



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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INSIDE

Australia's nursing and midwifery trailblazers
Recognising Aboriginal and Torres Strait Islander nurses and midwives

What is the best model of care?
Specialising older patients on the ward

In the line of fire
Nurses reveal how they lived through the bushfire crisis

2020 YEAR OF THE NURSE AND MIDWIFE

RECOGNISING OUR TRAILBLAZERS

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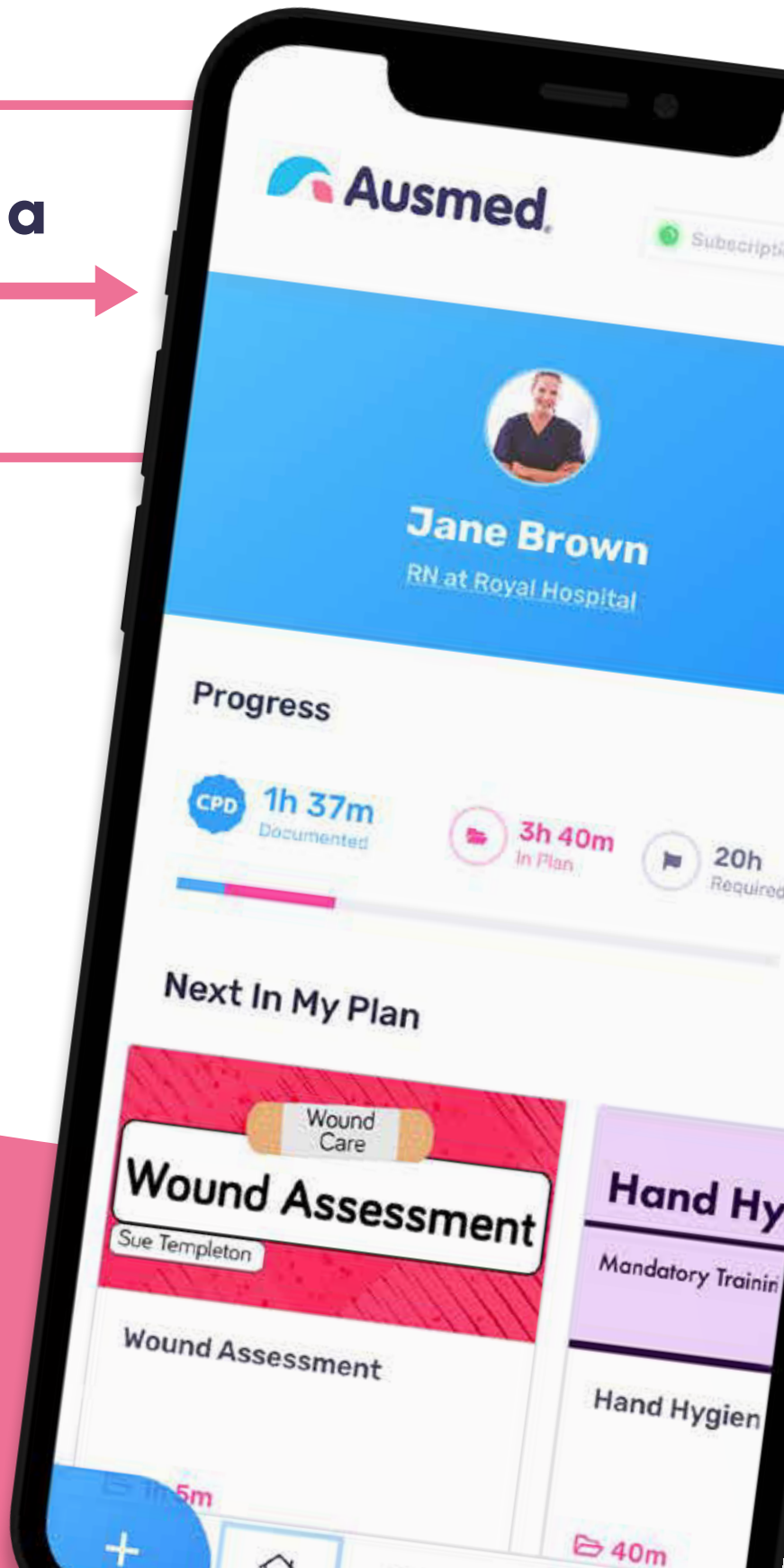
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It's been a tough start to 2020 for many Australians, including nurses, midwives and carers affected by the devastating bushfires across our nation recently.

Annie Butler

ANMF Federal Secretary

In the wake of the destruction felt across the nation, it is only now that the enormity of the social, economic and the health implications on so many is becoming clear.

According to recent research more than 75% of Australians have been affected directly or indirectly by the recent fires - the ramifications of which will be long lasting. As nurses, midwives and carers and as a nation we must continue to support those individuals who are in need.

Worryingly, evidence suggests that the frequency and scale of bushfires and other natural disasters will continue to escalate in the wake of the climate emergency we are now facing.

Consequently, it's imperative that as individuals and as a nation we do all that we can to mitigate the risks.

Recently I attended the ACTU's Emergency Service Summit which explored the most critical issues facing frontline workers, including nurses and midwives, who respond to natural disasters, including the recent bushfires.

At the summit, frontline workers including registered nurses Lyndsey Ohman from the ACT and Diane Lang from NSW, gave gripping first-hand accounts of their experiences during the fires.

Their stories highlighted the best in humanity, demonstrating selfless acts of bravery and extraordinary leadership in order to help fellow Australians.

It therefore goes without saying that the government must continue to provide ongoing support to these workers in the form of healthcare and compensation as required.

Moving forward, governments must act swiftly to provide properly funded public services across the country to ensure the nation is prepared for future emergencies. Additionally, a comprehensive prevention plan to address climate change and bushfire risk needs to be put in place.

As mentioned in the last issue of the *ANMJ* one of ANMF's priorities for 2020 is to pressure all levels of government to rapidly expand measures, to protect communities from climate change.

In doing so the ANMF is participating on the Australian Climate Action Roundtable Alliance made up of major Australian business and environmental, farmer, investor and social welfare groups. Our goal is to find ways to reduce emissions and to safeguard people's health through climate policy.

Furthermore, the ANMF is supporting the Climate and Health Alliance, of which the union is a founding member, with their campaign calling on the federal government to develop a national strategy on climate health and wellbeing.

In the spirit of the Year of the Nurse and Midwife the *ANMJ* is showcasing a number of inspirational nurses and midwives, like frontline responders Lyndsey Ohman and Diane Lang, mentioned earlier in this editorial, who have demonstrated outstanding care, commitment and leadership skills to those in marginalised communities and most in need.

As trailblazers, their determination to make a difference within their communities epitomises what this year is all about.

Their stories demonstrate that as nurses, midwives and carers we can all make a difference to influence positive change that is just for our patients, our communities, and our professions.

Annie

DIRECTORY

CANBERRA

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

MELBOURNE & ANMJ

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

FEDERAL SECRETARY

Annie Butler



ASSISTANT FEDERAL SECRETARY

Lori-Anne Sharp



ACT

BRANCH SECRETARY
Matthew Daniel



NT

BRANCH SECRETARY
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SA

BRANCH SECRETARY
Elizabeth Dabars



VIC

BRANCH SECRETARY
Lisa Fitzpatrick



OFFICE ADDRESS
2/53 Dundas Court,
Phillip ACT 2606

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

OFFICE ADDRESS
16 Caryota Court,
Coconut Grove NT 0810

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

OFFICE ADDRESS
191 Torrens Road,
Ridleyton SA 5008

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

OFFICE ADDRESS
535 Elizabeth Street,
Melbourne Vic 3000

POSTAL ADDRESS
PO Box 12600, A'Beckett Street,
Melbourne Vic 8006
Ph: 03 9275 9333 / Fax: 03 9275 9344
INFORMATION HOTLINE
1800 133 353 (toll free)
records@anmfvic.asn.au

NSW

BRANCH SECRETARY
Brett Holmes



QLD

BRANCH SECRETARY
Beth Mohle



TAS

BRANCH SECRETARY
Emily Shepherd



WA

BRANCH SECRETARY
Mark Olson



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

OFFICE ADDRESS
106 Victoria Street
West End Qld 4101
POSTAL ADDRESS
GPO Box 1289
Brisbane Qld 4001
Phone 07 3840 1444
Fax 07 3844 9387
qnmu@qnmu.org.au

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

OFFICE ADDRESS
260 Pier Street,
Perth WA 6000
POSTAL ADDRESS
PO Box 8240
Perth BC WA 6849
Ph: 08 6218 9444
Fax: 08 9218 9455
1800 199 145 (toll free)
anf@anfwa.asn.au

Front cover:

Trailblazing midwife Leona McGrath
Photographer Jessica Hromas

Editorial

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

Advertising

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

Design and production

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Moving state?**Transfer your ANMF membership**

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

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CLOSING THE GAP REPORT SHOWS JUST TWO OUT OF SEVEN TARGETS ON TRACK

The 12th Closing the Gap report has revealed inroads in Indigenous early childhood enrolments and Year 12 attainment but lack of progress across health, education and employment.

Launched in 2007, Closing the Gap outlined targets to reduce inequality in Aboriginal and Torres Strait Islander people's life expectancy, children's mortality, education and employment.

This year's report, released in February by Prime Minister Scott Morrison, shows only two out of seven targets are on track.



The target to halve the gap in mortality rates for Indigenous children aged under five has not been met.

Despite improvement, the target to halve the gap for Indigenous children in reading, writing and numeracy has not been met, while efforts to narrow the gap between

Indigenous and non-Indigenous school attendance have also been unsuccessful.

While Indigenous employment rates remain stable, the target to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians was not met.

The target to bridge the life expectancy gap by 2031 is also not on track, with Indigenous men and women living until 71.6 and 75.6 years respectively, more than seven years less than non-Indigenous people.

Two of Closing the Gap's targets remain on track, the aim to have 95% of Indigenous four-year-olds enrolled in early childhood education by 2025, and halving the gap for Indigenous Australians aged 20–24 in year 12 attainment or equivalent by 2020.

WORKPLACE SEXUAL HARASSMENT RIFE, REPORT FINDS

Workplace sexual harassment is 'prevalent and pervasive', the report following the National Inquiry into Sexual Harassment in Australian Workplaces has found.

The Inquiry examined the nature and prevalence of sexual harassment in Australian workplaces, the drivers of harassment and measures needed to prevent and address sexual harassment.

Undertaken by the Australian Human Rights Commission and led by Sex Discrimination Commissioner Kate Jenkins, the Respect@Work report makes 55 recommendations aimed

at establishing a new approach for government, employers and the community to better prevent and respond to sexual harassment in the workplace.

It describes the current system for addressing workplace sexual harassment in Australia as complex and confusing for victims and employers to understand and navigate.

Making a complaint often places a heavy burden on individuals, it adds, with most people who experience sexual assault never reporting it.

The report's recommendations propose a new victim-focused approach that draws upon five key areas of focus – data and research, primary prevention, the legal and regulatory framework, workplace prevention and response, and support, advice and advocacy.



People with dementia urged to plan future medical treatment to maintain choice

Dementia Australia and Advance Care Planning Australia have released a joint position statement outlining recommendations to improve choice, control and wellbeing for people affected by dementia.

Advance care planning gives people greater control over the care they receive if they become too unwell to speak for themselves – but plans must be put in place when a person still has capacity.

Experts are now urging people in the earlier stages of dementia to make a plan for the future to ensure they have choice in the care they receive.

Research shows 68% of people living with dementia don't have an Advance Care Directive and that 30% of advance care planning documentation is completed by someone else.

The joint statement focuses on the need for greater public education and raising awareness of advance care planning, and makes recommendations on the role of the health and aged care sectors to support high-quality, legally-compliant advance care planning, as well as a system-wide approach to increase uptake.

Queensland pushes to make the pill available over the counter

Queensland Premier Anastacia Palaszczuk has written to the Morrison government in a bid to 'down schedule' the oral contraceptive pill so women can access it easily over the counter at pharmacies without having to renew their initial prescription.

"We're asking the federal government to down-schedule the pill so that in the future, pharmacists can supply the pill more regularly, where it is safe to do so," the Premier said.

"These changes are about improving reproductive healthcare for women in Queensland and in particular, regional Queensland where sometimes it's easier to access a pharmacy than a doctor."

In the meantime, the Queensland government will make its own legislative changes to allow women to obtain an interim supply if their prescription has expired.

Pharmacists will be able to supply a full standard pack once within a 12-month period.

"It will mean when a woman can't get her usual repeat pill prescription, pharmacists will be

allowed to provide one full pack of her usual pill," the Premier said.

"Most women who take the pill have done so since they were teenagers and are used to managing their reproductive health. But there are situations where a woman can't get an appointment with a doctor or can't make one."

The Queensland government is also moving to make Urinary Tract Infection (UTI) medications more easily accessible for women through pharmacies.

Queensland Health has engaged a consortium led by the Queensland University of Technology to manage the development and implementation of a statewide trial of the management of UTIs by pharmacists.



Health system failing children with autism spectrum disorder, parents say

Parents of children with autism spectrum disorder (ASD) are calling for changes to mainstream health services as new research from the University of South Australia shows significant gaps in health practitioners' knowledge, understanding and treatment practices for children with ASD.

The study found that families with children who had ASD interactions with mainstream health services, were generally negative, which significantly outweighed any positive experiences they may have had.

Commonly frustrated by healthcare professionals' lack of awareness of ASD and how to appropriately accommodate children with ASD, parents said they often felt unheard, dismissed and blamed for their child's health issue or behaviours.

Paediatric and occupational therapy expert, UniSA's Dr Kobie Boshoff, said the findings highlighted the need for healthcare professionals to modify their approach and treatment of families of children with ASD. "The common message we're hearing from parents of children with ASD is that there is a critical need for change in Australia's healthcare system, not only in terms of how healthcare professionals treat children with ASD, but also how their parents are engaged throughout the process."

Calls for minimum staffing in aged care

Aged care providers should have to meet mandatory minimum staffing requirements, including having a registered nurse on duty at all times, under sweeping workforce recommendations made by Senior Counsel Assisting, Peter Rozen, to the Aged Care Royal Commission in February.

In a submission to a hearing in Adelaide examining *'The future of the aged care workforce'*, Mr Rozen argued it was time for real action on staffing numbers and skills mix, remuneration, working conditions and training in order to achieve safe, high-quality care for elderly residents.

His submission recommended:

- An approved provider of residential aged care services should have to meet mandatory minimum staffing requirements
- Registered nurses, including nurse practitioners, should make up a greater proportion of the care workforce
- All aged care workers should receive better training
- Unregulated care workers should be subject to a registration process with a minimum mandatory qualification as an entry requirement
- The care workforce should be better remunerated and should work in safe workplaces
- Organisations should be better managed and governed
- The Australian government should provide practical leadership

ANMF Federal Secretary Annie Butler said Mr Rozen's submission echoes feedback from aged care workers at the coalface.

"We support Mr Rozen's recommendations to mandate the minimum number of nurses and qualified care staff that would be rostered, ensuring better, safer, continuity of care for residents," Ms Butler said.





Lori-Anne Sharp

ANMF Assistant
Federal Secretary

Female workers unite to improve super and get a little fitter in the process!

Eight kilometres was the daily average walked in the halls of Federal Parliament recently when members of the three largest female dominated unions collectively met with over 45 politicians from all political persuasions to talk superannuation.

Over four days in December 2019 and February 2020, the ANMF, along with the Australian Services Union (ASU) and the Shop Distributive and Allied Employees Association (SDA) who collectively represent over 600,000 workers across the country, and fall within the middle to low paid income bracket, met with politicians. The delegation of members work in healthcare, social and community services, local government and retail sectors.

The delegation met with the politicians to highlight the need to lift the government's freeze on compulsory superannuation that was put in place in 2014. Under the freeze superannuation remains at 9.5% until 2021, rather than increasing the rate to 12% by 2019-20 through annual increases of 0.25%. As it stands, this current rate will damage retirement savings, particularly for many women who will be facing poverty as a result.

At Parliament House ANMF members confidently shared their individual stories with politicians on the impacts of this freeze, with some losing \$5,000 of stolen super during this time. This does not include the ongoing effect of compounding interest that would be earned if that lost money was invested in a superannuation fund.

The delegation of members who visited Parliament did a brilliant job at communicating their personal stories, the barriers that exist for women and the financial impact this has had on their retirement savings. In between the meetings and lobbying there were many conversations, kilometres walked, stories shared, media appearances, and friendships formed. It was also determined that without any doubt of the entire delegation, it was the nurses who have the fastest stride! No surprises there.

We also discussed and lobbied on the need for:

- Superannuation Guarantee (SG) to be paid on every dollar earned, removing the \$450 threshold. Currently if you earn \$450 or less per month from an employer, there is no legal obligation to be paid superannuation. This disproportionately affects women who commonly work in part-time and casual roles.
- Superannuation to be paid on all parental leave (awarded in some state Enterprise Bargaining Agreements).

