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ANMF's priorities 2021

INSIDE

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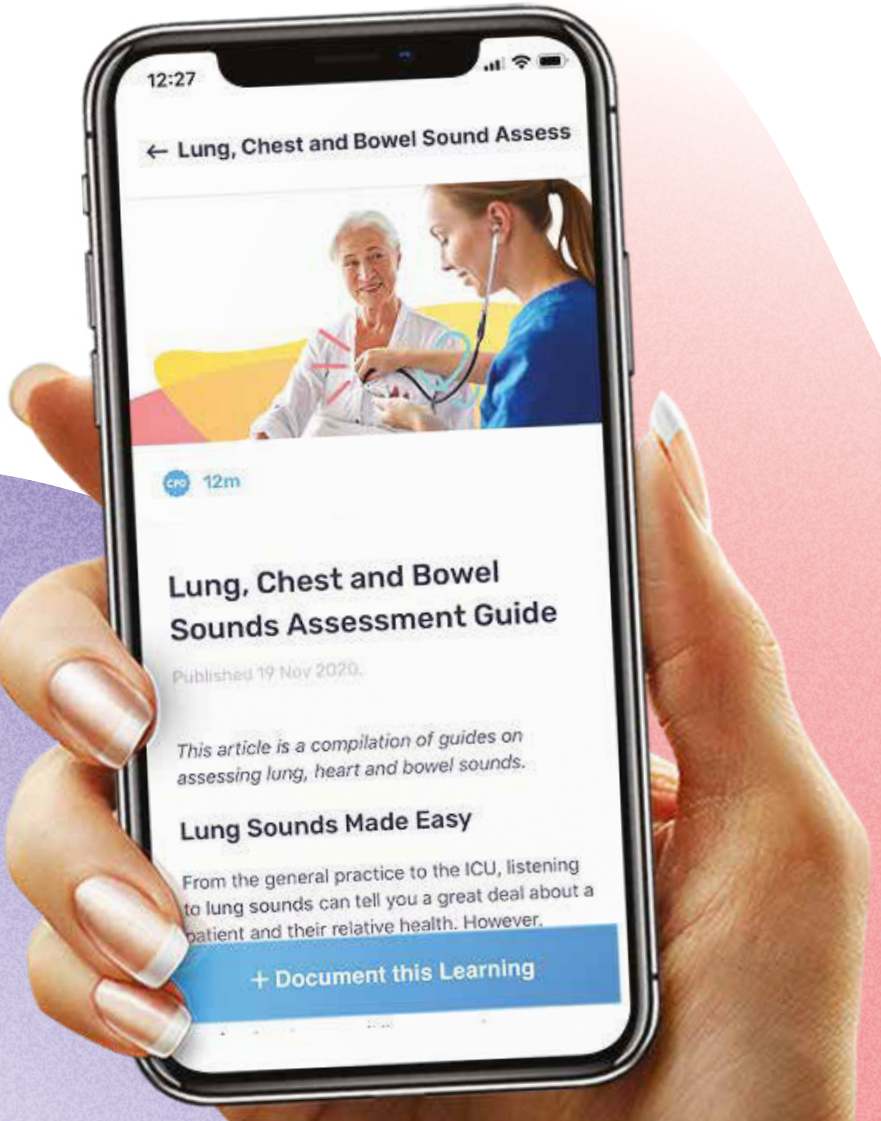

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By the time the *ANMJ* hits your mailbox I hope you had the chance to enjoy some time with family and friends over the festive season and to relax, rejuvenate and recover from the year that was 2020, the International Year of the Nurse and the Midwife. The year that was intended to highlight and celebrate the work of nurses and midwives but which ended up turning the world on its head.

Annie Butler

ANMF Federal Secretary

In Australia, 2020 started with bushfires that raged across the country. Not long after we were hit by the COVID-19 pandemic, the likes of which had never been seen before. The extraordinary efforts of many, none more impressive than those of nurses and midwives, saw the pandemic effectively contained by the end of 2020 and the country's focus turn to recovery. But the pandemic has taken its toll – physically, economically and emotionally. The impact of the uncertainty and anxiety it created had many of us searching to find our fortitude, reassessing personal and professional priorities and reflecting on what we value the most.

Although not as the original script for 2020 intended, the pandemic thrust the work of nurses and midwives into the forefront and the public's consciousness in a way that had not previously existed. The public realised that when faced with a truly devastating health crisis, it is nurses, midwives and other essential workers who will pull us all through.

Around the globe, this led to an outpouring of gratitude and appreciation for nurses and midwives and their compassion, professionalism and courage, which seemed exceptional but which are actually the core features of our professions.

But, while very welcome we need more than one year's appreciation and gratitude from the community, we need genuine recognition. This means that nurses and midwives must be at the key decision-making tables, they must be included in the development of healthcare policy and enabled to work to their full scope of practice.

They must also, critically, be truly valued. This means ensuring safe workplaces and working conditions, including safe staffing and workloads and decent pay and conditions, across all sectors.

And where this is most critically needed, as the pandemic has just shown us, is in aged care. As you would be well aware, the ANMF has persistently warned successive governments about the dangers of chronic understaffing in aged care. