you reflect on your own practice and attitudes".

Nurses are central to the care of people living with BBV and are well placed to be leaders in dismantling stigma and discrimination in healthcare settings. To do this, nurses will need to challenge their own attitudes and beliefs, those of their nursing peers and the structures they work in.

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'Empathy moments' in first year nursing and midwifery student curriculum

By Julie Shepherd

Empathy is defined as the ability to understand the feelings or ideas of another and to see their experiences as unique without making comparisons to one's own experience (Rossitor, Scott & Walton 2044).

It is recognised as a core attribute in the practice of nursing and midwifery and contributes to therapeutic communication (Rossitor, Scott & Walton 2014).

Amid the busyness of providing healthcare, skills and technology can command a focus of importance within the care environment, often at the expense of the approach to care giving.

As nurse and midwifery academics teaching communication and professional skills and development of attributes valuing the essence of caring with clinical requirements is of significant importance.

Embedding empathy into the curriculum in an authentic way poses a number of challenges. Leading academics such as Levett-Jones (2018), have addressed this matter and promoted the teaching of empathy through generously sharing the Virtual Empathy Museum (www.virtualempathymuseum.com.au) which allows access to a range of resources.

Inspired by Levett-Jones and using the tools from the museum, this article describes the perspectives of first-year nursing and midwifery students and academic team members on embedding empathy within the first-year continuum.

Patient stories from the museum involve the patient's perspective of their care experience.

Case study 1: Iona's story (Pich & Brampston 2018), tells of one young woman's experience of a traumatic brain injury and her long road to recovery.

The students were asked to share and reflect on how this story made them feel, why the care differed and how Iona's care could have been improved?

The following themes describe typical reflections from the students:



Julie Shepherd teaching nursing and midwifery students [Jarvis Paech (role playing as the patient), Brendan Miller, Hayley Muller and Susan Overden]

- Iona's story highlighted the importance of respectful communication
- Communication in healthcare is integral to how the patient is made to feel
- Providing empathy in care provision is critical to the whole patient experience
- For Iona to have her hair cut off, contradicts person-centred care
- Iona's story highlighted how poor attitudes can be so damaging to the patient
- Iona's dignity was diminished by the poor attitudes of the nurses

Case Study 2: John's Story (Brand 2018), illuminates John's experience of having a stroke, his recovery and highlighting of his ongoing challenges, with students asked to share their thoughts and feelings about their assumptions of stroke victims, patient feelings, and how John's story would influence their future care of others.

Themes of student reflections included:

- Understanding John's values will aid in delivering more person-centred care
- The importance of the patient perspective was highlighted in John's story
- Empathy is critical in caring for stroke victims
- John's story emphasised the importance of dignity and self-determination in care provision

Outcomes of these stories, reflections and guided discussion have had a profound impact on the students who were able to look at the patient experience through the perspective of the patient and then provide

insights on the influence of this learning on their practice.

Voicing their feelings has helped build students' empathy while learning to identify as a professional.

For the academic team, using these stories and strategies has provided rich resources and insights into the importance of promoting the essence of care. Witnessing the personal professional growth of students in this way has been most rewarding.

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- » **Rehabilitation and Specialty Mental Health Services.**

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Oral Health Matters: Enhancing the undergraduate nursing curriculum

By Ajesh George, Jacqueline Rojo, Albara Alomari, Anne Marks, Amy Villarosa and Ariana Kong

Good oral healthcare is not only essential for maintaining dental health, but it also promotes general wellbeing and improves confidence.

Systemic health can also be impacted by oral health; cardiovascular disease and the deterioration of existing diseases, such as diabetes, are linked to poor oral health (Kane 2017). Therefore, the health of our teeth and gums should form part of nurses' daily care and education provided to hospitalised patients.

Supporting our nursing students and subsequently our workforce in undertaking this task is imperative for the future of oral healthcare in Australia.