- Urgent need to address the barriers faced by women, including the gender pay gap.
- Keep to legislated promise to increase superannuation to 12% by 2025.
- Protecting the universality of the superannuation system and rejecting any attempts to make superannuation optional for some workers.

There will be a lot of debate about Superannuation in 2020. The ANMF are extremely concerned that the Morrison government will renege on their promise to keep to the legislated 0.5% incremental increases to reach 12% by 2025.

We know that some Federal LNP ministers are opposed to increasing the SG and support the notion that superannuation should be voluntary for low-income earners.

It is critical we stand up and take action so that all Australians can look forward to a comfortable retirement and that the barriers that exist for women are addressed. Women who retire on average with 47% less superannuation savings than men should not be penalised for taking time out of their work to care for the community. Our superannuation system was established to provide a safety net for all working people in their retirement. The system needs to be improved and extended, not limited.

DID YOU KNOW?

Superannuation guarantee is legislated to increase in 2021 by 0.5% increments yearly to 12% by 2025



ANMF Federal Assistant Secretary Lori-Anne Sharp (centre) and ANMF members in Canberra

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Towards better nursing communication through emerging technologies

By Philip Shields

BACKGROUND

Underpinning nursing informatics research is the notion that nurses must be involved in the development and testing of emerging technologies, not just be passive users of 'black boxes'.

More importantly, universities and governments must consider skills development that prepares nurses for digital roles that may not have been conceived today but which will enable nurses to confidently pursue emerging career opportunities in the future (NIA 2019).

A good deal of nursing informatics research is about communication and how we effectively talk to others. A general theme through the literature is the notion of 'making nursing visible' through communication (Shields 2018), (Butler et al. 2006), (Wolf 1999). An overused 'frankenword' in the literature is 'interoperability', which simply means, 'the ability to talk to dissimilar systems'.

Systems may be human or machine. Human 'systems' may be patients, families or administrators. Machine systems may be computers which transfer patient details to another hospital. A major thrust to assist in 'interoperability' is to standardise terminology. That is, we cannot be understood by others if we don't use the same language. One way of facilitating 'interoperability' and making nursing visible is through a classification of standard terms.

WHAT IS THE INTERNATIONAL CLASSIFICATION OF NURSING PRACTICE (ICNP)?

The ICNP is an agreed upon classification of standard nursing terms on the Web. The World Health Organization and the International Council of Nurses (ICN) created the ICNP in 1992. The terms describe concepts which enable nurses to describe and report their practice in a consistent way. Consistency helps to ensure that nursing is visible in multidisciplinary settings, thereby future-proofing the profession (ICNP 2017).

The ICNP provides consistency because it is a framework for sharing data about nursing and for comparing nursing practice across disciplines. Standardised terms are used to support care and effective decision-making, and to inform nursing education and health policy. Finally, the ICNP is an international standard that facilitates the description and comparison of nursing practice locally, regionally, nationally and internationally (ICNP 2017).

HOW IS THE ICNP CONSTRUCTED?

The ICNP is an 'ontology' which means the terms are arranged in an 'axis' with a parent term (class) at the top and all the terms under it are related to it in some way. This hierarchical arrangement makes it easier to search for a specific term.

HOW CAN I USE THE ICNP IN DAY TO DAY PRACTICE?

The ICNP provides a handy ICNP browser. The browser displays all of the terms in alphabetical order. The browser may be useful for obtaining the 'standardised' term as a replacement for one in your notes or reports. In doing so, your writing is aligned to a global standard. The browser includes:

- The axis name
- The code of the term (for machine use)
- The term's parents. Parents are related terms that are above the current term in the axis.

THE BIOPORTAL

The ICNP also resides in Biportal. Biportal is the world's largest repository of medical ontologies. It contains 800+ ontologies including the Systematised Nomenclature of Medicine (SNOMED), Logical Observation Identifier Names and Codes (LOINC) and Human Disease Ontology (DOID). Everything in Biportal is arranged like an ontology with terms at the top of an axis (I find this easier to use). To use an ontology in Biportal, navigate to your preferred ontology then select 'classes' which will show all of the top terms. It is a simple matter to search or click any axis under the term for related terms.



THE FUTURE

Manually searching for a term is interesting but may become tedious after a while. Nurse developers are constructing a prototype web application that looks at electronic nursing notes and suggests standardised words from the ICNP in real time. The prototype works as a proof of concept and you can try it out at ontohealth.com.au go to demonstrations => ICNP text suggester. The application will supply a bit of text or you can cut and paste your own text in the text area.

Author

Philip Shields RN PhD is a Nurse Informatics researcher at Victoria University



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International Nurses Day

Facing challenges head on: Nursing through leadership and advocacy

By Kathryn Anderson

On 12 May nurses around the globe will celebrate International Nurses Day.

This year celebrations will be extra special given the World Health Organization has designated 2020 as The Year of the Nurse and Midwife.

The theme for 2020, ***Nurses: A Voice to Lead – Nursing the World to Health***, demonstrates how nurses are central to addressing a wide range of health challenges.

Katy Condliffe from central Victoria is a shining example of a nurse who has been a leader in Australia and abroad.

As a registered nurse and midwife of 15 years, Katy works as a practice nurse in a Gisborne medical clinic and as a midwife/registered nurse at the Kyneton District Health hospital. She is also a board member for World Youth International (WYI) to help advise on nursing and midwifery programs the organisation runs in Kenya and Nepal.

When Katy first began her nursing and midwifery career she volunteered to help build houses and assist in community work in Papua New Guinea. Following that experience she went on to volunteer in Odede, Kenya doing similar work through WYI.

During her time in Odede her team leader helped her organise outreach medical camps to provide care to local communities.

“I was the only medical person on my program, but the whole team got involved in helping with the care.”

Loving her experience, Katy went back to Odede the following year on another WYI overseas program to deliver healthcare. However, once again, she was the only nurse/midwife on the program. Nearing the end of her time in Odede, Katy met another volunteer nurse, who was commencing her volunteering experience. Recognising that the nurses could do more working together than individually, the pair came up with the idea of starting a volunteer program specifically for nurses and midwives to work in Odede.

Approaching WYI with their initiative back in 2010, the organisation agreed and Katy returned to Kenya but this time as a team leader with a group of nurses.

“Nurses and midwives are at the forefront of healthcare and so can see a wider picture and lead from that aspect.”



Katy working in Kenya

During their volunteer experience, the nurses worked in medical camps in remote areas, they were the first healthcare team to work in a newly opened Mama Ann's Odede Community Health Centre, and instigated a number of initiatives such as an HIV group, seniors' outreach program, women's groups and community health workers' education.

One of Katy's most memorable moments from that trip was opening the maternity program at the health centre.

“Before Mama Ann's Odede Community Health Centre opened, women either had to travel significant distances in labour, often removed from their family or when unable to do so would birth at home with no medical support. We started many initiatives to promote women coming to the clinic to receive care.”

One of the first births Katy attended was with a mother who had been pregnant twice before but had lost both babies late in pregnancy and at birth.

“I was nervous looking after her with significantly less medical back up than I was used to in Australia. She laboured well and with another volunteer we were privileged enough to be at the birth of her live and very healthy looking baby girl. The smile, disbelief and complete amazement at her birthing a well child was incredible.”

On the back of what Katy and the other volunteers achieved in Odede, WYI has continued to run healthcare programs,

staffed by Australian nurses, midwives and other healthcare workers.

Over the years the program, aptly named Nurses in Action, has grown from strength to strength. The organisation, which has run more than 30 programs in Odede and more recently programs in Nepal, has significantly supported healthcare services in these communities.

Katy said the experience of volunteering, including her time as a team leader, helped her recognise what nurses and midwives are capable of and why they are leaders in their own right.

“World Youth International was fundamental in finding my nursing leadership and acknowledging it, [in Kenya and at home],” Katy says.

She says the experiences volunteering gave her included confidence in her own abilities and to take up leadership roles working back in Australia.

Reflecting on leadership, Katy believes all nurses and midwives in their everyday practice are leaders, especially through patient advocacy.

“Nurses and midwives are at the forefront of healthcare and so can see a wider picture and lead from that aspect.”

Yet she says often the professions are not recognised for what they do or that some nurses and midwives do not see themselves as leaders even though they lead every day.

“I think sometimes it's just a realisation that what you've always been doing is leadership.”

Now Katy is taking her leadership skills to the next level after being appointed a director of WYI's Board earlier this year.

Katy accepted the position not only because she helped start the Nurses in Action program from the grassroots but also because WYI aligns with her values.

Katy says as a board member her goal is to help continue developing the Nurses in Action program to flourish and grow.

“I want to bring my skills and knowledge to the management team,” she says.

Katy says more nurses and midwives should be appointed to boards and leadership panels.

“I think more nurses and midwives are especially needed on community health and hospital boards because we see the wider picture, coming from that place of patient and community advocacy.”

Katy believes dedicating this year to the nurse and midwife, will not only highlight what the professions do but help nurses and midwives realise what is possible.

“The year of the nurse and midwife is helping us realise our potential and letting the next generation of nurses know that nursing can be more than initial healthcare, it can be much broader than that as well.”



Shannon in Nepal

When every day is different

‘A day in the life of’ is a concept that has failed me as a casual employee. I refer to myself as an orphan of our industry.

By Shannon Weiley

With the 21st century casualisation of roles, I belong to no-one, I have to strategically consider how to maintain a healthy referee base, and at times fight for educational opportunities as who wants to invest in a temporary presence.

Despite these challenges, casual and sessional contracts are, for now, the right choice for me. I thrive on the fact that every day is different.

This could be the innate emergency nurse in me, or maybe I was just born with a little gypsy blood. I love the freedom to stick with what is working and the potential to politely move on when things are not.

By working in a range of diverse settings, I stay fresh, always have something new to bring to the table, or should I say, clinical floor, and I believe for me casualisation prevents episodes of ‘burn out.’ When I feel myself fading, I start to look at new opportunities.

I peruse my resume and see roles with overlapping dates. I’m currently active on four casual pools and working for five tertiary providers and my references are never the same as bi-annually they expire.

The concern that my resume represents me as an industry tramp occasionally grounds me, yet only until the next opportunity tempts me. I have never encountered any barriers. I have found that it is accepted as the nature of the work, and with this comes diversity and experience.

My ability to pick up clinical shifts in a range of settings has blessed me with an ability to experience many types of nursing.

I started my nursing journey in emergency.

Emergency nursing is a soulmate of mine, I try to break away and find myself cyclically drawn back.

If I find myself clinically complacent with cynicism creeping in I up and move on. Two variables you never want to add to your patient’s care and nursing skill set. I find that mixing up my clinical environment allows me to grow in non-emergency nursing skills, while retaining emergency qualities and staying up to date.

For example, after all these years I found myself challenged when showering and redressing a patient with an IDC with hourly measures; to my, then surprise, that chunky, plastic box just won’t fit through the leg of a tracksuit pant!

Enlightenment I never would have attained in ED as we rarely shower patients. Rotating clinically keeps me real and gives me empathy for all our colleagues in a range of roles and environments and enhancing my teamwork and inter-professional practice. I believe to walk a day in other’s shoes does everyone a world of good. I am now working in a small rural clinic with the aim of gaining some more remote nursing skills before embarking on a future dream of mine to be a travel nurse. As a casual I don’t get involved in politics, I genuinely look forward to seeing colleagues and I’m excited to see what each and every shift may bring.

The greatest advantage however to my casualised career is that I am able to take advantage of all the amazing opportunities that come my way. I often accept contracts as a clinical facilitator, working for multiple universities.

I get to work in hospitals all over the state familiarising myself with curriculums. This places me in a constant state of reflection and my higher order thinking skills are constantly in overdrive, exhausting, yet extremely motivating.

The inertia excites me. I get to see potential in everything and having to be so flexible and adaptable in my roles allows me to always find a silver lining, no matter where I am or what my role is I have to find a way to make things work and I love that.

In my facilitation role I am privileged to be a part of hundreds of undergraduate nurses’ journeys, while continually learning and having new experiences myself. To know that so many nurses may take even the smallest part of me with them as they find their own paths is an honour.

The most recent highlight of my career to date would have to be my study tour to Nepal. I embarked on a two-week clinical placement with a group of undergraduate students with the aim of leaving my foot abroad, accomplishing my lifelong dream of participating in aid work and ultimately taking one step towards ‘saving the world.’ To my disbelief those 17 days were the most humbling days of my career and my life. Those experiences and stages of enlightenment will however have to be presented in another submission as my word count has been exhausted.

Author

Shannon Weiley is a registered nurse, nurse academic and clinical facilitator, who is currently living on a 120 acre hobby farm on the Mid North Coast with her family.



Vicki Broad and client Hannah Brigante

International Day of the Midwife

International Day of the Midwife is celebrated across the world each year on 5 May. It's an opportunity to highlight the pivotal role midwives play in delivering care and advocate to strengthen the profession. Falling within the global Year of the Nurse and Midwife in 2020, the International Confederation of Midwives' (ICM) activities throughout the year will be underpinned by four themes – Celebrate, Demonstrate, Mobilise and Unite. They focus on celebrating the work of midwives, demonstrating the impact of midwives and case for investment in the profession, mobilising midwives to become advocates for the profession and midwife-led continuity of care, and uniting midwives towards a common goal of gender equality.

By Robert Fedele

Prior to 2007, expectant mothers living in the small rural Victorian town of Robinvale would have to travel elsewhere to access midwifery care, leaving many without adequate antenatal care and midwife-led continuity of care throughout their pregnancy journey and after giving birth.

At the time, the Robinvale District Health Service (RDHS) local hospital weathered about six emergency births per year without the expertise of midwives and doctors.

That was up until Vicki Broad, the town's sole full-time midwife, joined the service and set up a unique midwifery program delivering antenatal and post-natal care in the district.

The shared care model gives local pregnant women access to a wide-range of services including antenatal classes, blood tests and ultrasounds, and support from a visiting obstetrician.

Expectant mothers from Robinvale, which



Midwife Vicki Broad with client Lee Shi LA



Midwife Vicki Broad (right) and client Mandy

has about 100 births each year, still travel to the Mildura hospital to have their babies, then Vicki continues providing care via outreach home visits following discharge.

"We put one article in the newspaper and from that I got a call and just had people flooding in. Basically word of mouth got around and I've been busy ever since," Vicki recalls of the program's inception.

Robinvale is a bustling multicultural area, largely due to its vast agricultural farms growing produce such as grapes, olives, almonds and carrots, that attract many migrant communities looking for work.

The melting pot typically includes people from Tonga, Malaysia, Cambodia, China, India, Thailand, Hong Kong and Vietnam.

Some of them are refugees and asylum seekers.

Vicki, RDHS' Maternity Services Manager, says many of the women who move to Robinvale from these communities tend to be of child-bearing age, meaning midwifery care is in high demand.

It also presents many challenges, as pregnancy can be tough for first-time mothers, and especially for migrant and refugee women settling into a new country.

"Often these women are a little bit reluctant to come in initially," Vicki says.

"Sometimes they present later in pregnancy

and it can obviously create some problems as they miss out on that early pregnancy care.

"When we screen them for their emotional health they can have higher scores than the general population and if they do we organise counselling for them."

Vicki says the service now provides a host of written resources for migrant women in their own language, along with access to telephone interpreters, and help with booking appointments.

She says midwife-led continuity of care remains the biggest priority through the pregnancy journey.

"Even though some of our women are from non-English speaking backgrounds and perhaps classed as higher risk, we actually have very good outcomes. We have very few pre-term births and statistically we don't have a huge amount of complications."

Vicki says developing an emotional rapport with this cohort of women from the community is crucial.

"The best part of this program in Robinvale is that they actually see the same midwife over and over and you have the ability to develop a rapport with them, so you really get to know these women.

"With the home visits, because I know the women it's actually quite comfortable. Often, their partners are there as well and

I know both of them. I've got families that I've been through three or four pregnancies with so the rapport is really quite strong."

In this vein, Vicki says one of the most memorable moments of her time in the role involved an asylum seeker woman she cared for later asking her to be godmother to her baby boy.

Since beginning more than a decade ago, Vicki believes the midwifery program has made a huge impact, improving access and continuity of care, decreasing complications and enabling more women to be supported with comprehensive care.

The program, which earned Vicki a 2010 Nursing and Midwifery Excellence Award from the Victorian government, is always evolving and recently branched out to include women's health services, such as Pap smears.

"Every day is different and every day has different challenges and the multiculturalism adds another dimension to that," Vicki says.

"It is a super enjoyable job and having so many different clients from so many different backgrounds is really rewarding and at a basic level just being able to help. They just appreciate the care so much."

Vicki, who grew up on a farm and followed her lifelong dream to become a midwife, says International Day of the Midwife presents a chance for the profession to reflect, unite and celebrate each other's impact.

"It's a very proud day for me," she says.

"I'm so happy to wear that cap and even if it's just me here I am thinking of midwives around the world doing what we do and I'm just really proud to be a part of this profession."



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

Multiple errors lead to an avoidable death

In 2015 a 75 year old 'healthy' woman died from the results of an operation that she did not need to have.

