



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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INSIDE

Treating mask related skin injuries during a pandemic:
Wound nursing consultants give their perspective

Professor Emerita Jill White
reflects on the Year of the Nurse and Midwife and what's next

Focus on education:
How nursing and midwifery academia are rising to the challenges of educating students during the pandemic



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OF CARE ARE
RESHAPING HEALTHCARE

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Annie Butler
ANMF Federal Secretary

What a difference just three months can make. When I wrote the editorial for the ANMJ's July edition, although having endured a very torrid first half of 2020, Australia had gained control of the COVID-19 outbreak with daily new cases at the beginning of June reaching zero.

At the time of writing this edition's editorial, 26,651 Australians had been infected with COVID-19, with, sadly, 810 deaths and, most concerning, more than 580 of those deaths occurring in aged care.

The main contributor to this situation has been the pandemic's second wave in Victoria, which has shown us just how rapidly this virus can get out of control and how devastating its impacts can be – especially in aged care. It has also led to a situation, unlike the first wave, of a divided country where the majority has been able to ease restrictions, while Victoria's restrictions have necessarily progressively tightened.

This has made the efforts of Victorian nurses, midwives and personal care workers all the more extraordinary.

With daily cases reaching more than 750 at the peak of the state's second wave, increasing numbers of hospitalisations and rapid spread of the virus across more than 120 nursing homes, the response from Victoria's healthcare workers, health officials, unions and governments has been remarkable. This is especially so with regard to privately run aged care in Victoria.

In a sector which is ill-equipped to deal with outbreaks of infectious diseases, particularly the likes of COVID-19 as was signalled by the tragedy that unfolded in Newmarch House, in NSW in April this year, the virus quickly took hold, infecting thousands including aged care workers themselves.

This meant that while thousands of workers had to be placed in quarantine, thousands of shifts in aged care had to be filled by nurses and care workers from Victoria's public and acute private hospitals, Australian defence force personnel as well as dozens and dozens of nurses from interstate. So while dedicated aged care nurses and carers have been doing what they can in impossible circumstances to protect and care for their residents, more than 20,000 shifts have been covered by nurses from all over the country putting their hand up to help.

The efforts of all these nurses cannot be commended highly enough. They didn't sign up to work in aged care, but as nurses they signed up to care for everyone and provide care where it's needed most. And while these efforts truly demonstrate the essence of our

profession and the dedication of nurses, it should not have been allowed to come to this.

As many of you are aware, the ANMF has been warning successive governments of the dangers of chronic understaffing in aged care for years. Warnings, which, although recognised by the current Royal Commission into Aged Care Quality and Safety (the Commission), have not been heeded by the Federal Government.

Consequently, too many lives have been lost prematurely, while families and aged care workers have been left with untold grief and devastation. And too many facilities continued to run on insufficient numbers of qualified nurses and carers with the right skill mix to be suitably prepared to fight the outbreak.

In August, the Commission's examined the sector's response to the COVID-19 outbreak in aged care.

From the evidence given, Senior Counsel Peter Rozen QC, concluded that none of the problems caused by the coronavirus pandemic was unforeseeable, adding that tragically not all that could have been done was done.

That despite the federal government being solely responsible for aged care, neither the Commonwealth Department of Health nor the aged-care regulator developed a COVID-19 plan specifically for the aged-care sector.

The ANMF wrote 10 times to the Aged Care Minister Richard Colbeck, offering solutions on the mounting issues plaguing the aged care sector. Disappointingly, once again, the government did not accept our advice, or the ANMF's proposed actions to protect older Australians from COVID-19.

As we head towards the end of this extraordinary year, the ANMF would like to express our admiration for your outstanding efforts. We wish you peace, goodwill and happiness over Christmas and beyond, and offer our continuing commitment to support you and the professions. May 2021 be a better year for everyone.

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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GLOBAL PLAN TO ELIMINATE CERVICAL CANCER

The World Health Organization (WHO) has endorsed a strategy for the global elimination of cervical cancer and has supported the implementation of a national cervical cancer plan.

The strategy, *Accelerating the Elimination of Cervical Cancer as a Public Health Problem*, is designed to advance women's health, strengthen global health systems and address inequities between and within countries to help eliminate cervical cancer.

The elimination resolution was led by the Australian government and underpinned by key Australian innovations that have positioned Australia to become the first country in the world to eliminate cervical cancer.

These include the initial development of the HPV vaccine by Professor Ian Frazer, Dr Jian Zhao and collaborators at the University of Queensland, in addition to Australia's world-first implementation of HPV vaccinations and complementary HPV-based cervical screening.

"Globally, there are over 300,000 deaths from cervical cancer each year, and over 90% of these deaths worldwide occur in low and middle-income countries," Adjunct Professor Karen Canfell, Chair of Cancer Council's Screening and Immunisation Committee explained.

"In work Cancer Council has done to support WHO's planning, our team and our collaborators have found that as many as 74 million cases could be averted and 62 million lives could be saved if 78 of the poorest countries in the world are able to rapidly scale up HPV vaccination, cervical screening and access to cancer treatment services.

"The target is ambitious but achievable. We have the technology to eliminate cervical cancer, and the peer-reviewed evidence to show it is feasible. We now need the political will in all countries to make it a reality," she said.



AFRICA DECLARED WILD POLIO FREE

Africa has been proclaimed wild polio free after four years without a case.

The Africa Region is part of the six World Health Organization (WHO) regions, five of which represent over 90% of the world's population and are now polio free.

Only two countries worldwide continue to see wild poliovirus transmission- Pakistan and Afghanistan.

As the world moves closer to achieving global polio eradication, the Global Polio Eradication Initiative congratulated the national governments of the 47 countries in the WHO African Region for today's achievement.

"Ending wild poliovirus in Africa is one of the greatest public health achievements of our time and provides powerful inspiration for all of us to finish the job of eradicating polio globally," said WHO Director-General Dr Tedros Adhanom Ghebreyesus. "I thank and congratulate the governments, health workers, community volunteers, traditional and religious leaders and parents across the region who have worked together to kick wild polio out of Africa."

ACT's fifth nurse-led walk-in centre open for business

Canberra has recently opened its fifth nurse-led walk-in centre.

Located in Canberra's inner north, the clinic is run by nurses and nurse practitioners who provide treatment for minor injuries and illnesses.

ACT's other nurse-led walk in centres are situated in Tuggeranong, Weston Creek, West Belconnen, and Gungahlin.

The centres, which have been running since 2014, have been highly successful, significantly reducing the number of presentations at Emergency Departments. To date, the centres have treated more than 282,000 patients and presentations continue to grow year on year with more than 67,000 in 2019.

To learn more about Canberra's nurse-led walk in centres, read ANMJ's feature on how nurse-led models of care are reshaping healthcare on page 10.

Sterile water proven effective as pain relief for women with labour back pain

Sterile water injections provide effective pain relief for women with labour back pain, according to University of Queensland-led research.

Dr Nigel Lee from the UQ School of Nursing, Midwifery and Social Work said the injections were previously seen as controversial but this study shows they are safe and effective.

"Some midwives have used this practice in order to provide pain relief for a number of years, however until now, there has always

been limited research to suggest that it works," Dr Lee said.

"In fact, many hospitals refused to support the procedure, viewing it as 'midwifery voodoo'.

"This research provides definitive evidence that water injections offer effective pain relief for the majority of women with labour back pain."

Dr Lee said twice as many of the women who received the water injections in the study reported their pain reduced by at least half, for 90 minutes or longer.

"Unlike normal labour pain, back labour pain is unpredictable and often continues

between contractions with no break.

"Most drugs provided for labour pain are ineffective for back pain which may persist even after an epidural has been given.

"Water injections have been shown to be simple, effective and safe, and to have no effect on birth outcomes."

Professor Sue Kildea from Charles Darwin University said the simplicity and safety of the procedure made it of enormous value to women around the world.

"Water injections will not only be of benefit to women wanting to avoid pain relieving drugs during labour, but also where women have little or no access to pain relief during childbirth, such as home birth and countries with developing health systems," Professor Kildea said.

REPORT SHEDS LIGHT ON SEXUAL ASSAULT IN AUSTRALIA

Women in their late teens are more likely than other Australians to be victims of sexual assault, with young men of the same age group the most likely to be perpetrators, according to a new report from the Australian Institute of Health and Welfare (AIHW).

The report, *Sexual assault in Australia*, shows that in 2018, police recorded about 18,300 sexual assaults against victims who were aged 15 and over when the assaults were reported.

The rate of sexual assaults reported to police was seven times higher for females, with more than 154.4 assaults per 100,000 females, compared to about 23.5 per 100,000 males.

The sexual assault rate was higher for Australians aged 15-19 than any other age group.

The report brings together data from a variety of sources and includes new analysis.

According to estimates from the Personal Safety Survey, the proportion of women aged 18 and over who were sexually assaulted at least one in the 12 months prior to the survey increased from 1% in 2012 to 1.6% in 2016.

In 2016, it was estimated that perpetrators of sexual assault were four times more likely to be someone known to the victim than a stranger.

In 2018, the majority (97%) of sexual assault offenders recorded by police data were male, with young males aged 15-19 the highest offenders of any age group.

Sexual assault can have a range of consequences for victims, AIHW spokesperson Louise York said.

CATSINaM appoints new CEO

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) has appointed Professor Roianne West as its new Chief Executive Officer.



A renowned leader in health, academia and research, Professor West brings a wealth of experience to the position and ensures the organisation is primed to realise its vision of Aboriginal and Torres Strait Islander nurses and midwives playing a pivotal role in achieving health equity across Australia's health system for Aboriginal and Torres Strait Islander Peoples.

Professor West's drive to improve Aboriginal and Torres Strait Islander health echoes a family tradition and includes careers in nursing spanning four generations.

She has completed a Bachelor of Nursing, a Masters of Mental Health Nursing and a PhD which developed a model of excellence

for increasing the number of Indigenous nurses.

Beginning her journey as an Aboriginal health worker in an Aboriginal Community Controlled Health Service, she holds decades of broad experience in leadership positions across hospitals, policy, VET, and academia.

Australia's first Nursing Director in a tertiary hospital with a dedicated portfolio of Indigenous Health, Professor West was also the country's first Professor of Indigenous Health, Foundation Chair in First Peoples Health, Director of the First Peoples Health Unit and the inaugural Dean of First Peoples Health at Griffith University.

"We face exciting times ahead in the midst of our challenges as Aboriginal and Torres Strait Islander Peoples," Aunty Dr Doseena Fergie OAM, CATSINaM Inaugural Elders Council Member said.

"We are confident that Roianne's unique style and the networks she has fostered will open new doors of opportunity for our organisation to walk through."



Lori-Anne Sharp

ANMF Assistant
Federal Secretary

Growing gender inequity in the wake of COVID

Female-dominated industries have been at the forefront of Australia's COVID-19 pandemic response.

For example our nursing, midwifery and carer workforces (of which 89% are women), have swung into action, showing extraordinary strength and sacrifice while delivering quality care to the community and dealing with new challenges daily.

Teachers, early childcare educators, retail workers and cleaners are the other essential workers, all of which belong to highly feminised industries (ie. 96% of early childcare educators are women) and have also kept us going.

Yet despite this heavy reliance on female-dominated industries in responding to COVID-19, federal policy so far has failed to address existing and escalating gender inequalities.

Australia was lagging on gender equality well before this pandemic hit. In 2020, the World Economic Forum's Global Gender Gap Index ranked Australia 44 out of 153 countries. Each year we've slid down the rankings, having started at 15th when the index launched in 2006. The top four positions are occupied by the Nordic countries, all of which are leaders in providing extensive access to childcare. New Zealand comes in at number six.

Outside the professional realms, women are also the majority of unpaid carers. Before COVID women already did double the amount of unpaid work than men. They are more likely to care for sick family members and take on education-related responsibilities while children are home from school.

Preliminary survey results from the University of Melbourne show mothers are spending an extra hour each day on unpaid housework and four extra hours on childcare. Fathers are spending about half of that effort, putting in 30 extra minutes on housework and two additional hours on childcare during the crisis. On a field that was already uneven, the public health crisis is further widening the gap between men and women in paid and unpaid work.

Early announcements of free childcare were welcomed by many- access to childcare is a key enabler of women's participation in the workforce. Unfortunately, the rapid end of this policy along with the termination of Job Keeper for early childhood educators (the only group of workers who have had Job Keeper stopped prematurely) unfairly discriminates against women. Questions about why such a positive policy initiative that supports women was reversed, have yet to be answered.

So far during this pandemic, federal stimulus announcements have primarily targeted the building, construction, manufacturing and defence industries, all largely male dominated. We have not seen the

same level of targeted measures in female-led industries or in the care economy.

Aged care investment in skills training and increased staffing levels is most apparent. Existing and future commitments in aged care funding will only benefit residents and those who care for them if the funds are tied to the provision of care staff. In the absence of any accountability or transparency in how this funding is allocated, means there is a further risk that profits will win out over care delivery.

The federal government's announcement to allow for early access of savings designated for retirement has seen almost three million Australians draw from their retirement nest eggs. Although men currently have accessed the scheme in higher numbers, women have withdrawn higher amounts and are more likely than men to have drained their accounts. We know that due to the gender pay gap and career breaks women take for caring responsibilities, they already retire with up to 47% less retirement savings than men.

Women over the age of 55 are already the fastest-growing group of Australians that are financially insecure, and this pandemic will set women further behind. Modelling undertaken by Industry Super Australia shows that a 30-year-old who accesses \$20,000 from super now could lose about \$100,000 when they hit retirement.

A 40-year-old could lose more than \$63,000. Any short-term benefit is likely to be outweighed by the long-term consequences that could see more women retire in poverty or experience economic insecurity in retirement. It is critical the federal government keeps its election promise of delivering the planned superannuation legislated increase to 12% by 2025. This will see 0.5% increments yearly from 1 July 2021.

The casual workforce has been hit hard during this pandemic with many either losing their jobs or experiencing a significant reduction in hours, particularly in the accommodation, food services, retail and hospitality sectors. Again, women, who are overrepresented in lower-paid, insecure and casual jobs are disproportionately impacted.

Health and economic crises can intensify existing gender inequalities and the full impacts and effects are still being assessed and understood. Nonetheless, we know that gender equality has a long way to go in this country and we hope that policy shaping the post pandemic recovery efforts both acknowledges and improves gender inequities. If the government can place gender firmly at the centre of its considerations, there is a very real opportunity to improve gender equality in this country.

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James Lloyd
ANMF Federal
Vice President

COVID-19: Our encroachment on the natural environment a factor in its emergence

The year 2020 will always be known as the year of COVID-19. Not many could have predicted this global pandemic which seemed to arise from nowhere.

The impacts of COVID-19 have been widespread: world recession, social unrest and isolation, limitation of human movement, political instability and of course, significant impacts on human health and our health services.

But with social isolation and physical distancing, we can sit back and reflect on the impacts we make on our world.

From the beginnings of civilisation, as humans, we have manipulated the natural world for our benefit.

The rise of societies and concomitantly, our scientific knowledge, has benefitted us overall. In the last 100 years, civilisation has granted us with lifesaving therapies such as antibiotics, allowed increased consumption of goods and services, raised the global standard of living - lifting hundreds of millions of people out of poverty, invented technologies that enable instant communication and transfer of ideas and data, increased world trade, and allowed the capacity to feed 7.8 billion people. By this tally, we have been successful as a species.

However, there has also been significant impacts on our earthly life support system - we are causing massive impacts on our planet's fragile ecosystems. We are releasing catastrophic amounts of carbon dioxide in the atmosphere, our waterways and seas are clogging plastic debris, and rainforests are still being logged at ever increasing rates. Rampant urbanisation demands more resources as the natural world staggers to cope with ever-escalating amounts of deadly pollutants. Urbanisation and high density living worldwide, and greater national and international travel will increase the likelihood of people coming in contact with infectious diseases.

One aspect of these human impacts now recognised is the actual and potential effects we have in the prevalence of new infectious diseases. Studies show that long-term warming trends tend to favour the geographic spread of infectious diseases around the world. New and resurgent vector-borne communicable diseases have been recorded due to our warming climate.

COVID-19 is the latest infectious disease arising from our collision with nature. A vast majority of new diseases come from animals - from interactions with wildlife and high density farming in particular. Factory farms are forcing animals to live in densities that would not naturally happen, allowing viruses to

the increased ability to spread, mutate and transmit to humans.