Traditionally, the responsibility of providing oral healthcare to Australians has been with dental professionals. However, there is an increasing number of people presenting to general practitioners, emergency departments and hospitals seeking oral health interventions. This, compounded with the association between oral health and systemic health and the general lack of oral health awareness among patients (Ahmad 2016), highlights the definitive need for nurses and other health professionals to be trained in promoting and assessing oral health among their patients (Ahmad et al. 2017). Although systemic health is often comprehensively covered in great detail in the undergraduate nursing curriculum, oral healthcare is often overlooked in higher education and has not received the focus that is required (Dolce 2012).

There is increasing impetus for nurses to adhere to various guidelines which identify a key role nurses can play in promoting oral healthcare. To bridge the gap and lay the foundations for oral healthcare in nursing across Australia, The Centre for Oral Health Outcomes & Research Translation (COHORT) (www.cohortaustralia.com) in collaboration with School of Nursing and Midwifery at Western Sydney University are



Paula Sanchez, student learning how to deliver effective oral care. Photographer: Ajesh George

incorporating an oral health program into the undergraduate nursing curriculum. The program has already been integrated in the first year into the primary healthcare unit and will now be expanding into second/third year pathophysiology and professional practice units. COHORT has been successful in improving the knowledge and confidence of undergraduate midwifery students in the promotion of oral health (Duff et al. 2015), and this experience is informing the nursing curriculum development. It is an exciting time at the university, as students begin to learn about the importance of oral healthcare in order to control disease and provide holistic patient care.

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Sri Lankan breastcare training program

An Australian–Sri Lankan partnership: Fostering the development of the breast care nurse role

By Kim Kerin-Ayres and Meagan E Brennan

Breast cancer is the most frequently diagnosed cancer and the leading cause of cancer-related death among women worldwide and is a major burden in low and middle income countries (LMICs) (Torre et al. 2017).

The role of the specialist breast care nurse (BCN) is well developed in Australia, where nurses have been an essential component of the breast cancer workforce since the 1990's (Ahern and Gardner 2015; Cruickshank et al. 2008).

The role has been defined as “a registered nurse who applies advanced knowledge of the health needs, preferences and circumstances of women with breast cancer to optimise the individual's health and wellbeing at various stages across the continuum of care, including diagnosis, treatment, rehabilitation and palliative care” (Yates et al. 2007).

Sri Lanka, like many developing countries has a developing health system in which there are very few specialist roles in nursing.

Breast cancer is now the most common cancer in Sri Lankan women and the incidence has increased from 17.3 per 100,000 in 2001 to 24.7 per 100,000 in 2010 (Gunasekera et al. 2018; Fernando et al. 2018).

Despite nurses forming the largest group of healthcare providers in developing countries, there is a lack of specialty training and the important role that nurses can play in cancer care may not be recognised (Challinor et al. 2016; Fernando et al. 2016). There are limited opportunities for ongoing education and career progression with only 1% of nurses having a postgraduate qualification (De Silva and Rolls 2010).

This project, to provide education for nurses in Sri Lanka working in breast cancer care, was initiated by Zonta, an international charity that works to empower women. A project team comprising of members of a club in Sydney and in Colombo, worked to establish the training initiative. Links were established with the Ministry of Health (MoH) and Sri Lankan cancer specialists who supported the project. Key nurses were identified by the MoH from each of the nine provinces, and the training was delivered to 50 nurses over two days. The content was developed by two Australian health professionals with experience in breast cancer training for nurses, and covered a broad range of topics from benign disease, screening, diagnosis, treatment and supportive care. The workshop combined presentations with small group roundtable discussions to provide hands on instruction in clinical breast examination and encompassed ways that nurses could educate their local community about breast health. There were specific lectures about the role of the BCN in Australia and discussion about how nurses in Sri Lanka could contribute at all stages of the cancer trajectory.

Evaluations were positive, with the nurses overwhelmingly desiring further opportunities to participate in similar style workshops, with the ultimate aim of building local capacity for specialist nursing roles.

Nurses play a vital role in the provision of care at all stages of the cancer continuum, and workshops such as this provides a model for nursing role development within low and middle-income countries experiencing a growing cancer burden.