The failings of the hospital staff, systems and policies led to the Coroner commenting that, 'sometimes the word 'error' or 'a series of errors' is inadequate to describe a situation' and [in this case] has the '... propensity to disguise the scale of the inadequacies in the medical treatment of M (*Inquest into the death of Irene Magriplis* [2017] NTLC 008). The errors, whilst individually simple, had a collective catastrophic outcome.

M was experiencing abdominal pain, nausea and mild jaundice- following blood tests and a CT scan. An endoscopic retrograde cholangiopancreatography (ERCP) was performed by a surgeon who found and biopsied a fleshy tumour.

A second ERCP and biopsy showed a suspected Ampullary adenoma with low grade dysplasia, but no malignancy.

Expert evidence during the Inquest described how surgery involving the ampulla or the pancreatic duct or pancreas was high risk and ought only to be carried out in appropriately resourced facilities – at a minimum an ICU and 24 hour access to gastroenterology and interventional radiology.

Unfortunately, this was not the view of the surgeon who dissuaded M from seeking a second opinion, confident that he could adequately perform the surgery.

Straight after the surgery M complained of burning pain in her abdomen and continued to do so until her death three days later from septic complications due to a bile leak.

The Coroner stated that M's treatment was problematic in that there was a failure to:

- Undertake sufficient testing to determine whether the high-risk surgery was required.
- Consult a multidisciplinary team regarding the diagnosis and treatment options for a high risk and complex case.
- Inform M of the risks of surgery.
- Properly investigate her drop in blood pressure, and identify the amount of fluid draining from her abdomen postop and take her back to theatre sooner.

Underpinning these failures was poor note keeping by both doctors and nurses and a failure of communication between them. A core issue concerned the failure of the surgeon to identify the amount of fluid that was draining from M's abdomen.

This brought into question the accuracy of the fluid balance chart the management of which was noted to be a core nursing skill required in the HDU. The Coroner held the view that the nurses on the three shifts were unable to properly and accurately make entries in the FBC. For example on one shift there were no progressive totals for intake or output – a significant omission as the object of the chart was to determine the fluid balance. Furthermore, entries were made in wrong columns and on two occasions figures entered were crossed out and no further entries made to replace them.

On another shift there were no outputs noted from midnight apart from an entry reading: 7am '400-drain changed' [with no note of the colour of the fluid] that was entered at 8am.

As such there were no hourly amounts recorded, which would have highlighted the ongoing leakage of fluid during the night to anyone reviewing the chart before the entry at 8am. Whilst it is possible that the surgeon did not see this entry at 8am (but would have benefitted from hourly recordings) evidence was given by a nurse that she telephoned the doctor to get permission to change the drain. Unfortunately, the intervening time [two years] meant that the nurse could not recall the specific phone call or conversation.

A simple note in M's case notes recording this action would have provided evidence that the conversation occurred – alerting the surgeon to the large amount of drainage and would also have served to refresh her memory of her actions at the time. The surgeon claimed that had he been aware of this drainage he would have taken M straight back to theatre.

The Coroner noted that despite the many inadequacies in M's care there should also have been systems and policies in place that would prevent high risk surgery being conducted where there are no resources to mitigate the risks.

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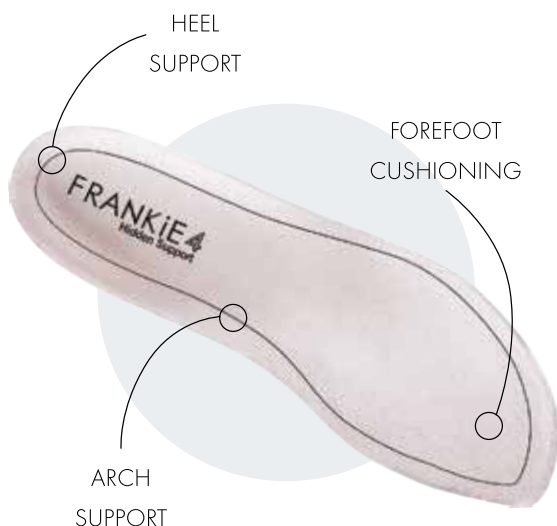
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2020 YEAR OF THE NURSE AND MIDWIFE

RECOGNISING OUR TRAILBLAZERS



Photography Jessica Hromas
From left Leona McGrath and
midwifery student Maiysha Craig

By Robert Fedele

The World Health Organization declared 2020 the Year of the Nurse and Midwife to highlight the important work nurses and midwives carry out in a bid to strengthen the professions in the hope of achieving universal health coverage.

In Australia, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) is running its own campaign, *Recognising Our Black Nurses and Midwives*, to raise the profile of Aboriginal and Torres Strait Islander nurses and midwives and the strength and resilience they bring to their practice and the health system.

"The 2020 Nursing Now campaign has been linked to the 200th anniversary of the birthday of Florence Nightingale and this

has disappointed all the Indigenous Peoples around the world who were colonised by British settlers including Australia," a joint position paper released by CATSINaM states.

"We see this as a sign of lack of recognition of Indigenous People including Aboriginal and Torres Strait Islander people who have been healing, birthing babies and treating illness using traditional medicine for more than 80,000 years."

Three trailblazing Indigenous nurses and midwives shared their journey with the ANMJ.



LEONA McGRATH

Witnessing the birth of her niece when she was a teenager planted the seed to Leona McGrath becoming a midwife.

But it wasn't until years later that she felt confident enough to pursue the profession.

"I just thought how wonderful it would have been if I could have done that but I didn't think I was smart enough to do it," she recalls.

A proud Kuku Yalanji, Woppaburra woman, Leona grew up in Brisbane then moved to Redfern in Sydney in 1982 with her mother and siblings, largely due to "brutal" racism.

At the time, the suburb was at the heart of political activism around civil and land rights for Aboriginal and Torres Strait Islander people.

It's also where the Aboriginal Medical Service was established in 1972, the first Aboriginal Community Controlled Health Service in Australia, where Leona went on to volunteer as a student midwife and is now a board member.

"Aboriginal and Torres Strait Islander people experienced racism in all forms in public health facilities because they just didn't feel safe but we had the medical service to come to," she says.

A single mother of three, Leona had her first daughter when she was 20, an experience that opened up her eyes to gaps in culturally safe care and inspired her to become a midwife to care for women from her community.

"I went into the system and it was an all-white system. I know if there was another black face in that clinic my pregnancy journey would have been a whole different experience."

At age 36, Leona enrolled in a Bachelor of Midwifery at the University of Technology Sydney.

At the same time, she heard about NSW Health's Aboriginal Nursing and Midwifery Cadetship program, which provides a study allowance, 12 weeks paid employment in a public hospital, and support from an Aboriginal mentor, with the opportunity to undertake a new graduate position.

"It was about making a difference in our communities because we know that if we can get

our pregnant mums and their babies healthy we're going to make a change in health outcomes between non-Indigenous and Indigenous people," she says of her motivations.

Leona trained at the Royal Hospital for Women in Randwick, then undertook her graduate year at its specialist Malabar Midwifery Service for Aboriginal families, before obtaining a permanent role at the hospital with another group practice.

There, she was able to demonstrate the importance of having an Aboriginal midwife involved in care and before long many community members began seeking out her services.

A year later, Leona started working at NSW Health as the senior advisor for the Aboriginal Nursing and Midwifery Strategy, running the cadetship program which first gave her a pathway.

"My passion shifted and it was about me supporting and increasing our workforce," she explains.

Leona was among less than 10 cadets who undertook the program back in 2006.

Last year, the figure increased to almost 200 nursing and midwifery students.

Nevertheless, Leona says numerous barriers persist.

The attrition rate remains high and racism is still a significant problem.

One woman Leona studied with was so traumatised by the racism she experienced in the health system that she was lost to the profession for good.

"It's making our system a lot more accountable and safer for our people," Leona says of more Aboriginal nurses and midwives entering the system.

"It's still really heartbreaking to hear the experiences of some students but that just goes to show how strong and determined and resilient our people are. They're sticking it out because they know they're going to make a difference for their community."

In 2019, Leona took on a new role as Executive Director with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), building on her advocacy.

A large part involves sharing her own story.

"You can't be it if you can't see it. It's imperative that we get out into communities and say 'yes, we are nurses and midwives' and be able to show our people that it is possible."

In 2020, the Year of the Nurse and Midwife, Leona says CATSINaM's *Recognising Our Black Nurses and Midwives* taps into truth telling.

"Unfortunately still today, Aboriginal and Torres Strait Islander people are portrayed in a negative way, that portrait of us in the media is the same old narrative and we want to flip that and start celebrating and highlighting our successes."



DR SALLY GOOLD

Growing up in the inner Sydney suburb of St Peters, trailblazing Aboriginal nurse Sally Goold was exposed to the profession during several stints in hospital as a child.

"I thought they [nurses] were wonderful people and they treated me very well," she remembers.

"I thought I'm going to be a nurse one day. Of course, when I said this to people they said 'you'll never get in'. I said 'of course I will, why wouldn't I?' And they said 'because you're black'."

The knockers only made Sally more determined to achieve her dream.

A Wiradjuri woman, she was the first Aboriginal student nurse to train at the Royal Prince Alfred Hospital and overcame barriers and discrimination to become the first Indigenous registered nurse in NSW.

"I knew I had to succeed. I couldn't let my family down and the people who had faith in me."

Early on in her career, Sally worked as a junior sister at the hospital within its operating theatres.

"It was an extremely enjoyable time but it was difficult because you had to prove yourself."

In 1971, she helped establish and run the Aboriginal Medical Service in Redfern, after being sought out by founders, the late Dr Fred Hollows and Dulcie Flower.

Sally was the first Aboriginal RN to work at the health service, slowly building up rapport with the community and making an impact.

"It was one of the most extraordinary experiences of my life," she says.

In later years, Sally would shift into nursing education, joining the Queensland University of Technology, where she lectured for six years.

While there, she organised community visits for students to Aboriginal communities to increase their awareness of cultural issues, safety and respect.

"I loved teaching and I loved being with the students. They were wonderful."

In 1995, she undertook a Masters degree, choosing to investigate *'Why are there so few Aboriginal registered nurses?'*

The answers she found were complex – racism, discrimination and lack of student support systems.

The low numbers of Indigenous nurses spurred her on to change the system.

In 1997 she founded the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) during a special forum attended by 28 Indigenous registered nurses and became the organisation's first Executive Director.

Priorities included recruiting and retaining Aboriginal and Torres Strait Islander people into the nursing profession.

More than two decades on, CATSINaM, as it is now known, has helped boost the Indigenous nursing and midwifery workforce into the thousands and is considered a prominent peak body with an influential voice.

"It's a wonderful organisation and I'm so proud to have been involved in its inception," Sally says.

Sally, who lives on Bribie Island and says she couldn't have succeeded without the support of her late husband George and son Cameron, achieved numerous honours throughout her decorated career.

She was awarded an Order of Australia Medal (OAM) in 1986 for service to Nursing Education and Aboriginal Health, named Senior Australian of the Year in 2006 and had an award named after her by CATSINaM that recognises outstanding Indigenous nurses and midwives.

But the highlight remains making it as a nurse.

"To pass my exam as a little black nurse and be able to do this [nursing] gives me great pride."





TED MURPHY

Healthcare is just one piece of the puzzle, explains nurse Ted Murphy.

For example, listening to patients and engaging them in their own care has the power to lift experiences and develop mutual learning.

"I recall working with an old man who had returned to country to die," Ted says.

"He had decided it was his time. There was little by way of a remote palliative care service at that time and we had to wing it for the most part. One of the greatest privileges I've experienced was this old man teaching me what was needed for the 'proper' way for him to die on his country, surrounded by family."

Ted is a Jinaburra man hailing from Dahmengah, north of Brisbane, and despite living in the Northern Territory since 1997, it's still the area he feels most connected to and calls home.

In his early days in Queensland, Ted worked as a motor mechanic and landscape gardener before finding nursing.

"I enjoy helping people," he says of the career shift.

"I find it very difficult to ignore those in obvious need who seek help."

Ted undertook his grad year at the Redcliffe Hospital and stayed on to work in intensive care.

The memory of his first day as a fully-fledged RN remains strong.

"The sudden realisation that I was responsible for eight or so patients was both sobering and terrifying. Fortunately, my more experienced colleagues made allowances for this and took great care to see that I was supported where necessary and allowed to "fly solo" when appropriate."

Over the next two decades, Ted's career trajectory saw him move to the NT and work across the health system as a nurse, educator and manager.

His posts have included working in the prison system, remote area nursing, lecturing students, nursing at the Royal Darwin Hospital and strategic responsibilities with the Northern Territory Department of Health.

He describes nursing as confronting on some days, a vocation rather than a job, and always rewarding.

"It's a privilege to be able to help in those moments of fear, joy and dire need that others experience."

As an Aboriginal and Torres Strait Islander nurse leader, Ted believes improving access to healthcare and outcomes for his people rests with policymakers needing to listen to those at the coalface.

His current role is Director of Nursing and Midwifery Education and Research (Informatics) at the NT Government, providing specialist advice on primary healthcare matters to the Northern Territory Core Clinical Systems Renewal Program.

"Aboriginal issues need Aboriginal solutions," he says.

Ted acknowledges racism remains a significant issue and is visible in many forms, particularly the disparity in access to healthcare.

"Is there racism in healthcare? Absolutely. But it's not obvious. For example, if you need a kidney transplant and you're Aboriginal and live in a rural or remote area, your chances of going onto a transplant list is much less than that of a non-Indigenous candidate living in a major metropolitan area."

A board member and the NT Director of CATSINaM, Ted says the organisation's mission to increase the Aboriginal and Torres Strait Islander nursing and midwifery workforce in order to achieve health equality remains at the forefront.

"We now have a voice at a national level and a burgeoning acknowledgement of the legitimacy of Indigenous knowledge in mainstream arenas. Because of CATSINaM, we no longer have to "leave our culture at the door"."

As a role model, Ted's advice to the next generation striving to make a difference to their communities acknowledges a long road ahead.

"We're over-represented as clients in prisons and in hospitals and clinics, yet under-represented in professional caregiver roles," he says.

"I'm confident that having a proportionate number of nurses and midwives to work with our own mob, we can meet that challenge.

"[Remember] you are Aboriginal and/or Torres Strait Islander first, a nurse or midwife second. Act with probity, honesty and cultural integrity. While much has been done, the job isn't finished."

Older patient specialising in acute hospital wards: What's your policy?

By Jacqueline Cook, Dr Debra Palesy, Professor Lynn Chenoweth, Dr Samuel Lapkin

ABSTRACT

Despite the widespread practice of older patient specialising in acute hospital settings, there is no evidence of the best model, or any clear guidelines around this practice. This study reports the findings of a focus group discussion aimed to explore ward nurses' views on older patient specialising in relation to indications, practices and required skills and knowledge. Delirium was the most common reason for older patient specialising. Inexperienced staff and increased workload were identified as stressors. Compassion, recognising and responding to delirium, and appropriate communication skills were reported as essential for older patient specialising. These results may help to inform discussion around policies and guidelines for specialising older patients in hospitals.

KEY WORDS

Older patient; specialising; nursing; hospital

KEY POINTS

- Delirium and associated risks/behaviours are the most common reasons for older patient specialising in acute hospital wards.
- Specialising is beneficial for patient safety, although nurses also consider it to be a stressful practice.
- Staff who special are not always the best fit for the role.
- Consistent policies and guidelines for specialising may improve outcomes for both patients and staff.

INTRODUCTION

People over 65 years of age are now the core business of acute health services (Australian Institute of Health and Welfare (AIHW) 2017). Many older people present to hospitals with multiple comorbidities and are at increased risk of developing further complications during admission (Bail & Grealish 2016).

Complications such as urinary tract infections, pressure injuries, pneumonia and delirium are even more common in older people with an existing cognitive impairment such as dementia (Bail & Grealish 2016).

In acute hospital wards, older people can quickly become disoriented and agitated, requiring 'specialising' to prevent accidents, injuries and clinical deterioration (Wilkes et al. 2010; Wood et al. 2018). However, the practice of specialising in hospitals is controversial. As specialising is usually unplanned, there may be no formalised process for commencing and ceasing specialising in hospital wards (Carr 2013; Feil & Wallace 2014; Wood et al. 2018).

It can be undertaken as either one-to-one or cohorting (ie. one nurse for two or more patients with similar conditions) (Lang 2014).

Staff who special have varying qualifications and experience. Registered nurses (RNs) and enrolled nurses (ENs) occasionally act as specials (Feil & Wallace 2014), but they may be recruited from existing ward staff and replacement staff not provided, leaving the remaining staff responsible for larger numbers of patients (Portelli et al. 2016).

Due to the high cost of specialising, assistants in nursing (AINs) are often given the role (Dewing 2013).

Inadequate training and supervision in providing care to older patients with complex needs and challenging behaviour is concerning, leading to safety issues for both patients and staff (Carr 2013; Dewing 2013; Feil & Wallace 2014; Portelli et al. 2016; Wilkes et al. 2010; Wood et al. 2018).

