VOLUME 26, NO.11 JUL-SEP 2020

COVID-19

Face Shield

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AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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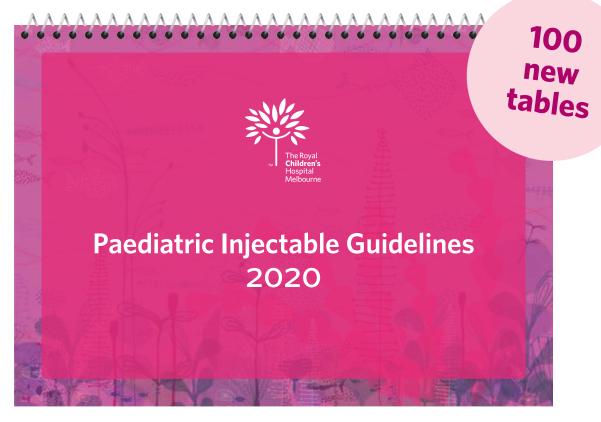
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EDITORIAL



What an extraordinary year International Year of the Nurse and Midwife has been so far.

Annie Butler ANMF Federal Secretary

As a nation that has dealt with catastrophic bushfires followed by the global COVID-19 pandemic, the valuable work nurses and midwives do has never received such prominence as it has right now.

The appreciation and recognition received is well justified in these unprecedented and trying times as nurses and midwives have demonstrated a level of compassion, professionalism and courage which seems exceptional but is actually the core feature of the professions.

When the pandemic hit Australian shores earlier this year, the nation swiftly implemented measures to mitigate the spread of the virus and build capacity within our health system. Throughout, nurses and midwives have been seen front and centre as frontline workers, instigators in developing new models of care and as valued collaborators with government, relevant professions and other significant organisations in order to protect the health of our community.

How nurses and midwives have supported the community at this time is featured in this issue of the journal. South Australian Nurse Practitioner Toni Slotnes-O'Brien, who was part of a virtual nurse practitioner-led diabetes clinic, is one example. Practice nurse Gabby Combe, also from regional South Australia, who initiated a drive-in flu immunisation program, is another.

There are many other inspiring stories in this issue such as from registered nurse Nicky Gabell from South Australia and ICU nurse Stephanie Lee from Tasmania, who cared for patients with COVID-19 on the frontline.

Fortunately for Australia the effects of the coronavirus pandemic have been significantly less than the devastating scenes we have seen across the Northern Hemisphere - attributable largely to the way Australians came together to contain the virus through restrictions, physical distancing and other measures.

Nevertheless the lives lost due to COVID-19 and the ongoing hardship many Australians continue to face will be devastating for some time yet.

But as restrictions ease there will be many lessons we can draw on to establish new ways of working and living that could better our society and healthcare as a whole.

To achieve this, nurses and midwives must be at decision making tables, develop healthcare policy, work to full scope of practice and be included in public and health policy debates. Without a doubt the inclusion of nurses and midwives to this extent would significantly guide future improvements for the benefit of our health system.

This is particularly true in aged care where, prior and during COVID-19 nurses, carers and residents have faced significant challenges such as unsafe staffing and unsatisfactory conditions.

Now more than ever it is crucial the government listens to nurses and carers and acts to instigate appropriate and mandated staffing and skills mix.

To this extent the ANMF was engaged in continuing discussions with the Aged Care Minister Richard Colbeck in the height of the pandemic and we will continue to participate in the Aged Care Royal Commission as it recommences proceedings. These issues need to be addressed and as a matter of urgency.

As I sign off, I want you to know that I could not be more proud to be a nurse right now and I could not be more proud of all nurses, midwives and carers and your work. I am extraordinarily privileged to be able to represent you. It's been a difficult time but I am deeply inspired by your efforts across all sectors. Your work gives so much support to the community and continues to improve our health and aged care systems and our society.

Annie

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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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LORI-ANNE



Lori-Anne Sharp ANMF Assistant Federal Secretary

Looking after your mental health during the COVID-19 pandemic

As a society we are experiencing one of the most challenging health, social, emotional and economic periods in our history.

Impacts of the COVID-19 pandemic on the community have been devastating with everything from the loss of loved ones, fear of contracting the virus, social dislocation, business closures and massive job losses. The emotional and psychological effects are likely to impact the wellbeing of many in our community and will be more heightened for health professionals as they respond to a range of difficult and challenging circumstances.

At the same time as workers around the country were making the shift to working from home and navigating back to back zoom meetings, nurses and midwives across the country were preparing themselves and the healthcare system to respond to a global pandemic.

As circumstances rapidly unfolded, we witnessed healthcare professionals swiftly coordinate the planning of a surge workforce, including the synchronisation of public health units to manage and expand contact tracing, thousands of nurses volunteering to up skill or retrain in acute and intensive care education, preparation and expansion of intensive care units and the establishment of widespread COVID-19 screening clinics.

Recently, I caught up with two friends and ex-nursing colleagues as they reflected on the initial weeks following the declaration of the COVID-19 pandemic. Both have been nursing for over 25 years and currently nurse in the areas of primary health and oncology. During our discussion common themes emerged as they both spoke of feeling expendable in the early days, as there was a division of workers who were able to work from the safety of their homes and those who couldn't.

They disclosed feelings of anxiety and fear, which were also common amongst many peers as work and

home pressures increased. Concern for patients and the potential fatal impacts of the virus on vulnerable patients weighed heavily. Fears of bringing the virus home and affecting family members was at times overwhelming when at the same time adapting to lifestyle changes including home schooling. Uncertainties regarding the adequate supply of personal protective equipment and the unfolding horrors of global images of the pandemic and effects on health professionals was alarming and contributed to the fear. Fortunately Australia is in a considerably improved state of affairs now but all of these valid concerns played heavily on mental health wellbeing in the early days of the pandemic response.

To date Australia has been extremely successful in the management of the COVID-19 and flattening the curve. As we continue to navigate through these strange times during the coming months and seek to avoid a second wave of COVID-19 infections, we must also remember not to neglect our mental wellbeing and seek help when needed.

With very little warning nurses and midwives on the frontline have been vital in the preparedness of responding to this global pandemic. We should not underestimate the toll COVID-19 has had on mental health. Whilst feelings of fear, anxiety, grief and loss are normal during these times as we adapt to the many changes in our life, it is important to seek extra help when needed. It is crucial that we support each other and reach out to those peers who may be struggling and in need of help.

If you or your colleagues need support now or in the future I have included some valuable support networks for you to consider below.

NURSE AND MIDWIFE HEALTH PROGRAM VICTORIA (NMHPV) is a free, independent and confidential support service for Victorian nurses, midwives and students of nursing and midwifery experiencing health issues related to their mental health. Ph: (03) 9415 7551 (BH) or email: admin@nmhp.org.au

NURSE & MIDWIFE SUPPORT: Available 24/7 nationwide on 1800 667 877 or nmsupport.org.au

BEYOND BLUE'S CORONAVIRUS MENTAL WELLBEING SUPPORT SERVICE: 1800 512 348

BLACK DOG INSTITUTE'S specific online, 24-hour-available e-health hub: blackdoginstitute.org.au/ten/



Kristen Wischer Senior Federal Industrial Officer

Think before you send: Professional conduct and online communication

Health practitioners, nurses and midwives are bound by a code of conduct and professional standards. In addition, many workplaces will have policies setting out the standard of behaviour expected with regard to electronic communication with colleagues, patients, clients and residents as well as their families and representatives.

During the period of lockdown, we have all relied on electronic communication- both to work and to stay in touch with friends and family. It's been a great tool and we'll all come out of this with new found digital skills.

However it is also timely to remember that the boundary between your professional life and your personal one can sometimes be blurred and when devices are our main means of communicating, the risks of stepping over the professional line are greater than ever.

Two recent disciplinary board hearings involving health practitioners illustrate the risks.

In the first ', a nurse in charge at an inpatient treatment unit was found guilty of unsatisfactory professional conduct because his judgement and care exercised in the practice of nursing fell significantly below the standard expected.

While on duty, the nurse used his phone to send his partner a sexually explicit picture. He left his phone at the nurses' station desk with the image still displayed. Patient A, who was admitted for drug and alcohol detoxification saw the photo and asked the nurse to send him the photo and also sought personal contact with the nurse. The nurse sent Patient A the photo. He did not report the incident and later said he felt pressured and scared. He resigned before the matter was heard.

At the hearing, the nurse's conduct was found to be unprofessional because he ought not to have been viewing and sending material of a sexual nature at work, ought not to have left his phone available and should not have sent the photo to the patient. His failure to report the incident was a failure to respond appropriately. The Tribunal determined to suspend the nurse's registration for two years.

The second case ², concerned a medical practitioner working as a doctor in a public hospital. The doctor was well regarded in his practice and by his colleagues and had no complaints about his practice. The doctor posted highly inflammatory sexist and racist comments in online chat forums that were based overseas. It was clear from the posts that the doctor was an Australian medical practitioner.

The doctor admitted to his posts being inappropriate

and that he was not sufficiently aware of the Code of Conduct or workplace policies in relation to online communication. He stated that he did not believe his overseas posts would impact his practice.

The Medical Board observed that although the posts were not made in connection to his practice and were made after hours, they nevertheless did impact his practice. The Board held that the posts were 'expressions inconsistent with the good repute of medical practitioners and the relationship of trust between medical practitioners and patients, who are of course, members of the public'. The Board suspended the doctor for six weeks.

These cases illustrate that personal communication can be the basis of a finding of professional misconduct even where the origins of the communication are private and not made in connection with the health professional's practice. While the conduct in these cases is clearly inappropriate, it is not difficult to see how professional boundaries can be blurred particularly when we are working at home. Risks might include:

- Using work devices and servers for personal communication which means your employer can access this communication;
- Leaving confidential patient/client information open where other members of your household may be able to view the material;
- Having shared family passwords that may give access to confidential and private work information;
- Communicating with patients online may make the usual professional boundaries provided by working in an office, consulting room or ward with colleagues harder to maintain. The ability to draw the line between professional and personal communication can be a lot more difficult in an online setting.

Online communication has never been more important for us to stay connected professionally and personally but it is vital to keep the two distinct. It is important to remember to be aware of both where and how you communicate, regardless of the location of your office and the forum of communication. The obligation to observe professional boundaries and standards remains the same.

1 Health Care Complaints Commission v Keegan [2018]NSWCATOD3

2 National Board of Australia v Christopher Kwan Chen Lee [2019]TASHPT3



'It's surreal': Nursing during the COVID-19 pandemic

Dealing with COVID-19 has highlighted the bravery, compassion and professionalism of many nurses working on the frontline. Earlier this year, in the height of the pandemic, intensive care nurse Stephanie Lee shared her insights about caring for patients during the pandemic. Robert Fedele reports.

"Entering my patient's room was something I'd done many times before but this time it felt slightly surreal," says intensive care nurse Stephanie Lee of treating her first COVID-19 case on Good Friday.

"I walked in and introduced myself to my patient. After that, it felt like any other shift. My job was to care for my patient and try and make them feel more at ease in their time of need." Stephanie works in the Intensive Care Unit (ICU) at Tasmania's Launceston General Hospital (LGH).

The global COVID-19 pandemic has penetrated Australia's states and territories to different degrees. At the time of writing, Tasmania had more than 225 cases.

"It's surreal because you are watching it unfold in other countries, and thinking 'Wow'. And not just in third-world countries, it's [overwhelmingly] developed countries with great healthcare systems [too]."

Stephanie admits feeling a little unnerved when she arrived on shift and was told she would be caring for a confirmed COVID-19 case, the first escalated to the hospital's ICU.

She headed back to the change rooms and prepared to put on personal protective equipment (PPE) by removing her makeup, as it stains goggles and prevents a solid seal. The full PPE kit comprises hospital scrubs, a yellow gown, a white apron, two pairs of gloves, an N95 mask, goggles, a hairnet and rubber boots with shoe covers.

"Although I went about receiving handover for my patient as normal, there was a feeling of preparedness from all the staff around me," Stephanie recalls.

"I would be working inside the negative pressure room with the patient and one of my fellow nurses would be working outside the room.

"It definitely made the pandemic feel much more real. We had been preparing and training for weeks, but now it was right here in front of me."

Stephanie soon settled into the routine of a typical shift, caring for the patient and assessing vital signs.

She lists having to use whiteboards and an intercom to communicate with colleagues outside of the room, and wearing PPE for long stints as the most challenging parts.

"The longest stretch I did in full PPE was three hours and it definitely takes a toll on you. You're breathing becomes laboured and you aren't able to touch your face to readjust your mask or goggles. By the end of my shift I had indents all over my face."

TACKLING THE GLOBAL COVID-19 PANDEMIC

Like many hospitals around the country, LGH has been priming itself for a potential influx of patients infected with the virus.

It has a COVID-19 screening clinic outside the hospital and a dedicated COVID-19 ward to care for patients with the virus who do not require intensive care and the help of a ventilator to breathe.

High-risk patients who presented to the Emergency Department were being immediately screened.

In response to the crisis, the ICU split its operation between critically ill COVID-19 patients and those requiring general care.

At this stage, the LGH has dealt with relatively few COVID-19 cases and its efforts are focused on putting the correct procedures in place, minimising staff risk of exposure to the infection and making sure healthcare is delivered as seamlessly as possible.

As a frontline nurse, Stephanie now wears normal clothes when heading to work before getting changed there into her uniform, a gown, gloves and face shield.

Like many of her colleagues she bought additional footwear made of rubber that could be wiped down and cleaned, which they leave at work after finishing a shift.

Uniforms are laundered in hot water, with Stephanie showering before leaving work and again after arriving home.

"I'm lucky that I actually live alone so I don't have to worry about bringing it home to other family members at the moment," Stephanie says.

"But I'm definitely social distancing from the rest of my family. I actually just spoke to my grandmother on the phone and explained to her, because she doesn't speak good English, that I can't come visit for an indefinite amount of time until we don't have these patient groups. It's just taking those extra precautions to make sure we're keeping everyone around us safe."

SPOTLIGHT ON INTENSIVE CARE

Intensive care units are staffed by teams of highly-trained clinicians, as patients require complex treatment to survive.

Caring for critical COVID-19 patients experiencing respiratory failure involves intubation, where nurses and doctors administer sedation before inserting a breathing tube into the airways that's hooked up to a ventilator that pumps air into the patient's lungs to keep them alive.

> "We deal with death and dying on a daily basis in our workplace so it's not something that's new to us," Stephanie says of the current situation in Australia.

"But obviously any person who comes in with something that's potentially reversible, that we can help them with, we're always going to do everything we can to help that person. So (whether it's a COVID-19 patient or any patient) we always have that sadness when we haven't been able to help that particular person."

Stephanie says the delivery of healthcare in the face of COVID-19 is much the same but nurses and hospital staff remain on high-alert.

One noticeable difference is the empty corridors and lack of hustle and bustle since the hospital enforced visitor restrictions, but Stephanie believes the biggest change since COVID-19 is a newfound recognition for the profession.

"My job probably hasn't changed, but people's awareness of what I do has changed. I've had so many more people reaching out to me and checking in with how I'm going. As a nurse, that's not something that we're really used to; we're usually the one's looking after people."

Stephanie, who also works part-time as a lecturer at the University of Tasmania, says responding to the pandemic has been challenging, largely due to uncertainty surrounding the virus.

"It's the unknown of not knowing what's coming, for us as nurses, for management, for the hospital. We're not sure what's going to happen so all we can do is prepare for the worst and hope for the best. We've just got this waiting game now to see if we have prepared enough."

WORKING TOGETHER TO KEEP EACH OTHER SAFE

While Stephanie's job is to look after critically ill patients, she is equally mindful of looking after herself and her mental wellbeing during COVID-19. She hasn't accessed any formal support services as yet, but says many nurses are doing it tough.

"There are nurses out there that are scared. We all have fears about what's going on and I would just say to them to reach out to their colleagues, their managers, anyone who they need to talk to, to actually discuss it and move on as much as they can, because if you hold all that fear in, I think that's when we start to have a workforce that is too scared to look after patients potentially," she says.

"I've just been taking time out for myself, shutting off social media for a little bit and just taking time to do those things for yourself like have a cup of tea, read a book, and sit outside in the sunshine. We can't go out into the community but we can do things at home that lift our spirits."

Stephanie says community-led campaigns such as 'Adopt a Healthcare Worker' have been heartening for nurses and healthcare staff.

"Yesterday we actually had one of our local schools drop off some letters and a little care package for ICU and all the nurses and doctors, just saying how proud they are of us and how they appreciate everything that we're doing, which I know touched a lot of people's hearts. Even our coffee shop across the road from the hospital, people have been shouting a coffee for a healthcare worker when they come in. You don't need those things but it's just really nice to know that there is community support for us at the moment."

Stephanie says the workforce is galvanised and that a great camaraderie is being built among staff as they protect and care for patients.

"We're just going to take it one day at a time. I'm really confident that we have an awesome team, and being in intensive care we rely on each other really heavily anyway, so we're ready for whatever the external world is going to throw at us and at least we know we've got each other's backs, whatever it is that does come."