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Deakin postgraduate critical care students participating in a Team-Based Learning session. Photographer: Simon Fox, Deakin University

Team-based learning promotes high level student engagement

By Elizabeth Oldland and Judy Currey

Critical care nursing students are expected to manage critically ill patients very early in their formal postgraduate programs. To accelerate acquisition of the key knowledge, skills and behaviours required for safe and high quality patient care, we introduced team-based learning (TBL) into the Deakin University postgraduate curriculum in 2009.

Team-based learning is a structured, innovative teaching strategy that promotes high level student engagement and produces significantly improved student learning outcomes including enhanced critical thinking, problem solving, and clinical decision making skills (Michaelsen et al. 2008). These learning outcomes are achieved through TBL by:

1. Holding students accountable for their own learning before and during class.
2. Devoting class time to the application of newly acquired knowledge to real clinical problems rather than delivery of facts.
3. Providing immediate feedback to students about their problem solving

and critical thinking skills and rewarding deeper thinking.

4. Developing students' team and communication skills through the creation of self-managed teams (Michaelsen et al. 2008).

In TBL, students engage with teacher guided learning resources before class, then complete a graded individual test of the core concepts for the topic at the beginning of class.

They then take the same test as a member of an ongoing team, explaining their thinking to one another to reach a consensus team answer.

The team receive immediate feedback, then apply their collective knowledge to a number of clinical case scenarios or problems, and simultaneously report their team's answer.

The teacher facilitates a discussion between teams, requiring students to articulate, defend and refine their thinking. Peer evaluation of each team member's contribution and team behaviours provides students with skills in giving and receiving behavioural feedback to improve their own and colleagues' performance. Team skills such as communication, negotiation, peer feedback and respect for others are inherent in TBL processes.

As patient safety improves with strong teamwork, it is essential that we prepare health professionals in team skills during their formal education (World Health Organization 2011). Our research of TBL supports the growing body of evidence that TBL improves student engagement, student

satisfaction, and attainment of critical thinking, problem solving, teamwork and reflective skills (Currey et al. 2015, Dearnley et al. 2018; Oldland et al. 2017). Nursing education must be designed to produce graduates who are not only equipped with discipline specific knowledge and skills but essential critical thinking and teamwork skills if we are to improve the safety and quality of the care patients receive. Team-Based Learning contributes to meeting this education goal.

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Specialty postgraduate nursing education impact study

By Lyndell Brodie, Margaret Butler and Philippa McLeod

St Vincent's Hospital Sydney (SVHS) has a long history of innovation in nurse education and is committed to maintaining postgraduate nursing educational programs for registered nurses (RNs) which pursue high standards of patient care.

SVHS provides postgraduate specialty clinical nursing courses capable of supporting and complimenting theoretical programs offered by most Australian universities in the specialty clinical areas of perioperative, anaesthetics and recovery, intensive care and cardiothoracic and heart lung transplant nursing.

A quality project was designed to investigate and measure postgraduate education outcomes and the perceived impact of the SVHS postgraduate specialty clinical nursing (SVHPGSCN) Courses on RN participants six months following course completion.

The methodology used a quantitative descriptive design using a questionnaire to ascertain if there has been a perceived change to the practice of the RN course participants following their experience of specialty postgraduate education. The questionnaire was adapted, with permission, from one originally developed by Dyson, Kirkpatrick and Lovell (2004), and more recently used by Barnhill, McKillop and Aspinall (2012).

A convenience sample was drawn from two groups of nurses: course participants (N=22) and senior nurse stakeholders (N=64). Questionnaires were distributed in July 2018. Return rates were 63% for participants and 55% for senior nurse stakeholders respectively.

The results showed both course participants and nurse stakeholders reported positive changes in the domains of:

- knowledge and understanding;
- application of knowledge;
- influence on critical thinking;
- patient care;
- communication and sharing knowledge in the workplace;
- workplace activities; and
- personal and professional development.