Despite the increase in older patients needing specialising in hospitals (Carr 2013; Dewing 2013; Portelli et al. 2016), there is no evidence of the best model, or any clear guidelines around when to commence or cease specialising, the best way to special, who should undertake the role, and how they should be prepared (Cook et al. 2018).



AIMS AND METHODS

Our study aimed to explore ward nurses' views of specialising older patients in hospital, including:

- Why older patients are specialised in acute hospital wards;
- How specialising is practiced;
- What knowledge and skills are needed for specialising.

We collected our data through a focus group discussion with nine RNs who work across the acute aged care wards in a large metropolitan hospital in Sydney, Australia. Two males and seven females varying in age and nursing experience participated in the discussion, but all had worked in aged care in a number of hospitals for at least three years. We asked open-ended questions to explore ward nurses' experiences of specialising older patients in their hospital wards.

The discussion was audiotaped and transcribed to help with data analysis. The transcript was read multiple times



that the patient in need of specialising was now being well cared for, they worried about the extra work they had to take on in keeping the special safe, as well as having to provide care for other patients. The issue of gender in assigning specials was also discussed. Comments were made regarding a male nurse who said that he was only allocated to special because of his gender and physicality, not necessarily his skills and experience in caring for older people.

Nurses reported that the practice of specialising varied across hospital wards. They felt that specialising should be done one-to-one, and were troubled by the increasing practice of 'cohorting' patients when specialising (ie. one special for two or more patients with similar symptoms). Cohorting was reported as stressful for nurses because of compromised patient safety and quality care when nurses needed to be in two places at once.

KNOWLEDGE AND SKILLS REQUIRED FOR SPECIALISING

Teamwork was discussed as an important part of specialising. While the nurses expressed concerns around AINs and junior staff being assigned as specials, they also reported that it was not necessarily the special's qualifications that were problematic, but their familiarity with the ward and their knowledge of how specialising should be carried out. They suggested that a pool of AINs who were familiar with the ward routine and the regular nursing staff could be trained up for the specialising role. They thought that this would help specials speak up if they felt unsafe or out of their depth when specialising complex older patients.

Nurses suggested that all specials should be trained in early recognition and response to delirium, including understanding the underlying pathophysiology. Training in how to manage challenging behaviours was strongly suggested. Nurses were upset at seeing inexperienced "terrified" specials when trying to address older patients' challenging behaviours, and said it was "heartbreaking" to see older patients being inappropriately managed while in a delirious state. Recommended training included practical strategies for breaking the holds of aggressive patients, and calling for help, along with training in the kinds of care that would elicit positive responses from older patients.

Compassion for older people was emphasised by the ward nurses as being

and key themes that were in line with the study's three main aims were developed and discussed amongst the researchers until agreement was reached.

RESULTS

WHY OLDER PATIENTS ARE SPECIALISED IN ACUTE HOSPITAL WARDS

Delirium and risks associated with patient safety were the most common reasons for specialising older patients. Nurses were concerned about patients falling, climbing out of bed, pulling out catheters and IV lines. They expressed frustrations at trying to prioritise their time on a busy hospital ward while managing these behaviours and keeping patients safe. Specialising was viewed as a favourable way of addressing these frustrations.

The nurses reported that commencing specialising was largely based on the ward nurses' intuition. They identified doctors, the Nursing Unit Manager (NUM) and

Clinical Nurse Consultants (CNC) as the main staff involved in the commencement of specialising once the need had been identified by a ward nurse, but were concerned about the lack of tools or criteria to support this process.

HOW SPECIALISING IS PRACTICED

Nurses were often reluctant to flag a patient for specialising because of the common practice of recruiting specials from the existing ward staff, resulting in an increased workload and compromised staff/patient ratios for the rest of the ward. This risk of losing a staff member vs. the risk to a patient's safety was reported as a major dilemma for the nurses.

When specialising was commenced, nurses were frustrated at being allocated specials who were mostly AINs or new graduate RNs and/or lacking experience in caring for older people. Rather than feeling reassured

absolutely essential when specialising. Required communication skills included the ability to communicate and act in a calm manner, and create a “safe space” for specialised patients. Nurses felt that specials who were untrained in effective communication techniques, particularly for those with dementia and/or delirium, were likely to react in unhelpful ways, causing stress for both the special and the older patient.

DISCUSSION

Our data indicates that older patient specialising is a highly stressful practice for regular ward nurses, the junior and unqualified staff taking on the role, and for older patients themselves. Formal policies or guidelines are needed to support specialising in hospital wards and improve outcomes for both staff and patients. (Box 1)

The specialising role is often unpopular, due to staff anxiety about managing challenging behaviours in older patients while trying to provide quality care (Flynn et al. 2016).

Specials can also feel isolated when specialising (Dewing 2013). However, confidence and job satisfaction levels in undertaking specialising improve when hospitals adequately orientate specials to the ward policies and procedures, and include them as part of the ward team (Flynn et al. 2016).

Specialising policies/guidelines should consider whether it is appropriate for new, junior or inexperienced staff to special, and how to support a team approach to specialising.

Specials also lack the knowledge and skills to provide quality care to older patients (Dewing 2013; Wilkes et al. 2010).

Untrained staff may be subjected to physical and verbal abuse from their specialised patients, feeling vulnerable and undervalued in the role (Wilkes et al. 2010).

Given that delirium is the most common reason for specialising older patients in acute hospital wards (Carr 2013; Dewing 2013; Portelli et al. 2016; Wood et al. 2018), education is needed around its early recognition and ongoing assessment. As more older people are admitted to hospital with an existing cognitive impairment (ACSQHC 2016), training programs for specials should include communication skills, underlying reasons for disorientation and agitation, managing extreme agitation, de-escalation strategies and diversional activities (Ayton et al. 2017; Bateman et al. 2016; Flynn et al. 2016).

Patient outcomes such as reduced hospital stay, improved pain management and fewer falls have been reported when specials are supported by appropriate training and recruited from a pool of existing hospital staff who are familiar with the ward routines, policies and procedures (Bateman et al. 2016).

Specialising policies/guidelines should make explicit the decision-making process for commencing and ceasing specialising (Feil & Wallace 2014; Wood et al. 2018). Some hospitals have successfully implemented algorithms, flowcharts and request forms that justify the need for specials (Feil & Wallace 2014), which have resulted in better collaboration between staff, patients

and their families (Wood et al. 2018) and improved patient outcomes such as falls reduction (Feil & Wallace 2014).

Organisational costs could also improve with specialising policies/guidelines. Hospital administrators are often reluctant to support specialising as costs are absorbed by ward budgets (Dewing 2013). The high costs of specialising have been identified mostly in terms of staffing costs per shift (Wood et al. 2018).

However, policies and guidelines to support specialising in acute hospital wards may reduce these costs through more stringent justification and closer monitoring of the process. Staff who feel assured that their staff/patient ratios will not be adversely affected by flagging the need for specialising (Portelli et al. 2016) may also experience increased job satisfaction (Wood et al. 2018).

This, in turn, may reduce the costs of both staff turnover, and also reduce costly patient adverse events (eg. falls).

CONCLUSION

Nurses in this study viewed specialising as a favourable practice in terms of fewer patient adverse events. However, they also identified stressors associated with specialising such as increased responsibility for junior or inexperienced staff, cohort specialising and increased workload. Specials need to have compassion for older people, be experienced in recognising and responding to delirium, and have appropriate communication skills. Consistent policies and guidelines are needed to support the specialising process.

BOX 1: KEY INCLUSIONS FOR A SPECIALISING POLICY

Formal tools or guidelines for specialising older patients in acute hospital wards should include:

- The qualifications and experience of staff who are most appropriate for specialising
- Required education and training for all specials
- A clear decision-making process for commencing and ceasing specialising
- Workload and staffing expectations when older patients are specialised



TABLE 1: FOCUS GROUP CATEGORIES, THEMES AND SAMPLE QUOTES

CONCEPT	THEME	SAMPLE QUOTES FROM FOCUS GROUP
Why older people are specialised in hospital	Delirium and risks to patient safety	"They need constant attention for... falls... agitation or interfering or absconding."
	Initiating specialising	"You flag them, you say I think this person's trying to pull out his catheter and I think this patient needs specialising."
How specialising is undertaken in hospital	Workload impact	"When we have to... special that means we are going to use [staff] out of our numbers. That means we are looking at more patients. We are giving one nurse focusing on one patient... the other two nurses will be dividing the whole ward."
	Type of staff undertaking specialising	"... usually an AIN who maybe has never worked in the hospital before or maybe never worked in aged care before and they are coming specifically for management of a patient who is very high risk of aggression or delirium."
	Problems with cohorting	"... basically you are compromising every time... you can't special both of them normally, they need constant attention for either pulling at lines, or falls, like agitation, interfering or absconding. You need to be intervening consistently and constantly and they want the staff member to care for both of them..."
What knowledge and skills are needed for specialising	Teamwork	"You spend a lot of time together, you need rapport with your colleagues and with your patients as well. If something goes wrong...all of us need to know that... someone has got your back..."
	Recognising and responding to delirium	"Noticing and observing what is going on in the person before they start to escalate, not only the triggers but watching those early signs before that behaviour escalates"
	Communication	"If you...start raising your voice or [the special] gets excited or agitated themselves because [the patient] is hitting out, you have to be calm and manage them..."

Jacqueline Cook is an RN, B.Nursing, Master of Clinical Nursing, Grad.Cert. Psychiatry of Old Age, Master of Nursing (Research) Student at the University of Technology Sydney Faculty of Health, University of Technology Sydney.

Dr Debra Palesy PhD, B. Nursing, Grad. Dip. Ed., M.Ed. is a Lecturer at the Faculty of Health, University of Technology Sydney.

Professor Lynn Chenoweth is a Professor of Nursing at the Centre for Healthy Brain Ageing, Faculty of Medicine, University of New South Wales

Dr Samuel Lapkin, RN; BN Hons (1st Class), Grad Cert Tertiary Ed; PhD. is a Senior Lecturer at the Faculty of Science Medicine & Health, School of Nursing, University of Wollongong

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James Lloyd

ANMF Federal
Vice President

Florence Nightingale: a reflection on a nurse ahead of her time

The World Health Organization (WHO) has declared 2020 the *Year of the Nurse and Midwife* – a recognition of the vital role we play in global health.

Nurses and midwives are involved in every aspect of the health of our clients and often we are the only healthcare professional available. Dr Tedros Adhanom Ghebreyesus, WHO Director-General, said, “Nurses and midwives are the backbone of every health system”.

He speaks the truth: globally, we make up 50% of the healthcare workforce.

Nursing and midwifery in the western world is where it is today due to the actions of nursing pioneer Florence Nightingale.

So what did she contribute to nursing and public health?

Florence Nightingale pioneered evidence-based care almost a century before David Sackett and Archie Cochrane, who are credited with modern concepts of evidence-based healthcare.

Florence was a keen mathematician and during the Crimean War (1854) she collected statistical data on the mortality rate of soldiers due to infection and being nursed in unsanitary conditions.

She then used this data to make simple yet important changes in the field hospitals -providing a clean environment, clean clothes, high quality food and sterile instruments. Due to these improvements, the mortality rate due to infection dropped from 60% to 42% and finally down to 2%.

Importantly, Florence Nightingale was also a pioneer in data visualisation with the use of infographics, effectively using graphical presentations of statistical data.

After the Crimean War, Florence Nightingale used her knowledge to lobby the British government for compulsory sanitation in personal homes of the middle and lower classes.

Florence also advocated for other parts of society, including abolishing prostitution laws that were harsh on women, and campaigned for hunger relief in India.

Other social reforms included improving healthcare for all sections of British and expanding the acceptable forms of female participation in the workforce.

Florence opened the world's first formal nonsecular training institution at St Thomas Hospital for Nurses and Midwives in 1860.

This created nursing and midwifery as a distinct profession in its own right and formalised the instruction and training.

Not long after starting her nursing school, she created the first district nursing service, believing that the most important place to care for the sick was in their own homes. This district nursing service was directed at providing healthcare for the poor and vulnerable.

Florence Nightingale also published one of the first textbooks related to nursing care: “Notes on Nursing – What is and what it is not” (<https://bit.ly/37qFak6>). In this book she wrote,

“The most important practical lesson that can be given to nurses is to teach them what to observe-how to observe-what symptoms indicate improvement-which are of none-which are evident of neglect-and of what kind of neglect.”

Florence authored about 200 books, pamphlets and reports. Importantly, she wrote some of her textbooks in simple English, so people with poor literacy skills in the 1800's had access to knowledge and could even join the profession.

Her nursing school and formalised nursing training also set up a viable and respectable option for women who desired to work in a profession outside their home. In essence, for women in that era, there were very few professions they could enter, especially professions that involved intellectual thought and reflection. Critically, nursing and midwifery gave women a profession in which they could change the world.

Florence Nightingale introduced many basic concepts that make ours a modern profession. But she was also humble. Upon her death in 1910, and according to her wishes, she refused to be buried in Westminster Abbey. Instead, she was buried in a small family plot at St Margaret's Churchyard at East Wellow.

She didn't need to be under the same roof as kings and queens. She, like her famous image of the nurse with an oil lamp doing her rounds, was all about the care of the individual.



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Beyond band-aid solutions:

An overview of a collaboration project completed by in-patient public hospital wound management Clinical Nurse Consultants (CNC) in Melbourne and surrounding areas

By Hannah Tudor, Sarah Sage, and Anthony McGillion

Melbourne's public health services are all unique but they share the same challenges in providing high-quality health services to Australia's second largest, and growing, city.

Australia's ageing population and proliferating chronic health conditions are increasing demands on all areas of health delivery (ABS, 2016).

In many organisations, the wound management CNC plays an integral role optimising patient care and minimising preventable harm, particularly in areas such as pressure injury prevention.

Leading organisational change towards best practice takes significant skills, time and resources. This is true for many advanced nursing roles, however, opportunities to develop these skills and be mentored by experienced peers can be challenging as many of these roles are also stand-alone.

In a system with many competing priorities it is imperative to find ways to allow organisations to share learning across networks; allow piloting of ideas and projects before wholesale system change, and mentor skill development.

Informal networking of wound specialist nurses at external events and conferences has been long-standing and has provided insight into the similarities and differences within wound management CNC roles across metropolitan Melbourne as well as the similarities in clinical challenges faced by health services.

To better understand the wound management CNC role, an online survey was conducted using Survey Monkey. The survey asked five structured questions and gained free text responses. The questions focused on capturing feedback on the challenges, frustrations and value of the role in public health services across metropolitan Melbourne.

Themes drawn from the results included experiences of professional isolation, difficulty driving large scale change and lack of opportunity for professional development. Results of the survey supported a proposal for inter-organisational collaboration. Funding awarded by the Royal Melbourne Hospital Foundation enabled an 18-month pilot collaborative group to be established, with the aim, if successful, to become self-sustaining beyond the pilot period. The initial proposal initially focused on the metro health services but was expanded

to include surrounding services due to interest. The group agreed to meet quarterly and after each meeting an online feedback survey was circulated to the members via Survey Monkey.

The post-meeting survey repeated questions around role challenges and enablers as well as questions pertaining to the running of the meetings. This allowed for the evaluation of the trend over time; an evaluation of the initial 12 months was conducted, gauging the group's overall experiences and perceptions of the collaboration.

In November 2017, the first 'Metropolitan Melbourne and Surrounding Areas Wound CNC Collaborative group' meeting was held at the Royal Melbourne Hospital, comprising of wound management CNCs and Stoma Therapy CNCs who had the portfolio of inpatient wound management leadership from 12 public health services from Melbourne and surrounding areas (Melbourne Health, Alfred Health, Austin Health, Barwon Health, Eastern Health, Monash Health, Northeast Health Wangaratta, Northern Health, Peninsula Health, Peter MacCallum Cancer Centre, St Vincent's Hospital and Western Health).

Four key priorities were established by the group including; collaboration and sharing of resources related to preventable skin harm; product and equipment discussion forum; research sharing and development; and professional development opportunities for members.

Evaluation of the collaboration indicated that it had a positive impact on experiences of professional isolation by providing a space for:

- sharing of knowledge;
- information and experience;
- promoted networking; and
- allowed collegial support and professional relationships to grow.

Members also drew support through group email communication where clinical queries or practice recommendations were shared. Health services were able to utilise the combined knowledge and experience of the group via their representative who was able to draw on the feedback and responses of the members.

Working together and avoiding duplication of effort meant all health services involved gained benefit from this group. This occurred through the sharing of local processes, allowing the group to discuss and debate best practice and establish consensus statements relevant to the field. Group consensus statements were then shared with local organisations for use in their own internal processes.

Feedback from members indicated they found the collaboration supported the streamlining of local processes and work prioritisation, inspiring participants to bring knowledge and ideas back to their health service.

Professional development opportunities were incorporated into the meetings through presentations provided by members of the group as well as guest speakers. The evaluation indicated that learning



Metropolitan Melbourne and Surrounding Areas Wound CNC Collaborative group meeting

opportunities during the meetings were valued. A sense of feeling inspired by others in the group and building a broader knowledge base was noted.