WORKING LIFE



Toni Slotnes-O'Brien

Toni Slotnes-O'Brien MNP, RN CDE, BAppSci, Grad Cert Diab. Edn is a Credentialed Diabetes Educator-Nurse Practitioner and Clinical specialist lecturer Flinders University, Health2GO Primary Health2GO Primary Health2GO

A virtual nurse practitioner led clinic during COVID-19

Never before have we seen such a rapid change in the way we practice diabetes education and management. This is a perspective from a nurse practitioner led clinic in South Australia.

During March 2020, face to face consults became challenging for reasons that were unforeseen and unexpected. COVID-19 changed the way we provide Diabetes management in private practice in a matter of days when the Australian government introduced temporary telehealth Medicare Benefits Schedule (MBS) item numbers. New temporary MBS telehealth items are available to help reduce the risk of community transmission of COVID-19 and provide protection for patients and healthcare providers (Department of Human Services, 2020).

Prior to COVID-19, telehealth for nurse practitioners was underutilised for several reasons including:

• Restrictions in MBS funding. Telehealth MBS item numbers were only available outside of major cities

for nurse practitioners. The specific requirements included to be in an eligible geographical area or eligible Residential Aged Care Facility (RACF) or eligible Aboriginal Medical Service (Australian Nursing Federation 2013.)

- Confusion on the best and safest platform to use. Safety, training and privacy factors need to be considered as well as a continuation of care coordination.
- Need for additional administration support including the set up and education to clients on how to use the available technology. The technology considerations depend on the size of the practice and the frequency of the service. Internet connectivity in rural areas has been problematic.



- Available time and need to transform a practice to a virtual clinic. Clinicians in primary healthcare are increasingly busy due to many factors including an ageing population, rising levels of risk factors such as obesity and the increasing prevalence of chronic illness (Australian Institute of Health and Welfare 2014).
- Inability to charge a gap. The MBS item numbers are limited, and many clinicians need to charge a gap to ensure business viability.

The number of nurse practitioner telehealth item numbers utilised between the financial year of July to June 2019 was 293 in total nationally. Clearly an underutilised service (Department of Human Services 2020).

WHAT WERE THE CHALLENGES OF THE PROGRESSION TO TELEHEALTH?

- Negotiating a rapid change;
- Prioritising vulnerable clients especially clients suffering from mental health issues and acute complications such as wound care requirement;
- Lack of essential data-having access to latest pathology results due to an inability for testing;
- Lack of IT training/skills and equipment (both from a practitioner and client aspect); and
- Lack of knowledge in available online resources.
 For instance, what videos are available that will assist in the education of insulin administration?
 What educational resource materials are needed?

SURPRISING ASPECTS OF INTRODUCING TELEHEALTH AND MOVING TO A VIRTUAL DIABETES MANAGEMENT AND EDUCATION CLINIC

Most telehealth appointments were/are conducted without the use of video. For example, via telephone

only. This presented issues in establishing a rapport due to the loss of nonverbal cues in communication, particularly in relation to new clients.

The number of 'no shows' or clients not presenting to the appointments in the clinic halved. Prior to COVID-19 non attended appointments averaged 15%. During the month of April, nonattendance decreased to 1%. Clients were more likely to attend a telehealth consult rather than a face to face consult. This could be related to the convenience of not needing to travel or the need to 'reach out' to a health professional during times of forced isolation. Several clients commented that the telehealth consult relieved their anxiety and they felt a sense of safety at having a health professional available on the end of the telephone if needed.

Clients embraced this technology and the amount of appointments normally seen each day did not decrease in any way during April. In fact, the client list increased as clients previously seen in a rural clinic started making appointments again due to the convenience of a virtual clinic with no need to travel several kilometres to attend.

All in all, a virtual clinic has transformed diabetes management and the question remains: Could this be the new norm?

When practitioners are over the initial shock of COVID-19, we can reflect on this time to ask how we can deliver care in improved ways. We will discover that we were the ones that failed to embrace telehealth. Our patients are ready – and the world is ready. Healthcare will never be the same again.

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FEATURE

A retrospective account of how Australia's nurses and healthcare system responded to the COVID-19 crisis

UP FOR THE CHALLEGE:

NURSES FACE PANDEMIC HEAD ON

As COVID-19 spread in the Northern Hemisphere, Australia braced for the worst.

In April theoretical scenario modelling by the University of Melbourne (Doherty Institute) Pandemic Modelling Team found an uncontrolled coronavirus pandemic would overwhelm our health system for many weeks. Around 89% of people would catch the virus, with 38% requiring some medical care. ICUs would be well beyond capacity for a prolonged period. Without action health officials warned hospitals would struggle to cope with the expected influx.

Within a short time, the healthcare system, frontline workers, governments and unions implemented measures to slow the transmission and prepared as best they could for what might eventuate.

Fortunately, thanks to Australians listening and adhering to official advice, the country has managed to avoid rates of infection seen in other countries and a significant decline in transmissions to date.

Throughout the crisis nurses have been front and centre of the pandemic, stepping up to the challenges with bravery and professionalism to care for patients with COVID-19 despite putting their own lives at risk.

The ANMJ looks back at how COVID-19 took hold and was managed from the perspective of nurses and midwives, the healthcare system and the community.

Nurses and midwives urge Australians to stay home and isolate

As the global COVID-19 pandemic began to threaten Australia, frontline nurses, midwives and carers united with a simple message for the nation – stay home where ever possible and follow social distancing guidelines to stop the spread of the virus and keep everyone safe.

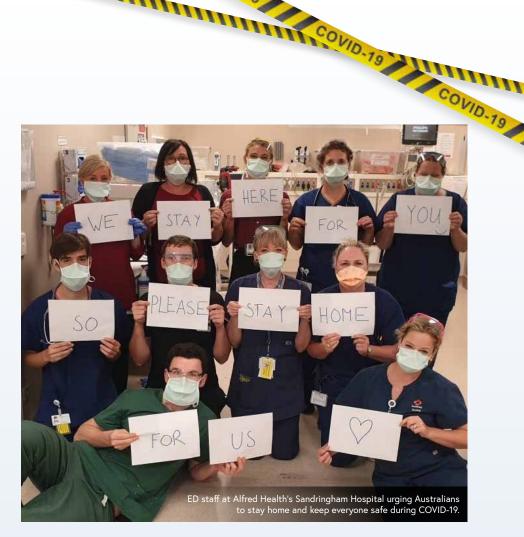
In March, the ANMF called on the public to follow guidelines, warning that Australia faced the real prospect of suffering the same fate as the Northern Hemisphere if the country was not pro-active in reducing the spread of transmissions.

"Having seen what's happening in Europe, we know that this type of behaviour is putting the health and safety of all of us at risk, including our critical health workforce," said Federal Secretary Annie Butler.

As the pandemic escalated, many of the ANMF's state and territory branches launched campaigns asking the community to play their part in the fight against COVID-19 by staying home.

They mirrored campaigns by hospitals and governments across the country.

The ANMF (Tas Branch's) social media campaign – *help us help you, isolate before it's too late* – pleaded for Tasmanians to protect frontline nurses, midwives and carers battling COVID-19 and ensure their sacrifices were not made in vain.



"We know that flouting the isolation requirements is putting all Tasmanians at risk. Most importantly, it is also putting the critical health workforce at risk," Secretary Emily Shepherd said.

A similar campaign by the New South Wales Nurses and Midwives' Association (NSWNMA), titled *help us to help you*, argued nurses and midwives were doing everything in their power to look after rising COVID-19 cases within the state and deserved the community's support and respect.

"Nurses, midwives and other health workers are hard at work in our hospitals and other health settings keeping us all safe," NSWNMA General Secretary Brett Holmes said.

"We can all make a difference in limiting the spread of COVID-19, and from a nursing and midwifery perspective that will save lives – not only the lives of patients but also nurses and midwives."

In late March, a survey of 400 Australian healthcare workers found nearly 80% were afraid of contracting COVID-19 and that many were critical of the speed of the federal government's response to the outbreak.

While some healthcare professionals were worried about their own safety, most were fearful of becoming infected and then passing it onto others, according to the research.

To acknowledge the courage of healthcare workers during COVID-19, the ANMF (SA Branch) launched its *#KeepThemSafe* campaign as a way for the public to show their support to those putting themselves on the line.

The campaign encourages the community to place signs in their windows, write a message on the footpath or upload a picture or video of themselves on social media using hashtags such as I'm standing with our healthcare heroes #KeepThemSafe #ANMFSA.



... most were fearful of becoming infected and then passing it onto others ...

Adapting to change: The healthcare system responds

As the reality of what implications COVID-19 could have on Australia's healthcare system, governments, institutions and healthcare workers quickly adapted and reconfigured to meet the potential demand on the healthcare system.

Over the first few weeks reforms and initiatives were developed across the healthcare system from preparing critical care units to updating best infection control practices, so as to ensure staff and patients remained as safe as possible during the COVID-19 pandemic.

To reduce unnecessary contact, stage four telehealth was implemented nationally.

The initiative under the Medicare Benefits Schedule allowed primary healthcare nurses, nurse practitioners, mental health nurses and midwives, along with other specialist practitioners and GPs to continue their practice and see patients without face to face contact.

"It means that the nurses who they know and trust can reach out to provide monitoring and support as part of the general practice team. This is critical for patient safety," said the Australian Primary Health Care Nurses Association President Karen Booth at the time of the announcement.

Hospitals and healthcare facilities had to revisit how they practiced and had to reconfigure their operations to ensure they were prepared should there be an influx of patients with COVID-19.

Registered nurse Nicky Gabel has worked on an overnight elective surgery unit at the Royal Adelaide Hospital for many years. In the throes of elective surgery being cancelled, which meant downscaling of work, Nicky arrived on an early shift one morning to be told they would be swapping to a designated COVID wing.

"The swap was done in a shift," she said.

"Fortunately we didn't have to open up as a COVID ward so I was sent relieving wherever there was a shortfall in the hospital."

However Nicky spent the majority of shifts on open COVID wards, in the COVID-19 screening clinic or at the main entrance doing screening for at risk visitors at the hospital. "Most of the patients I looked after while on COVID wards were being treated as positive until confirmed otherwise. Anyone with worsening or new respiratory issues was quarantined on the COVID wards until their swab results were known, regardless of risk factors."

To prepare for the pandemic Nicky was directed to the hospital's intranet learning portal to educate herself about the correct donning and doffing of PPE. She was also directed to the WHO website for information regarding COVID-19.

"I had already been fit tested the previous year for the N95 mask. It was a challenge at the beginning as things seemed to change every day."

On reflection Nicky said it was always a challenge coping with change at the best of times.

"My particular unit has had many changes over the last few years to cope with. But I also felt that this was an acceptable change for the health of the state and the hospital. If not us, then who?"

At the Royal Hobart Hospital long-inthe-works plans for their new K-Block redevelopment were altered in response to the pandemic.

ANMF Tasmanian Branch work representative and Royal Hobart Hospital Associate Nurse Unit Manager Tristan Streefland described the situation as "chaotic".

Tristan and his Assessment and Planning Unit team were set to move into their new facility late April after building delays pushed the move back from last year, but the pandemic disrupted those plans again, forcing his team to move their ward twice within a month.

The emergency department required Tristan's team to move out of their old space into another part of the hospital to claim the space as part of their Acute Respiratory Emergency Department, forcing them to move 28 beds into two different areas of the hospital before eventually moving into K-Block a month later.

"We're super excited to be in the new building but it's come at the expense of a lot of emotional stress and just everything that comes with moving not once but twice," Tristan said.

Not only were spaces reconfigured, nurses and healthcare workers had to find innovative new approaches to healthcare.

Practice nurse Gabby Combe (pictured) from Crystal Brook and Laura District medical practices in South Australia, led a drive-in flu immunisation event using a local footy oval and volunteers from the community.

More than 850 people were vaccinated across two towns, dwarfing each town's vaccination totals from the year prior while also demonstrating the importance of social distancing to locals.





Nurses step up to support **COVID-19** frontline

Australia ramped up efforts to combat COVID-19 by implementing broad strategies involving nurses to boost the health system's surge capacity so it could cope with potential demand triggered by the unfolding pandemic.

On 2 April, the federal government launched a \$4.1 million online training program, giving 20,000 registered nurses the opportunity to rapidly upskill and become equipped to transition into intensive care and high dependency units if needed.

Nurses rushed to sign up for the course, with content delivered via lectures, webinars, quizzes and handouts.

WA RN Jason Gordon, a nurse working in the ICU at Perth's Fiona Stanley Hospital, signed up to strengthen his knowledge and skills.

"My understanding with this sort of course is that it would give someone like me the skills to be able to manage a stable patient and then more senior nurses would care for the critical COVID-19 patients," he told the ANMJ.

Launceston General Hospital (LGH) ICU nurse Stephanie Lee welcomed nurses stepping up to support the frontline.

"It's positive in the sense that if we ever did come to a stage where we are so short of staff that we need other people, that those people are then going to be prepared. They're going to have some background knowledge to be able to assist us," she said.

ANMF Federal Secretary Annie Butler said it was essential the health system utilise all resources available, especially the skills and knowledge of the nursing workforce.

"During infectious disease outbreaks such as COVID-19, nurses are at the frontline of emergency response efforts. Nurses identify, manage and treat patients with confirmed or suspected COVID-19 infection, as well as ensure ongoing and everyday healthcare activities continue.'

provided \$2.5 million in funding for 3,000 scholarships for RNs not currently in clinical practice to undertake an online refresher course, run by the Australian College of Nursing (ACN), and re-join the health workforce.

One of its focuses was increasing knowledge on infection prevention and control in a post-COVID world.

The push to prepare the health system to respond to COVID-19 through additional training was reflected across the nation.

For example, state and territory health systems ran their own training programs to upskill thousands of nurses to work in intensive care, while the ANMF (Vic Branch) provided refresher courses for retired nurses

In a similar vein, AHPRA established a new pandemic sub-register to fast-track the return of up to 40,000 currently unregistered nurses, midwives, doctors and other health professionals to the workforce to join the COVID-19 fight.

The temporary sub-register, operating on an opt-out basis, will run for the next 12 months and enable qualified health practitioners to return to practice.

Significantly, Australia's workforce preparedness response in the face of COVID-19 has seen it explore numerous avenues, with local nursing students and graduates and international nursing students and overseas nurses among solutions put forward.

When first canvassed, the ANMF argued Australian nursing graduates and underemployed nursing workforce in health and aged care should be prioritised before turning to international students, and stressed that if international students were required to meet COVID-19 demand, the government must ensure they work within their scope and are adequately supported by RNs at all times.

PerformanceSubstrateSub

In unprecedented times, amidst a pandemic, PPE was in short supply globally.

In Australia the availability of PPE and its use varied widely across states and territories and the broad sectors nurses worked within.

"We're hearing from our nurse practitioners, many of whom work out in the community... but they're not getting access to the right PPE through the Primary Health Networks even though we understand it's been allocated to them," ANMF Federal Secretary Annie Butler said in late March.

Nurses and carers working in aged care also reported a significant shortages of PPE.

The ANMF's *Aged Care Covid-19* Survey found less than 30% of aged care facilities had enough supply of PPE, according to workers.

"Not enough facemasks and goggles (have to reuse and wipe with small alcohol wipes). No long arm gowns - only plastic aprons. No disinfectant wipes for equipment or surfaces," wrote one respondent to the survey.

"PPE equipment is locked in the employer's office, over the weekend it is not accessible. We do not have enough PPE if there was to be an outbreak," said another. So much was the concern across all sectors, healthcare workers instigated a change. org petition, *Australian Healthcare Workers demand safe Personal Protective Equipment for COVID-19*. The petition, which has attracted more than 160,000 signatures at the time of this report, called for adequate supplies of PPE, and increased manufacturing of PPE in Australia.

The petition also asked for clearer and universal guidelines for the use of PPE during the pandemic.

A sentiment echoed by Ms Butler who called on the government to develop nationally consistent policy underpinned by the latest evidence as it tackles the issue.

"In large acute tertiary referral hospitals, policies and protocols are clear, provision of equipment is generally better. But even that is not consistent across the states," she said.

With mounting concern non-urgent elective surgery across the country was cancelled from 1 April in an attempt to increase supplies and build capacity in the healthcare system.

When elective surgery partially resumed three weeks later, the government announced 60 million masks were being added to national stock levels and that they had 100 million set to arrive in the six weeks afterwards. ANMF (SA Branch) Director of Operations and Strategy, Rob Bonner, said PPE was the single largest issue he dealt with to help prepare nurses and midwives for what might come their way in South Australia. Meeting with state health officials twice weekly, he said the health and safety of nurses and midwives was a priority.

"[It has] I guess, been at the centrepiece of almost everything that we've been dealing with for the last few weeks.

"The experience in China and then what was playing out on our televisions, from Italy and Spain in particular and then later the UK, really galvanised our members... We had a level of member engagement where they had searched websites, looked for information about protection and then were picking up bits and pieces from all over the globe."

Working with members to ensure they were obtaining the levels of PPE necessary to practice safely, Queensland Nurses and Midwives' Union (QNMU) did what they could to allay people's fears, such as being the 'one source of truth', QNMU Occupational Health & Safety Officer James Gilbert said.