For both groups, more than 70% of respondents agreed or strongly agreed that

their postgraduate studies had positively affected all domains except workplace activities which saw a greater than 50% agreement with a positive change. **Figure 1** demonstrates the spread of responses received in each domain from the course participants group as does **Figure 2** for the stakeholder group.

This piece of work demonstrated that postgraduate education does have a perceived positive impact on nursing knowledge and care delivery. Although a small study, it provides evidence for the continued organisational support and funding for postgraduate nursing education. Ongoing investigation and measurement of postgraduate outcomes will provide further information in this area.

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FIGURE 1 Course participants responses received for each domain as % of total responses received

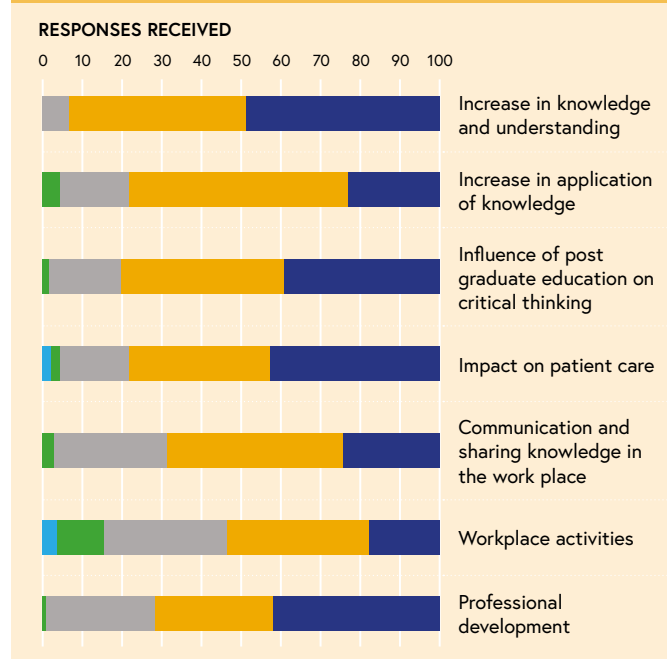
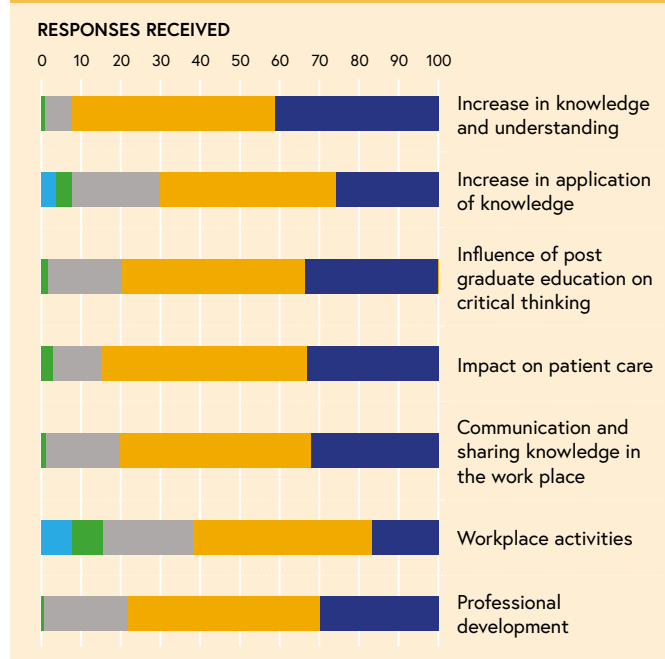


FIGURE 2 Stakeholder responses for each domain as % of total responses received



● STRONGLY DISAGREE ● DISAGREE ● NEUTRAL ● AGREE ● STRONGLY AGREE

A nurse led respiratory acute discharge service

By Deborah Murray and Jane Neill

Chronic Obstructive Pulmonary Disease (COPD) is a leading cause of death and disability worldwide (Lung Foundation 2018), and a common cause of avoidable hospital presentation and admission (Page et al. 2007).

Patients who present to hospital have a high risk of subsequent readmission due to re-exacerbation (Hakim et al. 2017). The cost to the Australian healthcare system is approximately \$900 million annually, with hospital presentations accounting for the largest share of health spending (Access Economics 2008).