Currently, no other collaborative group exists for wound management CNCs in in-patient public health services. There is a need for innovative strategies to improve patient care, minimise harm and to support advanced nursing roles (Duckett, Cuddihy & Newnham, 2016). Investing in clinical leadership through the support of inter-organisational collaboration has many potential benefits for staff attending the meetings, the health services involved and the patients they care for. The pilot program trialled over the past 12 months has already delivered benefits to those involved and their respective health services. By providing a platform for collegial support, networking and shared learnings, challenges such as experiences of role isolation, standardising best practice and professional development opportunities for specialist clinical staff can be better addressed. Further outcomes of the collaboration will continue to be explored.

With thanks to the Wound Management CNC Collaborative Group for their contributions and commitment to the 12-month pilot period of the collaboration. Carolyn Atkin RN (Stoma Therapy – Peter MacCallum Cancer Centre), Lisa Connolly RN (Stoma Therapy-Monash Health), Michelle Daly RN (CNC Wound – Northeast Health Wangaratta), Carmen George RN (Stoma Therapy-St Vincent's Hospital), Greer Hosking RN (CNC Wound – Austin Health), Diane Housiaux RN (CNC Wound – Alfred Health/Caulfield), Col Kilmner RN (CNC Wound – Western Health), Jacqueline McCowan RN (CNC Wound and Stoma – Monash Health), Donna Nair RN (CNC Wound – Barwon Health), Ai Wei Ng NP (CNC Wound – Melbourne Health), Kathy Puyk RN (CNC Wound – Alfred Health), Stephanie Rakis NP (CNC Wound – Melbourne Health), Liz Ryan RN (CNC Wound – Monash Health), Wendy Sansom RN (CNC Stoma Therapy – Eastern Health), Meagan Shannon RN (CNC Skin Integrity – Peninsula Health), Diana Wells RN (CNC Wound and Stoma – Monash Health) and Kerry Wirz RN (CNC Wound – Northern Health).

Authors

Hannah Tudor RN is CNC Wound – Melbourne Health

Sarah Sage NP is CNC Wound; Coordinator Chronic Wound Service/Wound CNC team – Melbourne Health

Anthony McGillion is Associate Professor of Clinical Nursing Practice at La Trobe University

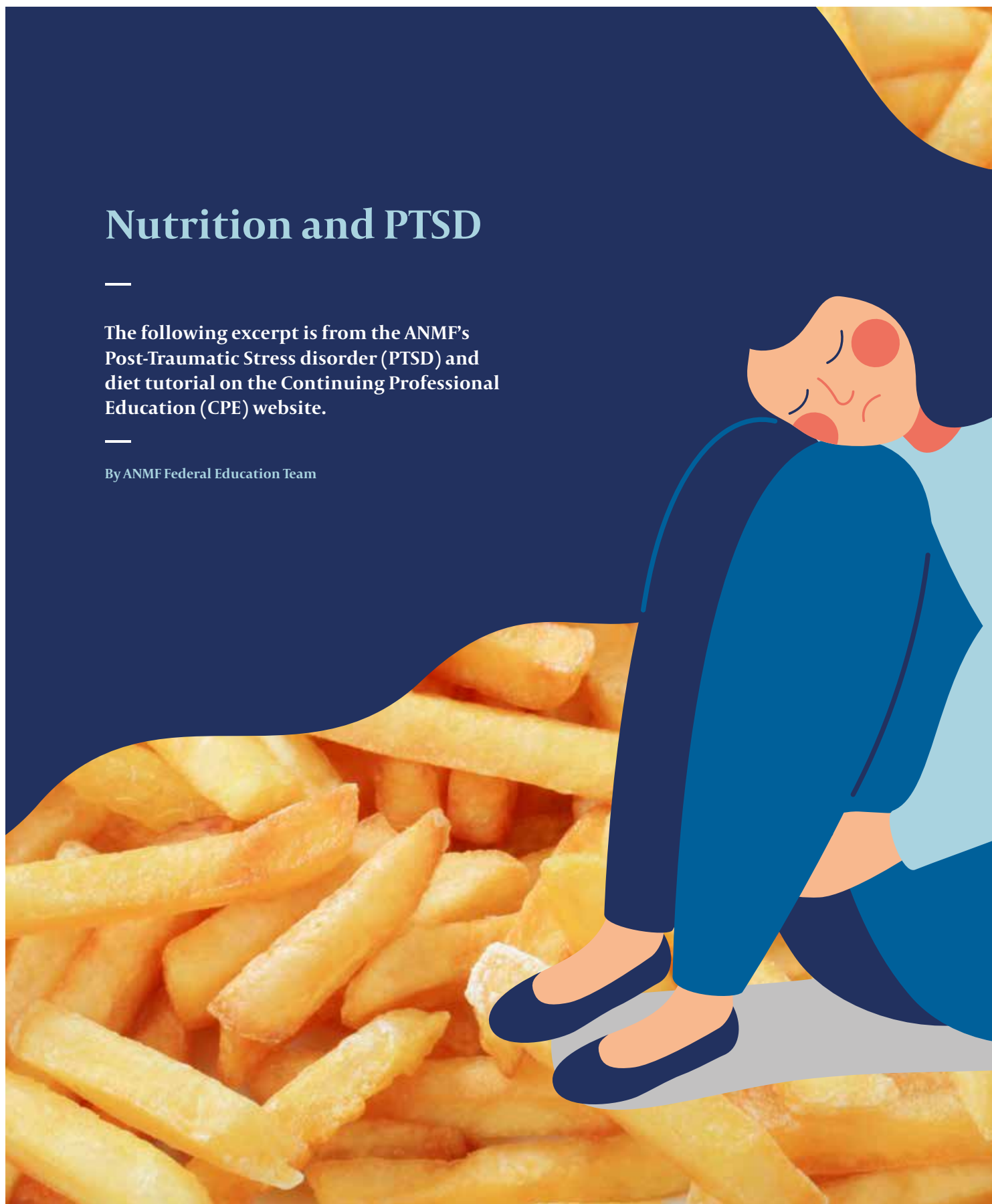
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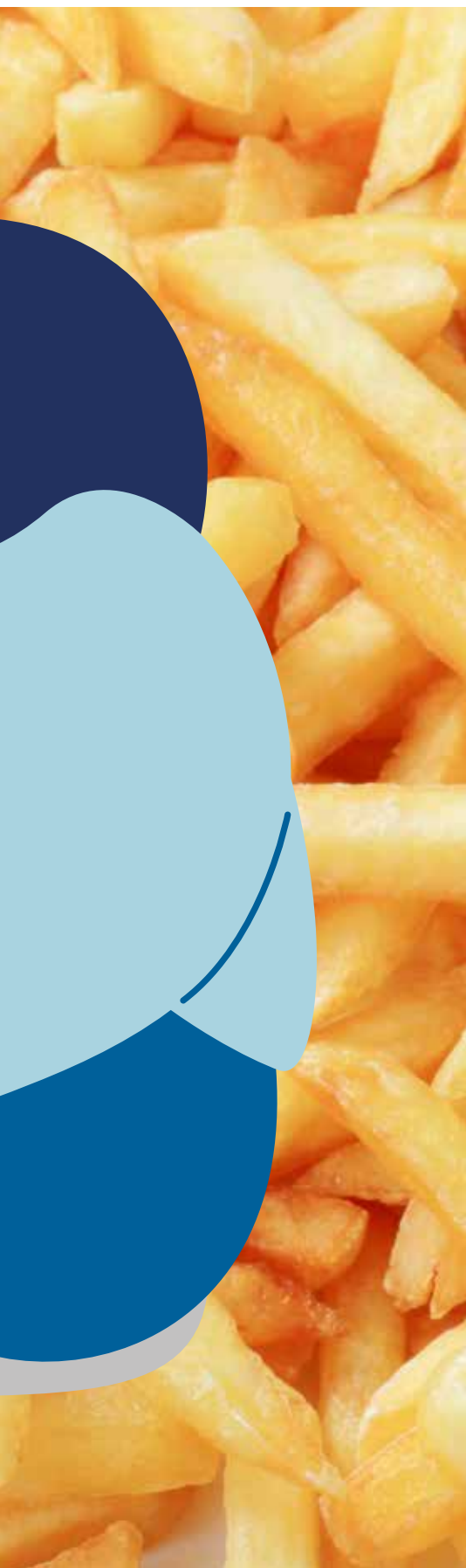
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Nutrition and PTSD

The following excerpt is from the ANMF's Post-Traumatic Stress disorder (PTSD) and diet tutorial on the Continuing Professional Education (CPE) website.

By ANMF Federal Education Team





This tutorial is a new addition to the courses on the CPE website and was written by Peta Adams, an accredited practising dietician for over 10 years.

Post-Traumatic Stress disorder (PTSD) is defined as 'the lingering, persistent psychological reactions to traumatic events or experiences' (Sareen & Mason 2018).

It is characterised by revisiting, avoidance/numbing and arousal symptoms. Also, hypersensitivity, hypervigilance, changes in mood and behaviours and aggression.

PTSD is considered to be the most debilitating mental illness with higher rates of suicide. People commonly suffer from depression, anxiety and mood disorders.

They are likely to have deficiencies in Neurotransmitters (NT) such as serotonin, dopamine, noradrenaline and GABA.

It is a manifestation of traumatic experiences. It causes the sympathetic nervous system to go into overdrive and release the stress hormones, cortisol and adrenaline over long periods of time.

Patients commonly suffer altered neural and cognitive behaviours, particularly related to food-brain areas of consumption (Sathyanarayana Rao et al. 2008).

They tend to struggle with the cognitive inhibitions of food and also alcohol and therefore often over eat and drink alcohol to excess (Farr et al. 2014).

WHO IS AT RISK?

- Ex veterans – it is the most common condition plaguing this population
- Witnessing death or severe injury (nurses)
- Involved in a life-threatening event such as natural disasters, robbery, car accident
- Sexual abuse (adults and children)

The risk is increased in repeated stressful life-events.

There is often delayed symptom development ~25% >6 months after the trauma (Sareen 2014).

Signs and symptoms of PTSD normally develop in a 3-6 month period after a traumatic event. However, sometimes it can take years for the symptoms to develop.

Symptoms include:

- Intrusive thoughts
- Nightmares
- Flashbacks
- Detachment
- Irritability and outbursts

- Headaches
- Disrupted sleep or insomnia
- Feelings of guilt

Also:

- Hypersensitivity including at least two of the following:
 - » Sleep issues
 - » Anger
 - » Poor concentration
 - » Startling easily
 - » Physical reactions (racing heart or increased blood pressure).
 (Sareen 2014).

Epidemiological studies show >90% of sufferers have at least one comorbid mental condition (Sareen 2014).

The burden of physical illnesses in Australians of those suffering from depression and anxiety, is around 43% (Clarke & Currie 2009).

Studies have showed a distinct and significant association between PTSD, diabetes, psoriasis, thyroid conditions, cardiovascular disease and stomach ulcers (Britvić et al. 2015).

PTSD can lead to central obesity and metabolic dysfunction

Increase in Leptin and Adiponectin (the hunger and storage hormones respectively).

Stress hormones such as cortisol and catecholamines further worsen this profile and contribute to metabolic dysfunction (Sagud et al. 2017).

Medications for PTSD can also have an effect on nutrition.

Selective Serotonin Reuptake Inhibitors (SSRI's) and Serotonin-Norepinephrine Reuptake Inhibitors (SNRI's) are the medications of choice to treat and manage this condition, however they increase gastrointestinal symptoms. People are likely to experience irritable bowel syndrome (IBS) symptoms temporarily or long-term.

They reduces GI tolerance to high fibre, high fat meals and snacks.

They may increase appetite, but their effect on weight is person dependent (some gain, others may lose weight).

PTSD is generally considered to be a biochemical or emotional dysfunction in response to trauma but nutrition can play a key role in the onset as well as the intensity and duration.



COMMONALITIES IN FOOD PATTERNS OF THOSE WITH PTSD INCLUDE:

- Skipping meals
- Poor appetite and desire for foods
- Desire for sweet foods (Sathyanarayana Rao et al. 2008).

Often their diets can contain a lower intake of crucial nutrients such as omega 3 fatty acids, essential vitamins and minerals due to convenience meals, limited fruit and vegetables and inadequate meat/dairy protein.

Common deficiencies are from amino acids and minerals that are precursors to neurotransmitters.

Those with PTSD are more likely to consume a higher energy (kJ) intake, with more frequent consumptions of fast foods, soft drinks and snacks.

Patterns of eating are likened to food addiction or bingeing, which is why there is a direct correlation of PTSD and obesity.

Food intake is often associated with mood and the consumption patterns relate to the dysfunction of the hypothalamic-pituitary-adrenal axis and low serotonin (Sathyanarayana Rao et al. 2008) as the reward circuitry of food and mood appears to be dysfunctional (Farr et al. 2014).

The cycle of over eating, in

particular high energy foods, leads to a dampening of the appetite suppressing effect of foods, increasing the neural reward system of consumption (Sareen 2014).

The main core macronutrients that are important to mood are carbohydrates and proteins and micronutrients (Sareen 2014).

This is an excerpt from the tutorial and if you choose to access the complete tutorial, you will find detailed information on foods that improve the symptoms of PTSD including macronutrients, the role of carbohydrates, the preferred glucose index, proteins and amino acids, Omega-3 fatty acids and vitamins and minerals.

An optimal diet for people with PTSD is offered including daily and weekly food inclusions and those that require limitation or exclusion.

If you are interested in nutritional advice for your clients or yourself, Peta has written three other tutorials for the CPE website:

- **Diabetes and diet**
- **Health eating for adults**
- **Metabolic syndrome and obesity, nutritional and medical management**



**60 minutes
CPD**

The following excerpt is from the ANMF's Nutrition and PTSD course on the (CPE) website. The complete tutorial is allocated one hour of CPD, the reading of this excerpt will give you 20 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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ONLINE EARLY APRIL

IN THE LINE OF FIRE

By Robert Fedele

Australia's far-reaching bushfire crisis has seen homes destroyed, native animals killed, devastating impacts on fire-affected communities, and people lose their lives. Like other frontline workers, nurses have been at the forefront of relief efforts.

'Everybody's been getting in and offering whatever it is they have to help'

The bushfire crisis that swept the nation first hit the ACT over last year's Christmas and New Year period, with smoke drifting up from fires raging along the south coast of NSW blanketing the sky.

"We spent about two weeks having the worst air quality in the world," recalls registered nurse Lyndsey Ohman.

"People were quite anxious about their health and breathing in the air."

As the bushfire threat intensified, led by the Orroral Valley Fire, which moved dangerously close to homes in the capital's southern suburbs, a state of emergency was declared in late January.

Lyndsey says locals living in the area, hit by devastating fires in 2013, were understandably hypervigilant.

A qualified chaplain since 2010, Lyndsey volunteered at two evacuation centres in Canberra during the bushfire crisis, providing emotional and spiritual support.

At the relief centre in Dickson in the middle of January, many people had been evacuated from towns in NSW including Cobargo, Batlow and South Durras.

Everyone who arrived recounted stories of destruction, loss and fear, Lyndsey reveals.

Some had found it hard to access available government grants.

Others were just exhausted and needed a rest.

Locals affected by the bushfire smoke also visited the centre, some staying overnight.

Lyndsey says many people walking into the centres were too distraught to register with the Red Cross and fill out forms, so she would take them somewhere quiet and just listen to their fears and hopes before introducing them to other available agencies providing accommodation, food, clothing, toiletries and bedding.

Lyndsey, who has previously been deployed to disasters including the Lockyer Valley floods in Queensland and New Jersey in the US following Hurricane Sandy, says her role as a chaplain invariably involves being a 'listening ear' rather than providing formal counselling.

A medical surgical nurse at a hospital in Canberra, Lyndsey says she felt compelled to help out during the crisis.

Her husband and daughter, both nurses, also assisted, with her daughter

volunteering with St John Ambulance in Cooma, Erindale and Dickson, providing first-aid as required.

At the relief centres, Lyndsey suggests people entered with two different mindsets.

Canberra had been relatively spared from the fires, meaning locals came in seeking information and contacts in the event the situation worsened.

On the flipside, people evacuated up from the NSW coast experienced fires at their doorstep.

"One man said the thing with the fires is you know it's there, you know it's coming, it's just a matter of time. It's different with flood, the flood is there, it comes, it sits there for a while, but you're not waiting for it to come. I think the anticipation must have just been awful."

In early February, bushfires continued to burn in Canberra despite much-needed rain. But the threat began to ease in many areas.

At the time, Lyndsey said she was hoping Canberra could return to some normality and be afforded a bit of breathing space.

Reflecting on the devastating impacts of Australia's bushfire crisis, Lyndsey says seeing the spirit of the nation banding together in the face of tragedy had at least provided some solace.

"If there had to be a good side to these fires and it's often hard to find one, that's what I would say. We've seen fires before, we've seen floods in Australia but I have never seen the community come and work together the way they have in this instance and it's sort of no-holds barred, everybody's been getting in and offering whatever it is they have to help."

Lyndsey represented the nursing profession at the ACTU's Emergency Services Summit in Canberra in February, joining other frontline workers calling for more resources and urgent action.