The clearing of forests and the resulting reduction of animal habitat forces species to occupy ever smaller and more fragmented habitats, resulting in an increased risk of species-to-species transmission of viruses. The hunting and selling of wildlife in wet markets have brought wildlife and humans in close proximity where animal to human disease transmission can easily occur.

SARS and Hendra viruses are examples due to close interactions of bats with other animal species. This has resulted in new deadly viruses that have affected human populations. Another disastrous example is the emergence of HIV in western countries in the early 1980s. The HIV virus jumped from apes to humans decades earlier due to hunting and eating of bushmeat. HIV went unrecognised and was confined to small areas in equatorial Africa until there were population pressures and commercialisation of small communities which introduced the virus to bigger urbanised centres, spreading across the world.

In addition, research has shown that the clearing of forests for farming has disproportionately favoured some species. It was discovered that small animals, such as rodents, songbirds and bats, become more abundant, sharing the spaces that humans now occupy. Smaller species are more likely to carry diseases, and hence more likely to transmit diseases to people.

The reason why smaller species carry diseases is thought that they invest more in reproducing at the cost of their immune system, making them more vulnerable to pathogens.

Human health depends on healthy ecosystems. The current COVID-19 pandemic is a warning that if we ignore this delicate balance, there are deadly consequences. If we are to lessen the risk of future pandemics, then we must cease the exploitation of the world around us and halt global climate change. We need to confront the underlying causes via biodiversity conservation and stabilising the climate. All world citizens must heed the clarion wake-up call of the COVID-19 epidemic and ensure that we renounce pillaging the natural world for our own mindless consumption. Rachel Carson, a 20th Century conservationist argued that "a war on nature is ultimately a war against ourselves."

'I put my hand up straight away': The SA nurses deployed to Victoria to help fight COVID-19

By Robert Fedele

Victoria was in the grip of escalating COVID-19 outbreaks and needed help from interstate volunteers to boost its health workforce.

South Australian registered nurse Kathie Spalding, who earlier this year stepped up to the role of Nursing Unit Manager at Lyell McEwin Hospital's COVID-19 testing clinic as the state tackled its own challenges, answered the call.

"I put my hand up straight away and rustled up a bit of interest from my clinic staff. Of the 16 nurses that came over [to Victoria] from South Australia, nine were from our clinic," she says.

"My family was the first consideration and once I got the green light, it was an easy decision to make to go over."

An Emergency Department nurse, Kathie shifted into a leadership role at Lyell McEwin's COVID-19 clinic in March.

The opportunity to join Victoria's COVID-19 frontline as part of a volunteer team of 29 nurses and paramedics, dubbed Team Alpha, added another dimension.

After confirming their interest, nurses and paramedics were informed they would be spending the next two weeks working in the community across Melbourne's COVID-19 hotspots, including Craigieburn and Fawkner, and be based at the Alfred Hospital.

"We had to make sure we were fitted to an N95 mask, that we had no health risks and that we were able to fulfil the responsibilities attached to the role," Kathie says.

In Victoria, SA nurses door knocked homes and tested consenting community members for COVID-19. They also helped collect kits and supported community members to carry out their own self-swabs.

Kathie says she was never afraid of contracting COVID-19 as nurses were armed with appropriate Personal Protective Equipment (PPE).

Days into the deployment, thousands of residents of Flemington's public housing towers were forced into "hard lockdown" to contain the spread of the virus, and resources, including Team Alpha, were diverted to the sites to conduct testing.

"Being so far out of our control, it was a little confronting. You were a little bit concerned about the rate [of cases] and I guess for us it was about the fact that it's so densely populated there comparatively so we just tried to support as much as we could."

The team returned to the community for a few days, moved on to support the Alfred's COVID-19 clinic, then flew home.

"Seeing the pressure everyone was under and seeing them all come together and help each other and uplift each other was just amazing," Kathie reflects.

"It helped me build up the confidence to step outside my normal day-to-day and it's given me more of an established empathy for what other healthcare networks are going through [during the pandemic]."

Back leading Lyell McEwin's COVID-19 testing clinic, Kathie says preparing for what lies ahead remains the focus.

"Our numbers have seesawed and I think we have been very fortunate. It certainly hasn't affected us like it has some of the other states. We're grateful for that and our hearts are going out to everyone else at the moment."

Go to [ANMJ.org.au](https://www.anmj.org.au) – INTERVIEWS to read the full story



Nurse Kathie Spalding, far right, with the team at Lyell McEwin's COVID-19 testing clinic



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HOW NURSE-LED MODELS OF CARE ARE RESHAPING HEALTHCARE



Nurses working in nurse-led models of care undertake comprehensive assessments, provide timely person-centred care, opportunistic education and support, continuity of care and link patients to other health professionals and services. Underpinned by advanced practice nursing care, innovative and cost-effective nurse-led models of care aim to improve access to healthcare and give people choice, enhance the patient experience, and boost outcomes, reports Robert Fedele.

Bega Valley's nurse-led Teen Clinic is a free drop-in service that allows local teenagers to talk about a broad range of health issues.

It was created in 2015 following a spate of youth suicides in the rural region.

"We were literally sitting around the staff room asking 'why aren't these kids coming in and getting help before it is too late?'" recalls Teen Clinic nurse Meghan Campbell.

General practices can be scary places for teenagers with health concerns, Meghan says.

To break down barriers, the Bega Valley Medical Practice established the confidential and non-judgmental Teen Clinic, which runs on Tuesday and Thursday afternoons between 1-5 pm.

A soft entry point for teenagers learning to navigate the health system, Teen Clinic covers medical and non-medical issues including general healthcare, contraception advice, mental health, bullying, STI screening, relationship issues and homelessness.

Without start-up funding, Bega GP and Practice Principal Duncan MacKinnon became a key driver of integrating the clinic into the practice.

The early intervention nurse-led model of care gives teens access to registered nurses, who act as facilitators to GPs and other health professionals.

All Teen Clinic nurses, who work autonomously in triaging, educating and screening this often vulnerable demographic, undertake additional education in areas like mental health and suicide prevention and sexual and reproductive health.

Since launching, Meghan says Teen Clinic struck a chord because nurses, arguably less intimidating to talk to than doctors, have more time to provide person-centred care which empowers youth to take control of their healthcare.

"Often we get young people come in and they don't even know why they're here or can't express it so we can sit and chat about

all sorts of other things until the real issues start to emerge.

"Before we started this we thought 'oh we're not cool enough, we're daggy'. Actually, they don't want someone to be cool. They just want someone who's real, authentic, open and non-judgmental that includes them in their healthcare."

Building acceptance of Teen Clinic involved forging relationships with the community and particularly schools and teachers, who often refer students.

Sexual health and mental health remain two of the biggest reasons teenagers visit.

"It's about opening up options and normalising accessing healthcare," Meghan explains.

"We get the whole gamut of health issues. Lots of it is sexual health and contraception, but often it's just opportunistic education around that too.

"Someone might come in with the flu or cold and we'll say 'by the way have you had an STI screen recently?' I love that the teenagers will come in for anything. They'll come in for an ingrown toenail, or they'll come in and say 'look I'm not getting along with Mum, I want to move out of home'.

Meghan believes Teen Clinic has made a profound impact.

"It's just fantastic to sit with a young person that's come in, nervous and scared about why they're there, and be able to put them at ease, maybe solve something for them on the day, make a plan with them about where they're going next, maybe book a return visit, and just see the relief on their faces. That's the stuff data will never capture."

Two years after launching, Teen Clinic was awarded a \$20,000 grant from the Australian Primary Healthcare Nurses Association (APNA).

More recently, it received Primary Health Networks Innovation Funding, enabling it to support nearby general practices to establish clinics in Eden, Merimbula, Narooma and Kiama.

But ongoing funding remains problematic, with Teen Clinic surviving on support from general practice principals who recognise its value.

"It's a real shame," Meghan says of the uncertainty.

"It's a simple solution that builds capacity into existing services and relative to other health dollars, it's a minute amount of money that would keep these going.

"Often these teenagers don't actually need medical care- they need nurse-led care."

WHY NURSE-LED?



Nurse-led models of care have been in place in Australia for decades and have proved incredibly effective, says ANMF Senior Federal Professional Officer Julianne Bryce.

Examples of nurses leading direct care delivery include emergency department triage and pre-admission clinics before surgery, diabetes education, stomal therapy, and now breast cancer nurses and general walk-in-clinics.

Ms Bryce says some nurse-led models target specific areas or conditions, such as sexual health, continence management, asthma, Parkinson's disease, breast cancer and homelessness, just to name a few.

Nurse-practitioner-led models of care also have the ability to be a real game changer. Nurse Practitioners (NPs) provide high levels of clinically focused, autonomous, holistic, comprehensive nursing care in a variety of contexts of practice which often includes the ordering of diagnostic tests and prescribing of medicines.

"Nurse-led models of care give people continuity of care," Ms Bryce explains.

"The increased access allows nurses to spend more time with the people they're caring for, answer their questions and build up a rapport that can lead to broader health education and health benefits.

"Nurses possess great health literacy and can often interpret information for people and their families, as they undertake comprehensive assessment, education, support and treatment of health issues using a nursing lens."

Ms Bryce says nurse-led models of care focus on meeting people's health needs but also empower them to become active contributors to their own health and wellbeing.

Despite the immense benefits of nurse-led models of care, Ms Bryce concedes funding and acceptance remain challenging, especially in primary care.

"A lot of the time nurses are providing this care in addition to their normal workloads and the only reason the nurse-led model of care continues is because they are just so determined and believe the service is too important not to provide it. This is not okay, these should be supported, funded models of care. We know they work," Ms Bryce says.

"The cost of establishing nurse-led models of care is always a major issue because the ongoing operation has to be offset by benefits. Research continually shows improved patient satisfaction, better quality

of life and improved clinical outcomes, better understanding of health issues and chronic conditions, and streamlined access to other health professionals. Nurses are excellent agents of connectivity as we know how the health system works, how to get access to resources and services and how to link people up with other health professionals."

Ms Bryce says people vote with their feet and that many successful nurse-led models of care have become vital services within communities.

"In an environment where the almighty dollar is important, and we spend so little on prevention, well run nurse clinics and nurse-led models of care can keep people well and living in their homes, managing their healthcare and chronic conditions, for as long as possible."

INCREASING ACCESS



In 2010, the ACT Government unveiled its first Walk-in-Centre in Canberra offering free healthcare for minor injuries and illnesses.

Open daily from 7.30 am to 10 pm, the centres, which now exist across five locations, are led by highly-skilled NPs and advanced practice nurses who provide treatment for a range of health issues, including but not limited to, cold and flu, cuts and burns, sinus infections and minor infections and wounds.

Nurses can remove sutures, apply wound dressings, offer emergency contraception, carry out blood glucose tests, treat minor fractures and provide X-ray referrals for suspected uncomplicated fractures.

Opportunistic health promotion, education and intervention is a core objective.

Based at the Tuggeranong Walk-in-Centre, Advanced Practice Nurse Kirsten Madsen joined the service four years ago after two decades working in intensive care.

"It was the opportunity to work autonomously in an innovative, quite unique healthcare service alongside other nurses," Kirsten says of the appeal.

The nurse-led model of care was established to relieve pressure from the Canberra Hospital's Emergency Department by providing an alternative healthcare option.

Nurses work collaboratively with GPs and link patients with other health services, such as the Canberra Sexual Health Centre or dental and allied health professionals.

"It's having that knowledge and helping people in their moment of need but then



Bega Teen Clinic

being able to refer them onto the next step for their healthcare.”

Before COVID-19, three of the centres were seeing a total of 250-300 patients each day - respiratory tract infections remain the most common reason people present.

The Weston Creek clinic rapidly transitioned into a COVID-19 testing/respiratory assessment centre in early March at the height of the pandemic.

Kirsten says the Walk-in-Centres encounter a wide range of clinical scenarios.

On a recent shift, she treated people aged from 11 to 60.

There was an ankle sprain, a person with a stye, someone with infected toenails, and an acute wound dressing that needed applying.

Nurses hail from diverse clinical backgrounds such as sexual health, ED, ICU, mental health and general practice.

“There’s a lot of incredibly skilled and intelligent nurses working across all areas of healthcare and I believe this nurse-led model of care allows us to utilise our skills and work to our full scope. We work autonomously and we’re cost-effective,” Kirsten says.

The Walk-in-Centres provide greater access to healthcare, particularly for marginalised groups.

“There are a lot of people who are disengaged from the health system and they

don’t have the financial means to access GPs on a regular basis for their healthcare needs, so I think we provide an important part of the answer for these people.”

Kirsten says success is measured by how many people present, wait and consultation times, a breakdown of the most common presentations and critically, consumer feedback.

“I think the service provides people with timely access to high-quality healthcare and we are supported by management to take as long as we need to deliver the best care. I think we make a difference.”

AREAS OF GROWTH



Over the past two years, Tasmanian Aged Care and Mental Health Nurse Practitioner Hazel Bucher worked in a shared care model alongside a GP across six residential aged care facilities, providing in-reach care and dealing with clinical issues.

Registered nurses would send emails about incidents and issues affecting residents and write down others in a book, such as pain issues, likely infections or if residents needed a review.

“I’d go see the residents one day a week and the GP would go to the same nursing home a couple of days later,” Hazel says.

Hazel, who helped set up and then ran a nurse-led memory clinic in Hobart for people experiencing memory loss over the

past eight years, says the focus of her work in RACF’s was on hospital prevention and trying to treat residents’ issues early before they escalated.

She says nurses are often the interface between people and healthcare.

Eventually, she assumed greater responsibility and took the reins at some of the smaller nursing homes and independently managed residents.

Previously, Hazel began an independent practice and built relationships with one RACF.

Based at this nursing home, Hazel was able to spend quality time with residents, identify issues and provide timely healthcare.

But communicating with a variety of doctors, who hold residents’ healthcare records offsite in their clinics, remained a barrier to providing holistic care.

“When I worked with a standalone GP, it was an improved model. I had access to the patients’ records, and when treating an issue for a patient, say with cellulitis of their lower leg, I could learn more about their health status over weeks and maintain that regular contact. I was able to manage every part of their illness, such as their blood sugars being a bit high, and get on top of it.”

Hazel says the best thing about working in aged care was that it allowed her to make a difference in the lives of an often forgotten cohort.

She believes nurse-practitioner-led models in aged care, which typically involve an NP being employed at a nursing home or working alongside a GP, can improve care outcomes for residents and help mentor and upskill staff, especially carers, whom she considers undervalued.

While she supports shared models, she ultimately believes standalone nurse-practitioner-led models of care in the aged care sector would better meet the needs of vulnerable older Australians.

In Australia, nurse-practitioners are required to work in shared models, unlike in New Zealand, where aged care nurse practitioners can work independently and free of collaborative arrangements, and can sign death and cremation certificates.

“If we could work truly autonomously and as trusted professionals like the New Zealand nurse practitioners do, nursing itself would be so much more visible and effective. Patients and their families would really understand what nurses do and are capable of doing.”

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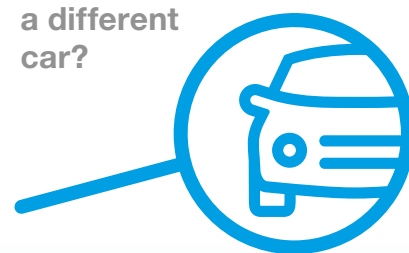
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Bereavement in older people

By Deb Rawlings and Kim Devery

In caring for older people, loss and grief are common (Van Humbeeck et al. 2016) with grief described as the response to any loss in life (Neimeyer et al. 2014). Losses include those common to humanity, such as loss of independence or of health, or those associated with the death of family members and friends. Older people have suffered losses throughout their lives, sometimes multiple losses (Stephen et al. 2013), responding to grief emotionally, physically and cognitively (Neimeyer et al. 2014). If older people are in Residential Aged Care Facilities (RACFs) they may experience the loss of fellow residents, some of whom they will have formed strong attachments with (Ní Chro'ín et al. 2011).

Staff members also grieve losses in RACF's (Gerow et al. 2010). The work-related impact of multiple losses is said to be complex, with an indirect influence on turnover, whereas positive reactions to grief can protect from burnout (Marcella and Kelley 2015).

Staff working in RACFs are increasingly providing care for people who die, with emerging evidence of strategies to support staff, residents and families (Boerner et al 2015; Vis et al. 2016). Organisational approaches to grief and loss will influence the care that is able to be provided, although it is difficult to define supportive care, or an appropriate response to normal grief and loss in healthcare or RACFs. However, it has been identified that acknowledging the sequential losses, training in grief and bereavement, and an organisational focus can help to address some of the issues (Marcella and Kelley, 2015).