Acute exacerbations of COPD are traditionally managed in hospital. The Respiratory Acute Discharge Service (RADS) was developed to reduce the impact of COPD on the patient and the organisation, as a winter bed management strategy in 2018.

Early discharge models for COPD exacerbation demonstrate reduced length of stay and presentation, providing that care is comparable to that delivered in hospital in terms of medical treatment (Yang et al. 2017). The service was designed to be consistent with best practice, and evidence based in terms of treatment for non-complex exacerbation of COPD.

The aim was to demonstrate: a total average length of stay (LOS) for the Diagnosis Related Group of less than the average 5.6 days; a saving of occupied bed days over winter; a readmission rate of less than 20%; patient satisfaction; a decrease in number of Department of Emergency Medicine (DEM) presentations compared to previous year; decrease in number of frequent presenters compared to previous year and a positive cost to benefit measure.

Once identified, the RADS team assess the patient against the following inclusion criteria: diagnosed simple exacerbation of COPD, ability to self-care, neurologically intact, adequate social circumstances, residing in their own residence, and usual oxygen requirement.



Once the patient is discharged on or prior to day four of admission, or admitted directly from the community, the team will visit the patient at home within 24 hours. Home visits take place equivalent to the traditional LOS and follow up is through a nurse led clinic one week after discharge from the service.

The results surpassed expectations. From June to September 2018, 139 patients were successfully managed at home having an average LOS in hospital of 1.3 days. This represents a saving of approximately 545 occupied bed days and the associated costs of over \$600,000.

Presentations to the DEM between July and September decreased from 130 to 37 and the number of frequent (more than three) presenters decreased from 17 to eight. The cost of having staff on call and rostered for weekends was far outweighed by the savings associated with bed days and the revenue generated from home visiting. Feedback from the patients has been overwhelmingly positive and the staff have reported high levels of satisfaction with the model.

The outcome is that the RADS program has now become the team's business as usual and there are plans to expand the service and extend the geographical reach across the health service.

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New HIV prevention tools for nurses

By Zindia Nanver and Melinda Hassall

HIV transmission in Australia can be prevented through an ever-expanding suite of strategies, including the use of condoms, clean injecting equipment, Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), frequent HIV testing and HIV treatment as prevention.

Nurses have a significant role to play in the prevention of HIV transmission through increasing their knowledge of current prevention strategies and by providing care that is free of stigma, discrimination and judgement.

Frequent testing and treatment of HIV are important strategies to prevent HIV, which nurses are increasingly involved with in general practice and sexual health clinics, evidenced by the evolution of nurse/NP-led clinics for testing and routine monitoring. Frequent testing enables early diagnosis, early access to HIV treatment and reduced possibility for transmission. When a HIV positive person is on treatment the viral load can be reduced to an undetectable level. When someone has an undetectable viral load they cannot sexually transmit HIV to someone else, a prevention strategy acknowledged internationally as Undetectable=Untransmittable.

If a patient has had a HIV risk exposure they can still prevent HIV by taking PEP. This can be provided by most sexual health and emergency departments, or via a HIV 5100 prescriber and must be taken within 72 hours of the exposure to minimise risk of transmission.

Nurses also play a key role in educating patients about prevention, testing for HIV, monitoring patients who are on treatment, screening for sexually transmissible infections (STIs), and ascertaining sexual history. Discussing sexual health and risk behaviour can often seem challenging and might be easier with some patients than others. There are skills you can develop to make you feel more confident to talk about sexual health.

You might use 'hooks' to start the conversation such as "We ask all our new patients in this clinic some sexual health questions", or "We are doing a sexual health

screening month, is it okay if I ask you some questions?", or "You mentioned that you are travelling overseas, have you also considered your sexual health?" When you have broached the topic, it is important to stay non-judgemental and provide space for the patient to feel comfortable talking about this topic. Normalise talking about sexual health and be prepared for the answers you might receive.