She shared her story, calling for better communication during bushfire crises, and support for vulnerable groups such as people being evacuated with Alzheimer's and dementia.

"It was a really good place to meet with people from other unions from all parts of the country because sometimes there's the temptation to think whatever's happening is only happening to you and in this scenario we managed to talk to each other and tell each other our stories showing that we're not on our own."

'The weather was so daunting it felt like Armageddon'

NSW registered nurse Diane Lang was working a routine night-shift on the surgical ward at South East Regional Hospital in Bega on New Year's Eve as bushfires razed towns along the coast.

"Because I was on night-shift and I was isolated I didn't really know what was happening except that I could see the sky was black, the flames from the hospital in the distance, and just a glow."

Hospital staff were listening to scanners and the radio to monitor the situation, readying themselves for potential admissions and injuries.

The widespread fires struck towns including Cobargo, Quaama and Eden.

Roads in and out of the area were closed as new fires emerged in nearby Bemboka.

A NSWNMA Branch Councillor and delegate, Diane lives around 40 kilometres away in the tourist town of Merimbula, where the local bowls club and RSL were turned into evacuation centres for those affected in surrounding areas.

At the hospital, with the situation unfolding, Diane stayed on to help in whatever way she could.

She finished her normal 10-hour shift before heading off for a two-hour snooze and returning to help out on the ward until the afternoon, mainly with discharge and making sure people were safe and had a plan.

"There were quite a few small burns and a couple of major burns where people had to be eventually transferred to Concorde Hospital," Diane recalls.

"I stayed on that morning and just helped with discharge and getting people who could go home out because we needed to have enough beds available in case we had a lot of people admitted."

Diane says staff working at the hospital experienced a huge emotional toll.

"The weather was so daunting it felt like Armageddon. It was so dark and scary looking that we were all freaking out because fires were everywhere. We didn't know if people's houses were safe, what staff were safe, because communication was down in one of the areas and there's a lot of staff that live out in Cobargo and Quaama. We were really distressed."

Diane drove home that evening, packed a suitcase with essentials in the event her

own property was lost to the bushfires, then returned to the hospital to take on extra shifts.

For the next week in early January, she lived out of her campervan in the hospital carpark and went to work as many of the fires blazed out of control.

During the crisis, NSW Health sent extra nurses to the stretched hospital to help out.

"A lot of the nurses had been working extra shifts. We were tired. When you live in that kind of atmosphere you get a bit fatigued and hot tempered because of your circumstances.

"We had people who were taking time off work because they were evacuating their houses. Some had to be evacuated four or five times. They often had to worry about family and children and some of them lost homes and properties and animals."

Diane says hospital management were extremely supportive during the crisis and that the hospital and community deserve enormous credit for their collective efforts.

But she argues the hospital has had longstanding understaffing issues and that resources were already stretched prior to the bushfires, with the tragic events strengthening the case for safer levels and ratios.

"We need more nurses on the floor," she said after speaking at ACTU's Emergency Services Summit in Canberra in February.

"My message was we need more services and we need to make sure that our mental health is addressed adequately by making sure we have enough staff."

Diane had close friends who lost everything due to the bushfires and joined others in rallying around communities as best she could.

When speaking to the ANMJ in early February the fires were still a daily threat, with homes continuing to be lost.

In the face of tragedy, she said it had been humbling to see the generosity of people emerge and communities stick together.

People like those mending fencing for farmers who lost kilometres of fencing, or those clearing rubbish and cooking meals.

"I just look at the devastation it's caused in this area, the landscape and the homes. But the beautiful thing is it has made the community stronger and it shows you that humanity is good with all the things that people do to come and volunteer and help us."



Debbie Richards

Federal Industrial
Research Officer

Changes to the national paid parental leave scheme you should know about

A number of welcome changes to the national Paid Parental Leave (PPL) Scheme have been introduced or are expected to come into effect this year. While the scheme still falls short on a number of levels, this round of changes will remove some of the current anomalies and impediments affecting access and offers more flexibility about how and when paid leave may be taken.

The PPL Scheme provides eligible working parents with up to 18 weeks of payment at the National Minimum Wage (currently \$740.80 per week) when they take leave from work to care for a new born or recently adopted child (Australian Government, Parental Leave Pay, 2020). (This is separate and in addition to any paid parental leave entitlements negotiated in enterprise agreements or via other employment arrangements). The scheme also provides fathers and partners with two weeks paid leave for the same child but the total received from both payments can't be more than 18 weeks' pay (Australian Government, Dad and Partner Pay, 2020).

CHANGES TO THE WORK TEST

Changes to the 'work test' commencing on 1 January 2020 (Paid Parental Leave Amendment (Work Test) Act, 2019), allow more parents to qualify for the payment. To satisfy the work test, you need to have worked 10 of the 13 months before the birth or adoption of your child AND a minimum of 330 hours, (around one day a week), in that 10 month period.

Two changes to the work test have been implemented.

The first increases the gap allowed between each work day in the test period from eight to 12 weeks. This will benefit workers who may have irregular hours or long breaks between periods of employment and will enable some who currently miss out to qualify for PPL.

The second change relates to circumstances where pregnant women have to cease work due to the hazardous nature of their employment. Instead of the work test applying to the 13 month period before the birth of the baby, it will now apply to the 13 month period prior to ceasing work. This means women who cannot be transferred to a safe job or don't receive paid 'no safe job' leave under the Fair Work Act will not be disadvantaged by the circumstances or nature of their employment.

MORE FLEXIBLE ACCESS TO PARENTAL LEAVE PAY

Under the current PPL scheme, eligible parents are paid the parental leave payment in a single

continuous block of up to 18 weeks, which must be claimed within 12 months of the birth or adoption of their child. Currently, if a parent returns to work before 18 weeks, the balance of the paid entitlement is lost. New legislation will provide parents with more options in relation to how the 18 week payment can be accessed and who may access the payment.

The changes proposed in the Paid Parental Leave Amendment (Flexibility Measures) Bill 2020 (Parliament of Australia, Paid Parental Leave Amendment (Flexibility Measures) Bill 2020, applicable from 1 July 2020) provide two types of parental leave payment:

- An initial period of 12 weeks called the PPL period administered under the same rules as the existing 18 week period ie. must be taken in the 12 months after the birth of a child ;
- The second type is a new flexible PPL arrangement of up to six weeks (30 days) where eligible parents/claimants can claim up to 30 days parental leave payment whenever they choose. Parents/claimants will be able to take this part of their entitlement any time before their child turns two years old.

Flexible PPL may be used in a variety of ways including the following examples described in the Bill's explanatory memorandum (Parliament of Australia, Paid Parental Leave Amendment (Flexibility Measures) Bill 2020):

- Claim the 30 flexible PPL days straight after their PPL period ends so taking 18 straight weeks;
- Use the parental leave payment in the 30 day flexible PPL period to support a gradual return to work. For example a full time employee may arrange with their employer to return to work three days per week and apply to be paid the flexible parental leave payment on the two days per week they are not working;
- Return to work any time after the initial 12 week period and subsequently claim up to 30 days of flexible paid parental leave anytime before the child turns two;
- With the permission of the primary claimant, the flexible PPL entitlement can also be transferred to an eligible partner/claimant to use anytime before the child turns two years old.

At the time of writing, it was expected the Legislation would be introduced in the Autumn sitting of Parliament.

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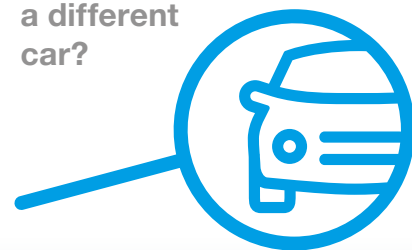
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**Naomi Riley**

Federal Professional Officer

CPD – more than a mandated requirement

Recently I was appointed Federal Professional Officer for the ANMF. I feel privileged to be in a position to advocate for nurses and midwives across Australia and I thought I would take this opportunity to introduce myself.

When I started out in nursing and midwifery I had no real expectations beyond graduation about what I wanted for my long term career. It didn't take me long to realise the numerous employment opportunities available to me by having nursing and midwifery qualifications, and then I found it hard to decide what nursing and midwifery work I wanted to do.

As I completed further study and expanded my skill set, my work became more varied and as a result I have worked in many different areas often balancing a few different jobs to do a little bit of everything I love about nursing and midwifery.

My overarching passion is maternal and child health, from conception through to early childhood health, and everything in between.

My second passion is expanding my knowledge and skills, and, whilst continuing professional development (CPD) is a mandatory requirement, I see it also as a gateway to not only increasing one's depth of knowledge in a specific area, but also enabling flexibility to move across numerous roles within nursing and midwifery professions.

There can be confusion around how to meet CPD requirements when working across nursing and midwifery roles. I hope to clarify this here.

WHAT IS CPD?

CPD is a key component of nursing and midwifery practice, not just because it is a mandated requirement for registration (see Nursing and Midwifery Board Australia (NMBA) *Registration standard: Continuing professional development*). Investing in CPD serves multiple functions, including, but not limited to, maintaining and advancing competence with clinical skills; ensuring evidence informed practice and discovering innovative care practices; understanding one's own scope of practice, strengths and limitations.

Ultimately, investing in CPD ensures healthcare consumers are the recipients of high quality, safe and competent care that supports optimal outcomes for their health and wellbeing.

DUAL REGISTRATIONS AND CPD

Those that hold registration as both a nurse and midwife are required to complete a minimum of 20 hours of CPD, per renewal period, for each registration. While nursing and midwifery are separate professions, the NMBA recognises there is shared practice that is common to nursing and

midwifery. Therefore, if a CPD activity can be shown to be relevant to both nursing and midwifery practice and your context of practice it may be counted as evidence for both nursing and midwifery CPD hours. The key being that the CPD undertaken is relevant to your context and scope of practice for each registration that you hold.

DEMONSTRATING RELEVANCE

The CPD process should ideally start with reflection. This can be informal and self-directed, or through formal processes such as a performance development review or (reflective) clinical supervision.

Reflective processes should identify one's context and scope of practice, and strengths, learning needs and new areas of interest. By defining your context and scope of practice you can identify how you utilise each of your registrations in your nursing and/or midwifery roles. CPD goals can then be set for the coming renewal period, for each registration you hold and areas of shared practice, if any, identified.

CPD activities can then be selected to meet these goals, giving CPD purpose and relevance to each individual, their scope of practice, learning needs and career aspirations.

Once CPD activities have been undertaken, a reflection should be completed outlining what was learnt, how nursing and/or midwifery practice has been influenced, and if goals were achieved or further CPD is required.

There are many templates available to support nurses and midwives to undertake this process, including one provided by the ANMF which can be found at anmf.org.au/cpe. This documentation forms part of the evidence demonstrating your compliance with CPD requirements and is best done as CPD activities are undertaken.

Further information about CPD requirements can also be found on the NMBA website at nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx

I encourage you to see CPD as an opportunity, not just a tick-a-box for your registration. By investing in the CPD process as described above, and setting out to learn and develop in an area that is meaningful to you and your work, nursing and midwifery professions will continue to keep giving back to you as they have done for me.

**Dr Micah D J Peters**

ANMF Federal Office
National Policy Research
Adviser and Editor-
in-Chief of AJAN

**Casey Marnie**

ANMF Federal Office
Research Assistant

Both are based in the
Rosemary Bryant
AO Research Centre,
School of Nursing and
Midwifery, University
of South Australia.

Writing for the Australian Journal of Advanced Nursing

For many nurses and midwives writing for an academic journal may be daunting. With the relaunch of the ANMF's Australian Journal of Advanced Nursing (AJAN), we want to inspire and support nurses and midwives to be more engaged in writing, reviewing, and using research evidence.

To kick off 2020, the World Health Organization-designated Year of the Nurse and Midwife, the ANMF has relaunched the new-look, peer-reviewed academic journal; the *Australian Journal of Advanced Nursing*. I am honoured to step into the role of Editor-in-Chief and look forward to working with the journal's Editorial Board and team to make AJAN something ANMF members and the wider nursing and midwifery community can use and respect as a source of high quality and engaging evidence to support improved practice, research, and policy.

There are three groups vital to the existence and success of an academic journal; readers, reviewers, and authors. In running AJAN we will be sure to support engagement from each, and hopefully, inspire you as individuals to be actively involved with the journal in all three capacities.

In this column we are focusing on writing for AJAN. The first thing to consider when writing for a journal is understanding the publication's mission and scope; what topics and material does the journal focus on? What types of papers are acceptable? With AJAN we remain broad and inclusive in our scope whilst offering a journal that is also aligned to, and supportive of, the goals and mission of the ANMF. Importantly, in line with the multidisciplinary nature of nursing and midwifery, and the wider context of healthcare, AJAN welcomes submissions addressing issues and topics facing midwifery, carers, and other professions beyond nursing and midwifery.

In terms of 'what sort of papers', we are again seeking to be inclusive. Any original primary and secondary research is welcomed, along with review articles, practice guidelines, and commentaries. We will also consider reports on evaluations, quality improvement and implementation projects and are also hoping to publish personal narratives or reflections that convey the art and spirit of nursing and midwifery. In any case, we will be focusing on quality and clarity of expression, and where relevant, alignment to appropriate standards for the conduct and reporting of research or reviews. We encourage submissions on topics that span clinical, professional,

policy, economic, social, ethical, managerial, methodological, and political issues and welcome ideas that involve and impact upon nursing and midwifery practice, health- maternity- and aged- care delivery. Further, if you have an idea for a paper but are not sure if it is within scope, please don't hesitate to write to the journal, explain your idea and why you think it might be of interest. We are happy to offer guidance where we can.

Once you are confident that you have an idea for a paper, or a manuscript ready for submission, it's tempting to simply say "follow the author guidelines". In a way, it is almost that simple; not following a journal's instructions for authors seems to be the most frequent thing an editor will quote when discussing the reasons why a paper may be rejected. By familiarising yourself with what AJAN requires in terms of your submission (eg. headings, layout, formatting, and referencing style) one common hurdle to publication is easily jumped.

To further support authors and reviewers in getting involved, the team at AJAN will be working hard over the next few months to develop a suite of submission and editorial resources. We aim to provide clear templates for laying out a paper for submission, comprehensive referencing style guides, and tools for assessing the quality of reporting in different kinds of papers.

Our main hope is that you will become a regular reader of AJAN. We would also like you to come with us on this journey to build AJAN as an authority. We invite you to think about the work you are involved with and how your knowledge and perspective might be something that is valuable to communicate to and beyond the ANMF's growing membership. As Professor Emerita Jill White AM suggested in her guest editorial for our first issue of the year; 2020 will be a time for celebration and a time for the spotlight to be on the professions of nursing and midwifery – let's show the world what nursing and midwifery offers, the evidence base for our claims, and the priorities we have for health, aged, maternity, disability, and social care.

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FOCUS

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Facilitating a good death in residential aged care settings, with support from community palliative care

By Margaret O'Connor and Marian Allison

Sally, a long-term resident had advanced dementia and was slowly deteriorating; she was bed-bound, eating little and unable to communicate. After several admissions to hospital for aspiration pneumonia, the hospital suggested no further treatment, as she was approaching the end of her life. Staff were unsure how best to assist Sally's comfort at this stage of her life.

This not uncommon scenario is frequently encountered by residential aged care (RAC) staff who often worry about how to care for a dying person (Tan et al. 2013).

Community palliative care services offer multi-disciplinary end-of-life care for people in their own homes (including aged care, as the person's final home).

Responding to calls for assistance, Melbourne City Mission Palliative Care (MCMPC) is trialling support for people living in RAC settings, with a Clinical Nurse Consultant (CNC) a link between aged care and palliative care.

Following referral, the CNC assessed Sally. Together with staff, she met with Sally's daughter and discussed her mother's poor prognosis and the futility of further treatment; but the daughter worried that staff would not be able to manage her mother's care.

The CNC developed a six-step framework to respond to calls:

1. **Responding:** since most information was readily available in the RAC home, a simplified referral meant the CNC visited within 24-48 hours. The CNC reiterated that any change in the resident's condition (needing to call the general practitioner (GP) or send the resident to hospital), meant a changed status, which ought to raise a question of involvement of palliative care (Lee et al. 2013).
2. **Visiting the RAC:** a bedside nursing assessment, always including staff in activities and conversations, used case-based teaching and role-modelling, with the CNC responding to uncertainties. Training in end-of-life care develops skills but may be confronting to a carer's beliefs and values (Phillips et al. 2011).
3. **Developing an agreed care plan:** together the CNC and staff developed a care plan, containing aspects like approaches to symptom management; communication with relatives; and anticipating prescription requests.
4. **Access to medications:** is a significant problem and anticipating medication need includes those for pain, anxiety, nausea and respiratory

secretions; although specific drugs may vary (O'Connor & Gatens 2014). The CNC encouraged staff to be proactive with the GP when requesting medications.

Staff sought a review of Sally's care on the GP's next visit and with the CNC's encouragement and guidance, requested a medication review and all unnecessary medications were ceased. They also requested prescriptions, in case Sally experienced pain or agitation.