AIM

To examine approaches to grief and loss identified by students who work with older people.

METHODS

Palliative and Supportive Services at Flinders University, Adelaide, offers post-graduate courses in Palliative Care/Palliative Care in Aged Care by distance education. In one topic we invited students to share their practice approaches, experiences and views about grief and loss in relation to older people. All students were invited to participate in the study and were assured of anonymity and confidentiality. Over a five year period, 176 students were eligible to be

included and 66 students provided consent to have their online posts included. Ethics approval was received. The activity required students to address the following point:

How does your organisation or practice setting recognise issues of grief and loss for families, for staff and/or for fellow residents?

RESULTS

The themes emerging from the data analysis were: 1) providing support, and 2) rituals with the latter also considered as an organisational response.

Sub-themes were also pre-determined in the 'providing support' category due to the nature of the activity: organisational support/support for bereaved families/ staff support/support for other residents or patients. We have intentionally used the word staff here as it encompasses any worker who is involved in the care of older people.

PROVIDING SUPPORT

In terms of organisational culture/support for patients and families, 52 respondents (78.8%) reported that this was an important aspect of their professional/organisational response to loss. Of 66 respondents, 22 (33.3%) wrote of issues of grief and loss in relation to other residents. Not all respondents were working in RACFs, and across many settings, patients or residents were affected by the death of a neighbour who shares their room, floor, unit, service or facility. In relation to grief and loss in staff, of 66 respondents 61 (92.4%) highlighted issues in this category with counselling the most frequently cited (n=36).



RITUALS

Of 66 respondents 56 (84.8%) commented on rituals of many different types. Of these, 39 mentioned rituals which are conducted within organisations and examples are shown in Table 1.

Table 1: Examples of rituals (*see next page*)

DISCUSSION

There is little agreement on the definition of organisational culture, which can include a range of social behaviour such as language, behaviours, beliefs, ceremonies and rituals (Norton and Gino, 2013). Despite this varied construct, organisational culture is described as being expressed in care delivery and teamwork (Etherton-Beer et



al. 2013) and is positively associated with positive patient outcomes (Braithwaite et al. 2017).

Many individuals are affected by the death of a resident/patient, not only their family but also the staff who cared for them as well as fellow residents/patients (Ní Chro'ínín et al. 2011), providing the imperative for organisations to acknowledge and address support strategies. Within the workplace there were commonalities in how families were supported following a death, and while provision of bereavement support is less common in RACFs (Vacha-Haase 2013) than in Palliative Care Services where it is embedded (Stephen et al. 2013), we can

see an increase in the recognition of the need for this. Students included ways to address it: support from staff before death; a phone call to the family following death; and encouraging families to come back and visit after a death are increasingly offered in these settings.

Staff in RACFs experience loss and grief following the death of a resident in a similar way that families do (Boerner et al. 2015). Feelings of grief and loss can be cumulative with implications for organisations in terms of those staff who may be in danger of burnout (Harrad and Sulla 2018), often seen in a loss of interest, and in negative attitudes to work (Wilkinson et al. 2017).

Investment in supportive strategies arguably help staff dealing with ongoing losses, in turn helping to reduce stress, compassion fatigue and subsequent burnout and related absences (Wilkinson et al. 2017). Some organisations do have formalised access to counselling by health professionals (internally) who are trained in staff support, such as a social worker or bereavement counsellor, although these are likely to be larger organisations and often palliative care services. Others have formal external arrangements in place, such as an Employee Assistance Scheme (EAS), available in many organisations, although it is unknown how often these services are accessed.



RITUALS PERFORMED

Lighting candles
Playing music
A memorial board
Placement of flowers and/or a photograph
Use of a quilt to cover the body or coffin (sometimes made by a resident)
A memorial garden
Memorial or remembrance services
A guard of honour as the deceased leaves the facility
(made up of staff and/or other residents)
A special symbol on the door of the room of the deceased
A Christmas tree bauble
Special client property bags
Staff acknowledgement via sending
a card to the family

In our study, those working in RACFs spoke of the loss and grief experienced as a result of the bonds and relationships formed over the years. Staff support in bereavement was provided in different ways: staff being allowed to go and say goodbye to a resident who had died after the family left; extra time allowed in handover to talk through a death; debrief sessions held to acknowledge the loss of a patient at meetings. These could be in the form of a death or case review (what went well and what didn't) or a critical incident analysis. Other practices included: not to lay out the body alone, the acceptance and encouragement of bereavement visits and funeral attendance, a positive trend however, as it implies team or organisational support for colleagues.

If formal organisational access to support is not provided, then this role will often fall to senior staff or to colleagues who act as mentors. Alternatively, there were

organisations in which these issues were not well recognised, where bereavement visits and funeral attendance are not an accepted part of practice, or where strategies have been previously put in place but had not continued. Van Humbeek and colleagues (2016) describe organisational culture as having the ability to impede 'grief care' such as how staff are enabled to support residents and families in grief and loss. Healthcare Assistants have been identified as a group who need support following a death in RACF sometimes experiencing negative emotions and stresses (Cronin et al. 2020). Regular reflective debrief sessions can help to support staff, provide identification of learning needs and help build workforce resilience (McIntosh 2020).

There has been recognition of the impact that a death may have on the residents, as multiple losses are prevalent for older people (Van Humbeek et al. 2016). For

some it will be the reminder of their own mortality, for others the reminder of other losses, or that they developed a friendship with the resident who died. We found that there appear to be various ways in which residents are informed of a death, including: a newsletter with a list of those who have died, or rituals that are regularly practiced. There were reports of fellow residents being allowed to spend time with the person who is dying, encouragement to share stories about the person who has died, or in some cases offer of assistance to attend the funeral at a local church (one example saw the funeral televised).

However, in contrast, some organisations only inform fellow residents of a death if the resident is known to them, or perhaps if they are in the next room or seated together for meals, or if they ask where the person has gone (Tan et al. 2013). If deaths go unacknowledged there is perhaps the

danger that residents will feel that it is not acceptable to openly mourn a loss, and as older people suffer ongoing losses not only of fellow residents but also of family and friends, this can potentially cause disenfranchised grief (Djivve et al. 2012).

Rituals can be what people turn to in the face of loss, to help with psychological recovery and alleviate grief (Norton and Gino 2014). Rituals in healthcare have been used in a number of years in palliative care (Rawlings and Glynn 2002) and it was encouraging to see so many in RACFs in recognising the death of a resident (Dempster 2012). Memorial books/books of remembrance (Walter 2003) are used in RACFs which can contain staff messages, memories of the person who has died, as well as reflections. Also described were a photograph on display (perhaps accompanied by flowers or candles), a card with a short story of that person's life; a room blessing after a resident has died and before a new resident moves in (Maitland et al. 2012); and symbols displayed on the door of the room when someone has died. It was not clear if this was in place of, or in addition to notifying residents verbally of a death.

We also found local customs following a death that included family planting a rose in the garden, a plaque in a memorial garden, the family being given a plant to take away, and a gift to family of a card that the resident wrote before they died.

There was also mention of how the deceased's body leaves the facility, with a move away from it being hidden with the coffin taken out the back door. As well as the body leaving the facility by the front door, some respondents reported the use of a guard of honour (family, staff, other residents) (Masaki and Asai 2013), and of a special blanket or quilt used to cover the coffin.

In their study, Tan and colleagues (2013) describe that fellow residents find hiding the death and removal of the body as disrespectful. Although there are an increasing number of rituals being identified in RACFs there are still those who have nothing, either because they have not identified the need or because they are unaware of the possibilities of what the organisation can put in place.

OPPORTUNITIES TO ADDRESS

For organisations, supportive care in grief and loss needs to be identified as a priority (Birken et al. 2015). Some organisations have no recognition of staff/family or other residents' needs in relation to grief and loss, while others have made inroads with external and internal strategies to address this. Failure to acknowledge the relationships between staff and residents, and the subsequent impact of cumulative deaths and ongoing losses can be detrimental to the workforce (Harrad and Sulla, 2018). Strategies such as debriefing sessions and rituals (even small ones) can provide ongoing benefit and help build resilience (McIntosh 2020). Some of the examples provided here can be a way in which to help staff and other residents/patients to grieve the losses and acknowledge the person who has died.

For nurses working to enhance the care of older people there are lessons here in the need for care of other residents or patients when someone dies. This can be achieved by notifying residents or patients of a death and allowing them to explore their feelings of loss and grief. As always, staff gain strength and support from colleagues but also with recognition of self-care requirements in facing ongoing losses. The negative impact of ignoring this can be seen in the grief and loss sequelae although there is still more work to be done and certainly there needs to be stronger evidence around these important aspects of care.

CONCLUSION

Grief and loss are of importance to the general community and in particular RACFs where residents live through and staff professionally manage, sequential multiple losses of life transitions. While it is encouraging to see that individuals and some organisations are developing and practicing compassionate approaches and responses to grief and loss, there is more work to be done and certainly there needs to be stronger evidence around these important aspects of care.

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THE IMPACT OF A GLOBAL PANDEMIC ON THE INTERNATIONAL YEAR OF THE NURSE AND MIDWIFE

In 2020, the International Year of the Nurse and Midwife and planned culmination of the global Nursing Now campaign, the role of nurses, midwives and carers has been thrust into the spotlight in the face of the COVID-19 pandemic. Robert Fedele writes.

In April, when British Prime Minister Boris Johnson was discharged from hospital after recovering from coronavirus, he singled out two intensive care nurses for standing by his bedside and providing the care that saved his life.

The praise was symbolic of the increased visibility and appreciation of nurses worldwide amid the COVID-19 pandemic.

"It showed that he saw the intellectual work that nurses do along with the compassion and caring," reflects Emeritus Professor Jill White, Nursing Now Campaign Board member for the World Health Organization's (WHO) Western Pacific Region.

"To have some important policymakers see nursing in that way was terrific. It's just a shame it takes a life-threatening episode for that to occur."

The intention of 2020 International Year of the Nurse and Midwife was to raise awareness about the complex work nurses and midwives do, help drive universal health coverage and get more nurses and

midwives involved in policy and decision-making. But COVID-19, justifiably, has taken priority.

"The campaign hasn't quite been the celebration that we had hoped it would be," Professor White says, referring to targets to get more nurses included in policy conversations.

"While the public express gratitude to nurses for the role that we're playing [during this pandemic] there is still a long way to go in converting clapping and chocolates to inclusion in policy about everything from proper fit testing of masks to appropriate access to Personal Protective Equipment (PPE).

"More than anything, we need inclusion of nurses at high-level decision making at the state and federal level. That will really show that both the International Year of the Nurse and Midwife and the pandemic have actually had some positive outcome, not just for nurses, but for the health of the public into the future."

Throughout the pandemic, the media and public have often referred to nurses as the frontline.

But Professor White considers them the last line of defence against COVID-19 and says the public must continue to abide by social distancing restrictions, handwashing and wearing masks if the battle can be won.

Another ongoing narrative compared nurses to superheroes.

"It's good to be recognised as important but more important to recognise that in doing what we do, we are doing our job, competently, in a well-educated way, appropriately," Professor White argues.

"When we get put on pedestals, when people get called superheroes, they become something other and that doesn't necessarily help with us being seen in our rightful role as incredibly important contributors in an ongoing way to healthcare."

At the beginning of the International Year of the Nurse and Midwife, Professor White



“More than anything, we need inclusion of nurses at high-level decision making at the state and federal level. That will really show that both the International Year of the Nurse and Midwife and the pandemic have actually had some positive outcome, not just for nurses, but for the health of the public into the future.”



encouraged nurses and midwives to make their voices heard and capitalise on the opportunities to promote the professions.

The call to arms hasn't necessarily gone to script, but Professor White says nurses and midwives have broadly demonstrated and showcased their work. The challenge is to keep up the momentum.

“We really need, at the end of all this, to be absolutely analytical and political about the role we have played, the lessons we have learned and the way in which we can make a better health system more fitted to be able to respond to emergencies, whatever they are, and to really work to our full scope of practice.”

Professor White believes COVID-19 has reinforced how appropriate healthcare demands well-educated nurses in the right numbers and the right places, especially politics, where they can hold governments to account and lead change.

Some positives to emerge in the wake of the pandemic include increased access to nursing expertise via the expansion of Telehealth, she says.

“Telehealth has shown us that the idea of people with chronic and complex diseases having to get up, get dressed, find transport and go and sit in GP surgeries and wait to see a healthcare professional and then retrace their steps all the way home is inappropriate.

“We've got technology that can be embedded in the home that can be giving real-time information to health

professionals, distant from the patient, where remedial action can be taken via Zoom, Skype, phone, and people can live their lives with assistance, particularly from registered nurses.”

With the world focused on fighting COVID-19, the Nursing Now Campaign Board have decided to extend the campaign into next year.

Extending the International Year of the Nurse and Midwife is also being considered.

Launched in 2018 by WHO and the International Council of Nurses (ICN), the landmark three-year global nursing campaign set out to raise the status and profile of nursing so that the profession could work to its full scope and drive universal health coverage.

One of the campaign's biggest successes has been the Nightingale Challenge, which has currently helped promote more than 30,000 nurses globally into leadership programs.

“It's caused nurses to have conversations with each other about what they need to do differently to have more political influence and make the case for what they do and how to extend that,” Professor White says.

“It's given nurses a source of pride, but I think it hasn't extended, certainly in Australia, outside nursing to people of influence that we had hoped. We hoped that nurses would engage, not necessarily just with politicians, but with people of influence to make them better understand what contemporary nursing is about and for those people to become advocates for the profession.”

Australia's contribution to the campaign has focused on pushing for greater access and equity in healthcare.

“COVID-19 has underlined everything that Sir Michael Marmot has been saying for the last probably 30 to 40 years about social determinants of health. It's absolutely painted that so clearly, that these dreadful diseases hit the most vulnerable, the most unprepared and those with the fewest resources to be able to deal with it. That must change. We absolutely cannot have such blatant health disparities.”

As the International Year of the Nurse and Midwife draws to a close, Professor White says she remains continually moved by the solidarity shown by nurses and midwives working across all healthcare settings.

“The immediate focus is trying to be good members of our communities and helping educate people through our role modelling behaviour of the importance of handwashing, social distancing, wearing masks, and adhering to curfews and government restrictions where they exist.

“I also think looking after each other's mental health, and our families' and communities' mental health is incredibly important. We will come out of this, and when we do, we cannot just celebrate coming out, we have to do the hard work on making sure this never happens again in this way. Nursing's role in the building of resilient communities, I think that's probably the most important.”



Linda Starr

An expert in the field of nursing and the law Associate Professor Linda Starr is in the School of Nursing and Midwifery at Flinders University in South Australia

A 10-year ban for breaching professional boundaries

Crossing professional boundaries is a breach of trust – particularly when this involves sexual misconduct.

A recent study identified that whilst sexual misconduct cases (alleged sexual relations and sexual harassment or assault) amongst 15 health professions are rare, the impact they have on those involved and the general community is significant and long lasting (Bismark et al. 2020).

During 2011 and 2016, the Australian health regulators received 1,507 notifications of sexual misconduct against 1,167 registered health practitioners – 2% of the total number of registered health practitioners in Australia.

Two hundred and eight practitioners were subject to more than one report during that time. Psychiatrists were subject to the most number of notifications regarding sexual relationships followed by psychologists and then general practitioners.

Nurses and midwives were subject to 224 - 19.2% of the sexual misconduct notifications (Bismark et al. 2020).

Furthermore, this study identified that there were more notifications made regarding male rather than female practitioners, that practitioners tended to be middle aged rather than younger and that there were more notifications made in regional and rural areas than metropolitan areas (Bismark et al. 2020).

The findings of a recent case filed against a registered nurse - Monteduro (M) by the NMBA is an example of a sexual boundary breach.

The allegations of professional misconduct against this practitioner were that they failed to observe a proper professional relationship with patient VXJ when she was an inpatient and after she was discharged from the facility, a breach of professional boundaries with VXJ having a sexual relationship with her following her discharge and giving false and misleading explanations in the investigation on more than one occasion.

VXJ was a psychiatric patient who was first diagnosed with bipolar disorder and late schizoaffective disorder following psychotic episodes, having been admitted in an acute state following thoughts of harm to her parents, herself and her dog.

M was one of the nurses who provided care for VXJ and so would have known that she was a vulnerable person. During her admission, M gave VXJ his mobile and home landline telephone number, evidence provided during the hearing indicates that VXJ rang these numbers more than 250 times during her admission, however, there was no mention of this in her case notes.

In 2012 following her discharge VXJ moved in with M where a sexual relationship began, although the practitioner denied this. During this time M took several steps to prevent their relationship from becoming known, reduced her medication to a point where she was experiencing symptoms and manipulated her into not seeking psychiatric care.

VXJ later bought a property at Jervois where they both lived together in a de facto relationship. VXJ also assisted M financially. The relationship ended in 2015 due to alleged domestic violence where VXJ reported M to the police for assault and rape.

Having considered the evidence and noting the inconsistencies in the practitioners' statements during various interviews, the close proximity between VXJ's discharge and their cohabitation, and that the relationship commenced whilst M and VXJ were in a nurse patient relationship the tribunal concluded that M acted contrary to the Code of Professional Conduct, fell below what would be the expected reasonable standard of care which amounted to professional misconduct.

The tribunal further noted that M owed a duty of candour and cooperation throughout the investigation which was breached through his false and misleading statements finding that M was not a fit and proper person to be registered as a nurse.

The tribunal ordered that M be reprimanded, cancelled his nurses' registration, disqualified him from applying for registration for 10 years, prohibited him from providing any health service for 10 years and ordered him to pay costs of the proceedings.

Patients rely on healthcare practitioners to be trustworthy and practice in an ethical manner with integrity and without taking advantage of them. Any breach of professional boundaries threatens this trust and has the potential to undermine the public's confidence in the profession. It is important that all health practitioners are aware of their legal and ethical obligations where they form a reasonable belief that a colleague has breached professional boundaries and take the appropriate action necessary to protect the public.

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Tara Nipe

Federal Professional Officer

COVID-19 reveals systemic flaws

At the time of writing new cases of COVID-19 were emerging in NSW, Queensland and Tasmania, while Melbourne was in lockdown – this virus spreads phenomenally quickly.

Marginalised communities and those in aged care are the most vulnerable and have been devastatingly affected. This isn't by chance; despite union campaigning on issues from public housing to insecure work, decades of prioritising profit over people has created perfect pandemic environments. We see this most clearly and heartbreakingly in nursing homes.

Facility owners and providers used to have to pass probity conditions to ensure they were fit and proper persons to care for vulnerable people. In 1997, with the claim that ownership doesn't affect the delivery of care, probity was replaced by an 'approved provider' process separating owners from providers by only evaluating key personnel, like managers.

Anyone can purchase a company that operates nursing homes, regardless of their personal or business track record.

Since this regulatory change, some providers have said they're creating homes for consumers, and cut registered and enrolled nurse positions while increasing reliance on care workers.

However, people move into nursing homes because they can't safely live independently or with family. Care workers provide invaluable care, but many residents' complex nursing and medical issues mean registered and enrolled nurses can only meet their healthcare needs. Further, most facilities have reduced the overall workforce – aged care staff, both nurses and care workers, have too much to do in the time available.

The federal government provides the majority of aged care funding, yet there's little transparency about how this money is spent. It's certainly not on making sure the number and mix of staff are appropriate, food is nutritious, or that there are necessary supplies.

The Royal Commission into Aged Care Quality and Safety has heard evidence from multiple witnesses about the restriction of essential stock like continence aids. It's no wonder, then, that personal protective equipment (PPE) was in short supply when the pandemic began, nor that few care and support staff were trained inappropriately to use and dispose of PPE. This combination of a lack of equipment and knowledge increased the transmission of COVID-19 within nursing homes.

Aged care staff are frequently employed part-time, for shifts as short as four hours. This means less continuity

for residents and often, because pay rates are so low, the need for employees to have multiple jobs in the sector. Care workers are too often seen as replaceable, making it harder for them to speak up about issues and concerns. Casualisation and insecurity of the aged care workforce have directly contributed to viral spread between nursing homes. Much of the COVID-19 toll is attributable to these systemic issues, not because staff in the sector have been careless.

It's clear that the systems causing these issues must be changed.

In August 1919 the Victorian government lifted an 11-week lockdown instituted because of pandemic influenza. Trades Hall's executive committee met days later and, to both increase the number of adults in employment and improve what's now known as work/life balance, began campaigning for a shorter workweek. It took almost three decades, but the 40-hour week was introduced in 1948.

COVID-19 will not leave a single aspect of our lives, our habits, or our society unchanged. There's no doubt we'll be dealing with the physical, psychological, and economic effects of this virus long after we have effective treatments and/or vaccines.

While many of those consequences are already devastating, we're also offered a unique opportunity to reflect on 'business as usual' and determine what we want to transform. It's clearer than ever that how essential and societally valuable someone's work has little connection to the recognition and remuneration they receive. This has to change.

Whether it's in aged care, acute, disability, primary or community care, nurses and care workers don't want NHS-style applause – that's nice, but what we want is substantive change that recognises the value, meaning, importance, and skill of our work. We want our voices to be heard on policy, reform, and governance. We want the system that provides care to frail, older, vulnerable people to be staffed with the right number and skill mix of qualified, supported nurses and care workers. We want that system to be mandated and enshrined in law. That's the first step to repairing the system. Once the crisis is weathered, it's time for us all, as a society, to repair, transform, and prioritise what really matters – people.



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Mask-related skin injury during a respiratory pandemic: A wound CNC perspective

By Sarah Sage, Monika Samolyk and Donna Nair

Healthcare workers (HCW) are using personal protective equipment (PPE) more often and for longer wear times to reduce the risk of contracting or transmitting COVID-19.

The authors have noted images of nurses from around the world with significant mask-related facial skin injuries and the expeditious development of HCW guidelines, to prevent these skin injuries.

It is proposed that there needs to be an exploration of PPE mask related skin injuries [PRSI (m)] and the application of these guidelines in the Australian context. The expertise that Clinical Nurse Consultants (CNCs) in wound management have, in iatrogenic skin injury prevention, makes them well positioned to offer insight into this challenge. For the purposes of this opinion piece, skin injury is defined as an alteration of skin integrity due to an external cause or factor.

Until further evidence becomes available, the authors suggest the following principles on protocol development, for PRSI (m) in Australian HCWs:

- Application of Australian Occupational Health and Safety legislation and regulatory practices, when designing protocols for mask use;
- Where possible managing one hazard should not introduce another hazard or compromise existing risk mitigation, eg. risk of infection is not increased by the application of prophylactic dressings/creams.

The nature of the COVID-19 infection (eg. high virulence, long incubation period, asymptomatic carriers, and severe health outcomes for some people) has necessitated a high degree of care when using masks to ensure their effectiveness in protecting HCWs against infection. It was noted that in online crowdsourced discussion groups such as “Nursing in the time of COVID-19 - A clinical forum” and informal discussions within health service networks, nurses were seeking advice, in order of descending frequency, for: rashes and allergy-type descriptions, pain, acne and facial itching or sores.

Two main themes identified in these forums from a skin-integrity perspective were:

1. A limited understanding of what was causing the harm, and
2. A wide variation in the ideas and suggestions to protect the skin of HCWs.

This knowledge gap between the causes of PRSI (m) and best practice prevention/treatments, is consistent with the experience of wound CNCs, who educate clinicians on pelvic skin injuries, and is witnessed when educating HCWs on pressure injury identification and differentiation from other aetiologies such as dermatitis, including incontinence associated dermatitis (IAD).

The parallel between identification of IAD versus pressure injury (PI)s and their subsequent treatment, is a useful analogue, as these skin injuries can appear together and guidelines do not recommend dressings to prevent IAD, (Beeckman et al. 2015) nor to use a barrier cream to treat a PI, (EPUAP, NPUAP and PPPIA 2019). HCWs deserve the same level of evidence-based prevention and treatment to protect their skin. This difficulty in identification may exist due to the complexity and overlapping causes of skin injury (Beeckman et al. 2020), rather than a knowledge gap per se.

Internal health service reporting identified that contact dermatitis and exacerbation of acne was reported in HCWs wearing masks for long periods; however, this contrasts with evidence that pressure is a frequent cause of injury (Jiang et al. 2020). Other suspected mechanisms of injury include friction, moisture, the interaction of the HCW skincare in a humid environment or other factors, yet to be identified.

To understand the application of the prevention strategies in the authors' local clinical settings, as recommended in the Canadian document, ‘Prevention and Management of Skin Damage related to Personal Protective Equipment: Update 2020’ (NSWOCC 2020) and the PRPPPE white paper (Alves et al. 2020), two of the authors informally tested a range of available masks with suggested skin injury prevention strategies. The authors experienced pain and discomfort directly from some of the masks and skin irritation from the removal of some of the dressing materials used for prevention. Many of the recommended interventions affected the ability to achieve a correct mask fit or led to the seal being lost within a short space of time (<30 minutes). Furthermore, it was noted that some of the dressing

suggestions, in the aforementioned guidelines, did not meet the criteria for a prophylactic dressing, recommended as first line prevention for patients.

The authors consider that the existing frameworks for identifying and treating IAD and PI may be able to be extrapolated to these HCW mask-related skin injuries and propose the following considerations to prevent and treat PRSI (m):

- Pressure/shear protection for HCW should follow the same principles as the best practice for patient pressure injury prevention.
- Dermatitis prevention should be in line with occupational dermatology practice and IAD prevention may provide a starting point for research. However, when dermatitis occurs, the principles for treating IAD can be applied:
 - Remove the cause of the irritant
 - Do not apply anything to the skin that would prevent the treatment of dermatitis (eg. any interventions that create a physical barrier and prevent medicated creams from being effective, or leave residue on the skin).
- For intact skin, where there is no current evidence of injury, any prevention must not compromise mask function and effectiveness. However, when a HCW develops a PRSI (m) (of any severity or cause), the individual risk management plan should balance the skin injury and infection risks. This may include referral to clinical experts.

The responsive development of guidelines from global regions, suffering high COVID-19 infection rates and significant mask shortages must be acknowledged, however, they may not be suitable for broad adoption in Australian healthcare settings.

Instead, these guidelines offer directions for further research, and Australian health services are well positioned, because of low community transmission rates, to do this work. The authors hope that these suggested guiding principles, encourage the development of Australian guidelines to prevent PRSI (m), and for HCWs to report PRSI (m) and recognise these skin injuries as being unacceptable.

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Daniel Crute

Federal Industrial Officer

Paid pandemic leave is a must

The Australian union movement has been calling for paid pandemic leave since March this year. Paid pandemic leave would provide workers with the right to up to two weeks of paid leave per occasion to self-isolate as a result of the COVID-19 pandemic.

The ANMF, ACTU and other health unions, made applications to the Fair Work Commission (FWC) for paid pandemic leave in all health awards. Unions demonstrated that health and aged care workers are at higher risk of exposure to COVID-19 and provided strong evidence on the need for paid pandemic leave.

Employers vigorously opposed these applications.

The FWC initially ruled against granting the leave, however, in late July, in light of developments in Victoria in the aged care sector, FWC decided it was prepared to grant leave under the *Aged Care Award*.

Following submissions from the ANMF and HSU, the FWC also determined that entitlement to paid pandemic leave should apply to nurses and other health professionals who work in residential aged care. The *Nurses Award*, *Aged Care Award* and *Health Professionals and Support Services Award* now provide the following:

Workers are entitled to up to two weeks of paid pandemic leave if they cannot work because:

- their employer, government or medical authorities, require them to self-isolate or quarantine;
- they have to self-isolate or quarantine while waiting for a coronavirus test result;
- they are showing symptoms of coronavirus and have been advised by a medical practitioner to self-isolate or quarantine;
- they have come into contact with a person suspected of having contracted coronavirus; or
- of government or medical authority measures taken in response to coronavirus (for example, closing a facility).

Employees who want to take paid pandemic leave need to be tested or agree to be tested for coronavirus for each occasion of leave, or they are not entitled to the leave.

Employees cannot take paid pandemic leave if they are entitled to take paid personal leave instead. Employees also cannot take the leave if they're entitled to workers compensation due to contracting coronavirus.

When taking paid pandemic leave:

- **Full-time employees** must be paid their base pay rate for their ordinary hours of work

- **Part-time employees** must be paid the higher of either their agreed ordinary hours of work or an average of their weekly ordinary hours of work for the previous six weeks.
- **Casual employees** must be paid an amount based on an average of their weekly pay over the previous six weeks.

Unfortunately, paid pandemic leave in the aged care awards does **not** apply to employees covered by an enterprise agreement.

This lack of mandated paid leave for most workers highlights why a fix is urgently needed Australia-wide and not just in aged care.

For months Australian unions have been calling on the Commonwealth government to implement a national paid pandemic leave scheme for all workers, including precarious workers like casuals and those working in the gig economy.

The ACTU identified the importance of paid pandemic leave being legislated "... in order to keep working people and the community at large safe from a second peak" (ACTU pandemic leave 2020).

This did not occur, with a second peak occurring in Victoria.

In August, the ACTU and Business Council of Australia, usually industrial opponents, wrote to the Commonwealth government urgently seeking paid pandemic leave with the following principles:

1. Incorporate a leave entitlement in the *Fair Work Act* consistent with the FWC aged care awards decision;
2. Provide for reimbursement to employers to facilitate the entitlement, similar to JobKeeper; and
3. Funded by the Federal Government and where necessary the relevant state governments.

In response, the Commonwealth government implemented a pandemic leave disaster payment of \$1,500 a fortnight for workers without sick leave who need to self-isolate, but only where a state/territory declares a "state of disaster", such as Victoria did in July. This simply does not go far enough.

With workers still fearing loss of their income or job, Australia will continue to run the risk of people presenting to work who should instead be self-isolating. Paid pandemic leave is one of the important missing links to defeating COVID-19. It needs to be implemented immediately throughout the country.

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End PJ Paralysis:

An initiative to reduce patient's functional decline

By Sue Sweeney, Shane Crowe, Wendy Watson, Bodil Rasmussen, Karen Wynter and Sara Holton

ABSTRACT

End PJ Paralysis is a patient and clinician engagement model that originated from the National Health Service (NHS) in the United Kingdom and was adapted to the Australian context by Western Health (WH).

The model aims to reduce functional decline by encouraging patients to get up, dressed in everyday clothes, and moving. End PJ Paralysis is a nurse-led initiative, implemented in all five WH hospitals with a focus on acute and subacute ward beds (approximately 500 beds) and included both patient and nurse education campaigns.

The initiative was launched with a very successful whole of organisation 'wear pyjamas to work' day, including the CEO, executives and senior clinicians.

We found that the initiative reduced the number of falls, the number of hospital-acquired pressure injuries and patient's length of stay; and improved patient experiences: the patients reported that they felt 'better' and 'more like themselves' when they were dressed in their own clothes. Nurses and midwives also reported positive experiences.

End PJ Paralysis is an effective and acceptable way to reduce the impact of immobility associated with staying in bed, by supporting hospital inpatients to get up and get moving.

KEYWORDS

Immobility, functional decline, falls, pressure injuries, length of stay, patient experience

KEY POINTS

Immobility in hospital can have multiple adverse consequences for patients, including deconditioning, loss of functional ability and cognitive impairment, all of which have the potential to increase a patient's length of stay.

End PJ Paralysis is an effective and acceptable patient and clinician engagement model which reduces the impact of immobility associated with staying in bed, by supporting hospital inpatients to get out of bed and moving.

Initiatives that encourage mobilisation and reduce or prevent a decline in hospital inpatients' physical function appear to have a positive impact on patient outcomes and may reduce healthcare resource utilisation.

INTRODUCTION

Immobility is a common problem for hospital inpatients (Mahoney 1998). It can lead to deconditioning, functional decline, cognitive impairment, an increased risk of falls (Mahoney 1998), and complications such as pressure injuries, pneumonia, deep vein thrombosis and urinary tract infection (Lindgren et al. 2004; Wu, Li et al. 2018). All of these consequences of immobility have the potential to increase a patient's length of stay and reduce their quality of life (Hoyer et al. 2016; Wu et al. 2018).

To improve patient outcomes and promote earlier discharge, initiatives which target mobilisation are required. The End PJ Paralysis initiative (Health Service 360 2020), which was started in the United Kingdom (UK) in 2016 by nurse educator Professor Brian Dolan, aims to get patients in acute hospital wards out of bed, dressed and moving, and reduce the time patients spend in hospital by putting an end to 'pyjama paralysis'.

The initiative is based on the premise of promoting functional independence and early mobility during a patient's admission (Ward et al. 2018). Having patients in their day clothes while in hospital, rather than in pyjamas (PJs) or theatre gowns, enhances their dignity and autonomy and has the potential to reduce their length of stay.

The End PJ Paralysis model, shifts a patient's perception from 'I'm sick' to 'I'm getting better'. The initial program in the UK resulted in improved patient care; reduction in falls, pressure injuries and length of stay; enhanced patient wellbeing; and high levels of staff satisfaction (Fitzpatrick et al. 2019).



Western Health CEO Russell Harrison (centre back row) and staff at the 'wear pyjamas to work' day (26/6/19).*



Western Health CEO Russell Harrison (far right) and Professor Brian Dolan (centre) and Western Health Executive staff at the 'wear pyjamas to work day'.*



Western Health ward staff at the 'wear pyjamas to work day'.*

PROJECT OVERVIEW

Western Health provides healthcare services to the western region of Melbourne, which has a population of approximately 800,000. Western Health (WH) manages three acute public hospitals as well as a day hospital and transition care program. A wide range of community based services are also managed by Western Health, along with a large Drug and Alcohol Service.

Western Health adapted End PJ Paralysis to the Australian context. In contrast to other health services in the UK and Victoria which have implemented the program, Western Health conducted the program across all four of its hospitals (as opposed to the usual one ward in other settings), created its own marketing material which included posters and brochures for staff and patient education, and adapted the program's microsite which records data about the program so that it was specific to Western Health.

End PJ Paralysis was implemented at Western Health in mid-2019. Western Health wanted as many patients up and dressed in their own clothes by 10am.

Based on the outcomes of the UK study, the End PJ Paralysis initiative at Western Health aimed to improve the safety and quality of the healthcare delivered on inpatient wards by reducing the number of falls, hospital acquired pressure injuries and length of stay; and have a positive impact on patient experience and staff satisfaction.

The initiative was also consistent with the new national Comprehensive Care Standard (Australian Commission on Safety and Quality in Health Care 2019) which includes

management and prevention of falls and pressure injuries, cognitive impairment and poor nutrition.

The End PJ Paralysis campaign emphasises the quality of patient time and experience by involving staff in a 100 Day Challenge. The purpose of the 100 Day Challenge is to focus attention on getting patients mobile earlier, create a bit of fun and a competitive spirit while introducing, and encouraging staff commitment to, a different way of working.

Western Health participated in the End PJ Paralysis 100 Day Challenge from June–October 2019. As part of the challenge, staff encouraged patients (where appropriate) to bring their day clothes and well-fitting shoes to hospital, along with their nightwear and toiletries. Western Health staff were also encouraged to wear their pyjamas to work for one day at the start of the campaign and encourage patients to 'Get Up, Get Dressed and Get Moving'. It was hoped by wearing their pyjamas to work for a day, staff would provide a visual prompter to get patients thinking about the benefits of getting back into their regular clothes sooner to aid their recovery and get home quicker. The day was well supported by the Western Health leadership team, including the CEO, executive team and senior clinicians who all wore their pyjamas to work. Prizes were awarded for the 'best dressed' staff member and 'best decorations' in hospital wards, and the day was promoted on Western Health social media.

Training was also provided to Western Health staff to support the implementation of the program. This included online training, a

one day face-to-face workshop, fortnightly webinars and regular email updates about best-practice data collection, key messages such as the value of patients' time, and sharing successes, challenges and knowledge.

An education campaign for staff and patients was also introduced. This education campaign aimed to empower clinicians to use their clinical judgement for each patient and helped staff identify which patients were spending unnecessary time in bed.

Brochures and information were given to patients, carers and staff about the benefits of the program and helping patients to become more mobile. These included innovative and fun communication methods such as flyers for patients' meal trays, a 'doctor's script pad' poster, and email signature blocks for staff.

Western Health volunteers were also involved, assisting with patient information and arranging a clothes drive for patients who did not have easy access to clothes of their own.

The End PJ Paralysis program was implemented across all Western Health hospitals, which included a total of 500 beds in acute and subacute wards. The program was successfully undertaken at a time when there were many competing priorities and much change occurring at Western Health. This included the opening of a new hospital (Joan Kirner for Women and Children), the implementation of an electronic medical record system, and expansion of the emergency department at Sunshine Hospital.

RESULTS

During the challenge data were collected about the possible indicators of the success of the program including twice weekly data about the number of patients who were in their clothes at 2pm, mobilised by 2pm and ate their lunch out of bed, daily and overall data about the number of falls, new pressure injuries, and length of stay.

PATIENTS DRESSED AND MOBILISED

The campaign increased the number of patients who were mobilised from around 50% to almost 80%, and those who were dressed increased from about 40% to 50-60% (depending on the ward).

The average number of patients who were dressed in one 36 bed ward before the campaign was only two, and this increased to between 20-25 during the campaign. Before the campaign, 18 patients (in the 36-bed ward) were mobile, and during the campaign, an additional four patients were out of bed and mobilising in this ward.

PATIENT FALLS

The number of inpatient falls per 100 bed days decreased after the End PJ Paralysis campaign was implemented (Table 1).

See Table 1

PRESSURE INJURIES

There was a decrease in hospital acquired pressure injuries per 100 bed days from before the campaign. The reduction in pressure injuries continued after the campaign had finished.

See Table 2

LENGTH OF STAY

Although the average length of stay increased slightly during the campaign, it decreased after the 100-day campaign had finished.

See Table 3

PATIENT FEEDBACK

The End PJ Paralysis campaign improved patient experience at Western Health, and patients reported that they valued the opportunity to dress in their everyday clothes while in hospital.

My father is so proud and has always taken such a pride in the way he dresses. He rarely left the house without a shirt and tie. I know he would be embarrassed for his family and friends to see him in pyjamas. Wearing clothes has given him back his dignity, and he seems so much happier. (Daughter of an elderly patient admitted to Western Health)

I know I am not 100% well enough to go home, but I feel so much better walking around in my own clothes. (Western Health patient)

I feel more like me and want to do more. (Western Health patient)

I like myself better when I am dressed and in my own clothes. (Western Health patient)

STAFF FEEDBACK

Across all sites, Western Health staff appeared to engage with the program and provided positive feedback, including about the 'wear pyjamas to work' day.

I just wanted to let you know that wearing PJs to work was a great initiative. It seemed to relax people, and I had one of the best days at work in my two years of being here - it brought many of the departments together in a relaxed and fun way. It's a great initiative for improving patient care, and I did notice that staff did realise how it feels for patients wearing PJs during the day. (Western Health nurse)

DISCUSSION

The End PJ Paralysis initiative implemented at Western Health appears to have reduced the number of falls on each ward, the number of hospital-acquired pressure injuries and length of stay; and improved patient and staff experience. It is expected these positive trends will continue given the substantial education about the importance of patient mobilisation and the continuing support and commitment of Western Health.

Although there were a number of potential barriers to implementing the initiative,

such as ensuring patients had clothes available and laundered, several factors contributed to the project's success:

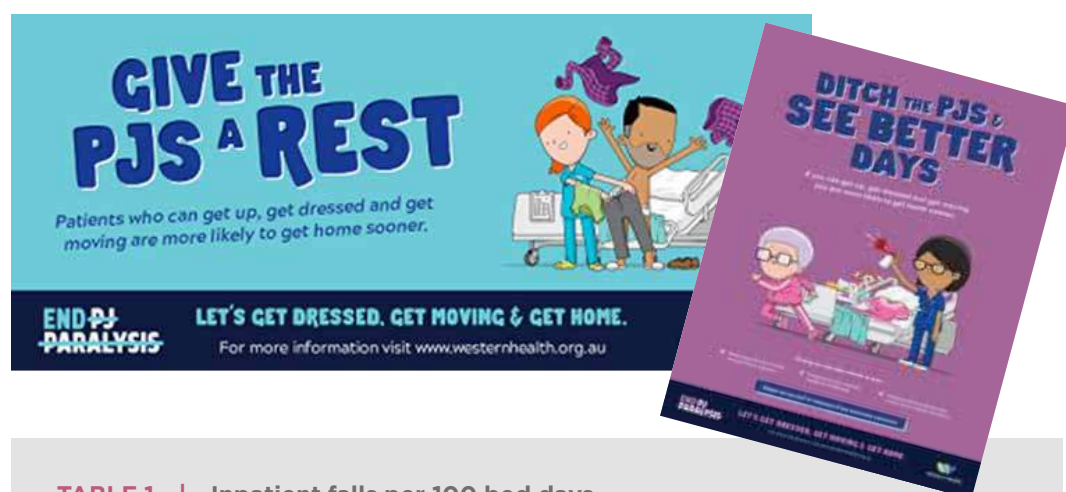
- Leadership support was crucial;
- Multidisciplinary involvement was vital to the program's success;
- Staff already exposed to a large amount of change required a simple message of improving care with minimal effort;
- Fun 'Western Health' cartoon images and keeping the message visual and simple were a key success factor in capturing the attention of staff, patients and visitors;
- Having the whole organisation wear pyjamas resulted in commitment to the challenge from Western Health staff;
- Success and learnings about the challenge were able to be shared by participation in global and state-wide conferences, and communication within Western Health via internal presentations and staff newsletters; and
- Recognition that the health service needs to closely monitor falls, pressure injuries and length of stay after the initial initiative to ensure continued improvement.

CONCLUSION

Deconditioning through prolonged bed rest is one of the most common reasons for delayed discharge from hospital, with prolonged immobility a major factor in the decline in muscle strength and muscle mass, as well as physical and cognitive function. The End PJ Paralysis campaign has had significant benefits for Western Health patients and assisted Western Health to deliver the best possible patient care.



Western Health ward staff at the 'wear pyjamas to work day'.*

**TABLE 1 | Inpatient falls per 100 bed days**

Time Period	Total bed days	PI developed in hospital	PIs per 100 bed days	% Change (compared to the previous time period)
Pre (01/04/2019 - 30/06/2019)	80,058	67	0.084	
End PJ Paralysis (01/07/2019 - 30/09/2019)	81,875	68	0.083	-0.8%
Post (01/10/2019 - 31/12/2019)	79,230	65	0.082	-1.2%

Source: Western Health Riskman (Incident Reporting Database) and iPM (patient administration system)

Table 2 | Pressure injuries developed in hospital per 100 bed days

Time period	Total bed days	Inpatient falls	Falls per 100 bed days	% Change (compared to the previous time period)
Pre (01/04/2019 - 30/06/2019)	80,058	543	0.678	
End PJ Paralysis (01/07/2019 - 30/09/2019)	81,875	539	0.658	-2.9%
Post (01/10/2019 - 31/12/2019)	79,230	523	0.660	0.3%

Source: Western Health Riskman (Incident Reporting Database) and iPM (patient administration system)

TABLE 3 | Average length of stay

Time Period	Number of inpatient episodes	Average length of stay (excluding HITH and ICU)	% Change (compared to the previous time period)
Pre (01/04/2019 - 30/06/2019)	35,226	1.86	
End PJ Paralysis (01/07/2019 - 30/09/2019)	35,911	1.88	1.2%
Post (01/10/2019 - 31/12/2019)	35,897	1.79	-4.6%

Source: Western Health Riskman (Incident Reporting Database) and iPM (patient administration system)

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* Please note that the photos were taken before the COVID-19 pandemic and physical distancing.



Sandra Downing

Unintended pregnancy prevention and care education: Are we adequately preparing entry-to-practice nursing and midwifery students?

By Sandra Downing, Dr Judith Dean, Lydia Mainey, Mary-Claire Balnaves, Dr Lisa Peberdy, Dr Ann Peacock and Dr Joyce Capiello

Achieving universal health coverage (UHC) demands an optimised workforce where nurses and midwives are able to provide the best quality care in accordance with their full scope of practice (World Health Organization 2020; Bender et al. 2016).

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However, political, legislative, and educational barriers prevent nurses and midwives from working to their full scope in the area of unintended pregnancy prevention and care (UPPC) (Mainey et al. 2020).

One important contributing factor is the inadequate coverage of the subject in nursing and midwifery curricula (Mainey et al. 2020).

With unintended pregnancy and abortion affecting one-quarter of Australian women (Taft et al. 2018; Scheil et al. 2017), nursing and midwifery educators must seriously consider matching the scope of practice of graduating students to health needs of this population.

ROLE OF NURSES AND MIDWIVES: PROMOTION OF WOMEN'S REPRODUCTIVE HEALTH

Nurses and midwives are at the forefront of protection and promotion of women's reproductive health. Ideally positioned to support UHC in UPPC, they work across multiple healthcare settings and represent 55% of all registered health practitioners (Australian Health Practitioner Regulation Authority 2019).

Working to their full scope of practice in UPPC, especially in a decentralised health system, would greatly increase equity in UPPC access irrespective of geographical location (de Moel-Mandel et al. 2019; Hulme-Chambers et al. 2018).

UNINTENDED PREGNANCY

An unintended pregnancy, also termed untimed or unplanned, is a relatively common occurrence in a woman's reproductive life. A 2018 Australian study found that in the previous decade, approximately 26% of pregnancies were unintended (Taft et al. 2018), suggesting a need for improved access to health education and pregnancy prevention services.

OPTIONS FOR UNINTENDED PREGNANCIES

Options for women with an unintended pregnancy include parenting, adoption, and abortion. A common misconception is that all unintended pregnancies are unwanted and end in abortion, however, up to two-thirds of women with unintended pregnancies, continue to term (Taft et al. 2018).

Between 2018 and 2019, 253 Australian born children were adopted, suggesting this is not a common decision (Australian Institute of Health and Wellbeing 2019). Abortion data is not collected nationally, however, South Australian data suggests that over a lifetime, one-quarter of Australian women will have an abortion (Scheil et al. 2017).

NURSING AND MIDWIFERY EDUCATION CURRICULUM AND UNINTENDED PREGNANCY

Ideally, all graduating nurses and midwives should possess the knowledge, skills, and confidence to provide UPPC services. A consistent, evidence-based curriculum is crucial for the development of a graduating workforce who are comfortable with providing quality UPPC. In Australia, the accreditation requirement for all entry-level nursing/midwifery degrees is that they align with the nursing/midwifery standards for practice.

These standards are purposefully abstract and do not specify learning outcomes, enabling individual educational providers to determine the benchmark for a work-ready nurse/midwife graduate (Schwartz 2019). Consequently, UPPC education is inconsistent across degrees and highly dependent upon academics who prepare the nursing curriculum.

To date, there is limited Australian and international literature related to UPPC in nursing and midwifery

entry programs. Studies conducted in the United States of America and Japan found that these topics were often included as part of ethical discussions rather than technical evidence-based instruction (Cappiello et al. 2017; Mizuno 2014).

PROPOSED STUDY

A collaboration of nurse/midwife academics from four Queensland Universities and the University of New Hampshire (USA) are conducting a study which aims to:

- examine whether and to what extent specific content related to UPPC are included in Australian accredited tertiary educational programs that lead to registration as a nurse or midwife;
- explore the barriers and enablers to the inclusion of this content;
- explore whether final year student nurses and midwives and new graduates feel adequately prepared to support women with UPPC; and
- develop recommendations for curricular reform

The research will be undertaken using a three-phased exploratory mixed methodological approach. Firstly, a descriptive cross-sectional survey of nursing/midwifery academics/educators will explore and map the inclusion/exclusion of UPPC content. Phase 2 interviews with up to 20 participants will explore the phenomenon in more depth. Finally, a descriptive cross-sectional survey of final year students and new graduates will explore their UPPC educational

experience and how well prepared they feel to provide UPPC services.

Nurses and midwives are powerfully positioned to support women's reproductive autonomy. As educators of this workforce, we are responsible for ensuring our graduates are confident and competent to provide UPPC services. The results of this study will provide insight into current curriculum content and inform future curriculum development for nursing and midwifery programs in Australia.

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Practical COVID-19 policy decisions: fit checking and testing for P2/N95 respirators

Nurses and care workers account for a notable and likely underestimated proportion of COVID-19 infections and deaths around the world. This is likely to be underpinned by the fact that these workers provide more frequent direct care for people with COVID-19 exposing them to higher viral loads.

Further, many workers do not have access to a sufficient quantity and quality of personal protective equipment (PPE). Here, we discuss some of the evidence and policy behind the use of respirators for COVID-19 infection control – specifically ‘fit testing’ and ‘fit checking’.

PPE is one of the most contentious areas of debate regarding the ongoing COVID-19 pandemic. Shortages persist around the world, and strategies to conserve supplies have resulted in crisis-level responses such as reuse of non-recyclable items and authorisation of non-PPE grade equipment including fabric face coverings. Shortages have not been this severe in Australia however, access to, and the use of, PPE remains a concern for many. Elsewhere we have discussed the importance of evidence-based policy and practice regarding the use of PPE and have highlighted that inconsistent policy and training is likely to result in errors and potential contamination and infection (Peters, Marnie and Butler, 2020). As the pandemic continues, evidence regarding how COVID-19 spreads is continuously emerging. Earlier guidance which suggested the suitability of PPE for droplet and surface contamination has been updated to account for potential airborne transmission.