Ask open questions such as "Do you have sex with men, women, or both?", "When was your last sexual contact?" "Do you use condoms?"

Consider asking questions in a culturally appropriate way when needed and assure confidentiality. You can also display posters in your service to encourage patients to ask about these topics.

When discussing sexual health, you can investigate their risk for HIV. Don't assume people are at risk for HIV, and don't guess their sexuality. When a patient is considered to be at risk for HIV they can consider PrEP. PrEP can be prescribed to those who have had a past and/or future risk for HIV which can include men who have sex with men, heterosexual, trans and gender diverse people, and people who inject drugs. PrEP is also safe for women who wish to become

pregnant but are at risk of acquiring HIV. PrEP is a co-formulation of tenofovir and emtricitabine, which can be taken daily or on-demand and can prevent a HIV negative person from acquiring HIV. PrEP has been available on the Pharmaceutical Benefits Scheme (PBS) since 1 April 2018 and can be prescribed by a GP or Nurse Practitioner (NP) to any eligible person living in Australia (Update on PrEP for HIV Clinicians). If the patient is Medicare ineligible, PrEP can be imported via the personal importation scheme.

So how does PrEP work? A HIV negative individual takes a sufficient dose of anti-retroviral drugs (ARVs) to establish high levels of ARVs in their blood, genital tract and rectum before any exposure to HIV. If HIV exposure occurs, the ARVs stop the virus from entering cells and replicating. PrEP has been proven to be 95-99% effective when taken daily.

Nurses are also key in monitoring patients while on PrEP. People require screening every three months while on PrEP. During this assessment they will undergo STI screening, HIV testing, and a medication review to ensure there are no drug-drug interactions. It is also necessary to discuss adherence to PrEP and discuss methods to improve this. The three monthly check-up



is also a good opportunity to discuss other prevention strategies for STIs and HIV. Ask the patient if they have experienced any side effects and consider discussing mental health associated with sexual activity.

In conclusion, seek information and explore opportunities in your practice to incorporate sexual health discussions, STI and HIV screening with your patients. PrEP is one of many different HIV prevention strategies; as a nurse you can discuss the right one for your patient. For more information on PrEP and STI screening please see the PrEP guidelines and STI guidelines.

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Transition to Specialty Practice Program

By Rachel Longhurst

In 2016 a 10 bed metropolitan ICU in the ACT introduced a 12 month Transition to Specialty Practice Program.

The program consisted of theoretical modules and competency assessment, alongside graded exposure to more complex patients. While these programs are not a new concept, this unit had never had one.

At the time, the program was implemented mainly to address challenges in attracting and maintaining skilled staff, and to assist in addressing inconsistencies in knowledge and skill development, thereby ensuring staff had the same level of baseline knowledge provided.

These programs are supported by the Australian College of Critical Care Nursing's 2017 Position Statement on Critical Care Education, which identifies all critical care facilities should provide transitional programs and they should incorporate

core competencies, promote incremental development and include structured supervised practice.

A 2018 study by Madhuvu, Plummer and Morphet supports these programs being designed as a mechanism to support and educate staff, and to facilitate the recruitment and retention of nurses in specialised areas of practice. Madhuvu et al. (2018) identified that a lack of Australian research had been done on these programs, but through their study found that the majority of the participants reported positive results from completing such programs.

During 2018 a two year review of the Transition to Specialty Practice Program was undertaken to evaluate its success and identify areas for improvement.

At this point, fifteen staff had been through the program to completion. Evaluation results were positive. Data had been collected from each participant post orientation and at three points throughout the program: three, six and 12 months.

The two week orientation program incorporated four days of intense learning through lectures, practicals and simulations, and the remainder of the time as supernumerary, working with a senior clinician to care for a patient.

All staff surveyed found orientation to be either very good or excellent, identifying that it was well organised and met their learning needs. They identified that it made them feel comfortable, welcome and supported.

Staff identified the most helpful components of the program included the structured learning in modules, competency assessments, the ability to apply theory to practice and the support of a supernumerary education team. They found the education team being given a clinical load, the education team not being available on every shift, in particular night shifts, and the education team not always being available to them individually, the least helpful components of the program.