5. **Liase with management:** the CNC endeavoured to meet the nurse-in-charge and/or manager, to explain their role, and ensure support for staff with aspects like symptom management, education, or family meetings.
6. **Involve family:** the CNC noticed that staff seemed uncomfortable discussing death and dying, employing distracting tactics like keeping cheerful. For staff, 'dying well' meant emphasising comfort and dignity and keeping the person as happy and comfortable as possible, with their family involved (Casey et al. 2011). Awareness of, and preparation for death may reduce family burden and guide decisions (Fried 2009).

The CNC and staff talked to Sally's daughter about the goals of palliative care, particularly in keeping Sally pain free. Seeing staff involved in the conversation was a way to engender the daughter's confidence. Sally deteriorated further over the next few weeks and died comfortably, with the CNC visiting once more to support staff.

This project demonstrates the importance of contributing knowledge into RACs. The shared understanding and mutual responsibility for improving end-of-life care, is beneficial in linking staff concerns with learning from practice (Manley et al. 2016).

*MCMPC (mcm.org.au/palliative-care) accepts referrals from RAC services in the Melbourne local government areas of Darebin, Hume, Moreland and Yarra.

Authors

Margaret O'Connor, Emeritus Professor of Nursing, Monash University & Research Consultant, Melbourne City Mission Palliative Care

Marian Allison, Aged Care Clinical Nurse Consultant, Melbourne City Mission Palliative Care

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How do general practice nurses perceive and communicate lifestyle risk discussions?

By Sharon James, Elizabeth Halcomb, Susan McInnes and Jane Desborough

A growing demand in primary care necessitates a shift towards preventative initiatives (Swerissen et al. 2018), such as communicating lifestyle risk reduction.

General practice nurses (GPNs) have a key role in health promotion and managing chronic disease in the community (Australian Primary Healthcare Nurses Association 2017), and supporting people to reduce risks from obesity, overweight, tobacco and dietary intake could prevent 38% of the total chronic disease burden (Australian Institute of Health and Welfare 2019).

However, little is known about GPNs' views about discussing lifestyle risk or how lifestyle risks such as smoking, nutritional, alcohol intake and physical activity are discussed with consumers.

Under the supervision of Professor Liz Halcomb, Dr Jane Desborough and Dr Susan McInnes, Sharon James is undertaking a doctoral research project about this issue. Fifteen GPNs and 40 consumers from south-east New South Wales and Canberra participated in the project.

The thesis reporting from this project will be submitted this year.

The project explored how lifestyle risk was communicated between GPNs and consumers by video-recording chronic disease management (CDM) consultations and interviewing GPNs about their perceptions of communicating lifestyle risk. Video recordings were used to understand nonverbal and verbal communication occurring between GPNs and consumers (James et al. 2019). Semi-structured interviews explored GPNs' interactional strategies as well as the barriers and facilitators to lifestyle risk communication with consumers.

To date, promising results relate to GPNs' person-centred strategies to engage consumers about lifestyle risk reduction including rapport building, ongoing relationships, and nonverbal techniques such as gesturing and eye contact (James et al. 2020). Additionally, where autonomous roles, organisational support and consumer prioritisation of risk reduction strategies were implemented, this supported GPNs to engage in lifestyle risk discussions. However, issues such as workplace priorities, funding, factors limiting GPNs' access to ongoing professional development, and consumers' awareness of GPNs' role in lifestyle risk communication need to be addressed.

The research team thank the GPNs, consumers and practices who participated in the study.

Authors

Sharon James (PhD Candidate) is in the School of Nursing, University of Wollongong

Professor Elizabeth Halcomb (Professor of Primary Healthcare Nursing), is at the School of Nursing, University of Wollongong

Dr Susan McInnes (Lecturer), is at the School of Nursing, University of Wollongong

Dr Jane Desborough (Senior Research Fellow), is at the Department of Health Services Research and Policy, Australian National University

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Primary healthcare has a central role in addressing global sustainable goals

By Fiona McDermid, Ana Smith and Kathleen Dixon

The Sustainable Development Solutions Network (SDSN) (2019) states that universities play a vital role in addressing global challenges and achieving the Sustainable Development Goals (SDSN 2019).

It is also well recognised that primary healthcare has a central role to play in achieving these goals (Pettigrew et al. 2015).

With an ageing population and the associated burden of disease, the Report of the *Independent Review of Nursing Education* (Schwartz 2019) emphasises the need for primary healthcare and recommends that nurses must be prepared academically and clinically to enter the workforce in a range of practice environments and provide socially appropriate, universally accessible and scientifically sound healthcare. Primary healthcare is a social model of healthcare focused on the social determinants of health. Nurses and midwives play a vital role in promoting and practicing primary healthcare in Australia through partnerships with multidisciplinary teams and local communities to prevent illness and promote health across the lifespan working in a range of clinical and nonclinical roles, in urban, rural and remote settings (APNA 2019).

Despite this need for a shift in the focus of health service provision the education of undergraduate nursing and midwifery students has historically concentrated on an acute care model in the hospital setting with an emphasis on disease processes rather than primary healthcare.

Western Sydney University is committed to the Sustainable Development Goals and has acknowledged the responsibility 'through their teaching to equip the next generation of leaders, innovators and thinkers to understand the global challenges facing the world and the role they can play in rising to meet these challenges' (SDSN 2019). The School of Nursing and Midwifery at Western Sydney University meets this challenge through its commitment to promoting an understanding amongst students and graduates that health and wellbeing is influenced by the social determinants of health and that the provision of healthcare is shaped by social, environmental, political and economic factors at both the national and

global levels (Talbot & Verrinder 2017, pp 4-7).

The School has a long history of promoting an understanding of the importance and significance of primary healthcare action as a means by which to achieve a sustainable healthcare system capable of decreasing health inequities and improving the health of all citizens (World Health Organization 1978, p 1).

The first Bachelor of Nursing course offered by the University of Western Sydney (Hawkesbury) in 1992 adopted a primary healthcare model that advocated action by governments that would enable a more humane and just healthcare system.

The School's commitment was to move away from the disease oriented medical model of health to one where nurses acknowledged that people's health and wellness is overwhelmingly created because of the circumstances of their lives.

These circumstances are shaped by 'individual, social and environmental determinants of health' (Bircher & Kurvillia 2014, p 363).

It was noted then that 'Primary healthcare must be seen by nurses and educators in nursing as not only the profession's greatest challenge but also its direction for the future' (Vardenaga & Dixon 1992).

This concept continues to underpin the nursing and midwifery curriculum and is threaded throughout our nursing and midwifery courses from undergraduate to postgraduate programs.

The overarching aim of educating students on these essential concepts, is to create an understanding of healthcare beyond the hospital setting. Students explore the health of Indigenous Australians and develop an understanding of healthcare systems in developing and developed countries. There is significant Aboriginal and Torres Strait Islander people's content in one discrete unit of the course with an emphasis on the history, culture, social and economic conditions for Aboriginal and Torres Strait Islander peoples in addition to the integration of Aboriginal and Torres Strait Islander health issues and outcomes into all units of this course, across the full three year program.

The School of Nursing and Midwifery introduces primary healthcare principles in the first semester of the nursing program and utilises innovative, interactive and digitally enabled strategies to educate on health promotion, illness prevention, the interconnecting principles of equity, access, empowerment, self-determination and inter-sectoral collaboration. Primary healthcare curriculum strategies promote an understanding of the WHO Director General's proposition (2017 cited in Lin & Kickbush eds. 2017) that the Sustainable Development goals provide

a rare opportunity to use intersectoral collaboration as a 'health beyond the health sector' approach to responding to 'social, economic and political determinants of health'. This is a 'flagship initiative' that provides future nurses with an insight into best practice to improve population health and health equity.

Given that 193 countries are committed to the UN Sustainable Development Goals and that this is considered a blueprint for achieving a better and more sustainable future for all, nursing's contribution to these goals through primary healthcare is vital. Yet the likelihood that these goals will be met by 2030 is remote (Editorial 2020), highlighting the importance of nurses taking up the challenge.

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Authors

Dr Fiona McDermid PhD, RN, RM.
GradCert Emergency, GradDip Mid is from Western Sydney University

Ms Ana Smith, MA (Education and Work), BA,
RN is from Western Sydney University

Dr Kathleen Dixon PhD, MHA, BA, Grad Cert CFH,
RN is from Western Sydney University



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Karen Booth

Primary healthcare nursing: Where great nurses go to do more

By Karen Booth

Primary healthcare nurses working to their full scope of practice can improve the health of Australians.

Australia's health system is facing burgeoning healthcare costs, shifts in the burden of disease, and a growing and ageing population. APNA has long purported Health Workforce Australia's projections of a nursing workforce shortfall of 85,000 nurses by 2025, and 123,000 nurses by 2030. This means we need to be smarter about how we deploy the nurseforce we have.

To sustainably manage Australia's health, a strong preventative health focus is required. Primary health care nurses are positioned and primed to play a fundamental role in addressing the current and future health needs of Australians.

However, they often find their roles are limited by funding models that restrict or do not recognise nursing input, and limited understanding among other healthcare professionals, patients and policy-makers about their true capacity and professional scope.

Many primary healthcare nurses report that their education, training and qualifications are not used to the full extent in their current role. Around 27% of nurses responding to APNA's Workforce Survey felt they could do more and 12% indicated that most of the time, they don't get to use their knowledge and skills to the full extent, with 47.5% of nurses reporting that they had suggested to their employer or manager they could better use their skill set to undertake more complex clinical activities or extend their role in the workplace within their scope (Australian Primary Health Care Nurses Association, 2019).

That means the skills of nearly half of the nursing workforce in primary healthcare are being under utilised.

Primary healthcare nurses have a long history of practical engagement in community-based care. Nurses are the largest health workforce in Australia, and a significant and growing part of the primary healthcare workforce providing preventive health interventions, chronic disease management and coordination, management of long term conditions, screening and vaccination, general care for the sick, and care for our older population – true cradle to grave healthcare.

This community-based, practical, patient-centred care is exactly what primary care should be. It is what we know keeps people well and out of hospital.

So why isn't there more recognition of this area of healthcare?

The primary healthcare nursing role is broad. It is also invisible and poorly understood. Perceptions and attitudes by other health professionals and employers about the role of primary healthcare nurses limit the ability of nurses to work to their full scope of practice.

The scope and functions of primary healthcare nursing have evolved and expanded, and it's time that the industry caught up.

Nurses working in primary healthcare are clinicians, they are scientists, they are care coordinators.

Did you also know that they are digital marketers, business managers, teachers, public health campaigners, and mentors?

They are quality improvers, data analysts, risk managers, supervisors, strategists, health coaches, researchers, counsellors, evaluators, patient advocates, and agents of connectivity (Phillips et al. 2008).

With an impending nurse shortage and the average age of a primary healthcare nurse being 49 years, Australia can no longer wait for nurses to enter primary healthcare mid-career.

We need to attract new nurses into primary healthcare, and increasing the profile of primary healthcare nursing is essential to attract new nurses and retain the current workforce.

A greater understanding and support for the full breadth of the primary healthcare nurse role by all members of the healthcare team is essential to enhance effective team-based and person-centred care.

When primary healthcare nurses are more visible, and enabled to work to their full scope to enhance the health system and improve population health outcomes, then we're on our way to a healthy healthcare system and a healthy Australia.

So together let's make some noise, support your peers in primary healthcare, and get behind them to unleash the power of the primary healthcare nurse workforce.

Author

Karen Booth, RN, A&E Cert, BHScN, GAICD is President of the Australian Primary Health Care Nurses Association (APNA) and a veteran of primary healthcare reform.

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Meeting the needs of marginalised children: An innovative Nurse Practitioner led health care model at Uniting Care Wesley Bowden

By Yvonne Parry, Eileen Willis, Sally Kendall, Rhonda Marriott, Nina Sivertsen and Alicia Bell

The Department of Health, Action Plan for Children and Young People states 22% of all Australian children live in housing instability (Australian Government 2019).

Australian research states one in six children or 1.1 million children live in disadvantage or are marginalised (Davidson et al. 2018; Long et al. 2018; Sandstrom & Heurta 2013). Marginalised children are exposed to health inequities that result from socio-economic status, low SES communities, housing instability, lower parental education levels, and limited access to developmental supports and resources (American Academy of Pediatrics 2013; Pennsylvania 2014; Australian Government 2019).

Children experiencing multiple health determinants have increased levels of health inequity (American Academy of Pediatrics 2013; Parry et al. 2016; Parry, Ullah et al. 2016).

Collaborative research with the homelessness sector identified that current health service delivery models do not meet the needs of children living in housing instability (Department of Health 2018; Lau et al. 2016; Parry et al. 2016; Parry, Ullah et al. 2016; Rutter et al. 2017).

Children living in housing instability have poorer access to health services and appointment compliance, increased Emergency Department (ED) utilisation, and overall poorer mental and physical health outcomes (American Academy of Pediatrics 2013; Davidson et al. 2018; Goldfield et al. 2017; Pungello et al. 2010; Strong Foundations Collaboration 2019).

NURSE PRACTITIONERS

Nurse Practitioners (NP) are ideally situated to deliver cost effective and innovative models of healthcare (Adams & Schofield 2009; Jennings et al. 2015; Martin-Misner et al. 2015; QGH 2017; Woo et al. 2017;). All NPs can provide models of care using combinations of nursing care, diagnostic activities and intervention-based

treatments, including the use of medicines (Adams & Schofield 2009; Jennings et al. 2015; Martin-Misner et al. 2015; QGH 2017; Woo et al. 2017.)

A nurse practitioner program has been introduced by Uniting Care Wesley Bowden in collaboration with Flinders University College of Nursing and Health Sciences to provide for children living in housing instability. The program will result in:

- Increased acuity of care to meet complex health and social needs.
- Holistic, advanced and comprehensive assessments.
- Extended collaborative care services eg. longer support and consultation/ treatment times.
- Supported interdisciplinary referrals addressing the multimodal interventions required by children

This structured, community embedded, intervention by a paediatric ED nurse practitioner (NP) with the skills to provide an advanced paediatric full health assessment of the children aged 0-18 living in housing instability provides linkages to early intervention mental and physical health services. The NP supports the family to improve the uptake of referrals to medical, allied health and mental health services to improve health and wellbeing outcomes for children. The NP support

parents to navigate and participate with various interdisciplinary services (figure 1) required by children.

Expanding the use of NPs to meet the community and marginalised populations needs is an example of practical ways in which nurses operate to their full scope of practice.

Authors

Dr Yvonne K Parry, PhD, MHSM, GradCertEdu, BA, RN is a Senior Lecturer at the College of Nursing and Health Sciences, Flinders University.

Emeritus Professor Eileen Willis, PhD, M.Ed, BEd. is at the College of Nursing and Health Sciences, Flinders University.

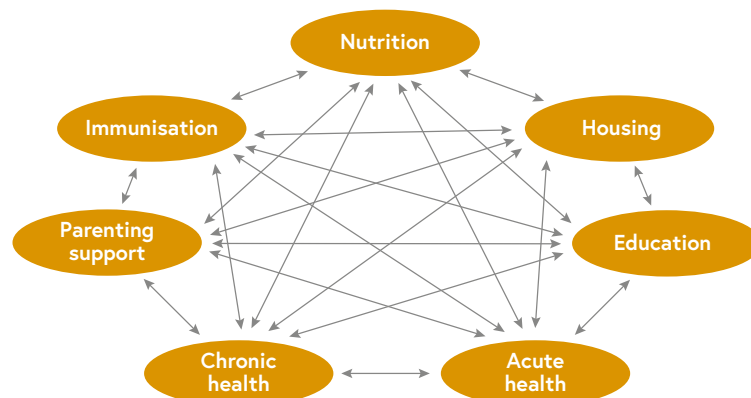
Professor Sally Kendall, MBE, PhD, RN, RHV, MFPH is at the Centre for Health Service Studies, University of Kent UK, Professor of Community Nursing and Public Health, and Chair of the European Primary Care Forum, Adjunct Professor Murdoch University, Ngangk Yira Centre for Aboriginal Research.

Professor Rhonda Marriott, PhD, Dip Psych Nsg WAMHS, BSc Nsg Curtin, PG Dip Mid Curtin, MSC Nsg Curtin, Registered Nurse, Midwife, Professor, is Pro Vice Chancellor Aboriginal and Torres Strait Islander Leadership, and Inaugural Director of Ngangk Yira (Sun Rising) Research Centre.

Dr Nina Sivertsen, Arctic Indigenous Sámi woman from Northern Norway, RN, BNsg (Hons First Class), Grad Cert Ed (Higher Ed), PhD is a Lecturer at the College of Nursing and Health Sciences, Flinders University,

Alicia Bell, BN, GradDip Emer Nursing, MNP is a Nurse Practitioner at the Uniting Care Wesley Bowden, Inner Southern Homelessness Service.

FIGURE 1: REFERRAL NETWORKS AND NEEDS FOR CHILDREN



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Addressing the experience of moral distress in community health nursing

By Diana Guzys, Kathleen Tori and Carey Mather

Moral distress, a phenomenon increasingly identified in nursing practice (Rushton 2017), results when the integrity of professional identity and internalised values are disrupted due to constraints placed on professional practice (Morley 2019; McCarthy 2015).

Perceived inability to act in accordance with best practice has been proposed as a contributing factor in the experience of moral distress (Whitehead 2015). Moral distress is linked to burnout, high staff turnover and professional attrition (Rushton 2016; McCarthy 2015).

Much of the focus in nursing literature relates to the experience of moral distress and high acuity care roles, however moral distress similarly occurs in community health nursing, due to organisational and practice constraints restricting the delivery of optimal healthcare.

Targeted funding and other efficiency strategies such as service rationing constrain healthcare practice, undermining professional values and identity (Austin 2012; Musto 2012). Nurses must recognise and act to address the influence of systemic constraints on professional practice and agency.

Despite having a professional and ethical responsibility to challenge less than ideal practices, traditionally nurses have not been explicitly educated to use skills to influence and improve the practice environment.

Contemporary nurses must be confident to appropriately address issues of concern for themselves, colleagues and on behalf of patients or clients.

Genuine understanding of nursing ethics and ethical responsibilities of the profession, adopting an attitude of leadership in nursing, as well as skills in critical reasoning, critical reflection and recognising the socio-political embeddedness of health and healthcare are required.

Due to its mandate for population health political advocacy is particularly relevant to community health nursing practice (Spenceley 2006). Community nurses become more politically competent through critical examination of health policy and participation in professional bodies.

Confidence to appropriately act to create change in the practice environment empowers moral resiliency. Factors contributing to moral distress in community health nursing need to be addressed to reduce the negative consequences of experiencing ongoing moral distress and prevent attrition from the nursing workforce.

Authors

Diana Guzys is a lecturer in Nursing at the University of Tasmania.

Dr Kathleen Tori NP is the Associate Professor/Associate Head, Learning and Teaching for the School of Nursing, University of Tasmania

Dr Carey Mather is a senior lecturer in Nursing and is Fellow of the Higher Education Academy.

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Nursing Issues: Improving women's health in regional areas is vital

Wendy Abigail, Nina Sivertsen, Christine McCloud,
Maree Eastman and Helen Tonkin

Women's health services play a vital role in addressing the healthcare needs of women in both metropolitan and rural and regional areas. However, rural and regional women have been shown to have the poorest health outcomes of all women groups (AIHW 2019).

There are approximately 110,000 females aged over 10 years residing in the rural and regional Local Government Area (LGA) Networks in New South Wales.

According to NSW Women's Health Framework (2019) women in rural and remote areas of Australia face inadequate, inaccessible and poorer women's healthcare than urban women.

This Flinders University research project, run in partnership with a Local Health District in NSW, is focusing on exploring what is needed to improve women's health services in regional NSW.

The National Women's Health Strategy 2020-2030 listed maternal, sexual and reproductive healthcare, healthy ageing, chronic conditions and preventative health, mental health and health impacts of violence against women and girls as the top five key priority areas for women in Australia (Australian Government Department of Health 2018).

The strategic goals consider the social determinants of health, prioritises those at highest risk of poor health and aims to be responsive to all women through a life course approach (Australian Government Department of Health 2018).

Women's healthcare encompasses a broad range of issues. These include (but are not limited to) menstrual issues, contraception, screenings (eg. sexually transmitted infections, breast examination, cervical, pregnancy), sexual and reproductive health, family violence, mental health, continence, menopause and relationship and lifestyle counselling.

Services are provided to women from the age of ten years and include vulnerable and disadvantaged groups such as culturally and linguistically diverse (CALD) women, lesbian, gay, bi-sexual, transgender, intersex and queer (LGBTIQ) women, Aboriginal and Torres Strait Islander women, women living in isolated areas and homeless women.

Aiming to identify women's experiences of using specific women's health services in rural and regional areas of New South Wales (NSW), the research project is being conducted by Flinders University researchers in conjunction with NSW women's health nurses. The project is co-funded by the Australian



Women's Health Nurse Association and the Northern NSW Local Health District including the Clarence, Richmond and Tweed/Byron Networks of Clarence, Richmond and Tweed/Byron.

The project aims to identify and describe women's experiences of using rural and regional health services.

The purpose of the research is to contribute rigorous evidence to support service provision and guide policy and program development in NSW as well as other rural and regional areas across Australia with similar population groups.

Early findings of the research suggest that women attending women's healthcare services appreciate women-centred care that is sensitive to women's needs and has a gender specific focus. However, the participants describe many barriers to receiving the care in the rural and regional areas including access issues such as location of services, service availability, travel distances, costs, Indigenous care issues, and lack of promotion of services.

Further findings of this project will identify where gaps in healthcare provision exist and where improvements in care can be made. Additionally, the findings may be a valuable resource to inform future research and health policy. Quality evidence based information is vital for policy decision-making in Australia (Banks 2009). Evidence supported practice and policy is a clear commitment of the Australian government to the Primary Health Networks where the focus of healthcare provision includes understanding of local community needs, using the best available research evidence (The Department of Health 2014). Full project findings are estimated to be available by mid-year of 2020.

AUTHORS

Dr Wendy Abigail, PhD, RN, BN (Hons First Class), GCH (Diabetes Ed & Management), Grad Cert Ed (Higher Ed), Family Planning Cert, is a Senior Lecturer at Flinders University

Dr Nina Sivertsen, PhD, RN, BNg (Hons First Class), Grad Cert Ed (Higher Ed), is a Lecturer at Flinders University

Dr Christine McCloud PhD, RN, Tutor is a Research Assistant at Flinders University

Maree Eastman, RN, Grad Cert Women's Health/Family Planning, is a Clinical Nurse Consultant Women's Health Grade 2

Helen Tonkin, RN, Grad Cert Women's Health/Family Planning is a Clinical Nurse Consultant Women's Health Grade 2

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Maternal depression on the rise in poor countries

Women in low and medium-income countries struggle with many health issues in pregnancy and childbirth, but little attention is given to antenatal depression, which is on the rise in many developing countries, a new PLOS ONE paper shows.

A study by Flinders University public health researchers found rising levels of reported antenatal depression in these countries, and recommends more services are urgently needed – particularly in low-income economies.

“Depression during pregnancy is often believed to be an issue of developed countries,” said biostatistician Abel Fekadu Dadi, who led the systematic review and analysis of antenatal depression levels in low and middle-income countries.

“From the study, we found 34 and 22.7% of pregnant women in low and middle-income countries respectively had depressive symptoms during pregnancy,” said Mr Dadi, who is also affiliated with the Institute of Public Health at the University of Gondar, Ethiopia.

“Moreover, compared to non-depressed pregnant women, depressed women had respective rates of 2.41 times and 66% higher risk of preterm birth and low birth weight.

“We found that antenatal depression is highly prevalent and increases over the duration of pregnancy. We also noted increases in prevalence over the last 10 years.”

Antenatal depression has detrimental effects on the physical, psychological, mental, and overall wellbeing of mothers and newborn babies, he said, stressing more must be done to raise awareness with health practitioners and policy-makers in developing economies.

“It is vital for these governments to address women’s mental health issues before and during pregnancy to improve health outcomes for both mothers and babies, and contribute to socio-economic development and Sustainable Development Goals,”

says co-author Associate Professor Lillian Mwanri, from the Flinders College of Medicine and Public Health.

Key findings include:

- One in three (34%) and one in five (22.7%) of pregnant women in low-and middle-income countries, respectively had depression.
- Having depression during pregnancy increased the risk of low birth weight and preterm births. Severe depression is known to directly lead to suicide in women during pregnancy or after birth – and to neonatal, infant and child mortality.
- A poor obstetric history, previous episodes of common mental disorders, poor social support, financial difficulties, a history of exposure to violence (during pregnancy or earlier), and unsatisfactory relationships were factors that increased chances of depression.
- Low-cost interventions such as psychotherapy services at maternity clinics – and relationship and partner support advice – are among the social and health system interventions badly needed in these countries.



The cost of caring in midwifery

By Alicia Carey and Evan Plowman

A midwife is a skilled practitioner who has successfully completed an educational program based on the essential competencies and framework of global standards for midwifery education (International Confederation of Midwives, 2019).

A midwife works in partnership with a woman and her family and support networks to provide advice, care and support during pregnancy, labour and the postpartum period (International Confederation of Midwives, 2019).

It is common for midwives to rapidly build strong, therapeutic relationships with women and their families as they work with families in a significant event in their lives.

The additional empathy that healthcare professionals working in specialty areas demand increases the incidence of compassion and fatigue burnout, placing midwives at a high risk of experiencing secondary traumatic stress (Leinweber and Rowe, 2010). Due to the nature of the profession, midwives often forgo breaks, work double shifts and work extra hours which are often unpaid (Davies, 2016).

In caring professions this is common practice to sacrifice meeting their own needs to provide safe, quality care due to an emotional connection that may have developed over the care period (Leinweber and Rowe, 2016). Over time, this can lead to increased stress levels and burnout, which in turn leads to midwives leaving the profession.

Secondary traumatic stress is a known occupational hazard for professionals who work in healthcare; midwives may develop symptoms of post-traumatic stress disorder (PTSD) after caring for patients who experience trauma (Beck, LoGiudice and Gable, 2015).

Midwives are particularly vulnerable due to the nature of the work and the close bond that is formed by emotional reactions during pregnancy, birth and postpartum. Risk factors for midwives developing traumatic stress include: long shifts with inadequate breaks, a lack of control organising off-duty time, redeployment being moved to other clinical areas with little notice by managers to backfill staff, and anxiety about making mistakes (Davies, 2016).

Burnout in midwifery has also been linked to insufficient financial and human resources, a lack of professional recognition and professional development, and inadequate support from managers (Davies, 2016).

Currently across Australia there are 294,390 practicing registered nurses, 26,438 registered nurse/registered midwives with dual registration and 5,243 registered



midwives who are currently practicing (Nursing and Midwifery Board of Australia, 2019). Staff shortages lead to healthcare professionals with different skill sets and backgrounds supplementing specialty midwifery areas. A midwife may be replaced with a registered nurse or enrolled nurse which can create more stress for the midwife (Francis and Mills, 2011).

This creates a vicious cycle where midwives leave the profession in greater number, further compounding the staffing shortage.

With maternity services in regional, rural and metropolitan areas being understaffed, it is vital that midwives and other health professionals working in maternity services are supported to ensure that safe care is provided. It is important that midwives are able to identify when they are feeling burnout and stressed by a situation, and seek help. It is also imperative that professional relationships are nurtured and supported; that all healthcare professionals look out for each other, and advocate for themselves and the teams in which they work.

We need to protect the art of midwifery to ensure that women and families receive healthcare that is safe and responsive, and to ensure that we can retain the skilled and dedicated midwives in our current workforce.

If you are experiencing stress or burnout related to your current or past practice, you may like to access Nurses and Midwives Support nmsupport.org.au/

Authors

Alicia Carey RN/RM- BoN, GradCertMentalHealth, Master of Science (Midwifery), PhD Candidate is a Lecturer in Nursing and Midwifery at Charles Sturt University, Wagga Wagga NSW.

Evan Plowman RN – BN / B ClinPrac(Para), MN, GradCertCritCare is a Lecturer in Nursing at Charles Sturt University, Wagga Wagga NSW.

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Genetic profile may predict type 2 diabetes risk among women with gestational diabetes

Women who go on to develop type 2 diabetes after having gestational, or pregnancy-related diabetes are more likely to have particular genetic profiles, suggests an analysis by researchers at the National Institute of Health and other institutions.

The findings provide insight into the genetic factors underlying the risk of type 2 diabetes and may inform strategies for reducing this risk among women who had gestational diabetes.

The study was conducted by Mengying Li, PhD of the Division of Intramural Population Health Research at NIH's Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), and colleagues.

"Our study suggests that a healthy diet may reduce risk among women who have had gestational diabetes and are genetically susceptible to type 2 diabetes," said the study's senior author Cuilin Zhang.

"However, larger studies are needed to validate these findings."



Gestational diabetes (high blood sugar that first occurs during pregnancy) increases the risk of complications for mothers and their infants.

In most cases, the condition resolves soon after the baby is born, but nearly half of women with gestational diabetes go on to develop type 2 diabetes later in life. Type 2 diabetes increases the risk of heart disease, kidney disease and other health problems. However, little research has been done on the genetic factors influencing a woman's risk for progressing to type 2 diabetes after gestational diabetes.

In the current study, researchers analysed data from 2,434 women with gestational diabetes who participated in the Diabetes & Women's Health Study.

The study followed women before, during and after pregnancy and captured data on their health later in life. Of the original group, 601 women with gestational diabetes went on to develop type 2 diabetes.

Previous research has linked variations in certain genes (called single nucleotide polymorphisms) to a higher risk of type 2 diabetes. In the current study, researchers checked genetic scans of the 2,434 women for the presence of 59 gene variants thought to be more common in people who have type 2 diabetes.

The researchers found that women who had the largest proportion of these gene variants were 19% more likely to develop type 2 diabetes, compared to those who had the lowest proportion of these variants.

The researchers also ranked the women's diets according to the proportion of healthy foods. Among women who adhered to a healthier diet, the risk associated with the gene variants was lower than that of the other women, but the differences between the two groups were not statistically significant.

The authors believe their study is among the largest to date that looks at genetic factors underlying development of type 2 diabetes among women with prior gestational diabetes. However, the number of women participating in the study may not be large enough to find a significant interaction between healthy diet and genetic susceptibility in relation to this risk, explained Dr Zhang.

The study was published in the *BMJ Open Diabetes Research & Care*.

Reference

Li, M, et al. Genetic factors and risk of type 2 diabetes among women with a history of gestational diabetes: findings from two independent populations. *BMJ Open Diabetes Research & Care*. 2020.



New research into suicide in pregnant women and new mums

Suicide is the leading cause of maternal death in Australia during pregnancy and the 12 months following birth, according to Perinatal Anxiety and Depression Australia.

Perinatal Anxiety and Depression Australia (PANDA) is taking part in a Suicide Prevention Australia research project to help build understanding of the factors contributing to suicide attempts in pregnant women and new mums.

"The research aims to develop effective ways to assess and manage suicidal risk in this vulnerable group," said PANDA CEO Julie Borninkhof.

Murdoch Children's Research Institute and James Cook University will collaborate with PANDA on the study. PANDA's key role in the research project will ensure that people who have experienced perinatal suicidality are meaningfully involved throughout the life of the project by contributing to the study design, data collection and analysis, and the communication of key findings.

Co-development and design has now begun on this important project that will no doubt provide significant insight into understanding, responding to and talking about suicide for expecting and new parents across Australia.

The research is being funded by the Australian government.

Pregnant women with very high blood pressure face greater heart disease risk

Women with preeclampsia are four times more likely to suffer a heart attack or cardiovascular death, according to a US study.

Approximately 2 to 8% of pregnant women worldwide are diagnosed with preeclampsia, a complication characterised by high blood pressure that usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal.

Doctors haven't identified a single cause, but it is thought to be related to insufficiently formed placental blood vessels. Preeclampsia is also the cause of 15% of premature births in the US.

The researchers at Rutgers University, New Jersey, analysed cardiovascular disease in 6,360 women, aged 18 to 54, who were pregnant for the first time and diagnosed with preeclampsia in New Jersey hospitals from 1999 to 2013 and compared them to pregnant women without preeclampsia.

They found that those with the condition were four times more likely to suffer a heart attack or cardiovascular death and more than two times more likely to die from other causes during the 15-year study period.



"Women who were diagnosed with preeclampsia tended also to have a history of chronic high blood pressure, gestational diabetes, kidney disease and other medical conditions," said lead author Mary Downes Gastrich.

Ms Gastrich said the study suggested that all women be screened for preeclampsia throughout their pregnancy and

that treatment be given to those with preeclampsia within five years after birth. "Medication such as low-dose aspirin also may be effective in bringing down blood pressure as early as the second trimester," she said.

The study was published in the *Journal of Women's Health*.



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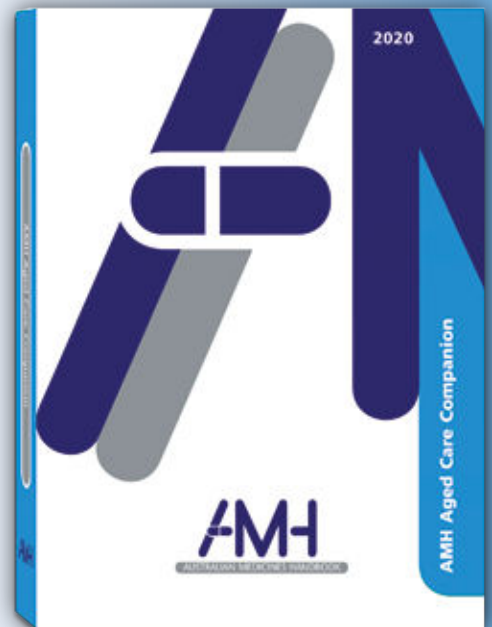
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