"Clearly there were hiccups, mainly around supply issues: We had the PPE, but it wasn't getting to the workplace." he said at the time.

COVID-19

Changes to elective surgery

Restrictions to elective surgery to alleviate the potential short fall of PPE and ensure capacity across the healthcare system led to unexpected implications.

Announced with only a day's warning, from 25 March non-urgent elective surgery was to be cancelled.

The decision sent shockwaves through the private sector placing nurses' jobs at risk.

Within 24 hours, in NSW alone, more than 600 private hospital nurses were stood down.

"We've now got a situation where more than 600 nurses are being forced to take accrued leave, or are scrambling to find a job elsewhere, before needing to join the queue for benefits," said NSW Nurses and Midwives Association (NSWNMA, ANMF NSW Branch) General Secretary Brett Holmes at the time.

A day after the announcement, the government conceded it had rushed the decision and subsequently pushed back changes until 1 April, allowing pre-booked surgeries to proceed.

Following, the Health Minister Greg Hunt guaranteed the ongoing viability of private hospitals in exchange for access to staff and beds should the pandemic grow significantly in size.

The announcement meant 57,000 nursing and midwifery jobs were guaranteed, with the states and territories splitting the \$1.3 billion bill with the federal government.

Speaking at the time, ANMF Federal Secretary Annie Butler praised the initiative, noting that it would save the jobs of thousands of members while shoring up the nation's response to COVID-19.

"To combat COVID-19 and protect the health and wellbeing of all Australians we need to use all resources available," Ms Butler said.

"This includes utilising the significant skills of nurses, midwives, doctors and others, guaranteeing job security for them and physical resources, such as ICU beds, ventilators and personal protective equipment (PPE) for the best care and treatment of COVID-19 patients."

ANMF (SA Branch) Director of Operations and Strategy Rob Bonner also said given the availability, or the lack of availability of PPE

at the time, it was absolutely critical that the government cancelled elective surgery at that time.

> "Otherwise they'd have continued to chew up the use of gowns, masks, goggles, face shields and the like," he said. "But I don't think they were quite aware of the flow-on implications of what they were doing."

On 27 April, following advice from the Australian Health Protection Principal Committee (AHPPC), federal and state governments had begun to remove some of its original elective surgery restrictions.

The government moved to a 'one-in-four' surgery list arrangement for all Category Two and 'important' Category Three Surgeries, estimating that 25% of elective surgeries would resume in both the private and public sectors as a result.

On the advice of the AHPPC critical dental and endoscopic procedures, screening programs, assisted reproduction (IVF) and procedures representing low risk, high value care as determined by specialist societies, as well as the needs of children whose procedures have exceeded clinical wait times and those at low risk of postoperative deterioration could be reinstated.

The federal government indicated further changes throughout the month of May as cases of COVID-19 decreased.



The impact of COVID-19 on aged care

Early in March, the ANMF said more registered nurses were needed across the chronically understaffed aged care sector to protect the workforce and vulnerable nursing home residents during COVID-19.

It lobbied for financial support for the workforce if forced to self-isolate due to COVID-19, as well as appropriate Personal Protective Equipment (PPE).

Later that month, the ANMF called for a ban on all non-essential visits to nursing homes, advocating the need for safe and compassionate entry into nursing homes.

The federal government soon after introduced visiting restrictions at nursing homes, including limiting visits to a short duration and encouraging additional measures such as screening visitors for fever.

On 20 March, it announced an additional \$444.6 million funding for aged care, including \$234.9 million for a COVID-19 'retention bonus', with full-time direct care workers, including registered nurses, enrolled nurses and carers, eligible to receive \$800 per quarter for two quarters.

In May, the government injected a further \$205 million into aged care to help keep facilities open during COVID-19.

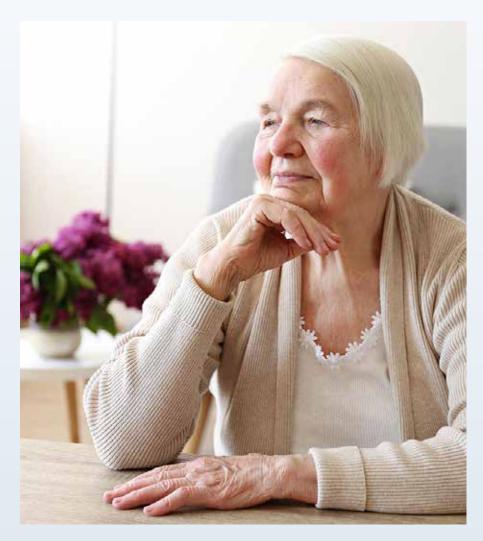
With funding to help the aged care sector manage COVID-19 topping \$850 million, ANMF Federal Secretary Annie Butler argued the federal government had to ensure money was directly spent on employing more nurses and suitably qualified staff, as well as appropriate PPE.

"Without clear transparent requirements of providers to publicly account for how they spend these funds, we cannot be confident that the money will be used to implement the safety measures that are urgently needed," she said.

During May, the national cabinet launched a nationwide code for visiting nursing homes during COVID-19 in a bid to guarantee consistent policy.

It was sparked by thousands of complaints from families denied access to loved ones after strict measures were introduced.

The 'Industry Code for Visiting Residential Aged Care Homes during COVID-19' outlines 13 principles, including that providers continue to facilitate visits in a variety of ways, such as utilising technology or window visits.



The ANMF argued the code ignored the need to implement the right numbers of staff with the right level of skills to protect vulnerable older Australians.

It developed its own guidelines, 'Principles for safe and compassionate entry into nursing homes', which stipulate achieving safe and quality care demands every facility must have registered nurses on duty on every shift; sufficient numbers of experienced care workers; and sufficient additional staff to undertake screening procedures and any other safety measures.

The ANMF's national Aged Care COVID-19 Survey found up to 80% of aged care workers reported no increases in care staff at their facility to prepare for a COVID-19 outbreak, less than 30% said their aged care facility had enough supplies of PPE, while 77% reported their employers had only recently updated or implemented infection control procedures for staff.

Ms Butler praised the inspiring efforts of aged care workers keeping older Australians safe during COVID-19 but said the union remained concerned about the sector's preparedness to deal with outbreaks.

COVID



Nurses abused over COVID-19 fears

While not the norm, some nurses, midwives and other healthcare workers on the frontline of Australia's fight against COVID-19 were subject to abuse from members of the public as cases of coronavirus grew nationally.

In early April, reports emerged of nurses being spat on and verbally assaulted in NSW by community members who feared they may be spreading the disease.

NSW was not alone, with most states and territories experiencing similar behaviour.

The NSWNMA said nurses and midwives across the state were being directed not to wear their uniforms outside hospitals and workplaces following a spate of incidents, including a nurse who was assaulted after boarding a train while wearing scrubs, and nurses being refused service at supermarkets and cafes.

"Please do not treat nurses, midwives and other health workers like they are infectious," NSWNMA General Secretary Brett Holmes pleaded.

"These trained professionals should be respected and must not be abused, spat on or assaulted as they move through our communities, to and from their workplaces." Not long after, the NSW government introduced tough new laws for individuals who assault nurses, midwives, police, paramedics and other frontline staff, including a \$5,000 on-the-spot fine for offenders who spit or cough on them, and possible imprisonment

Disappointingly, Mr Holmes said the union had received dozens of reports from members who had been abused.

"We've heard that a nurse had another customer kick her trolley in a supermarket and hurl abuse, yelling: 'I don't want your f... viruses, stay the f... away from me!' leaving the nurse in tears."

Similar laws to protect frontline workers during COVID-19 were introduced in other parts of the country.

Western Australia introduced tougher penalties for assaults and threats on 'essential frontline workers', including people who threaten to injure, endanger or harm frontline workers by exposing them to COVID-19 facing up to seven years in jail.

The Queensland government announced people who deliberately spit, sneeze or cough on frontline workers, such as nurses and midwives, would be fined up to \$13,000 under their new laws, including \$1,300 onthe-spot fines.

> Health Minister Greg Hunt slammed reports of people abusing healthcare workers and warned anyone who deliberately spread the coronavirus to health workers, such as by coughing on nurses or doctors, could face life in prison under the general criminal laws that apply in every state and territory.

> "The most serious of these offences may carry maximum penalties up to imprisonment for life, if somebody was to take a step which led to the death of a healthcare worker, if it were a deliberate transmission," Mr Hunt said at a press conference in April.

Early on during the pandemic in Victoria, several incidents emerged of nurses being verbally abused while walking to and from work by passers-by who wrongly believed they were spreading the virus.

"Appreciate the nurses and the midwives and the carers in aged care for the expertise that they have and the extraordinary efforts they are making at this particular time," ANMF (Vic Branch) Secretary Lisa Fitzpatrick told 3AW's Neil Mitchell.

"As well, there's over 2,500 nurses and midwives that have volunteered to come back and help on the frontline if they're needed as additional workforce. We've got young students who are in their final years who are now coming into the workforce, who will be working. So patience, some respect and continued support and acknowledgement does go a long way."

Regrettably, assaults and aggression towards frontline nurses amid COVID-19 were mirrored globally as the pandemic unfolded.

The International Council of Nurses (ICN) called on governments to implement zero tolerance policies to stop attacks on nurses at a time when their mental health and wellbeing was already under threat.

"It is extremely alarming that nurses are being stigmatised for their life-saving work with patients who have COVID-19," ICN CEO Howard Catton said.

"The fact that they are also facing abuse and even violence is staggering. We understand that such stigma, abuse and violence is based on ignorance, fear and lack of information, but it is totally unacceptable. No nurse should have to endure verbal or physical attacks ever, and especially not now."

Gratitude for nurses

In contrast to abuse over COVID-19 fears, the majority of the community was outpouring their appreciation towards nurses and frontline workers who were caring for those inflicted by the virus.

Acts of appreciation included donations such as care products, meals and designated shopping hours for frontline workers.

One initiative that spread across the country was 'Adopt a Healthcare Worker'. Started by Chris Nicholas from Perth, the initiative connected community with healthcare workers in need of help.

Via the group, support was given in the form of home cooked meals, walking the dog, running errands, picking up groceries, virtual hugs and lending a listening ear.

The enterprise sparked Facebook groups in most states and territories and a national movement that now boasts over 140.000 members.

Registered nurse/midwife Arlene Campbell, one of the administrators of the Victorian group, which has 22,000 members, joined the campaign to show solidarity with frontline healthcare workers.

"It's about providing practical support for all healthcare workers that are on the frontline to allow them to actually stay there," Arlene said.

"Healthcare workers are blown away by the support from the community. We've always had support from the community but to know that there are people out there to do such small things like walk our dog is just amazing and businesses also coming forward and doing lots of free things for us as well. The support when we're out and about has been overwhelming."

The appreciation of nurses was also reinforced on 12 May-International Nurses Day as political leaders and celebrities joined the community in sending messages of tribute and support to nurses across the world.

In a video, streamed across ANMF social media channels on International Nurses Day, an array of Australian celebrities sent heartfelt messages of appreciation while they spoke about how nurses had made a lasting impact on their lives or their loved ones.

Comedian Hamish Blake, for example, thanked the nurses who stood by his grandma.

"You were there every day with my grandma for the last three years of her life. You made her feel safe, you made her feel comfortable, you had a lot of funny heated, spirited

debates with her and when she did pass away, you were there at the funeral," he said in the video.

Nurses who lost their lives to COVID-19 were also honoured in tributes from around the world.

Australian and New Zealand nurses marked their respect and dedication to their lost colleagues by holding an online vigil also on 12 May.

Streamed across ANMF social media channels, the video which featured images of nurses and midwives, joined by healthcare workers, union officials and politicians holding lit candles and messages of respect and support, was viewed by over 75,000 people from around the world.

While the actual number of nurses who have lost their lives to COVID-19 is unknown, reports from Global Nurses United (GNU), estimate over 300 nurses in 32 countries have died due to the virus at the time of print.

Yet while being applauded by the community was much appreciated, in recovery nurses and midwives wanted their true worth to be valued through being able to work to their full scope of practice, inclusion on health-related and workplace policy, appropriate skill mix and legislated ratios in health and aged care.



COVID-19 TIME LINE

Tracking some of the critical moments

Under six months Coronavirus took hold of the world viciously and quickly. At the time of this report there were more than 5.5 million coronavirus cases confirmed worldwide, with at least 348,000 deaths and two million recoveries.

While far from over, *ANMJ* tracks back how the virus unfolded across the globe and what Australia did to flatten the curve.

		V E		On New Year's Eve Chinese health officials notify the World Health Organization (WHO) about a 'pneumonia of unknown aetiology' in Wuhan.
	JAN 2020	▼	3	44 cases emerge in Wuhan, with 11 people severely ill.
2	2020		7	China reveals its scientists have identified the illness as a 'novel coronavirus', a similar virus to those which causes colds and flus, as well as SARS.
			11	The first death caused by the virus is announced by Chinese officials. The first recorded overseas case found in Thailand two days later.
			20	The first US patient tests positive for coronavirus
			23	The city of Wuhan is declared a quarantine zone, with around 5 million workers and residents scrambling to leave the city.
			25	Australia's first coronavirus case is detected in Melbourne.
			30	The virus spreads to five separate WHO regions, recording 83 cases across 18 countries, as the WHO declares the virus a public-health emergency of international concern.
F	=EB		11	The WHO formally issues a name for the coronavirus disease: COVID-19.
			20	Italy records its first death.
			26	With more than 80,000 cases and 2,700 deaths globally, the WHO declares that there are now more cases outside of China than within it.
			29	The US reports its first death.
Ν	MAR	V T		The first Australian death in WA – A 78-year old man who contracted the disease o the Diamond Princess cruise ship.
			7	Number of cases climb over 100,000 worldwide with Spain, Italy, France and the US recording the most number of cases. Three days later, Italy was under lockdown.
			13	Gatherings of more than 500 are cancelled across Australia from 16 Mar onwards, with the Australian F1 Grand Prix called off.

MAR

APR

- 20 Non-residents and non-citizens are barred from coming to Australia after the government declares a complete travel ban, a day after 2,700 passengers disembark from the Ruby Princess.
- 21 The number of COVID-19 cases surpasses 5 million globally.
- 23 Australian restaurants, cafes, bars, clubs, cinemas, gyms and places of worship close after preceding advice from the Australian Health Protection Principal Committee (AHPPC) health experts.
- 26 The US records more than 82,000 total cases, surpassing Italy and China's totals. At the time of publication, the US recorded more than 1.78 million cases.
- 27 Italy reports 919 deaths in a single day, leading the world in total deaths from COVID-19.
- 28 Daily case numbers peak in Australia, with 460 cases recorded in a single day.
- 29 Australia ramps up restrictions in an attempt to reduce the number of cases. Gatherings are limited to two people and public playgrounds and gyms close. States and territories are also empowered to enforce other social distancing measures as they see fit.
- 11 NSW Health informs Anglicare of an outbreak at the Newmarch House aged care facility, with more than 35 residents and nearly 30 staff contracting the disease and at least 16 people
 - more than 35 residents and nearly 30 staff contracting the disease and at least 16 people losing their lives. 12 After reporting more than 2,000 deaths in a day,
 - 12 After reporting more than 2,000 deaths in a day, the USA surpasses Italy in its total death count, eventually recording more than 70,000 lives lost before the middle of May.
 - 15 A special commission is announced by the NSW state government into the Ruby Princess cluster, with figures later revealing it is linked to 696 cases and more than 20 deaths across Australia.
 - 25 A worker from the Cedar Meats processing factory in western Melbourne is diagnosed with COVID-19, with a cluster of more than 100 cases linked to the work site.
 - 27 With the number of cases decreasing across the country, some Australian states and territories begin rolling back some restrictions independently of the federal government and national cabinet.
 - 5 The UK becomes the first European country with more than 30,000 deaths due to COVID-19, overtaking Italy's tally.
 - 8 With the exception of Victoria Australia records a significant decline in the number of reported COVID-19 cases over the previous two weeks. With less than 7,000 reported cases nationally, Australia's national cabinet announces a staged ease of lock down measures, to be undertaken over a period of months.

Cultural competence in healthcare: Our learning from 2017-2020 will shape our future

By Dr Jessica Biles

Keywords: cultural competence, healthcare, curriculum, learning and teaching

BACKGROUND

The concept of cultural competence has been a focus of many countries in an attempt to address healthcare inequalities. A variety of literature about cultural competence has been produced (Truong et al. 2014; Clifford et al. 2015), particularly in the education and health disciplines.

Historically the literature indicates that a number of definitions have emerged from a variety of disciplines. Health discipline definitions share key elements (Betancourt 2002; Goode 1995). These elements include but are not limited to: valuing diversity, being self-reflective, being conscious of the dynamics of cross-cultural interactions, institutionalising the importance of cultural knowledge, and making adaptations to health service delivery that reflect cultural understanding (Humphery 2000; Ranzijn et al. 2008).