Their biggest personal challenges included time management on shift, but also work-life-study time management; critical thinking; adjusting to the critical care environment; and the, at times, confronting nature of the work. Their biggest rewards included becoming comfortable with new skills especially non-invasive and invasive ventilation; improved confidence; and improved critical thinking.

Overall, staff commented that they enjoyed the program, were excited to come to work, felt privileged to be part of the program,

wanted to be part of this team, and they felt that it made the transition to a specialty environment easier.

At the end of the 2016 pilot program the staff involved fed back that study days would have been a useful addition to the program. Two study days were added to the 2017 program with favourable results, helping to consolidate learning at key points.

Using a semi-structured forum approach senior nursing staff and the education team were surveyed to identify key issues and challenges. Two themes emerged. One was ensuring the right people were being brought into the program, and two was having the work transition staff did acknowledged formally.

For the team, ensuring the right people meant transition applicants had at least one-year of nursing experience on application. This was to ensure they had gained time management, general care and prioritisation skills.

The team also identified having people who were prepared to do the work involved with the program was essential, as was having the resilience and coping mechanisms to support successful transition.

A one-year of registered nursing experience and the introduction of a highly structured interview process with a series of clinical and professional questions, and a short simulation, were implemented.

Following the evaluation, an application to an Australian university was submitted and the program now accounts for two subjects towards a postgraduate certificate in critical care.

The program will undergo further evaluation in 2020.

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The importance of continuing professional development

By Diva Madan

Continuous professional development is an essential part of nursing. Over the past few years, the Australian healthcare system, and nursing in particular, have undergone rapid and exceptional changes due to many reasons such as increased complexity of health issues, an increasing ageing population, rising medical technology costs and health expenditure.

In these changed clinical contexts, continuous professional development is paramount for nurses to ensure that they provide safe care. Crucially, continuous professional development is a mandatory legal requirement for nurses. Nevertheless, diverse factors shape successful teaching and learning in the clinical learning environment (CLE) which need to be attended to.

The quality of care and patient safety is a huge concern and relies upon the skills and knowledge of nursing staff. By means of continuous professional development, nurses can improve their knowledge, problem solving and clinical decision making skills, as well as their ability to provide evidence based nursing care to patients. Continuous professional development also helps nurses to enhance their professional leadership and advocacy skills that are critical to promote psychological, spiritual and cultural care (Witt 2011). Therefore, continuous professional development is an indelible part of safe nursing practice.

Continuous professional development is also a legal obligation of nurses. According to the Nursing and Midwifery Board of Australia (2016), it is a legal and professional responsibility of nurses to contribute to and support the professional development of their own and others. Nurses are required to engage in continuous professional development activities throughout the year to maintain their professional registration and capability for professional practice (Nursing and Midwifery Board of Australia 2016). Thus, healthcare organisations

should facilitate a highly interactive CLE with numerous professional development opportunities for nurses to optimise their clinical skills.

Although the CLE plays an integral role in effective clinical teaching and learning for nurses, several factors influence professional growth in the CLE. These include aspects such as the willingness of colleagues to share their knowledge and skills, a positive culture to promote professional relationships, adequate staff to patient ratios, access to learning opportunities, effective communication and teamwork (Ash et al. 2012).

Availability of adequate resources in terms of current policies and procedures also has an influential impact on CLE (Flott & Linden 2016). In addition to these factors, adverse effects on professional development and learning are also reported. For instance, Smedley & Morey (2009), reports that if an optimal CLE is not maintained, the situation may become stressful and challenging, which can affect the quality of care provided to patients. Ash et al. (2012) reiterate that being a vital part of nursing, teaching and learning warrant special consideration.

Overall, teaching and learning will always remain an integral part of nursing, empowering nurses with the skills and knowledge to function as safe, effective practitioners. Hence, identifying and addressing challenges in the CLE is critical to prevent adverse events and ultimately, enhance patients' healthcare outcomes.

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