The move to widespread recommendations of airborne precautions in high-risk contexts includes substitution of medical/surgical masks for P2/N95 respirators. To effectively ensure the safety of the wearer, all PPE must be the correct size and fit for each individual. A larger person is unlikely to fit into a small pair of gloves and gown and similarly may not achieve a suitable fit/seal with an incorrectly sized respirator.

Fit testing is a formal, empirical process of ensuring that each wearer can identify a respirator that can achieve a proper, airtight seal over the mouth and nose. Manufacturers and many jurisdictions recommend fit testing as a necessary component of best-practice respiratory protection programs. Fit testing is carried out with a trained operator, uses validated quantitative and qualitative methods, and ideally involves testing of numerous PPE brands, models, and sizes to find the one/s that fit correctly. With a wide variety of respirators and an even wider variety of human shapes and sizes, this is an obvious practical issue particularly when stocks/supplies are low. If only one or two brands/sizes are available for testing, the chances of finding a properly fitting respirator for everyone is reduced.

Further, some brands/sizes of respirator will never properly fit an individual person and achieve a proper seal. Fit testing also enables formal training in donning, using, and doffing respirators and is likely to facilitate improved infection control.

Because fit testing is periodic (Australian standards suggest annually), fit checking is also necessary to help ensure that a proper seal is achieved each time a respirator is donned. It is important to note however, that fit checking, as a subjective process, may not accurately detect leaks (Regli and von Ungern-Sternberg, 2020).

Fit testing establishes the range of suitable respirators that may be selected from for each individual worker and fit checking helps to ensure that a proper seal has been achieved each time the respirator is used. If a proper fit cannot be achieved – in either a test or check, a worker may be at risk and should not be made to work in contexts where a respirator would be recommended.

Despite the need for fit testing and checking which is clearly stated in pre-existing infection control guidelines (National Health and Medical Research Council and the Australian Commission on Safety and Quality in Healthcare, 2019) and referred to in the current Australian Government guidance (Australian Government, 2020a), guidance for health and aged care providers and workers appears to be inconclusive, particularly regarding the necessity of both fit testing and checking. Some guidance simply refers to existing challenges regarding the implementation of formal fit testing due to supply constraints (Australian Government, 2020b).

Both fit testing and checking contribute in different but linked ways towards the safeguarding of workers, and there are increasing calls to adopt both across the board. Keeping our health and aged care workers safe has never been more important, so ensuring access to a range of respirators and offering training on how to fit test and check for a proper seal is vital. While the direct, empirical evidence regarding fit testing and checking is somewhat limited, there are clear practical and pragmatic implications that come from ensuring staff, who are in direct contact with people with possible or confirmed COVID-19 infection, have access to the correct type and sizes of PPE they need to keep themselves, their patients, and loved ones safe.

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Ward Management of COVID-19 patient – case study outcomes at the Royal Melbourne Hospital – General Medical/Respiratory Ward-5SW

By Vara Perikala

COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is believed to be zoonotic in origin. The disease was first identified in December 2019 in Wuhan, the capital of China's Hubei province, and was declared a pandemic by the World Health Organization on 11 March 2020.

The incubation period of COVID-19 is from two to 14 days (WHO 2019; WHO 2020). Clinical symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste.

Most cases of COVID-19 result in mild symptoms, however, these can progress to pneumonia, multi-organ failure or cytokine storm (Hui et al. 2019; CDC Government 2019; Hopkins 2020; Mehta et al. 2020).

The standard method of diagnosis of COVID-19 is by nasopharyngeal and throat swab. Chest x-ray and chest CT imaging are helpful for diagnosis in individuals with a high suspicion of infection based on symptoms and risk factors. Bilateral multilobar ground-glass opacities with peripheral asymmetric and posterior distribution are common in early infection (Salehi et al. 2019).

AIM

This case study acknowledges the effectiveness of personal protective equipment (PPE), hand hygiene, and isolation. However, it will also show the importance of repeat COVID-19 PCR testing and treating pre-existing health issues and medical conditions that emerge as COVID-19 progresses.

A female patient, aged 41 travelled from the United Kingdom to Melbourne via Dubai on 17 March. The patient had a past history of asthma diagnosed at the age of 17, and has been managed with intermittent Ventolin.

On 20 March patient came to the Fever Clinic at The Royal Melbourne Hospital (RMH) feeling unwell and exhibiting respiratory symptoms. COVID-19 swabs were negative, and she returned home.

Three days later, the patient still felt unwell and returned to the RMH, displaying symptoms of a dry cough and fever. The patient was admitted to the General Medical/Respiratory Ward on 23 March and had repeat COVID-19 PCR swabs taken which returned positive results for COVID-19 and parainfluenza. The patient was isolated, and droplet precautions were implemented. Staff donned a gown, mask, gloves, and goggles, and maintained hand hygiene as per hospital policy. Later the patient was moved to a negative pressure isolation room. The patient improved after four days of IV and oral antibiotics and inhaled combination therapy treatment and was discharged to home on 31 March with oral antibiotics and inhaled combination therapy.

On 4 April, the patient experienced acute shortness of breath, severe cough and fever in the middle of the night. Her husband called an ambulance, and she was taken to the RMH Emergency Department (ED). In the ED, the patient suffered progressive respiratory fatigue and was intubated.

She was commenced on steroids and broad-spectrum antibiotics (Tazocin and Vancomycin) and admitted to the Intensive Care Unit (ICU) for ventilatory management.

The patient was extubated 7 April, however, she experienced increasing respiratory distress and fatigue post-extubation and was re-intubated within 24 hours. A CT pulmonary angiogram showed a pulmonary embolus on the right upper lobe and segmental and sub-segmental pulmonary emboli. Blood results showed D-Dimer was elevated at 2.88mg/L (<0.50), Ferritin was elevated at 585 ug/L (15-200) C-reactive Protein (CRP) was elevated at 85mg/L, erythrocyte sedimentation rate (ESR) 50mm/hr (1-19), and Liver Function Tests were out of range. She was commenced on anticoagulation therapy.

Towards the end of her 11 day ICU stay, the patient had repeat COVID-19 swabs taken by two practitioners; both swabs were negative. She started to improve and was extubated on 15 April. Patient's ICU stay was complicated with supraventricular tachycardia (SVT), metabolic alkalemia, acute kidney injury, myopathy and post-ICU delirium.

Two days after being extubated, the patient was transferred to the General Medical/Respiratory ward where treatment included metered-dose inhalers. Nebulisation was avoided because aerosol generating procedures pose a much higher risk of spreading the infection. Nasal prongs provided supplemental oxygen to maintain the SaO₂ at 92-96%. Fluid balance was carefully monitored to prevent fluid overload (RMH, 2020).

After having adequate sleep for two nights in the ward, the patient's delirium resolved. Home-based physiotherapy was organised to treat ICU myopathy. The patient was also referred to a neuro-psychologist for ongoing psychological support. The patient was discharged home on 21 April.

CONCLUSION

The author of this paper has observed that PPE, hand hygiene, and isolation are important measures for managing COVID-19 positive patients. However, it is also essential to repeat COVID-19 PCR testing, manage pre-existing health issues, and treat emerging medical conditions as COVID-19 progresses.

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Medicinal cannabis

By ANMF Federal Education Team

As medicinal cannabis products become more readily available to consumers for therapeutic use, nurses and midwives will be involved in the dispensing of the products and monitoring their therapeutic effects.

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

To ensure nurses and midwives have the underpinning knowledge to enter into this practice and to truly understand how medicinal cannabis works, the ANMF is offering this tutorial which is a basic introduction to medicinal cannabis.

Cannabis is one of the most investigated therapeutically active substances in history, far exceeding nearly all pharmaceutical agents (Hergenrather et al. 2017).

Cannabis has had a long and colourful history. Its use originated in central Asia or western China where it was used for its alleged healing properties for millennia. The first documented use dates back to 2800 BC when it was listed in the Emperor Shen Nung's pharmacopoeia (regarded as the father of Chinese Medicine) (Lambert Initiative 2019).

Medicinal cannabis is currently available in Australia via the Special Access Scheme (SAS) or Authorised Prescriber Scheme.

The term 'medicinal cannabis products' covers a range of cannabis preparations intended for therapeutic use, including pharmaceutical cannabis preparations such as oils, tinctures and other extracts.

The Australian government is facilitating access to medicinal cannabis products to appropriate patients for medical conditions where there is evidence to support its use (Therapeutic Goods Administration, 2018).

However, to fully achieve this, several legislative and regulatory changes have been implemented at the Commonwealth level. Additionally, the rules relating to medicinal cannabis products may vary

between states and territories and could affect access in those jurisdictions.

The Commonwealth developed amendments to the Narcotic Drugs Act 1976 to decriminalise the use and supply of medicinal cannabis (Therapeutic Goods Administration, 2018). The Therapeutic Goods Administration (TGA) in 2017 rescheduled certain medicinal cannabis products to schedule 8 of the Poisons Standard, making the prescription of medicinal cannabis legal in Australia. Victoria was the first state in Australia to introduce legislation to legalise medicinal cannabis, but other states and territories have quickly followed (Canstar, 2017).

WHAT IS CANNABIS AND IS IT THE SAME AS HEMP?

Cannabis is a genus of flowering plant in the family of Cannabaceae. It is indigenous to central Asia and the Indian subcontinent. The number of species within the genus is disputed.

Three species may be recognised:

1. Cannabis Sativa
2. Cannabis Indica
3. Cannabis Ruderalis (Wikipedia, 2019)

Cannabis, sometimes called marijuana, is a family of plants with two primary classifications Indica and Sativa. While cannabis can be considered a member of either the Indica or Sativa families, Hemp is a member of the cannabis Sativa family. Hemp and cannabis can appear similar, yet each plant has very clear distinctions (Cadena, 2018).

Cannabis features broad leaves, dense buds and has a short, bushy appearance. In stark contrast, Hemp features skinny leaves that concentrate towards the top of the plant. Hemp grows taller and leaner than

cannabis, with few branches beneath its upper portion.

When compared side by side, the two plants can each be clearly identifiable. As we dive deeper into the anatomy of the two plants, each has crucial differences in their chemical composition (Cadena, 2018).

Cannabis contains a variety of different compounds called Cannabinoids, two of which, and the most dominant, are Tetrahydrocannabinol (THC) and Cannabidiol (CBD).

Both cannabinoids have shown to provide profound benefits to the human body; however, THC induces psychoactive effects (gets the user "high"), while CBD does not contain any psychoactive properties (Cadena, 2018).

When comparing Hemp vs cannabis, Hemp contains a very low concentration of THC (0.3% or less), cannabis is abundant in THC with concentrations between 15 to 40%. Because of this, Hemp is grown primarily for industrial purposes, while cannabis is grown for recreational and medicinal purposes (Cadena, 2018).

Cannabis produces a variety of compounds known as cannabinoids, many of which have not been detected in any other plant (Leafly, 2019). Cannabis is a complex plant with over 400 chemical entities, of which approximately 140 are cannabinoid compounds. The active ingredients of the cannabis plant fall into three categories:

1. Cannabinoids
2. Terpenes
3. Flavonoids (Entourage Medicinal Nutrients, 2019)

Terpenes and flavonoids help enhance the therapeutic effects of cannabinoids, as well as providing individual health benefits. For example, terpenes have analgesic and/or anti-inflammatory effects, while flavonoids also benefit the immune system.

The entourage effect means that many of these compounds work synergistically to enhance the medicinal benefits of cannabis while diminishing the adverse effects, including psychoactivity.

Found throughout the brain, nervous systems and organs of humans and all mammals, birds, fish and reptiles, too, the Endocannabinoid System (ECS), is the body's internal system of cannabis molecules and receptors. Native and primitive, scientists predict that humans evolved to possess this system over 500 million years ago.



EDUCATION

The ECS is the largest biological system of receptors in the body, and some scientists believe it is the most important physiological system involved in establishing and maintaining human health. Its job is to maintain homeostasis, or balance, and to keep our cells and immune system healthy (Prima, 2019).

Scientists first discovered the ECS while trying to understand the effects of cannabis in humans. While much remains unknown about this system, what is well known is that the human body is full of cannabinoid receptors and produces corresponding molecules which cause the physical and psychological effects of cannabis in our bodies. Since its discovery, the endocannabinoid system has become a prime target of medical research due to its vast effects and therapeutic potential on the human body (Royal Queen Seeds, 2019).

In the 1990s, Dr Raphael Mechoulam discovered the endocannabinoid system in his laboratory at the Hebrew University in Israel. Together with his team, Dr Mechoulam uncovered naturally occurring neurotransmitters (called endocannabinoids) that are almost identical in structure to the compounds produced by the cannabis plant (called phytocannabinoids.) From here, active compounds in Hemp and cannabis were uncovered, resulting in the beginning of our understanding of how they impact human health (Prima, 2019).

Phytocannabinoids are naturally-occurring cannabinoids found in the hemp and cannabis plants. Science suggests that the most effective way to support our ECS is by ingesting phytocannabinoids. Hemp and cannabis are the only plants in the world that produce cannabinoids (Prima, 2019).

There are over 120 known phytocannabinoids in cannabis, and the majority are understudied and not properly understood.

Cannabinoids are known antioxidants and neuro-protectants, as proven by the US government's patent (Patent 6630507B1) stating that "cannabinoids have been found to have antioxidant properties and are found to have particular application as neuroprotectants or in the treatment of neurodegenerative diseases" (Royal Queen Seeds, 2019).

The term "endo" is short for endogenous, meaning originating or produced within an organism, tissue or cell. Cannabinoid refers to a group of compounds that activate this particular system (Royal Queen Seeds, 2019).

The ECS is made up of two primary cell receptors. CB1 and CB2. The agonists or keys for these receptors are cannabinoids that are produced by the body, as well as cannabinoids that come from outside the body, such as from cannabis (phytocannabinoids) (Royal Queen Seeds, 2019).

Imagine cell receptors in the body as a set of locks, each with a set of corresponding keys: chemical molecules called "agonists". Each time an agonist is bound to a cell receptor, it relays a message, giving the cell an instruction (Royal Queen Seeds, 2019).

CB1 receptors are found throughout the human body but mostly exist in the brain and spinal cord. They are concentrated in areas associated with the behaviours, such as in the hypothalamus, which is involved in appetite regulation, and the amygdala which plays a role in memory and emotional processing.

They are also found in nerve endings, where they can act to reduce the feeling of pain (Royal Queen Seeds, 2019).

CB2 receptors are typically concentrated in immune cells and the peripheral nervous system. When activated, they work to reduce inflammation as an immune response which is primarily believed to play a role in the body's immune response to diseases and certain medical conditions (Royal Queen Seeds, 2019).

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MINUTES
CPD

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

The complete tutorial details the following sub topics:

History of medicinal cannabis • professional organisation views • detailed information on cannabis and its constituents • different parts and uses • Australian cannabis legislation • medicinal cannabis around the world • Australian medicinal cannabis Special Access Scheme and clinical trials • cannabinoids and the endocannabinoid system • terpenes and flavonoids • the entourage effect, types of cannabis • cannabis products • cannabis consumption • conditions treated with medicinal cannabis • nursing care of the patient using

medicinal cannabis • current research and links to external organisations offering many articles on medicinal cannabis.

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

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

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

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

anmf.org.au/cpe



EDUCATION

PART 1



Life as a Care Coordinator – Kids GPS Service

By Jennifer Andresen, Sarah Donnelly and Cameron Harwood

Navigating the health system is often challenging. Confusion around who the best person to contact for a particular health issue or question is often part of the problem.

Imagine the challenges faced by a family of six, with one child newly diagnosed with a complex medical condition, who may not live close to a tertiary paediatric hospital. Life would immediately become more chaotic and stressful.

Kids Guided Personalised Service (Kids GPS) is a Network service covering both tertiary Children's Hospitals in Sydney. Kids GPS supports families of children with medical complexities by collaborating with their medical clinicians and care teams and creating a 'circle of care coordination' which places the needs of the patient and their family at the centre. There are also two Kids GPS hubs in the Southern and

Murrumbidgee LHDs which we collaborate with. The rural care coordinators are the main point of contact for these children and their families and reach out to us as needed.

Part of our role is to assist with discharge planning by connecting our families to their local hospital and collaborating with local services to ease the burden of frequent travel to Sydney. This is especially important when a child goes home with a medical device in situ, such as a nasogastric tube, a gastrostomy, a tracheostomy, or a Port-a-Cath requiring regular flushes. Kids GPS can arrange supportive education sessions with the specialist CNCs for metropolitan and rural-based health professionals if and when they need it.

To help support local hospitals and clinicians in providing the care of our children with medical complexities need, all have an individualised shared-care plan which identifies their individual care needs. The Kids GPS care plan eases the burden on the family, so they do not have to repeatedly tell their 'story' because we consolidate their child's medical history into one document. It explains the child's diagnoses, medical alerts, specialised management plans and lists the teams and clinicians involved in care. Having all the important details in a simple plan allows the parents to be empowered with the knowledge of who to contact for advice and who facilitates continuity of care with the local health services.

The Kids GPS Hotline is a 24-hour phone support service which enrolled parents can access for care advice and guidance at home, enabling the parents to establish confidence in caring for their child's ongoing care at home. The Hotline aims to avoid Emergency Department presentations by offering advice or an alternative ambulatory care pathway for medical review. In the last 12 months, the Hotline has received over 430 after-hours calls.

The Kids GPS Service began in 2014 and has continued to grow exponentially since. We currently have over 350 active patients enrolled, with 150 accessing the Hotline. Kids GPS continues to provide a personalised, supportive service to children with medical complexities and their families, by facilitating convenient care options, care closer to home, and care pathways that reduce hospital visits wherever possible.

Authors

Jennifer Andresen has a Masters in Clinical Education and Post Graduate certificates in Paediatrics, Oncology and Palliative care.

Sarah Donnelly has a Bachelor's Degree in Paediatric Nursing, Post Graduate Certificate in Paediatrics and is soon to complete her Post-Graduate Degree in Learning & Teaching in Healthcare.

Cameron Harwood has a Bachelor degree in Nursing and a Diploma of Project Management.

All are Paediatric Nurses who work in the Kids GPS Service at Sydney Children's Hospital Network.

Gaps in nurses knowledge of sleep health

By Aisling Smyth

Sleep is a fundamental biological requirement, necessary for life. While once we thought sleep was a passive process aimed at resting the body, we now know this is far from the truth.

Sleep is an active process which repairs, regenerates and restores physical and psychological health. The impact of poor sleep quality and/or quantity is becoming increasingly apparent with the emerging scientific literature. Inadequate sleep has been associated with a myriad of prevalent disorders including diabetes, obesity, cardiovascular disease and depression (to name a few) (Worley 2018).

Despite this research, assessment and management of sleep is rarely covered at any depth in the undergraduate nursing curriculum (Parliament of the Commonwealth of Australia 2019; Vallido, Jackson & O'Brien 2010).

Nurses report low levels of sleep knowledge and identify this as a significant barrier to managing their patients' sleep (Huang et al. 2018; Ye et al. 2013).

In fact, while student nurses acknowledge the importance of sleep education and promotion, they felt their educational programs did not adequately prepare them to undertake this role (McIntosh & MacMillan 2009). Instead, much of the sleep-promoting education delivered by nurses was derived from their own life and/or clinical experience (McIntosh & MacMillan 2009).

A recent Parliamentary Inquiry into Sleep Health in Australia recommended that sleep forms one of the pillar stones of health promotion alongside diet and exercise (Parliament of the Commonwealth of Australia 2019). The same report also identified

the 'important and integral' role nurses can play in delivering sleep interventions. To undertake this important health-promoting activity, sleep education must be integrated into curricula in both undergraduate, postgraduate and clinical education.

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Aisling Smyth (BSc., MSc., PhD., RN)

An Honours project as a unique educational opportunity

By Elissa-Kate Jay, Christopher Patterson and Lorna Moxham

As a form of nursing education, this honours project has provided me, as a BN Honours student, a 'deep level of learning' which resulted from attending a Recovery Camp before commencing the project.

Nursing students and mental health consumers on *Recovery Camp* during 2018 and 2019 were invited to share their ideas about mental health recovery on one large canvas artboard at each camp.

They contributed individual words and pictures of their own volition during the week. These collections of personal art narratives by both mental health consumers and nursing students were the data for the honours project.

Findings emanating from thematic analysis of the contributions to the canvas artboards, teach us what students and mental health consumers think to be important about mental health recovery and reflect what they feel while immersed in the camp. It has been an educational opportunity for the students and consumers who traditionally have not been given recognition as potential educators. The themes of *Healthy identity as one's true self*, *Teamwork and friendship*, *Positivity*, and *Gratitude for Recovery Camp*, add weight to other research about the recovery model of mental healthcare which also promotes these concepts (Picton et al. 2019; Sugiura et al. 2020).

Living for five days in the environment where data collection took place, allowed experiential learning which instilled in me an enthusiasm for the study and for the artwork data itself. Consequently, the writing of the study and the thematic analysis felt more relatable and provided new meaning to evidence-based nursing for me.

It has been more than learning about research theory from a removed vantage point, but rather, it has been an *engagement* in research throughout all of its stages.

The creation of this study and the findings that it discloses demonstrate education in its origins and its dissemination. It has been an educational journey and experience for the participants too, as arts-based research allows subconscious ideas to be realised and expressed, and they have been able to see how their perceptions align or contrast with the co-creators around them. As well, students are educated each day by consumers which is not at all the 'norm' on a mental health clinical placement (Patterson et al. 2016).

The humanness of this study has given me a new perspective, not realising sufficiently until now that

research truly comes from real people and often real life. It is humbling to realise that researchers apply themselves holistically to their study, often with much generosity to the areas that they believe in. It is also educational to work with supervisors who are experienced mental health clinicians as well as academic experts. I now understand that it is these double skills that help achieve the merging of theory with practice, which has been successfully producing applied nursing research. My awareness has been increased about all the participants and nursing researchers who have been present behind the scenes in the creation of policy guidelines. This study has gifted me with a form of nursing education that gives me an experiential and beginners look into an example of nursing research.

Policymakers, education institutes and other researchers may wish to use this study to guide further research and educate the public, healthcare professionals and consumers about mental health recovery, as it was generated in an environment (*Recovery Camp*) where empowerment and recovery have been shown to occur (Moxham et al. 2015).

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2018–2019 Canvas Art. Photo: Elissa-Kate Jay

Graduating Notre Dame student, Jessica



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Where are all the graduates?

By Kylie Russell and Tracey Coventry

The Australian government in December 2019 released the first report into nursing education since 2002, *'Educating the Nurse of the Future, report of the independent review of nursing education'* (Schwartz 2019).

The paper outlined 26 recommendations. Of note, the paper stated, several submissions which identified a disconnect between the number of graduating nursing students and the lack of jobs available for them (Schwartz 2019 pp. 61).

Which leaves us to ask, where do all the graduates go?

Nursing sustainability requires an understanding of current issues followed by planned action to secure the health workforce recommended for growing population groups such as mental health, aged care and rural and remote areas (HWA 2014a). The *Nursing workforce sustainability: Improving nurse retention and productivity report* (HWA 2015), identified the lack of congruence between the availability of employment for graduate nurses and the number of graduating nurses. The report recommended an 'increase in the breadth of graduate nurses employment opportunities' (HWA 2015, pp. 17).

Statistics provided by the Nursing and Midwifery Board of Australia (NMBA), and equivalent international organisations, provide registration

numbers but fail to account for those who do not register and are unable to distinguish between those successful in attaining employment and those choosing to leave (NMBA 2019).

In WA, the graduate RN unemployment has been increasing over recent years, with almost 70% of applicants for 2019 graduate jobs in WA public hospitals missing out (West Australian 2019). With employment opportunities available to graduates continuing to reduce, there is a limited realistic prospect of a supported graduate program for future graduates (West Australian 2020).

Despite the predicted shortfalls in the nursing workforce (HWA 2014b), there is a need for data about training and attrition, necessary for future planning of nursing education for the workforce.

The University of Notre Dame Australia is seeking to understand the pathway of our graduating students. Initial data collection in 2020 will provide essential information on the graduates' workforce destination in their first year of practice. With this understanding, we can ensure that our entry to practice programs are preparing our graduates for the reality of employment and the workplace. This research will track our graduates' journey for the first 18 months after finishing their degree. It is envisaged that findings from this study will support a wider state or national study.

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Nurse Inventions

By Heather Borradale

There are many frustrating moments in nursing and midwifery. The frustration of finding the person carrying the dangerous drug keys drove me to invent the DD Finder.

The DD Finder has a button that is located in the medication room when the keys are required the nurse or midwife presses the button and a pager device, which is attached to the keys vibrates and beeps.

The DD Finder ensures that valuable nursing time is not wasted walking around the ward calling 'who has the keys'.

Many hospitals have the DD Finder, and the feedback has been very positive. Debra Billington (DON, Gold Coast private) commented, "They [the DD Finders] have changed the culture of the wards so much and the best thing we purchased.

The buzzer is attached to the DD keys, and the call point sits in the treatment room. A staff member can go into the treatment room and get everything ready for the drug administration, ring the buzzer, the other staff member will come and assist. It saves so much time for all."

The DD Finder is also useful in hospitals that have installed the swipe or fingerprint system. There is commonly only one set of keys for PCA pumps. Therefore the DD Finder will locate the PCA pump keys.

Author

Heather Borradale RN, RM, BNurs, PhD candidate, is business owner of setpoint clinical solutions which creates products to save time for nurses and improve safety for patients and nurses

The package includes 2 Pager Units that attach to the DD keys and there is a recharging unit so no need for batteries. The units are robust which make them ideal for use 24 hours a day 7 days a week.

Pager Unit features

- Alerts with moderate beep, strong vibration and/or soft lights for ten seconds or less when stop button is pressed.
- Sturdy and reliable
- Small and lightweight: 8cm x 5cm x 2.5cm, 0.05kg
- Status lights for charging / ready / out-of-range / low battery
- Alert-cancel button
- Wireless ID programming from the DD Sender
- Rechargeable Ni-MH Batteries (included and installed)
- Standby up to five days on a full charge
- Installed AAA battery lasts one year and is user-replaceable
- Tough, ergonomic case with grips
- Note: not sealed against excess moisture or dust



Sender Unit/Transmitter features

- Easy to install and use
- No wiring required
- The DD Sender can be placed on flat surfaces, wall mounted or carried in a pocket
- Battery operated - uses user-replaceable AAA batteries
- UHF Frequency
- 1-year warranty
- Range up to 304 meters (or less depending on structures)



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Large scale digital innovation in South Australian nursing and midwifery programs

By Angela Brown and Naomi Rooney

South Australian nursing and midwifery students have spent the last twelve months transitioning to online monitoring of their clinical experiences at the University of South Australia.

The university introduced the popular PebblePad platform in the Bachelor of Midwifery in early 2019 as a staged implementation. The Bachelor of Nursing students followed with implementation of the platform across the program later in 2019.

South Australian nursing and midwifery programs have, unlike other states, been using paper-based records for many years. The shift to an online learning platform was a complex project impacting approximately 3,500 students and 215 partner sites. The project required venue support, extensive education in partner sites, resource development and student support to ensure

a smooth transition and positive experience for students and staff.

The benefits of the system include real-time access to clinical experiences for university staff that has allowed for feedback mechanisms and a closer relationship with clinical venues, clinical staff and students.

Using an online learning platform has transformed the ability to provide oversight, engage with students, provide feedback and allowed for more robust verification processes to be implemented. Research has supported the use of online portfolios and identified benefits that include the ability to demonstrate continuous development and level of preparedness for professional practice (Birks et al. 2016; Sidebotham et al. 2018).

Some barriers were experienced in the transition that included resistance from a minority of students who had used paper-based records previously. Other barriers were venue staffs' resistance to the change. This was particularly evident in some older staff members who were less familiar with the technology. We managed these issues by using mentors and providing one on one sessions were required to support students in the transition. The venue staff were offered multiple opportunities to provide feedback, attend in-service education, and almost all of the initial issues were quickly overcome with a targeted educational and supportive response. We also provided

a range of focused online resources and manuals to assist, as well as instructional videos and online drop-in sessions. A dedicated PebblePad coordinator was recently appointed to be the first point of contact between students and venues for support and troubleshooting any issues that arise.

Overall the project has transformed clinical record keeping in the undergraduate nursing and midwifery programs. We have transitioned from the outdated system where oversight only occurred at specific assessment points throughout a student's program to a system that allows real-time feedback, monitoring and participation in student learning and stronger partnerships with clinical venues using technology to enhance the student and venue experience.

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Work Integrated Learning experiences for mental health nursing education: The importance of clinical facilitators

By Renee Hall, Dana Perlman and Lorna Moxham

Clinical facilitators play an important role in the education of student nurses, particularly when students undertake their work as integrated learning experiences.

Work integrated Learning (WiL) also called clinical placements, have a profound impact on the development of knowledge, skills and attitudes and are recognised as experiences that inform student's decisions as to where they might work (discipline area) when they graduate.

Integral to this is the role of the facilitator. Currently, there is a lot of research on clinical facilitation, mostly from a student perspective. Yet there is a shortage of research undertaken that focuses specifically on mental health clinical placements from a facilitator perspective. None could be found related to a non-conventional clinical placement.

The first author undertook an honours thesis to fill this gap by exploring the

experience that facilitators have when enabling the learning of Bachelor of Nursing (BN) students in a non-conventional mental health clinical placement. The research approach was guided by Heideggerian phenomenology, which allowed the collection of rich, descriptive data and is highly relevant to understanding lived experience.

In this study, lived experience was the experience that the facilitators had when enabling the learning of BN students in a non-conventional mental health clinical placement. The WiL setting is a clinical placement known as Recovery Camp see – recoverycamp.com.au

Given this was a Nursing Honours project, the sample size was justifiably small. After ethics approval, five clinical facilitators (registered with AHPRA as RNs) aged between 35-61, with facilitation experience ranging from three to 43 years, consented to participate in individual semi-structured interviews about their experience.

This study utilised van Manen's six-step phenomenological approach to data analysis, which helped glean the meaning of the phenomenon being studied (Polit & Tantano Beck 2017).

The facilitators felt the WiL environment itself, played a significant role in student learning. They described the immersive nature of the WiL and how this particular learning environment enabled them to provide multiple opportunities for student learning which also, helped them develop their own clinical and educational skills. Overall, the students felt they had

an integral role in student learning, that they were important role models and were in a prime position to advocate for the discipline of mental health nursing given their specialist expertise and experience.

Clinical placements have a significant impact on whether a student chooses a particular discipline area to work in upon graduation. With a shortage of mental health nurses and the majority of graduating students not wishing to work in mental health, understanding the role of the facilitator is important given their capacity to influence the clinical placement experience positively.

If the facilitator can enhance student learning, role model positive mental health nursing behaviour, and advocate for mental health nursing as a discipline area of choice, more students may choose mental health when they are looking for work as a registered nurse.

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Chris Patterson, facilitator talking to a group of students



Family violence best practice: Engaging nurses and other healthcare professional students

By Jess Ison, Leesa Hooker, Molly Allen, Michelle Newton and Angela Taft

Family violence (FV) is a significant health issue for women in Australia and internationally (AIHW, 2019; WHO 2013). Globally one in three women have experienced violence from a current or former partner in their lifetime.

Intimate partner violence is the leading contributor to death, disability and illness for women between the ages of 15 and 44 (DVRC 2015).

Health professionals are often the first point of contact for victim-survivors and will frequently encounter them in their work. However, without adequate training, nurses and other healthcare providers attending to victim-survivors of FV may not recognise or be able to provide adequate support for the victim-survivor. There is a lack of existing undergraduate and post-registration FV education programs for healthcare providers (Crombie et al.

2017), with students often demonstrating misconceptions about the causes and impacts of FV and feeling poorly prepared to deal with FV situations in clinical practice (Beccaria et al. 2013).

Further, one in 10 female healthcare workers have been identified as victim-survivors of FV (McLindon et al. 2018), making the issue both personal and professional.

In light of these issues, we have designed a subject in the School of Nursing and Midwifery at La Trobe University for nurses, midwives and other healthcare students. The online elective subject "Family Violence Best Practice" will provide introductory knowledge and evidence-based best practice guidelines with an overview of FV and how healthcare professionals can help victim-survivors. We will also be evaluating the subject to monitor change in student FV knowledge and attitudes, and perceived preparedness to undertake the work. This will be the first time a separate, online FV subject is offered at La Trobe University by the School of Nursing and Midwifery, with high demand expected across the school and wider university.

FV is a serious health issue, with healthcare services playing a crucial role in the multisector response to FV (Garcia et al. 2015). Addressing provider FV skills and educational barriers is one large step towards improving the response to violence against women. As one of the few known FV subjects in Australia, the findings will be integral to intervening and preventing FV.

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Final-year undergraduate nursing students' perceptions of general practice as a career path

By Kaara Calma, Elizabeth Halcomb, Anna Williams and Susan McInnes

Health systems that have strong primary healthcare (PHC) have lower rates of hospitalisations and overall better health outcomes. This realisation has increased demands on building a PHC workforce to meet the changing needs of the community (Australian Government Department of Health 2013).

General practice remains at the 'heart' of PHC (Calma, Halcomb & Stephens 2019; Royal Australian College of General Practitioners 2018) however, it is a relatively underdeveloped career pathway in Australian nursing. Additionally, pre-registration nursing education remains largely focussed on acute care (Parker, Keleher & Forrest 2011).

Universities continue to face challenges in delivering PHC content within undergraduate nursing programs due to the limited availability of PHC trained academics, lack of PHC clinical placements and students' expectations to learn about acute care nursing (Calma, Halcomb & Stephens 2019).

As such, some nursing students have negative perceptions of PHC as a career path, considering working there would limit their future career options (van Iersel et al. 2018; Wojnar & Whelan 2017).

In our review paper, we found that the existing literature is focussed towards the PHC sector as a

whole rather than specifically exploring nursing students' preparedness and perceptions of working in general practice (Calma, Halcomb & Stephens 2019). Yet working in Australian general practice is known to be a somewhat unique environment given the small business nature and funding models (Halcomb & Bird 2020).

This gap in knowledge motivated Miss Kaara Calma to undertake a PhD project (in the School of Nursing at the University of Wollongong), supervised by Professor Liz Halcomb, Dr Anna Williams and Dr Susan McInnes.

This Doctoral Project uses a mixed-methods approach to address the complex research aims. Survey data has been collected from 388 final-year undergraduate nursing students from five universities in New South Wales. The data explored how prepared final-year undergraduate nursing students felt to work in general practice, and the factors that might impact on their preparedness to work in this setting. This was followed by interviews with a sub-group of 16 survey respondents to further explore their perceptions and preparedness for employment in general practice.

Findings will provide a new insight into undergraduate nurse education and its impact on graduate career choices around general practice. This data has the potential to inform strategies to enhance the preparation of nurses to seek employment in general practice following graduation. This is likely to enhance the uptake of general practice by new graduates which will address workforce shortages and provide career choices for beginning nurses.

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Navigating the COVID-19 'new normal' return to campus within a Bachelor of Nursing program

By Annette Saunders, Kathleen Tori, Carey Mather and Diana Guzys

The COVID-19 pandemic has created unprecedented challenges for academics in their support of student learning to provide timely, effective facilitation of student progression while observing social distancing, and other infection prevention and control measures (Dewart et al. 2020).

As isolation restrictions ease across most Australian states and territories, higher education institutions are moving towards models of education that better reflect discipline-specific requirements that necessitate on-campus attendance. For the School of Nursing, University of Tasmania, in the initial stages of the graduated move back to on-campus teaching, the safety of all stakeholders was paramount and only 'essential activities' warranted consideration. 'Essential activities' are simulation laboratory sessions enabling mastery of clinical skills required for progression, or prior to professional experience placement.

Before accessing on-campus activities, all University staff and students were required to successfully

complete an eLearning module in which the COVID-19 key infection control principles were discussed. Once on-campus, mandatory attendance at screening checkpoints included undertaking temporal temperature and health screening was undertaken, to exclude those with 'flu-like symptoms', recent interstate travel or having been in contact with a known COVID-19 case (University of Tasmania 2020). Only then was it permissible for students and staff to enter the simulation laboratories while adhering to the social distancing rules.

While COVID-19 restrictions have provided challenges to learning and teaching experiences, there were unintended positive consequences of a staged return to learning and teaching on campus. Development of infection prevention and control principles were embedded as students began simulation experiences by cleaning their workspace and equipment, donning masks and performing hand hygiene frequently. All equipment and fomites were thoroughly cleaned with alcohol wipes before and after each simulation session, and equipment was rested overnight.

Using the flipped classroom approach, with an emphasis on student-centred learning (Betihavas et al. 2016), students were required to complete theoretical components of their current year of nursing curriculum via eLearning before attending the on-campus skills demonstration and practice sessions. Social distancing requirements offered a unique opportunity in face-to-face classes for a staff to student ratio of 1:9, whereas in pre-COVID-19, the ratio was 1:24. The more personalised tuition reduced competition for resources and academic attention promoted a calm and effective learning environment with students being able to receive supported practice and individualised feedback. Students could undertake formal assessment when they felt confident in their ability to perform the required skills.

Students commented that due to low numbers in the laboratory, they had opportunity while social distancing, to develop a rapport with peers. The smaller student groups provided the opportunity for enhancing professional communication skills modelled by the academic, and international students had more opportunity to engage in conversation than sometimes occurred in larger groups.

The higher education landscape after the COVID-19 pandemic will be different. At least for the near future, the need to adhere to social distancing and other infection prevention and control precautions warrants ongoing logistical planning and evaluation to ensure that the learning environment remains safe for both students and staff. The commitment of the University of Tasmania in ensuring the students are supported to adapt to the impacts of COVID-19 and continue to learn during this difficult time remains the priority.



Annette Saunders, Lecturer at the University of Tasmania preparing for student learning while observing the COVID-19 pandemic return to campus infection prevention and control guidelines in the simulation laboratory

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Person-centred nursing education during isolation

By Rebekkah Middleton

Person-centred nursing education, and curricula, value the voice of all involved – academics, students, industry, clinical facilitators, people receiving care.

Only by embedding person-centred practice, values and frameworks at the heart of the learning environment can workplace culture be transformed, as nursing students are prepared to build an innovative quality nursing workforce of the future.

These aspects can be explored, critiqued and practiced in the university environment with people facilitating conversations and actions that can be challenged and supported simultaneously in tutorials and laboratories.

During COVID-19, an instant and unanticipated change occurred for student learning environments with everything moving online. How could the online nursing education experience replicate person-centred approaches to learning that occur in face-to-face interactions?

The online space had to establish agreed and shared ways of working together, to identify individual and group values, to clearly communicate activities, to be transparent in critical discussions and to use multiple intelligences to engage all learners in the process.

These factors had to be contextualised, connecting theory to practice meaningfully. And so required the respect for ideas and diversity, inclusivity, use of appropriate language, facilitation, collaboration, creativity, discernment and flexibility. These are very

challenging to action; however, in the intensity of the online environment, where cameras being turned on is optional, even being present is optional. Having (or doing) an experience does not guarantee learning, therefore authentic engagement by everyone (students and educators) is paramount to facilitate the learning process. Committing to ongoing lifelong learning, despite the difficulty, is required by all.

It is critical, however, to recognise that in isolation, not all students can adapt and 'cope' without supports in place, such as personal face-to-face connection and ongoing human interactions.

Online strategies, to complement educational learning, that allows opportunities to talk, to connect with others, to be encouraged, to mitigate stress should be prioritised to help students feel more connected, more like they belong.

When considering person-centred approaches to nursing education, these aspects are equally as important. Nursing education institutions should aim to provide a supportive environment, diminish power relationships and prioritise relationships in an effort to build person-centred processes. These begin with educators who can engage authentically, work with others (students, industry, etc.) values and beliefs, be sympathetically present, and share decision making (McCormack & McCance 2017). While challenging, these are imperative – in isolation and in 'normal'.

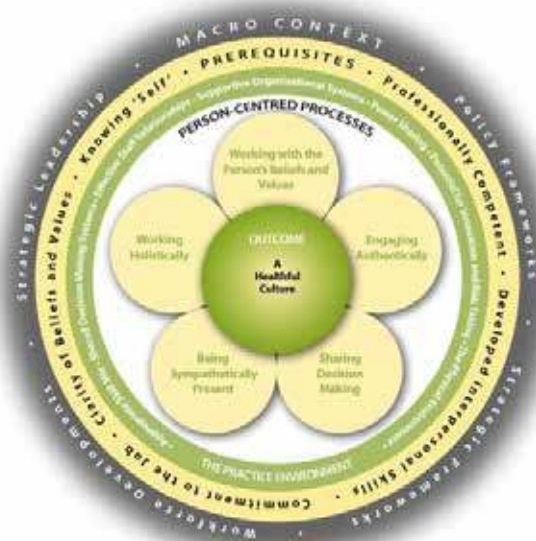
Staying focused on people – for and with – cannot be seen as idealistic and optional, but must be our fundamental philosophy, guiding actions and intentions as we seek to influence and build the future of nursing.

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Person-centred Practice Framework (McCormack & McCance 2017 amended, in press)

Socially distanced nursing and midwifery simulation during the COVID-19 pandemic

By Jo McDonall, Lauren McTier and Nicole M (Nikki) Phillips

The global COVID-19 pandemic seized the world's attention and catapulted healthcare into the spotlight. In many countries, the healthcare workforce was exposed to unprecedented pressure and complexity as they grappled with the exponential increase in COVID-19 cases.

Continuity of teaching and learning for undergraduate students was a priority for Deakin University's School of Nursing and Midwifery when the pandemic was emerging in Australia to ensure the sustainability of Australia's future nursing and midwifery workforce. A study from the UK highlighted feelings of pressure, fear and anxiety in students on entering the clinical environment (Swift et al. 2020).

To ensure students were prepared and felt supported for clinical placement, participating in facilitated simulation prior to placement was an important consideration.

University on campus teaching and learning activities rapidly moved online in week two of Trimester 1. The School sought an exemption from the Vice-Chancellor, Professor Iain Martin, to continue on campus face-to-face simulation. Unlike the vast majority of Victorian universities, Deakin's School of Nursing and Midwifery continued to facilitate simulations.

The simulations were conducted consistent with social distancing guidelines as stipulated by the Australian Government, Department of Health (Australian Government, Department of Health 2020).

Social distancing requirements were communicated to students and staff using videos, online posts and individual emails. A student-focused video demonstrated the movement of students through the simulation environment, and a facilitator-focused video covered the crucial and unique considerations for student learning. Environmental factors included removing any unnecessary equipment and objects that could not be cleaned with alcohol such as all linen, manikin/human simulator gowns/clothing and curtains. Social distancing posters and key signage were used throughout the simulation centre to support student and facilitator movements.

Safety of students and staff was paramount. Students were instructed not to attend campus if they had any COVID-19 symptoms, in addition, all students were required to complete a COVID-19 screening form based on the Victorian Department of Health and Human Services guidelines (Department of Health and Human Services, State Government of Victoria 2020). These were updated regularly as the guidelines changed.

Before attending simulations, students were instructed to wear their uniform and only to bring minimal personal items such as keys or a small bag. On the day of the session, staff directed the movement of students through the simulation centre ensuring social distancing was maintained.

One student entered the simulation room at a time, stored personal belongings, performed hand hygiene, donned gown, mask and gloves and made their way to the furthestmost bed from the door. Once the student was at the bed standing on the pre-determined floor marker, the next student entered the room. On completion students cleaned any equipment they used with alcohol wipes, emptied rubbish and tidied up the space, under the supervision of the facilitator. Students were instructed to leave the simulation room one at a time, starting from the bed closest to the door, doffing personal protective equipment, performing hand hygiene and collecting their personal belongings. Timing of the sessions was staggered to ensure cross over of students was minimised. Over 3,200 students participated in face-to-face simulations across Deakin's three campuses, Burwood, Geelong and Warrnambool.

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International Mobility Programs: Opportunities during COVID-19

By Jacqueline Johnston and Gulzar Malik

As ethnic and cultural diversity of society increases, healthcare providers must respond to ensure care is culturally appropriate to the population they serve. The impact of globalisation on health creates a need to develop curricula with emphases on internationalisation and capabilities, such as cultural awareness (Lilley et al. 2015).

One strategy for developing cultural awareness in nurses and midwives is the option of studying abroad as a part of their pre-registration education. It includes activities that allow students to travel overseas and encompasses a wide range of opportunities, including short term programs, semester-long exchange, and clinical placements.

An international experience can expand the student's perspective, enhance learning capabilities, and solidify one's position as a global citizen (Kokko 2011). In an increasingly competitive environment, it is important that students strengthen employability by standing out from fellow students at graduate year interviews.

The experiences students gain from international exposure, and the skills they develop, as a result, may include communication, cultural awareness, problem-solving, collaboration and flexibility, which are highly valued by employers.

At La Trobe University, the School of Nursing and Midwifery offers full semester exchange programs which allow students to visit a partner university in Sweden, Finland or the United Kingdom, for an entire semester and receive credit for that full semester of study.

For a more in-depth immersion into a new culture and environment, exchange programs are a popular option among students.

Short term programs offer students a shorter, more targeted international experience and provide opportunities to travel in university breaks or complete clinical placements overseas. As an example, last year, undergraduate students completed primary healthcare clinical placements in Nepal and Cambodia. They assisted with health clinics and provided targeted educational sessions to improve health literacy.

COVID-19 has temporarily halted international mobility programs, however, to continue to offer internationalisation experience, academics have implemented new ways to engage students with global citizenship programs. 'Internationalisation at Home' provides intercultural experiences, facilitates international collaboration and develops cross-cultural skills without students leaving their home universities.

This program offers opportunities for students to collaborate with students from another, or sometimes multiple universities in different countries. Students engage in weekly webinars and then work together with students from different countries on a clinical/community case study highlighting cultural differences in patient care, public health initiatives and learn about different healthcare systems.

It is paramount that academics keep exploring the ways that international experiences could be integrated into the curriculum. Though COVID-19 has closed the doors for international travel, at the same time, it has opened up several possibilities and opportunities to offer international experience differently.

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Rapid transition to eLearning within a Bachelor of Nursing program: Positive outcomes

By Carey Mather, Diana Guzys, Annette Saunders and Kathleen Tori

The challenge created by the COVID-19 pandemic early in 2020 for student engagement and continuance of high-quality learning and teaching experiences within the higher education sector in response to the restrictions to mobility was unexpected.

There was a rapid transition from face to face tutorials to fully remote digital content delivery of the undergraduate within the School of Nursing at the University of Tasmania program on four campuses in Tasmania and New South Wales.

The substitution of on campus experiences to the virtual classroom occurred following week three of semester one.

The university executive made a pre-emptive decision prior to government announcements, for the closure of on campus delivery of education (University of Tasmania 2020). The blended learning model of the undergraduate program, which used digital presentations, mitigated some of the challenges of this transition. The focus required was the transitioning of classroom learning to effective eLearning activities.

Face to face tutorials transitioned to the virtual platform of the learning management system (LMS). As the semester concluded, there was an opportunity to reflect on the imposed changes to learning and teaching. While there were lessons learned and opportunities for improvement it was found through the agility and capability of the staff and the adaptability and willingness of students, there were unintended positive consequences created by the rapid transition to the remote delivery of an online curriculum.

Engagement strategies to promote learning, reduce inequity and to meet altered needs of undergraduate students were positive additions. Strategies included increased flexibility by introducing evening tutorials and the opportunity for clinical assessments to be conducted virtually. Interactive digital



The authors meeting to discuss eLearning within the Bachelor of Nursing program at the University of Tasmania. From Left to right, top row Associate Professor Kathleen Tori and Diana Guzys. Bottom Row, Annette Saunders and Dr Carey Mather

tools were explored for their potential and adoption of polls as a previously unused educational activity were greeted positively by students. This digital tool was used for students to self-check and quickly identify where clarification of understanding of a topic was required. Small group break-out discussion groups within tutorial classes were randomised within the LMS.

Randomisation facilitated communication skill development, as students interacted with others within their class, rather than their known cohort. New patterns of engagement were observed with increased participation via text responses from students who were more reluctant to participate verbally in face to face classes, improving the quality and volume of their participation in class discussions.

It seems this medium has enabled new ways of working which have reduced dominance of some students as dynamics of face to face learning have shifted in the virtual classroom. The unintended positive consequences of developing professional, respectful communication were captured within the LMS.

Other anecdotal positive consequences included students relishing reduced travel burden in time, cost, wear and tear on vehicles and safety, due to less exposure on the road, especially for rural students. Additionally, those students who could speed type discovered they were an asset during small group work!

Mutuality of experience during these 'unprecedented times' demonstrated the capacity of academics to be flexible in what was a highly fluid environment, where they

role modelled the core attribute of being a nurse – capability. Similarly, students also showed they had the capacity to grasp the opportunity, engage with the changes and adapt to the 'new normal'.

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at all the funny entries. Unfortunately
there can only be one winner.



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