Contemporary Australian models of cultural competence in nursing are increasingly adopting the New Zealand approach to culturally safe practice where clinicians understanding power differentials is at the forefront (Australian Institute of Health and Welfare, 2019). Carberry (1998), a foundational author and writing from an Australian nursing perspective, suggests competency alone is dangerously insufficient. She contests the way to being culturally safe through the nurses' competence in delivery of cultural care is foundationally flawed through the power imbalance between nurse and client.

The mere fact that individuals can be excluded from health professional expert knowledge and 'othered' (p. 10) suggests that models need to move beyond safety. Increasingly we are seeing a values based approach being explored in the literature aligning with Carberry's foundational thinking.

Education of Australian professionals in cultural competence is believed to be

paramount (Hunt et al. 2015). More recent research in Australia has indicated that cultural competence training has resulted in preparedness to work with Aboriginal people (Paul et al. 2006; McRae, 2008; Hunt et al. 2015; Biles, 2017), understanding of health challenges (Mooney et al. 2005; Biles, 2017) and improved relationships between Indigenous Australians and non-Indigenous Australians, all of which can enhance access to mainstream service care (Si et al. 2006).

The onus of cultural competence is largely directed to educators providing learning opportunities to prepare health professionals for delivering their services in culturally appropriate ways rather than on individual leadership of health professionals.

Further, Australian understanding in cultural competence is largely directed towards Indigenous Australian cultural competence.

Of notable interest is that culture is not static making models depicting a static end point as problematic. More recently, this has been further explored by Universities Australia (2012) adding that the incorporation of institutional cultural competence as paramount in the development of undergraduate professionals. Steady progress has been made in implementing policy and frameworks regarding cultural competence in Australia but the impact of such is yet to be determined.

Internationally, cultural competence is generally perceived in healthcare as a five step process that is not static or linear and expands well beyond a monoculture and involves health equity more broadly (Yee et al. 2018). Cultural and linguistic competence is seen as vital to a large body of professionals across America, United Kingdom and Canada (Haywood et al. 2012; Papadopoulos, 2011; Aboriginal Nurses Associate of Canada, 2009). Initiatives are tested using a variety of tools with Campinha-Bacote instrument being the most widely cited in health professional research. Despite such approaches health outcomes remain imbalanced in most major developed nations. Minority populations have poorer health and racism towards clients is being increasingly reported (US Department of Health and Human Services, 2020; Australian Institute of Health and Welfare, 2019). With cultural competence education spanning further than 40 years it raises questions around its application and evidence based approaches.

Therefore this review has focused on identifying what has been evidenced via peer reviewed publications in the area of cultural competence in healthcare over the past three years with the view of seeking an understanding of where our knowledge has been reported and areas that require research focus.





SEARCH STRATEGIES

The following journal databases and websites were searched CINAHL (Ebsco), Medline (Ovid), Health Collection (Informit), Primo Search and Libraries Australia (for updated texts), Australian Indigenous Health Infonet, using the following keywords "cultural competence*", Indigenous, Australia*, education, health, nurs*, students, Subject Headings: (Cultural Competence OR Cultural Sensitivity -Education), Indigenous Peoples Australia, (Education - Nursing OR Transcultural Nursing) and Medical Subject Headings (MeSH): Cultural Competency, (Oceanic Ancestry Group OR Australia), Education (exploded).

Grey literature was not excluded in the initial search to ensure a comprehensive

evaluation of lessons learnt in higher education could be executed. This resulted in a total of 37 peer reviewed articles, four books and one report. Literature reviews and text were excluded to ensure that evidenced approaches were at the forefront of the exploration. In line with qualitative approaches this integrated review focus sought to identify common, rich trends in each paper that were unearthed through rigorous evaluation of content and meaning (Polit & Beck, 2019). Through a process of thematic analysis the following themes emerged: Values, Teaching and learning cultural competence, Measuring cultural competence and Pedagogical approach to cultural competence. While the search strategies incorporated health and nursing an overwhelming portion of research was driven from the nursing discipline.

FINDINGS

TEACHING AND LEARNING CULTURAL COMPETENCE

Teaching and learning cultural competence has been reported in a number of research projects over the past three years. Largely, approaches are based on encouraging student reflective exercises and immersive experiences (Merritt et al. 2018; Gower et al. 2018).

More novel approaches include Bennett, Hamilton & Rochani (2019) who discuss the challenges faced by academic teaching racial inequalities within nursing degrees. More novel approaches include Bennett, Hamilton and Rochani (2019) who discuss the challenges faced by academic teaching racial inequalities within nursing degrees.

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Their research spoke of the ART acronym (Affirmation, Reflection, Teachable moment, and Summary) and evidenced its success. Through affirming students' willingness to discuss important and sensitive subjects and then reflect the emotion of the experience enabled teachable moments. They discuss that nursing academia in America is largely made up of white women who lack skills in building a safe environment to discuss racial inequalities. Building on case studies and personal experiences is seen to be imperative to student teaching and learning (Bennett et al. 2019).

The duration of programs does influence learning with short programs generating no influence at all in medical programs (Gower et al. 2018) and longer immersive experiences generating more meaning however requires significant pre-immersive education and training for cultural shift to be lasting (Merritt et al. 2018).

The incorporation of case studies seems to be a common thread across many disciplines and also often seen as a way to measure the cultural capability of the approach (Kiersma et al. 2013; Hogan et al. 2018).

Further exploration on how community groups can influence/drive case study development should be the future focus if teaching and learning in this area.

MEASURING CULTURAL COMPETENCE

While Universities Australia (2012) mandated the inclusion of cultural competence in all undergraduate courses we have seen little published research that the impact of the content is being rigorously evaluated. In America, popular measurement tools include the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals – student version IAPCC-SV© (Campinha-Bacote 2009; Bryne 2020).

Using a mixed methodological approach Bryne (2020) cited that nursing students learning in cultural competence using simulation versus traditional lectures was reportedly no different and cited student learning to be at a point of being culturally aware.

The same Inventory tool was used in two unlinked nursing cohorts in Australia to assess student learning during an international placement highlighting a marked difference in many aspects with the exclusion of cultural desire (Choi & Kim 2018; Gower et al. 2019) cementing the importance of behaviours in culture competence development.

In an American study focused on pre and post cultural competence development after an international immersive experience using the same tool as the Australian studies indicated an overall increase that was maintained one year post the experience (Roller & Ballestas 2017) raising interesting considerations around the roll of curriculum and pedagogical approaches.

An Australian study focused on the role of empathetic cultural competence in midwifery students. Using the Jefferson scale of empathy student a pre and post study indicated that empathy level increased immediately after the module of students and then decreased one month post but still remained higher than initial scores (Hogan et al. 2018). It remains unclear how empathy aligns with foundational steps in most models of cultural competence.

Another Australian institution focused on measuring midwifery students learning in a newly developed tool that measured content against the Aboriginal and Torres Strait Islander health curriculum framework that importantly links capabilities to skills (West et al. 2018).

Interestingly, one approach to measuring cultural competence in health degrees was through mental health content. This group of scholars were interested in assessing educational tools and their impact in cultural competence and development.

The tool used in a pre and post study and linked with a validated empathy tool:



CLINICAL UPDATE

Kiersma Chen Empathy Scale a 15 item instrument (Kiersma et al. 2013).

Coupled with semi-structured interviews the study highlighted an increase in student's confidence when engaging with materials.

While Turkish nursing academics have focused on a pre and post evaluation using a Intercultural Sensitivity Scale and Cultural Intelligence Scale that identified that sensitivity increased with higher cultural intelligence adding value to pedagogical approaches (Goi & Erkin, 2019).

Australian and New Zealand physiotherapist academics (Te et al. 2019) have focused on assessing student self-reported growth through an American tool called the Cultural Competence Assessment (CCA) instrument (Schim et al. 2003).

Insight into personality traits in learners that impact their ability to respond to cultural competence was at the forefront with dogmatism being reported as a major inhibitor (Schim et al. 2003).

A dentistry course at an Australian university focused on the use of an adaptation to a tested American tool importantly focusing on both staff and students in their research (Rowland et al. 2006; Forsyth et al. 2018). The tool involved a mixture of qualitative and quantitative components and found a significant pedagogical gap that needed to be addressed by the course team. This study was then expanded to include in-depth interviews with learners (Forsyth et al. 2019) citing a greater need for Indigenous Australian focused content aligning with other health students perceptions of their learning (Biles, 2017).

What seems to be lacking is a consistent approach to cultural competence understanding across health disciplines and therefore evaluation. With such a mixture of tools being used for evaluation it is challenging to make sense of lasting meaningful changes.

PEDAGOGICAL APPROACH TO CULTURAL COMPETENCE

Moving beyond teaching and learning is the pedagogical approach to cultural competence. This was the overarching focus of nine articles. These articles looked beyond single subjects and instead focused on pedagogical approaches to embedding the philosophy of cultural competence within curricula. In a mixed methodological study faculty staff expressed an overall lack of support in their health disciplines that inhibited the attainment of cultural competence in their teaching (Chen et al. 2020). Concurring with this research a midwifery study indicated that midwifery academics required ongoing professional development in the concept of cultural safety to support their journey in cultural competence and the overall teaching and learning experience of midwifery students (Felming et al. 2019).

While there are many teaching and learning resources that have been developed there was limited discussion on pedagogical approaches to cultural competence within health curriculums. Aligning with a values system one American nursing school cites embedding an emancipatory approach to cultural competency can truly prepare nurses for social justice, racism and discrimination within the healthcare environment (Wesp et al. 2018).

A scoping review of cultural competence pedagogy in heath courses revealed that cultural competence is seen to combat racism and disparities in healthcare education yet a varied understanding of culture, cultural competence was common yet rarely defined, creating a praxis in understanding and teaching (Lewis & Steinert, 2019).

An Australian university seeking to embed cultural safety in a midwifery curriculum and retain Indigenous student midwives developed structural changes within the program to develop the role of an Indigenous Academic Liaison Midwife. While the program cited increased learner satisfaction and overall retention from Indigenous midwives, little was reported on the impact of the operational change (Schulz et al. 2018)

Butler & Berry (2018) present an interesting approach from a Canadian perspective that indicates that systemic structural changes need to occur in nursing policy and strategy to make lasting impact and change for consumers of healthcare. This places the onus on the professional bodies rather than the overreliance on curriculum approaches. Instead 360 degree communication and consultation being at the forefront for universities, in delivering cultural competence curricula is imperative to professional body and health service strategy implementation. While some progress has been made in implementing such philosophy within health curricula the impact of the course is underreported.

VALUES

The appreciation and role of values in cultural competence education is still evolving although not entirely new to the discourse. A long term scholar in the area of cultural competence has notably led the way in healthcare professional understanding of cultural competence values. In her widely tested approach, Campinha-Bacote, (2019) argues that humility and competence need to be blended for organisations to truly generate change. Most recently she has called this: cultural competemility. Campinha-Bacote, (2019) argues that cultural competemility is the way forward and essentially involves the total permeation of cultural humility into the five components of cultural competence.

Humility being the process of thinking of 'self' less and competence having traditionally five domains that require synchronous progression to generate meaningful change. Now, essentially the synchronous progressions has been contested (Biles, 2017) but most importantly the notion of competemility focuses on a values based system of reflection. Abdul-Raheem (2018) argues that cultural humility must be learnt by nursing educators to then be perceived and learned by students with simulation being an evidenced approach (Foronda et al. 2018).

Notably in this exploration of literature other scholars have dabbled in value based approach to cultural competence. Schultz and Baker (2017) describe the need for a clear understanding of unconscious bias. This requires skill development in unconscious bias training as well as attributes like accepting feedback, and self-reflection. In this study the scholar argue that cultural competence skills don't focus or reduce unconscious bias in current nursing curriculum impacting on client care (Schultz & Baker, 2017) and that unconscious bias tends to increase as students' progress through their degree (Chapman et al. 2013). Relying on a behaviour management system that explicitly details the behaviours that learners are required to take on with a variety of strategies that engage the behaviour was seen to be effective in a cohort of nursing students.

Markey & Okamtey (2019) believe that one way to overcome bias, insensitivity and develop competence is through professional values. They highlight that it is evidenced that nurses generally disengage from client care when not understanding cultural considerations demonstrating culturally insensitive approaches to their practise (Markey et al. 2017, 2018). For example if a linguistic barrier emerged the research suggests that a nurse is more likely to disengage then work with the client. This suggests that cultural competence alone won't combat nursing



behaviours and our current professional understanding of cultural competence in health isn't enough to combat such behaviours. Instead a focused curriculum of lived values such as care, compassion, commitment, communication and courage is said to lead to culturally responsive behaviours in nurses (Markey et al. 2017, 2018). Alexander-Ruff & Kinion (2019) echo Markey et al. sentiments through their narrative on cultural consciousness. Citing this as the central term for nurse's education to focus on education and assessment. They believe that a cultural consciousness is developed through self-reflection on values and behaviours, dialogues about race and immersive experiences. How values translate is largely unknown in both assessment and clinical practice.

DISCUSSION

In this review of literature pertaining to cultural competence both nationally and internationally in healthcare courses the focus was learning what has evolved in peer reviewed articles during the past three years within the bounds of the search strategies. What emerged was a relatively small body of work. It is apparent that nursing has a broad focus on cultural competence and has made attempt to develop resources, embed cultural competence as pedagogy and measure outcomes. This makes sense with nursing occupying a large portion of the health workforce both nationally and internationally (Wesp et al. 2018; Butler & Berry 2018). It is evident that allied health has made some steady progress in the development of resources with little evidenced exploration of pedagogical application (Te et al. 2019; Rowland et al. 2006; Forsyth et al. 2018).

What is evident in all literature is that cultural competence focused education is seen to combat racism in healthcare settings (Truong et al. 2014; Clifford et al. 2015).

Through preparing undergraduate or graduates through education the translation will become a culturally responsive workforce. While measuring the success of strategies in curriculum is varied institutions are somewhat confused on how to embed cultural competence with each paper citing a nuanced definition making understanding challenging.

This is heightened in the approaches to measure cultural competence. Campinha-Bacote, by large is the most cited scholastic approach to cultural competence both within Australia and other nations. Interestingly the approach somewhat differs from Universities Australia (2012) recommendations yet relevels the important exploration of values and behaviours in cultural competence learning and teaching.

From this review it is clear that an institutional approach is imperative to any course success. Staff teaching and learning cultural competence requires systemic support to ensure that experiences are meaningful to learners, aligns with the value systems of the institution and is embedded in evidence based application. In the past three years, while we have made some headway in measuring the success of cultural competence initiatives, the tools used by health courses are often different and piecemeal, making it challenging to gauge overall progression (Roller & Ballestas 2017; Choi & Kim, 2018; Gower, Duggan, Dantas & Body, 2019).

What is apparent is that personal values of learners has now been linked to cultural competence education. This is an exciting evolution that needs to be explored further and will make a difference in developing culturally competent approaches. The problem that is revealed when considering this is that most health disciplines enact cultural competence in different ways. This generates an interesting situation when measuring the success of applications will be challenging particularly when unearthing the nuanced values of cultural competence for health professionals rather than disciplines (Schultz & Baker, 2017).

As technology in healthcare advances and remains the priority the perceived soft behavioural aspects of professional's education remains overlooked.

Yet it is these very skills that have the power to transform experiences for consumers of care. Leadership in higher education

in collaboration with health services is imperative to the progression of cultural competence in healthcare.

One problematic focus to this review was the lack of voice in Indigenous and multicultural students. Unearthing their voices in teaching and learning experiences holds great weight that is yet to be discussed. In addition, if the end game of cultural competence is an improved health system that acknowledges staff bias and evokes a less racist healthcare system then the voice of Indigenous and multicultural patients is paramount. Surely, the voices of Indigenous and multicultural consumers of healthcare hold the greatest weight in assessing pedagogical, institutional learning and teaching experiences of healthcare professionals. This should be a priority for future research in this area.

CONCLUSION

While some progress has been made in cultural competence research to achieve optimal patient outcomes this work needs the support and funding of higher education and health districts to continue. Currently research and initiatives are piecemeal making progress difficult to determine.

Author

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REFLECTION



Rachel Byrne

Rachel Byrne is a team leader Maternal and Child Health, Child Youth and Family for the City of Casey, Victoria

Behind a screen: Supporting first-time parents in Casey during COVID-19

Located in Melbourne's outer South East, the City of Casey is one of the most populous municipalities in Victoria with more than 350,000 residents from over 150 different cultural backgrounds, speaking over 140 languages and following over 120 faiths. Last financial year (2018-2019) over 5,300 new babies were born in Casey, with approximately 2,140 of these babies born to first time parents.

The City of Casey Council is a large, vibrant and culturally diverse council which works tirelessly to support Casey's growing community, including families with increased vulnerability.

In response to the recent physical distancing measures put in place to prevent the spread of COVID-19, face to face contact between Maternal and Child Health (MCH) Services and parents, including new parents, had been reduced.

To ensure new families with young babies still received vital support, strategies and technology were put in place to undertake virtual assessments regularly, and families were referred to a medical practitioner if any issues arose.

However, without an end date in sight to the COVID-19 crisis, a review of how other MCH services could be delivered was urgently required to ensure new parents continued to get vital support.

For example, the City of Casey Council provides over 160 First Time Parent's Groups (FTPGs) per year to 2,140 new families. Historically, groups have run via face to face contact, in various locations for six weeks.

It was vital that during this time of increased stress and social isolation that Council continued to provide meaningful support to new parents. As studies have shown, first time parents groups offer an opportunity to develop social networks, gain self-confidence and provide lasting benefits to parents and to society. Relationships forged through participation in a FTPG can stretch across the family timeline and provide a support network through future births and major life events.

ADAPTING TO CHANGE

To adapt to the restrictions and continue to deliver FTPG sessions, Council worked to provide a virtual platform online that families could easily join using mobile phones, laptops or tablets. The challenge was creating the right climate so that a supportive, informal atmosphere was developed from the first week. Microsoft Teams became the platform to trial the virtual groups and the group facilitators mastered quickly the basics of the platform.

They engaged with parents booked into the groups and obtained their email addresses, with verbal consent to share with the participants in their group. A link was sent with basic instructions how to join the group each week. Virtual teams were offered and included support via telephone and email.

The facilitators reflected that the first couple of weeks of using the virtual platform required a greater input of time and effort from them, to promote engagement between the members. An effective strategy to support group engagement was to allow periods of time, at the beginning and end of the group for parents to talk, with the facilitator muting their microphone and turning off their camera so that parents could remain in the group and talk and show their babies (if the facilitator left, the group would end).

FEEDBACK

Feedback from parents has been very positive, with parents expressing gratitude that they had been offered an opportunity to continue to engage with other new parents.

"The group was a good way to make connections ... it provided a great alternative to connect with other parents...to learn what other parents are doing and to share experiences with each other."

"Seeing the faces of the other mums and chatting to them live online helped to connect with others. Even though it was behind a screen it was still nice to see other mothers."

"So happy to have this opportunity to connect that we may not have got otherwise under current circumstances, thank you... It gave us a chance to understand what each of us is going through."

Feedback from the facilitators was that they were grateful to have had the opportunity to continue to provide support to parents and pride around how much they have learnt and personally developed in their roles.



UNEXPECTED OUTCOMES

Several unexpected positive outcomes occurred as a result of the virtual sessions, including two parents who saw each other on the screen in the virtual sessions and later recognised each other when out on a walk. They had a conversation from a safe distance and planned to make contact again.

Another fantastic unexpected outcome was an increased uptake of the FTPGs in areas with historically low rates of participation.

The City of Casey Council has embraced the challenges and opportunities that COVID-19 has inadvertently presented and responded

with a more flexible and responsive FTPG program.

It has been a unique opportunity to be able to respond quickly to changing community and service needs, and think more broadly around what new parents want, and how to support families to build meaningful relationships that withstand social difficulties.

FUTURE PRACTICES

It is time to ask parents the question "how can we support you?" rather than offering a one size fits all approach. Throughout these changes we have learnt that by being brave we are capable of great things. We have more strength, more resilience, more resourcefulness, than we thought possible.

So, let's use this new-found confidence to look more broadly, through research, to ensure that the MCH service can provide a responsive and flexible program that reflects and supports the broad and changing needs of the community.



James Lloyd ANMF Federal Vice President

The evolution and necessity of vaccines

Since I last wrote in the *ANMJ*, our world has been flipped upside down and we are now recalibrating our shared reality. Our lifestyles are now regimented by a virus whose only purpose is to spread mindlessly. The path of getting back to our 'normal' lives is dependent on many factors, one of which is the development of a vaccine.

In the field of immunology, Edward Jenner has been credited with laying the foundation for modern vaccines. However, he was not the first person to inoculate for smallpox. China was the first to use inoculation against this disease. Their theories then spread to Western Europe where the Caucasus people used inoculation as a method to combat smallpox in the 1700's.

In 1774, Dorset farmer Benjamin Jetsy was recorded inoculating his family against smallpox by using a knitting needle to transfer pustular material cowpox via a scratch on the arm. He effectively gave his family immunity to smallpox.

But Edward Jenner, a country doctor in rural England, further developed and tested a vaccine for smallpox.

In 1796, he observed that milkmaids were not getting sick from smallpox. He hypothesised that they were immune due to their exposure to cowpox.

To test his hypothesis, he inoculated a farm boy with infected cowpox matter from the hand of a milkmaid. He then repeatedly exposed the boy to smallpox and observed that the child had only mild or no symptoms from this exposure. Jenner had in fact demonstrated smallpox immunisation based on an observed correlation. (His actions were, by modern ethical standards, completely reprehensible by exposing a child to a disease).

Jenner published a paper on his research in 1798. Initially, his research was ridiculed, in particular by the church. But once the obvious advantages of vaccinations were accepted, vaccinations against disease became widespread. By 1980, WHO declared smallpox eradicated - around 180 years since Jenner first published his research.

Now, due to scientists like Edward Jenner, we have vaccines that have all but eliminated diseases like polio, rubella and tetanus. We also have an HPV vaccine that can be given to both teenage boys and girls that decreases the risk dramatically of young women developing cervical cancer. Every Autumn a vaccine can be administered that decreases the risk of people contracting and dying from the yearly influenza.

We currently have no immunity to COVID-19 and research has shown that without a vaccine or treatment, our society is keenly vulnerable. Currently, our only defence until a vaccine is developed is social distancing, mass testing and contact tracing.

Worldwide, there are at least 120 vaccine candidates (as of late April 2020), of which six have been progressed to phase 2/3 trials. Scientists are cautiously optimistic that we will have a vaccine in 12-18 months.

Given that modern vaccines were developed only in the last 200+ years, we are still deeply defenceless without them. As summarised by Jermey Farrar, Director of the Wellcome Trust, "This infection is not going to disappear ... without science leading us to vaccines, we will get second and third waves of this ... Unless we do produce drugs and vaccines we are not going to have an exit strategy."



THE DRIVER'S SEAT

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

EDUCATION

Intravenous therapy and medications

The following excerpt is from the ANMF's Intravenous Therapy and Medications tutorial on the Continuing Professional Education (CPE) website.

By ANMF Federal Education Team

Intravenous (IV) therapy, which can be indicated for many reasons, comes with many safety considerations and guidelines in order to decrease the risk of complications and ensure patient safety.

It is important that all nurses and midwives are aware of safety precautions and always practice according to their skill level and hospital policies and protocols.

It is estimated that 40% of a nurses and midwives clinical time is related to medication management (Koutoukidis and Stainton 2017).

Medication safety is a national priority in healthcare, which is why it is one of the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Standards.

The Medication Safety Standard "aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks" (ACSQHC 2017).

Anyone caring for an individual with an IV infusion needs to be aware of their scope of practice in relation to IV therapy management.

This can change in different settings, hospitals and states, therefore, nurses and midwives need to ensure professional accountability and responsibility in regards to their practice in this area.

Many patients when hospitalised often need some form of IV therapy. IV therapy is often used when the enteral route for the patient is not appropriate or not possible. Indications for intravenous therapy can include:

- To restore fluid and electrolyte balance
- To maintain fluid and electrolyte balance
- For nutrition (parenteral nutrition)
- For the administration of medications (Tollefson et al. 2012).

The appropriate preparation is important for any patient commenced on any form of IV therapy. This means taking into consideration the appropriate insertion site and type of cannula needed if using a peripheral intravenous catheter.

The factors that influence the choices to be made include:

- The type of solution to be administered
- The duration of the IV therapy
- The patients general condition
- The availability of the patients veins (Farrell and Dempsey 2013)

There are also different venous access devices that can be used to gain access to veins, these include peripheral intravenous cannulas (PIVC), peripherally inserted central catheters (PICC) and central access lines.

These are selected based on the type of intravenous therapy the patient will be receiving, the duration of the therapy, as well as the patients' general health condition (Farrell and Dempsey 2013).

The patient should also be informed and educated about IV therapy and what to expect prior to its commencement.

This should include the type of access device they will be using; why the therapy is indicated; the duration of the therapy as well as any potential activity restrictions. The patient should also have the opportunity to ask questions and voice any concerns which they may have (Farrell and Dempsey 2013).

Fluids can be categorised in different ways, generally either according to their mechanism of distribution in the body and electrolyte loads or by their physical composition (Floss et al. 2008).

There are two categories of fluids according to their physical composition and these are:

- 1. Crystalloids: Solutions of small molecules in water such as sodium chloride, glucose, Hartmann's solution.
- 2. Colloids: Dispersions of large organic molecules such as Gelofusion.

These solutions can be further defined on their tonicity, or the measurement of osmotic pressure between two solutions.

Therefore fluid can be either:

- Isotonic: equal solute and solvent ratio
- Hypotonic: low solute (particles), high solvent (liquid)
- Hypertonic: high solute, low solvent (DuPont 2015).

Medications are often administered intravenously to ensure a constant level of the medication remains in the blood continually, or alternatively, the medication may be very irritating and therefore need to be given in a diluted form over a continuous and slow rate.

Some medications that are highly alkaline and irritating to the muscle and subcutaneous tissues can cause less discomfort when given intravenously (Crisp and Taylor 2012). Medications are given intravenously when:

- There is an inability for medications to be absorbed orally
- Rapid onset of action may be required such as in an emergency situation
- Very precise control over dosage may be needed
- They may be destroyed by digestive juices
- Inability of the individual to take medications orally (Crisp and Taylor 2012).

Antibiotics can also be given via the IV instead of orally in cases of severe infections such as sepsis. IV antibiotics are higher in concentration and reach the tissues faster.

It is important that the patient is educated and aware of the process involved with the administration of IV antibiotics and/or IV fluids.

Many patients may be apprehensive about receiving medications via this route and may need reassurance before the medication or fluids are administered.

Therefore education is important as it will help to reduce anxiety in the individual, as well as gain trust and cooperation which will also improve compliance with the treatment (Crisp and Taylor 2012).

It is also vitally important to gain consent prior to the administration of any IV medications or fluids which is also why patient education is so important.

The patient also needs to be educated on informing the nursing and midwifery staff if they experience any discomfort or pain from their IV site, which may occur both during administration of the antibiotics or medications or when not in use (Tollefson et al. 2012).

EDUCATION



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Tollefson, J, Bishop, T, Jelly, E, Watson, G & Tambree, K (eds) 2012, Essential Clinical Skills, 2nd edn, Cengage Learning Australia, South Melbourne They also need to be educated on any side effects which may be common with the medication to be administered.

If the patient needs to ambulate whilst connected to the IV fluid, it is important to educate them about safety measures to prevent them from falling or inadvertently removing their IV access device.

The patient may also need assistance when ambulating and if your patient needs to change clothes or hospital gowns when they have IV fluid running, the IV bag and line can be threaded through the clothing with the IV fluid still running therefore decreasing the risk of potential contamination (Tollefson et al. 2012).

Prior to the commencement of the IV therapy, the patient needs to be assessed on several things.

First of all they should be assessed on whether they still require the prescribed IV medications or fluids or if these could be administered alternatively through a different route.

If they are still requiring the IV route, they should be assessed to ensure they do not have any allergies to the medications or fluids, or that the medications and/or fluids are not contraindicated in any way (Tollefson et al. 2012).

They should also be assessed based on what the planned interventions are, their general condition and their medical diagnosis.

This is more of a systematic assessment of the patient and includes looking for signs of circulatory overload, fluid volume deficits, septicaemia and pulmonary embolism (Tollefson et al. 2012).

These assessments also allow other interventions and monitoring procedures to be put into place depending on the patients' condition and their indications for intravenous therapy.

These can include daily weights and input and output fluid balance charts which are essential in indicating fluid status. Input and output measures can also indicate if any excess fluid volume is being excreted through the kidneys or if it has diminished.

The patients' weight should be measured at the same time each day with the same scales to ensure accuracy (Crisp and Taylor 2012).



The following excerpt is from the ANMF's Intravenous Therapy and Medications tutorial on the Continuing Professional Education (CPE) website. The complete tutorial is allocated two hours of CPD, and will automatically be added to your portfolio when you complete your reflection on the learning.

Reading of this excerpt will give you 30 minutes of CPD towards ongoing registration requirements.

Be sure to add it to your portfolio on the CPE website

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

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

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Linda Starr

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COVID-19 – Doing the right thing?

The most recent pandemic has reminded us all of the occupational risks experienced by those working in health organisations.

As many struggle to deal with the 2020 COVID-19 pandemic we should remember and have some confidence knowing that managing infectious outbreaks is not new. For example, in 1918 there was the Spanish Flu, then HIV in the 1980's, SARS coronavirus (SARS-CoV) in 2003, H1N1 virus (bird flu) in 2009 and Ebola in West Africa from 2014-2016 (Freckelton 2020).

A good deal was learnt from these past experiences with considerable local and global policy development targeted at stopping the spread of disease and save lives.

This is not to diminish the magnitude of the spread and number of casualties from COVID-19. On 29 April 2020 there were 3,117,880 confirmed cases of COVID-19 across more than 185 countries and 26 cruise ships. On that date there were 1,968,138 active cases and the death toll had reached 217,212.

That healthcare workers (HCWs) are particularly vulnerable in these circumstances is evident from a report estimating that 23,000 HCWs had been infected with COVID-19 in more than 50 countries, including 2,609 in Italy, 3,300 in China and 455 in Spain (WHO 2020). At the time of writing the number of Australian healthcare workers infected with the virus had not been published.

Both Commonwealth and state and territory governments have power to make law and policy on how to manage a pandemic. They have done so in the past. In the current pandemic we have seen these powers exercised through quarantine and biosecurity orders prohibiting international travel, closing borders and through imposing limitations on public gatherings (Freckelton 2020).

Laws have also been enacted to provide protection for public officials, including HCWs in response to individuals who have spat, coughed or sneezed on public officials. For example, anyone who intentionally spits or coughs on a public official in any way that would reasonably cause fear about the spread of COVID-19 is guilty of an offence punishable by six months imprisonment and/or an \$11,000 fine through the courts or a \$5,000 on the spot fine (s 7 Public Health Act 2020 (NSW)).

However, not all harm in a pandemic is physical. Following the SARS epidemic it became apparent that there were psychological risks that HCWs experienced from the fear of working in hospitals and caring for SARS patients. Some staff experienced feelings of helplessness, anger and guilt whilst others experienced social isolation and ostracism (Bennett Carney & Saint 2020). Sadly, this has been the experience of some frontline HCWs during this current pandemic.

This raises questions like should HCWs be expected to work in high risk areas during a pandemic? Do employers have any particular obligations towards employees at these times? Both of these questions require more in-depth analysis than this column allows. However, there are rights and responsibilities of both employer and employee in the workplace.

Employers have an obligation under common law and legislation to provide a safe system of work that does not pose a risk to an employee's health. During this pandemic this is likely to include providing sufficient personal protection equipment (PPE) and policy guidelines and procedures to manage work loads and provide a safe working environment. There would also be an expectation that an employer who became aware that an employee was unwell, in particular showing any signs of, in this case, COVID-19 would require that employee to take immediate leave from their workplace until they were medically cleared to return (Freckleton 2020).

HCWs are bound by their contractual relationship with their employer and for the regulated professions, their professional obligations through the code of ethics, professional standards and code of conduct. HCWs also have a legal and an ethical duty to their patients, colleagues, employer and the general community. Hence HCWs are expected to attend rostered shifts and provide a reasonable standard of care that is respectful and unrestricted by considerations of illness – and they do.

The Nursing and Midwifery Codes of Conduct (2018) requires practitioners to promote the principles of public health. Hence there is an expectation that they would promote and practice social distancing and stay at home when unwell.

HCWs also have a legal and an ethical duty of care to their patients, colleagues, employer and the general community.

Historically this has been difficult for some who feel as though they let the team down by not soldiering on and often felt pressured by colleagues to attend regardless. However the Code of Conduct also requires nurses and midwives to maintain their health and taking action to reduce fatigue and stress on their health in order to practice safely and to support colleagues to do so as well. Hopefully adhering to these obligations will not only reduce the risk of spread of the virus amongst HCWs (and others) but will also help to reduce the psychological impact on staff that has been experienced in the past.



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Using evidence to make a difference in infection control and COVID-19

This year, International Nurses Day and International Day of the Midwife may not have been celebrated as festively as many would wish; COVID-19/ SARS-CoV-2 has derailed many plans and sadly led to the death of over 300,000 individuals globally, including 102 Australians at the time of report.

Unfortunately, these numbers will undoubtedly grow as the pandemic unfolds. That the developed nations of the United States, United Kingdom, and Italy account for over half of the COVID-19 fatalities worldwide, and the US by far the principal contributor to all reported deaths is one of the more disturbing facts.

While current figures appear low in comparison to deaths associated with the influenza pandemic of 1918 (approximately 50 million deaths), our ability to prevent, and treat infection has advanced considerably in the last century, an achievement that has been driven by the work of nurses and midwives.

As a novel (newly discovered) virus, COVID-19 presents several issues that fall beyond our current knowledge. While airborne transmission via small droplets has not been ruled out completely, it has also not been confirmed or fully understood (Meselson 2020). As aerosols exist on a continuum with droplets, identifying the pathogenicity of the SARS-CoV-2 virus in air samples is neither straightforward nor easily achieved independently of other potential transmission factors, particularly in real-world scenarios.

The most pressing issue however, is the lack of a vaccine. There is currently no known cure for COVID-19 and if a vaccine is developed, it will be a world-first for coronaviruses – no small feat, especially if it can be developed within the coming months. Until this time, the fundamentals of infection control and prevention are the most effective weapons in our fight against COVID-19. Interventions that nurses and midwives know well; like the backs of their (clean) hands.

Infectious viral particles can remain on the skin (exactly how long for is unknown – but still long enough to pose a risk). Correct and frequent hand hygiene particularly hand washing (over hand sanitiser) is therefore one of the most effective barriers to infection; nurses are well-placed to ensure that colleagues, patients, and community members are aware of this (Perkins 2017).

Proper cough/sneeze etiquette, avoiding touching the face – particularly the mouth, nose, and eyes as well as other objects or surfaces which may be contaminated, and ensuring that regularly touched surfaces are properly cleaned are also effective ways of reducing infection risk.

Maintaining distance between people is one of the more controversial contemporaneous recommendations in the raft of measures advocated by governments and organisations. This may be because there are confusing differences; the World Health Organization suggests one metre (WHO 2020), the US Centers of Disease Control and Prevention suggests two metres (US CDC 2020), and the Australian government suggests one and a half metres (Department of Health, 2020). Each isn't necessarily incorrect, but this is because none are based on solid, empirical evidence (Bourouiba, 2020). While saliva and mucus droplets and aerosols can travel beyond two metres from an uncovered sneeze or cough (Bourouiba 2020; Tang et al. 2013), combined with cough/sneeze etiquette the recommendations encourage people to remain a reasonable, but practical distance from one another to reduce the risk of transmission particularly in poorly ventilated, indoor environments. They also limit the number of people permitted in various settings which limits contacts.

With new evidence regarding COVID-19 continually emerging and often replacing or building upon existing information and recommendations it is important that nurses and midwives strive to maintain an up to date awareness of the best available evidence and to understand that inconsistent evidence may indicate a requirement for further investigation - no easy task, given already busy schedules and large patient loads.

To support nurses, midwives, and care workers, the ANMF has developed a series of Evidence Briefs to provide succinct, up-to-date, evidence on key topics regarding COVID-19, available here: anmf.org.au/ campaign/entry/coronavirus-covid-19-informationfor-members

While the first (and hopefully only) wave of COVID-19 appears to be subsiding in most parts of Australia, we're not out of the woods yet. Nurses, midwives, and carers have performed and will continue to perform excellently across their roles in health, maternity, and aged care keeping all members of the community, their patients, and clients safe. While celebrations may have been subdued this year, this year's days for honouring nurses and midwives reminded many of the valuable role you all play on the front line of Australian and global health. Thank you.



Julianne Bryce Senior Federal Professional Officer

COVID-19: An opportunity for change

Over recent months there's been increased focus on nurses, midwives and care workers as the most essential workers, the heroes of the COVID-19 pandemic. Instead of being unsung, our praises are being sung very loudly by journalists, politicians, TV presenters, celebrities, social media commentators, artists, royalty, and in many cases, one another. It's not high flying CEO's and investment bankers we need when threatened by a global virus, its nurses, midwives, teachers, and supermarket retail workers.

There's been long overdue recognition of all these essential workers.

Nurses, in particular, have been acknowledged as a valuable resource which both the Australian government and the Australian people have looked to for the frontline response to the pandemic.

In 2020, the International Year of the Nurse and Midwife, both International Day of the Midwife and International Nurses Day were celebrated like never before. It's great for nurses and midwives to be acknowledged and thanked for our work but what were we mostly celebrated for?

Largely it was for caring, compassion, humour, kindness, being there through tough times. Although all highly commendable traits and generally how I view all my colleagues, weren't you thinking like I was that nurses and midwives are so much more than that?

On IND, Professor Emerita Jill White spoke insightfully on The Drum about how the public perceives nurses and took the opportunity to remind viewers that while hand holding and compassion are important, nurses are hardworking, well-educated, intelligent, qualified professionals providing evidence-based healthcare. To change public perception, nurses need greater involvement in decision making and policy. This gained attention on social media.

My colleague, Tara Nipe tweeted while The Drum was airing, that: "The compassion and hand-holding components of nursing are what patients and family members remember, but education, lifelong learning, multidisciplinary team approach, critical reflection, and our evidence-based holistic perspective is why patients survive to have those memories."

The journalist who interviewed Jill White, Julia Baird, followed this episode of The Drum with an opinion piece reflecting on why nurses, who are crucial professionals, are too often underestimated. In this article, she details Jill's challenge to those who really want to show they value nurses, which is to:

- Ask your GP if they have RNs and NPs in their practice and whether they're able to work to their full scope;
- Ask your local aged care provider if they have RNs on staff and, if so, how many; and

• Ask your local MP if they seek input from RNs on health-related matters.

These are actions that we can all take but what else can we, as nurses and midwives, do? What responsibility are we taking for talking up the education and expertise required to be a nurse or midwife? Let's take the opportunity while we're being seen and heard to change the narrative on what it means to be a nurse and midwife.

With all the changes that the COVID-19 pandemic has brought with it, what changes would you keep? What else do we want to happen to ensure that nurses and midwives continue to be engaged in decision making and policy development for the future, not just when the chips are down in a global pandemic?

Here's my list of the changes I want for nurses and midwives:

- Enduring professional respect;
- Working to full scope of practice;
- Appropriate staffing and skill mix;
- Legislated ratios in health and aged care;
- Support for further upskilling;
- Support for career development/progression and further education;
- Recognition and inclusion in workplace policy and debate; and
- Recognition and inclusion in public and health policy debates.

How do we go about doing this? According to Jill White, what we need is determined, driven, social reform. Who's going to drive this change? Like we've seen in the pandemic, it's the community that has to make it happen. Together we can take up the mantle to educate the community about what it is we really do.

We need to take this opportunity, in fact every opportunity, to talk about nurses and midwives' education, commitment, vigilance, focus, communication, courage, professionalism, cultural respect, collegiality, research, technical capability, critical reflection and understanding of the evidence that informs our practice. This is how we sustain change, improve understanding of our professions, ensure engagement at the decision-making and policy level, and ultimately build a better health and aged care system for the future.

Extending the working lives of older personal care workers in the aged care sector

By Dr Aaron Hart, Dr Dina Bowman and Professor Shelley Mallett

Demographic ageing is driving longer working lives and growth in the aged care sector. In the aged care workforce, we can expect these trends to drive longer working lives among personal carers and other 'pink-collar' (ie. feminised roles requiring sub-tertiary qualification) workers. In this article we look to the public health literature to see which job characteristics might enable longer and healthier work-spans among this cohort.

Earlier and involuntary retirement is more common among women, informal carers, and those with lower retirement savings and household incomes (Irving et al. 2017). In Australia, women are overrepresented in the aged care workforce by nine-to-one (Mavromaras et al. 2017).

Twenty-seven per cent of the residential workforce and 39% of the home care

workforce are 55 years or older; older than comparable feminised industries (Isherwood et al. 2018). The increase in pension eligibility age to 67 by 2023 currently underway may induce some of these workers to stay in the industry longer, but, personal care roles tend to be heavy physical work and bodies age more quickly on lower strata of economic and social hierarchies (Curryer et al. 2018). In addition, most older aged care workers have informal care responsibilities (Mavromaras et al. 2017) which limit the hours they can work and the time they have for self-care.

It is likely that improving the quality of aged care work roles and employment conditions will help extend pink-collar work-spans, but job quality and employment conditions

CLINICAL UPDATE



in aged care have long been in decline. In Australia, the proportion of sector funding that has been dedicated to wages has diminished (Applied Aged Care Solutions 2017) and work intensity has increased (Kaine 2009).

Aged care workers have endured successive waves of austerity measures, and express concerns about the future sustainability of their organisations and their own employment (Mavromaras et al. 2017).

Increased marketisation and competition in the aged care sector is associated with diminished job quality and employment conditions for personal carers (Knijn and Verhagen 2003; Hayes 2017).

STRESS, AUTONOMY AND JOB SECURITY AFFECT ALL DIMENSIONS OF HEALTH

Low-paid workers are more likely to retire involuntarily due to health problems; and this has been partly attributed to their increased exposure to stress, lack of autonomy and work insecurity (Phillipson 2017; Rees Jones and Higgs 2013, Siegrist and Wahrendorf 2013).

Relationships between worker health and autonomy, job difficulty, and job security have been constituted through a specific lineage of public health research.

Karasek and colleagues (1981) proposed that the difficulty of the job interacted with the degree of 'decision latitude' or job control, to affect the phenomenon of 'workstress'. They demonstrated that, among male workers, 'work-stress' was positively correlated with coronary heart disease and cardiac and cerebrovascular death.

A meta-analysis using the 'work-stress' construct made similar findings: 'an average 50% excess risk for [coronary heart disease] among employees with work-stress' (Kivimäki et al. 2006 p. 431). More recently, Carr and colleagues (2016) examined relationships between retirement and work demands. They reported that providing older workers with increased sense of control, and ensuring contributions are adequately recognised, may delay retirement intentions and the timing of labour market exit.

A contemporary 'job quality' measure was constituted by Australian researchers, who added 'job security' to the 'work-stress' construct. They demonstrated that workers experiencing low job quality showed markedly higher rates of mental and physical health problems (Strazdins et al. 2004). Subsequent research demonstrated that, among older workers, higher 'job quality' was associated with improved selfrated health, psychometric mental health and biomedical health (Leach et al. 2010; Welsh et al. 2016).

Studies that investigate associations between various psychosocial work characteristics and one or more health dimension (biomedical, psychological or self-reported) tend to find strong associations. A literature review by Siegrist and Wahrendorf (2013) reported that being repeatedly challenged or over-taxed by demands, losing control over one's tasks, being treated unfairly and suffering from threats to one's legitimate rewards at work are associated with adverse physical, mental and self-reported health effects.

Psychometric studies that are sensitive to variations in work characteristics tend to find that the quality of work determines whether employment has benefits for 'mental health' (Butterworth et al. 2011; Siegrist and Wahrendorf 2013). Green et al. (2015) reported that job security was positively associated with psychometric mental health. Two studies reported that work characterised by role flexibility and employee control was associated with improved self-rated health, psychometric mental health and biomedical health (Welsh et al. 2016; van den Bogaard and Henkens 2018).

WORK CONTROL, MENTAL TASKS AND EMPLOYMENT CONDITIONS AFFECT COGNITION

Although research on cognition in later life has tended to focus on associations with individual 'lifestyle factors', there are a few studies that demonstrate connections between cognition and work conditions. One study of the health of older women reported that poorer cognition in later life has been associated with lower levels of control over how one's time is spent at work (Sabbath et al. 2015). Another found that manual and sales occupations show the greatest reduction in cognitive capacity in older age, and that people in occupations with cognitive demands work longer (McFall and Amanda 2017). Bonsang et al. (2012 p. 496) report that the cognitive decline associated with retirement is stronger among men than women, and speculate that this is because women's more domestic-centred lives means that the contrast between work and retirement is greater for men. Differences in later-life cognition has been found to be strongly associated with exercise and hobbies or interests outside work (Rogers et al. 1990; Gupta 2018; Health and Retirement Study 2017). One study reported that workers performing 'physical' (eg. pink collar) roles were found less likely to have exercise and hobbies or interests outside work; while those in 'mental' roles were more likely to exercise, study and attend groups and societies (Seitsamo and Ilmarinen 1997). One explanation for these connections is offered by research demonstrating that autonomy over personal time is

diminished by low pay and informal care responsibilities (Burchardt 2010).

FLEXIBILITY TO PERFORM INFORMAL CARE-GIVING ROLES AFFECTS MENTAL HEALTH, MORTALITY

Most older aged care workers have informal care responsibilities (Mavromaras et al. 2017). Spousal caregiving roles are associated with depression, particularly among women (Glauber and Day2018). Part-time work can attenuate the depressive effect of spousal caregiving among women, whereas for men, it tends to exacerbate it (Glauber and Day 2018). In Australia, around 80% of personal care workers have ongoing parttime contracts (Mavromaras et al. 2017). It may be that the health of older pink-collar aged care workers with spousal care-giving roles is fortified by ongoing work, but only if job quality and employment conditions are sufficiently favourable.

There is evidence that the relationship between women's health and their caregiving roles is mediated by job control. Sabbath et al. (2015) note that relationships between specific family circumstances and the health of older women was wellestablished, and proceeded to test whether lifelong work-stress and lifelong family circumstances predicted mortality risk among formerly employed mothers. They reported linear relationships between job control and mortality hazard within each family circumstance. The highest-mortality subgroup was previously married women who became single mother's later in life and had low job control. Sabbath et al.'s study underlines the significance of employment flexibility to accommodate family circumstances to the health of older-pink collar workers.

PHYSICAL WORK DEMANDS AFFECT SELF-REPORTED AND MUSCULOSKELETAL HEALTH

Because of ongoing physical demands in the context of declining physical capacity, and reduced opportunities for recreational exercise, longer working lives tend to diminish self-reported health among older pink-collar workers (Neuman 2008; Mavromaras et al. 2013). However, the clinical health effects of physical labour are more complex. The *Finnish research project on aging workers in 1981–1992* (Seitsamo and Klockars 1997; Tuomi et al.1997; Seitsamo and Ilmarinen 1997) categorised roles as primarily 'mental' or 'physical' and asked if participants had 'muscoskeletal disease', 'cadiovascular disease', 'respiratory disease' and 'mental disorder' as diagnosed by a physician. The study reported that, in some respects, 'physical work' was worse for health than 'mental work': the prevalence of cardiovascular and musculoskeletal disease was higher among physical workers than mental workers before retirement. However, among those who had retired in the Finnish study, cardiovascular disease was higher among white collar workers (Seitsamo and Klockars 1997). Other work in this vein has demonstrated that pink-collar workers are less likely to die of circulatory disease than white-collar workers (Basu et al. 2015). The authors of this study speculate that the causal mechanism might be differences in age, exposure to occupational hazards and lifestyle behaviours. This provides some further evidence that the right kind of aged care work can contribute to the health of older pink-collar women.

QUALITATIVE STUDIES CONCUR WITH PUBLIC HEALTH FINDINGS

Qualitative studies specifically investigating the health impacts of aged care work foreground many of the issues raised in the quantitative literature and provide more contextual detail. Evesson and Oxenbridge (2017) study risks and solutions for the psychosocial health and safety of home care workers in New South Wales. They argue that resource constraints and poor management diminished the intrinsic satisfactions of the work by compromising the standard of care. They also noted the increase in work intensity, workers' relative lack of power in negotiating preferred shifts, stressful incidents, workers' lack of support from management and the undervaluation of home care work. George, Hale and Angelo (2016) investigate New Zealand /Aotearoa aged care workers' perception of the effects of work on their health. Participants in the study reported a sense of satisfaction - they liked helping people - but they also found it stressful for a number of reasons: demanding clients and wide variations in client preferences for approaches to care tasks; time pressures and associated compromises in care; a lack of organisational support for home-based carers; a lack of professional standing

meaning that their insights into client wellbeing issues were overlooked by family members and other health professionals; and unpaid overtime to respond to client need beyond what was stated in the support plan.

CONCLUSION

Studies indicate that the health of pinkcollar workers in aged care is affected by stress, lack of autonomy, job insecurity, lack of cognitive tasks, inflexibility around informal care responsibilities and physical work demands. There is also evidence that the right kind of part-time work can be healthy for older women, especially those with spousal caring duties. A number of strategies for improving the sustainability of pink-collar aged care work can be identified in light of these observations. Ongoing professional development can give older workers the opportunity to develop new skills and shift to more specialised roles better suited to their ageing bodies. Designing job roles to be less procedural and task oriented, and to include a wider array of relational care practices, may offer workers more autonomy and cognitive stimulation. Employment conditions such as employee-controlled rostering flexibility and improved wages may expand workers time-sovereignty and increase their opportunity to invest in their own health and wellbeing. It would also reduce the friction between workers' non-labour responsibilities and their work schedules. Employing sufficient staff to reduce workintensity, and investing in appropriate equipment, may reduce the chance of injury and the damaging effects of stress.

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Emergency department nurses' narratives of burnout: Blurring of roles and professional identity

By Debbie Hetherington , Co-Authors: Dr Gillian Murphy, Nathan J Wilson, Dr Kathleen Dixon

Australian nurses are exposed to ongoing stressful work situations with emergency department nurses facing unique stressors: including traumatic emergency cases (World Health Organization [WHO], 2019). Constant exposure to such stressful events presents the potential for the emergency department nurse to develop emotional coping response mechanisms that run counter to their professional identity as a nurse, such as a loss of compassion towards others.

Exposure to ongoing stress at work may result in burnout, which has been defined as a condition that is the result of chronic workplace stress that has not been productively managed (WHO, 2019). There is growing research relating generally to burnout in hospital settings (Adriaenssens et al. 2011; Hunsaker & Heaston, 2015; Maslach, 2001).

Research about burnout specific to emergency department nurses is, however, scant. With reported retention rates among emergency nursing staff decreasing, it was time to focus on the experiences of the emergency department nursing cohort to explore the challenging issues they face at work.

Qualitative research methods are valuable in providing in-depth explanations of complex experiences to understand unexpected and unique events and experiences (Smith & Osborn, 2008). A narrative method was selected as Australian nurses have not been previously asked to discuss burnout, nor explicitly seeking their experiences about what it means to them and/or how they are affected.

The collective narrative revealed that participants experienced daily competing and conflicting personal and professional demands. These demands can negatively influence emergency department nurses' personal and professional lives. All the emergency department nurses discussed a love for their jobs and expressed a belief that their true vocation was working as an emergency department nurse. Despite the negative experiences inherent in emergency department nursing that the participants discussed, they strongly identified as emergency department nurses.

A key finding was the gradual merging of their personal and professional boundaries and roles after their exposure to the emergency department working environment. The emergency department nurses in this study had a strong sense of identity shaped by the environmental context in which they worked. They frequently spoke about their passion for emergency department nursing, and they demonstrated a belief that their experiences were strongly associated with their sense of self. However, after working within the emergency department and being exposed to what they believed was sometimes a volatile environment, participants talked about how this passion had shaped them. It had led them to believe that the rigorous demands of emergency department nursing were part of their innate person. They believed they would act within the expectations of the role, in personal and professional situations, and consequently, their identity and self-awareness had been shaped and boundaries blurred by the passion and exposure to form a professional nursing identity that had also become part of their person.

Professional identity is an important part of an emergency department nurse's career as it affects their attitudes and behaviours in the work setting and beyond. As such, understanding how they viewed themselves was an important part of this research. Dutton et al. 2010 stated that professional identity is created from attitudes, values, motives, and experiences, which are used to define the individual in the professional world. The way the emergency department nurses viewed themselves in their roles shaped their professional identities.

This information offers a useful insight to reflect and consider the emergency department nurses' position and how they developed their passion for, and identity as, an emergency department nurse. Through the creation of these professional roles and boundaries, participants seemed able to claim purpose and meaning for themselves. However, a range of workspecific pressures, such as the escalation of aggression within the emergency department, challenged their strongly held professional identity, which culminated in the participants believing they were possibly facing burnout.

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Plant-based for the planet

We are in the midst of a climate crisis. Almost half of the world's forests have been cut down, four hundred billion tonnes of ice are melting every year, sea levels and temperatures are rising, weather patterns have become unstable, rainfall is decreasing, and global emissions are rapidly increasing.

A cross 185 countries there have been a wave of climate protests, from the Extinction Rebellion's civil disobedience, to the United Nation Climate Summit protests; to youth climate activist Greta Thunberg and students who have protested across the globe; there is demand for action on climate change.

The Australian Nursing and Midwifery Federation (ANMF) have identified the 'Climate Emergency' as a key priority for 2020.

The public are demanding that the government expand measures to reduce carbon emissions to net zero by 2025, to act on drought management, to tackle the plastics problem, and find solutions for the energy crisis and alternatives to the burning of fossil fuels. With the 2030 target of 26-28% reduction in emissions nowhere near expected to be met; nurses and midwives have been called to campaign and support action to reduce carbon emissions.

We are told to 'refuse, reduce, reuse, rot, recycle; to take shorter showers, use water saving shower heads, turn taps off, walk or cycle instead of drive, switch to clean energy and turn appliances off at the wall when not in use; yet global emissions continue to rise.

But what if the single most powerful action you could take, was to change the way you eat?

In 2010 the United Nations (UN) called for a move toward plant-based diets and a reduction in animal products in order to save the environment from the impact of climate change. The UN Food and Agriculture Organization identified the need for a

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70% increase in food production by 2050, in order to feed a predicted 9.1 billion people.

As the demand for food increases, the consumption of animal products substantially increases having large environmental impacts increasing greenhouse gas emissions, land use and fresh water use. Globally animal agriculture is the leading cause of deforestation, species extinction, biodiversity loss, ocean dead zones, and ocean acidification.

Animal agriculture is the second leading cause of human made green-house gas emissions after the energy sector; responsible for 51% of carbon emissions, 18% of all greenhouse gas emissions, 80% of all water used and 80% of forest clearing. There have been numerous reports released over the past 10 years outlining the impact animal agriculture is having on climate change.

As food demand increases with a growing global population, the demand for animal products are growing, carbon emissions are rising, the planet is warming and climate experts warn, we are facing a catastrophic climate emergency.

Every year 56 billion livestock animals are bred and killed for human consumption. Agriculture is also the number-one user of water, responsible for up to one third of all fresh water consumption in the world today. With drought a constant issue in Australia, we are reminded to 'make every drop count'.

... what if the single most powerful action you could take, was to change the way you eat?

According to the Victorian government's Target 155 initiative, taking a shorter shower saves around 20 litres of water; but comparatively, a single beef burger patty takes 2,500 litres of water to produce, which is equal to four months of shorter showers! Eating a plant-based diet is estimated to save over 1.5 million litres of water a year.

Consuming animal products also requires more land to feed a person – eighteen times that required to feed a person eating a plant-based diet.

While there are economic arguments for ensuring efficient agricultural land use; there is also a significant environmental argument that cannot be ignored as we face a global climate crisis. One hundred and thirty six million acres of rainforest have been cleared for animal agriculture, and every day, up to 137 plant, animal and insect species are lost, due to rainforest destruction.

This is significant, as forests absorb and store large amounts of CO₂, which is released into the atmosphere when cleared or burnt. Repurposing agricultural land to grow food for humans, instead of livestock; and re-establishing forests are important in reducing greenhouse gas emissions and slowing global warming.

Oceans are also being destroyed by agriculture, with around 2.7 trillion marine animals pulled from the ocean every year. Three quarters of the oceans are now depleted or near-depleted, with a prediction that we could see fishless oceans by 2048. Secondary to nutrient rich run off from feedlots, farming and industrial pollution; oceans are becoming acidic, promoting algae growth which dies and decomposes, absorbing the oxygen out of the ocean, and killing marine life.

This has caused 400 dead zones around the world. Dead zones are worsened by climate change, but with global warming increasing, it is likely ocean dead zones will grow.

Climate change is real and human activity is the cause. With the climate crisis now declared an emergency by 45 countries around the world; much as we have had to do during the Covid-19 pandemic; individuals have a responsibility to change behaviours, and make different choices to minimise their carbon footprint. As ANMF members, heathcare professionals and role models for the community, we have a moral obligation to be the advocates that make the changes required to tackle the climate emergency.



FOCUS

REMOTE AND RURAL HEALTH & ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH



Reflections from a non-Indigenous academic teaching into an Aboriginal and Torres Strait Islander mental health program: a reflection in practice

By Krishna Lambert and Faye McMillan

The inequity in the healthcare status between Aboriginal and Torres Strait Islander and non-Indigenous people continue.

Despite targeted funding the gap between the population's remains evident by the life expectancy, the prevalence of chronic diseases, and mental health conditions among Indigenous communities (Wolfe et al. 2017).

A way towards improving Australian Indigenous health outcomes is to incorporate Aboriginal and Torres Strait Islander culture into courses. However, less consideration has been given to how this will be achieved.

It is not realistic to assume Indigenous content would be delivered by Indigenous academics, given the small numbers of Aboriginal and Torres Strait Islander health academics currently working in the university system.

Meaning, non-Indigenous academics are required to teach the Indigenous content. A recent study discovered, despite most teaching staff feeling comfortable teaching Aboriginal and Torres Strait Islander content, only 26% felt comfortable teaching Indigenous content to Indigenous students (Wolfe et al. 2017).

Cultural awareness has been identified as a way forward. Cultural competence requires the ability to act on 'cultural knowledge' (Health Workforce Australia 2015). The ability for healthcare workers and educators to act on cultural knowledge requires a level of personal and professional development and deep reflection (Wolfe et al. 2017; Forsyth 2020).

Recently, I was invited to teach first-year of the Bachelor of Health Science (Mental Health), which is a three-year full-time program, offered online with face to face residential schools. This program is open to Aboriginal and Torres Strait Islander students only. The program aims to develop Aboriginal and Torres Strait Islander mental health workers who can support and engage with their communities.

As a registered nurse academic who primarily taught into the nursing program, I was accustomed to teaching students where I had legitimised authority. However, teaching into the mental health program, I found myself feeling awkward and unsure. I thought I had no claim to teaching the material, and I lacked the lived experience and understanding of Indigenous ways of learning; I was a white, privileged, non-Indigenous academic.

The students were generous and accepting but also challenging. I was forced to reflect on my unconscious bias, my normalisation of white culture, my language, verbal and nonverbal cues, and stereotyping. It was confronting and uncomfortable. However, I had Indigenous colleagues who were willing to supervise and provide cultural mentorship. The experience has profoundly altered the way I teach Indigenous and non-Indigenous healthcare students. I encourage other non-Indigenous healthcare academics to seek out opportunities and to be willing to feel 'uncomfortable' and build capacity to teach into Indigenous programs.

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Bullying and threats to belonging in rural and remote practice

By David Stanley

A partnership between the Local Health District and nurse researchers in North-Western New South Wales lead to the establishment of a research study that considered perceptions of clinical leadership in rural and remote practice environments.

The study aim was to explore remote and rural nurse's perceptions of clinical leadership.

The methodology underpinning the study was qualitative with a specific focus on a phenomenological approach. The research used interviews with 56 registered nurses/ midwives, enrolled nurses and unit and hospital managers, in 14 different health facilities.

Each facility was selected because of their remote locations and as they offered different clinical profiles in terms of the bed capacity and clinical services. Ethical approval was secured from the relevant Human Research Ethics Committee prior to the study commencing.

Five main themes were identified:

- Leadership in Rural and Remote Areas;
- The Impact of Clinical Leadership in Rural and Remote Areas;
- Barriers in Rural and Remote Practice;
- Training and Development Challenges; and
- Rural and Remote Practice Challenges (Stanley & Stanley 2019).

A thread running through each of the five identified themes was bullying and threats to belonging.

The research identified bullying had a dramatic effect on many staff in rural and remote practice areas.

Many interviewees proposed that clinical leaders had a powerful effect on the standard of care in rural and remote clinical areas, if they are well supported, can access up-todate, relevant training and development and if issues of appropriate and adequate staffing are dealt with. However, bullying and threats to belonging were seen as issues that impacted on their ability to be effective clinical leaders or was seen to negatively impact on many new staff.

Resistance came from a number of spheres. With innovation and change not always being welcomed, and some 'veteran' staff, in a range of positions being seen to restrict, stop or at least, hinder change. It was also found that the rural or remote community had an impact upon the delivery of care: This was indicated when the community and the clinical facility were closely bound or co-dependent, this facilitated disproportionate power to some rural and remote area staff who held tight ties in the community or who had longevity in the clinical facility and community.

Many of these staff were seen to display 'bullying behaviours' to the point that new staff and staff establishing clinical leadership strategies faced significant challenges.

The study found that not all established staff demonstrated bullying behaviours, and this was not evident in all clinical environments. However, recognising and developing strategies for effective collaboration and engaged partnerships between new and established staff and the wider community was seen to be essential if new staff were to initiate appropriate innovation and deliver clear improvements in rural and remote areas.

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New perspectives on the reaches of antimicrobial resistance

By Joseph Rizzuto

Antimicrobial resistance (AMR) has been recognised as one of the most significant global public health issues facing the modern world (Davies 2013). The gravity of the issue led to the development of initiatives by the World Health Organization (WHO) to create a framework for a coordinated global surveillance program to monitor AMR, with the hopes of slowing the progression of the development of these resistant organisms (WHO 2001).

The results provided for the first time a global picture of the magnitude of the issue and it also revealed the lack of adequate surveillance in many parts of the world, most notably developing nations.

To fill the data void, researchers at the University of Wollongong (UOW) conducted a survey in the remote community of Patiswara and the regional city of Bhaktapur in Nepal concerning their antibiotic usage patterns and knowledge. The survey elicited patterns of overall worse practices and knowledge in the rural community. The most notable findings related to where antibiotics were sourced with 16.5% of individuals from Bhaktapur and 31.8% from Patiswara obtaining antibiotics from their friends. Additionally, high proportions reported not taking all of the antibiotics in both communities (32.2% in Bhaktapur and 63.5% in Patiswara). Antibiotic stock piling is speculated to occur in rural regions due to the burden associated with travel from a distant village to a local health centre making doctors feel inclined to give patients more than they need.

This issue has recently been put into context by the covid-19 pandemic. In relation to the disproportionate amount of deaths occurring in the regional city of Bergamo compared with the rest of Europe, Ilaria Capua, a virologist and director of the One Health Center of Excellence at the University of Florida, USA, reports, "Italy has the highest number of deaths from antibiotic resistance in the European Union. Pathologists will need to distinguish between SARS-CoV-2 as the primary pathogen or rather a mostly opportunistic pathogen that may pave the way to more severe respiratory infections caused by multidrug resistant bacteria (Paterlini 2020)."

The researchers at UOW caution us all to rethink our antibiotic practices, "we may want to think twice before not finishing a full course or sharing an old script with a friend." Antibiotics are being used inappropriately all over the world. In Australian hospitals, 23.3% of antibiotic prescribing did not comply with guidelines (Australian Government 2017). This needs to change. Less economically fortunate nations in the Western Pacific look to Australia to provide leadership and best-practice approaches to combat AMR (Australian Government 2017).

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Rural Hospital Nurses: delivering healthcare to rural Australia

By Sarah Smith

Hospitals are a vital part of rural communities; they are often the largest employer in rural towns and may be the only source of healthcare for hundreds of kilometres.

Given that rural hospitals have limited specialist, allied and medical services, nurses are essential to these facilities and often provide the majority of healthcare. Nurses working in rural hospitals often have a broad skill set and operate with limited resources and backup. Despite their important role in rural communities and their hospitals, there is little current research about this essential and unique workforce (Smith et al. 2018).

To explore the work the rural hospital nurse performs and the environment in which they work, a nation-wide cross-sectional study was undertaken by Sarah Smith, a rural nurse enrolled in a PhD at the University of Wollongong. The project is supervised by Professor Elizabeth Halcomb, Dr Jenny Sim and Dr Samuel Lapkin.

Registered and enrolled nurses working in rural public hospitals of less than 99 beds were asked to complete an online survey. The survey included questions about the practice environment, levels of job and community satisfaction, career intentions and nursing care left undone. Demographic information and hospital characteristics were also collected.

There were 383 responses completed that were received from rural hospitals and multipurpose services across Australia.

Most (86%) nurses were female and the average age was 47 years old. The study found nurses working in rural hospitals were mostly satisfied with their job and their community, however there are some indicators of stress and burnout. The practice environment was one of the most significant impacts on job satisfaction. Thirty percent of nurses intended to leave their current workplace within the next year, and 62% of nurses intended to leave their current workplace within the next five years.

The nurses perceived the quality of care they provided at their hospital was good,

however 63% had left some care undone on their most recent shift (Smith et al. 2020). It was also found that 68% worked more than their scheduled hours.

This data is important as care left undone may pose a threat to patient safety and may increase adverse patient outcomes. It may also indicate that the nursing hours allocated per patient in rural hospitals may be inadequate to complete the nursing tasks required.

The study is now in final stages and has provided an insight into the experiences of nurses working in Australia's rural hospitals. Full results from the study are currently under review for publication. For further information Sarah Smith can be contacted via email at: ss889@uowmail.edu.au

Author

Sarah Smith RN BN (Hons) is a PhD Candidate, School of Nursing, University of Wollongong NSW

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Where are the safe spaces for Aboriginal and Torres Strait Islander peoples within our hospitals?

By Glenda McDonald, Clarke Scott, Linda Ora, Lauretta Luck, Veronica Lloyd, Laura Kirsten and Rachel Scobie

This question resonated strongly as we searched for a respectful and comfortable way to connect with Aboriginal and Torres Strait Islander carers of people with life-limiting illnesses; to understand more about their carer journeys. Sadly, 70% of Aboriginal and Torres Strait Islander carers reported high distress opposed to 46% of non-Indigenous carers (Carers Australia 2016).

As seven co-researchers, Aboriginal and non-Aboriginal, we were working in nursing, research, Alcohol and Drug support and executive health positions in the same Local Health District (LHD). We collaborated to find the evidence on what local Aboriginal and Torres Strait Islander people and families needed as they cared for a loved one at the end of life.

The major questions were what was the community wanting from the mainstream palliative service and what could we cocreate to do better in future?

The project would indirectly evaluate the supportive and palliative care services in the LHD in terms of cultural safety, the quality of communication and collaboration between palliative care providers and Aboriginal and Torres Strait Islander carers.

The dilemma of safe spaces in hospitals for Aboriginal and Torres Strait Islander people revealed itself early.

The LHD Research Office were rightly concerned about the prospect of indemnifying researchers visiting private homes for interviews and recommended hospital venues only. Yet the Aboriginal co-researchers knew from experience that community members would encounter difficulties with travelling to a busy, tertiary hospital site, sitting in an unfamiliar office and discussing sensitive topics like Sorry Business. There were practical issues of potential participants, given their time constraints as carers. The question of how we could appropriately arrange research yarns with carers seemed likely to derail the project before it had even begun. Unfortunately, these time-consuming facets of research with Aboriginal populations can cause researchers to shy away, in times when we need to hear far more from Aboriginal and Torres Strait Islander people about their health needs and self-determined healthcare strategies.

Through the impressive brokerage skills of the Aboriginal co-researchers, relationships were built between the research team and two local Aboriginal Corporations who did provide safe spaces for community members. We met over food and cultural activities like weaving and painting, pictured. Aboriginal community-controlled health services have a long history of providing culturally appropriate and safe healthcare for the people they serve (Coombs 2018). Forging partnerships with organisations such as Sydney Region Aboriginal Corporation satisfied the requirements of the LHD Human Research Ethics Committee, enhanced the likelihood of carers consenting to participate and enabled culturally appropriate data collection.

However, the original question is still our challenge to all nurses and midwives in 2020 – where are the safe spaces for Aboriginal and Torres Strait Islander peoples within our hospitals?

Authors

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Ms Linda Ora is CNC at Supportive and Palliative Care Services, NBMLHD

Associate Professor Lauretta Luck is Director of CNMR, School of Nursing and Midwifery, Western Sydney University

Ms Veronica Lloyd is a Senior Aboriginal Health Worker at Supportive and Palliative Care Services, NBMLHD

Dr Laura Kirsten is Lead Clinical Psychologist at the Cancer Care Centre, Penrith NSW

Ms Rachel Scobie is the Aboriginal Health Manager, POPH Aboriginal Services, NBMLHD

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Linda Ora, CNC, (left) and Veronica Lloyd, Senior Aboriginal Health Worker (right), Supportive and Palliative Care, Nepean Blue Mountains Local Health District, talking and learning to weave at an Elders event at Sydney Region Aboriginal Corporation, Penrith, NSW



Aboriginal health practitioners as part of a multidisciplinary team in acute care settings

By Southern Adelaide Local Health Network

As you enter Jaiden and Mahalia's office you will notice a pinboard with a number of 'Thank you' cards. These cards are testament to the success of providing meaningful care to one of our most vulnerable patient populations – Aboriginal and Torres Strait Islander patients requiring heart surgery.

Aboriginal and Torres Strait Islander patients make up 20% of Flinders Medical Centre's (FMC) cardiac surgery annually. FMC's heart patient population span the northern most point of the Northern Territory to Southern regions of South Australia.

Mahalia Milera and Jaiden Graham are two of the first Aboriginal Health Practitioners

(AHP) to work as part of a multidisciplinary team in a hospital, and the first to specialise in cardiothoracic surgery and cardiology in South Australia. To better understand the AHP role is to understand that their priority is 'cultural care first, clinical care second', where clinical care includes vital signs, blood taking, advocating in consent procedures, aiding pharmacy in medication education and providing appropriate clinical patient education. Having a male and a female Aboriginal Health Practitioner is important for the gender balance in terms of delivering appropriate culturally sensitive care for our Indigenous patients.

One of the most profound changes we have seen since the AHPs joined the team is the cultural change in the care provided by non-Indigenous staff following Mahalia and Jaiden modelling the best care for our Indigenous patients.

"One nurse told me that at first, he was sceptical and felt the roles were just 'ticking a box', but said he can now see the unique care and understanding the AHPs provide to meet the needs of our Aboriginal and Torres Strait Islander patients, and he believes them to be a really valuable part of the multidisciplinary team (quote from Bronwyn Krieg, Project Officer, FMC)."

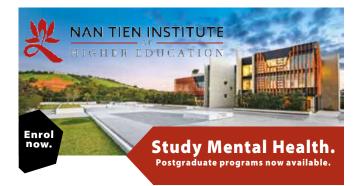
Flinders Medical Centre Cardiothoracic Surgical Unit (CTSU) was part of the Lighthouse Hospital Project (Lighthouse Hospital Project), an initiative of the Heart Foundation and the Australian Healthcare and Hospitals Association funded by the Department of Health to improve the care pathway for Aboriginal and/or Torres Strait Islanders presenting with coronary heart disease. FMC CTSU worked very closely with the Southern Adelaide Local Health Network Aboriginal Family Clinic (SALHN AFC) in employing a male and a female Aboriginal Health Practitioner as part of the cardiac surgery and cardiology multidisciplinary teams. The SALHN AFC provides the primary health service for the Aboriginal community in the south and the training ground for the Aboriginal Health Practitioner's Trainees in order to complete their Certificate IV in Primary Health Care (Practice) The clinic played an integral role bridging the gap between primary healthcare and hospital tertiary care and provides a pathway for AHP Trainees into focus areas of the hospital system: a future goal of SALHN.

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Quote from Bronwyn Krieg, Project Officer, Lighthouse Hospital Project, Flinders Medical Centre, Bedford Park, South Australia

Lighthouse Hospital Project: heartfoundation.org.au/ for-professionals/aboriginal-health-resources/the-lighthousehospital-project





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FOCUS



By Olivia Sonneborn



What do rural acute sector nurses need?

The future of the Australian health service will see a projected incongruity with the supply and demand of acute sector nurses, which currently make up 85% of the nursing workforce, with a need for 41,000 more acute sector nurses by 2030 (Health Workforce Australia 2014).

Perioperative nurses in rural areas can be requested to undertake the role of surgical assistants to substitute unavailable doctors, even though they have not embarked on further postgraduate studies or undertaken specific training (ACORN 2018; Hains et al. 2017).

This is an extended role rural and remote nurses often report feeling 'unprepared for', yet still perform in order to meet community health needs (Muirhead & Birks 2019). Increased demand on nurses to extend their scope of practice beyond their level of training, or 'role creep' is not limited to perioperative nurses in rural or remote areas, with insufficient educational support and services often cited as a barrier to nurse retention (Buykx et al. 2010; Cosgrave & Maple 2018; CRANAplus 2016; Fowler et al. 2017).

Accessible, quality education for acute sector rural and remote nurses must continue to be a priority and a focus for growth in the future to meet the increased demand on nurses to substitute doctor's roles to manage the growing burden on Australia's health service delivery.

Tertiary education, continuing professional development (CPD) learning and upskilling for

nurses needs to be flexible, accessible and affordable to meet the needs of rural and remote regions, considerations that education providers should continue to develop and improve for the future benefit of healthcare delivery and optimising patient outcomes from advanced practice nurses (Lenthall et al. 2011; Whitehead et al. 2019).

Author

Olivia Sonneborn, Masters of Nursing is Perioperative Practices Coordinator – LaTtrobe University, and Clinical Nurse Consultant at Alfred Health

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By Lynne Stuart (Mandandanji) and Leone Smith (Kamilaroi)

In 2020 Record Numbers of Aboriginal and Torres Strait Islander nursing and midwifery students enrolled at the University of Sunshine Coast (USC) who were successfully supported by USC's 'Capture and Keep' Indigenous nursing and midwifery (INM) Student Support Model.

HIGH PRIORITY: INDIGENOUS NURSING AND MIDWIFERY WORKFORCE

The CATSINaM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) is the national peak representative body who provide support and advocacy for Australian Indigenous nurses and midwives.

In the CATSINaM Strategic Plan for 2018 – 2023: **Priority 1**: states: "Develop and support recruitment and retention strategies for Aboriginal and/or Torres Strait Islander Peoples in nursing and midwifery" (CATSINaM 2018a).

The rationale why this priority area is of high importance is due to the value of Indigenous nurses and midwives in providing culturally safe care for Indigenous Australians, to expedite the national 'Close the Gap' targets. Thereby, building inclusive and culturally safe communities for all Australians (CATSINaM 2018b; Stuart 2017).

Universities are key education providers who have an ethical responsibility to support Indigenous nurses and midwives towards graduation, allowing them to take their place as integral employees of the Australian Healthcare Workforce (Stuart, 2017).

At USC, two (Lynne Stuart and Leone Smith) Indigenous nursing academics from the SoNMaP (School of Nursing and Midwifery and Paramedicine) have acted on CATSINaM's advice and responded spectacularly to advance this key Indigenous healthcare workforce priority. In 2020, USC have now achieved record numbers of Indigenous nursing and midwifery enrolments across all SoNMaP programs, as a direct result of implementing support strategies from USC's INM support model 'Capture and Keep'.

USC OVERVIEW 2013 - 2020

In 2013 at USC, there were 13 Indigenous students enrolled in SoNMaP nursing and midwifery programs, these students were supported and mentored by the Inaugural Indigenous nursing academic, Lynne, using the Indigenised INS student support model 'Helping Hands' (Stuart 2009; Best & Stuart 2014).

In 2016, enrolment numbers increased to 35 justifying funding to employ an Indigenous nursing academic, Leone, in the position of nursing and midwifery student liaison support.

The 'Helping Hands' INS model was then modified by the two Indigenous nursing academics to align more with USC's Indigenous student support structures, and hence USC's INM model 'Capture and Keep', became the new improved version of 'Helping Hands'.

In 2020 at USC, there are now a total of 74 Indigenous nursing and midwifery students (nursing: n=70) and (midwifery: n=4) enrolled across six USC campuses. Through our partnership with Queensland Health (QH), there were nine Indigenous nursing/midwifery graduands in April of 2019 pipelined into post graduate nursing and midwifery positions. The employment outcomes for USC's Indigenous student nurses and midwives will continue to be successful into the coming years, with further Identified QH positions becoming available to meet employment targets.

FUTURE DREAMING

Lynne: was the first Aboriginal woman to attain a 'Doctor of Philosophy' (2017) from USC. Lynne states, "attaining a PhD has proven without a doubt that 'Indigenous Nurses' can achieve in Higher Education. This means that all Indigenous nursing and midwifery students enrolled at USC can now see what they can be"!

Leone: was awarded the 2018 USC Vice Chancellor and President's Award for Excellence in Teaching and Learning. Funds awarded were used to support an International study tour – where a partnership was formed between USC and The North Dakota University's RAIN Program (Recruitment & Retention of American Indians into Nursing). Leone will facilitate an Indigenous nursing and midwifery student exchange program between the two universities.

Authors

Dr Lynne Stuart (Mandandanji) is an Aboriginal Registered Nurse, Senior Lecturer in Nursing and Lead Academic for nursing course: NUR332 – Aboriginal and Torres Strait Islander Health and Cultural Safety in SoNMaP at University of Sunshine Coast.

Leone Smith (Kamilaroi) is an Aboriginal Registered Nurse is the 'Indigenous Clinical Liaison Student Support Officer', and Lead for the School of Nursing, Midwifery and Paramedicine (SoNMaP) 'Capture and Keep' Program at University of Sunshine Coast

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CAPTURE and KEEP

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USC Capture and Keep brochure



Birthing on Country

Historically, Indigenous women birthed on country, on the lands of their ancestors, beginning their baby's spiritual connection to the land.

'Birthing on Country' (BoC) was the norm for thousands of years before Aboriginal and Torres Strait Islander women were displaced and encouraged to birth in other settings. Even today, with a better understanding of the importance of Birthing on Country, complications in pregnancy or access to relevant healthcare services impede a woman's ability to birth where she chooses.

The gap between maternal and infant health outcomes for Aboriginal and Torres Strait Islander women in Australia and non-Indigenous women is unacceptable. Many of the poor outcomes are preventable or modifiable with early intervention. A new model of care is vital for Aboriginal and Torres Strait Islander women, to ensure they can birth in a way that upholds cultural values and improves health outcomes for mothers and babies.

In response to these issues, The Australian College of Midwives (ACM) manages the 'Birthing on Country: Maternity Services Designed and Delivered for Indigenous Women' which began as a collaboration with University of Queensland (UQ), Charles Darwin University, the University of Sydney, and the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), with Merck, Sharpe and Dohme funding the project through their Merck for Mothers program.

One of the first tasks was to define 'Birthing on Country' and together with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and CRANAplus, ACM signed a joint position statement on Birthing on Country to underpin the Birthing on Country Project. It states that Birthing on Country models would better provide integrated, holistic and culturally appropriate care to provide the "best start in life" for Aboriginal and Torres Strait Islander families and communities. An effective Birthing on Country model is one where services can be tailored to women's needs, connection to culture is enabled and where women and families are able to define their own cultural practices and choices within a safety and quality framework. Respecting individual choice is central to the Birthing on Country model.

The main goal of the Birthing on Country Project is to improve engagement and health outcomes for Aboriginal and Torres Strait Islander mothers and babies; bringing together community members to work in partnership with Aboriginal medical services and State/Territory health services to provide culturally safe care. Birthing on Country is not only physical, but encompasses connection, spirituality, sharing of traditional culture and knowledge; it is integral to health and wellbeing that Aboriginal and Torres Strait Islander babies are born 'on Country'. Birthing on Country is about women accessing maternity care that they feel is clinically safe, culturally safe, inclusive of family and community, values Indigenous

and non-Indigenous ways of knowing and doing and allows for informed decisionmaking while being supported by a known midwife.

The Birthing on Country Project identified key sites where these culturally safe, Birthing on Country models of care could be established. Planning and design is well underway to ensure Birthing on Country becomes a real accessible option for all Aboriginal and Torres Strait Islander women. The new Birthing on Country website at **boc.org.au** provides important information about the positive progress of the Birthing on Country Program to date along with recommendations about the future implementation within Aboriginal and Torres Strait Islander communities.

Education in this important area of midwifery is also on ACM's agenda and we have just launched the Birthing on Country e-learning course designed to support the growth and awareness of Birthing on Country whilst identifying how and why current systems inhibit rather than support Aboriginal and Torres Strait Islander women.

The course supports the overall aim of the project to improve Aboriginal and Torres Strait Islander health outcomes, and ensure a future where sustainable Birthing on Country strategies and health services are implemented and maintained. ACM's e-learning resource has been developed with the leadership, cultural oversight and direction of key Aboriginal and Torres Strait Islander people, through the National Birthing on Country Strategic Committee and an established Working Group, ensuring Aboriginal governance and oversight to the project.

This resource is for all midwives and is available at midwives.org.au/shop Completion of this course will improve the learners overall understanding of the concept of Birthing on Country and its role in maternity services; how and where Birthing on Country services are currently applied; the rationale and requirement for increasing access for Aboriginal and Torres Strait Islander women to culturally safe maternity services; the positive benefits of implementing Birthing on Country models through examining the evidence of providing such services; the importance of providing culturally safe care to Aboriginal and Torres Strait Islander women; and knowing where to find further information or resources on Birthing on Country.



A simple initiative to facilitate choice in personal hygiene in patients undergoing haemodialysis via a central venous catheter in the tropics

By Wendy Smyth, Joleen McArdle and Cate Nagle

Haemodialysis is a lifepreserving treatment for endstage kidney disease.

Most haemodialysis units are in a regional or metropolitan city, and as a result patients from rural and remote locations who require dialysis need to relocate to receive treatment.

Naturally, many of those patients who usually reside hundreds of kilometres from the city are also Aboriginal and/or Torres Strait Islander. Coupled with this dislocation from community, haemodialysis brings many modifications to other aspects of everyday life.

For example, it requires patients to attend the unit usually three times a week, for several hours at a time, and necessitates changes to fluid and dietary intake, and the taking of medications. Whilst a fistula has for some time been the preferred vascular access route, many of our patients have long-term access via a central venous catheter (CVC).

The risk of infections of CVC exit sites is an ongoing concern. The use of sterile, dry and intact dressings over the exit site is an important first line of defence against exit sites. We had previously conducted a crossover randomised controlled trial and found that different dressing types only stayed intact two-thirds of the time. It was thought that sometimes this was related to patients showering between dialysis sessions.

However, in our tropical climate in north Queensland, it is unreasonable to expect patients not to attend to their hygiene as they wished. In this current multi-phase research study, we sourced two options that might be useful for patients to use – bathing wipes, and a waterproof dressing cover. Renal Unit nurses' survey responses indicated their in-principle support for the use of both products.

In Phase 2, all 27 patients with a central venous catheter told us about their usual and preferred hygiene practices. Although advised that having a bath was preferable, very few had a bathtub in their accommodation. Patients described inventive, laborious and elaborate strategies they used to try and keep their dressings dry while they showered. These included plastic wrap, holding a towel over the dressing while using the other hand to hold the shower, to wearing a garbage bag while showering. The patients indicated willingness to try the different options.

In Phase 3, 10 of the 22 eligible participants were Aboriginal and/or Torres Strait Islander. All patients were provided with their preferred option/s and instruction as to use. At each dialysis session, the exit site dressing was inspected for intactness and dryness. Conversational interviews with patients were conducted by the research nurses. Whilst both options had their place, the patients preferred using the dressing cover. This enabled them to confidently have a shower, and they appreciated being able to have both hands free to shower.

As one participant stated, the waterproof covers 'are deadly'.

Of importance, none of the participants had an exit site infection during the trial. This was such a simple intervention, which led to considerable positivity amongst the participants. The researchers are planning an additional follow-up phase to monitor longer-term use of the options by the participants.

Authors

Wendy Smyth (PhD, RN) is a Nurse and Midwifery Researcher at the Townsville Hospital and Health Service

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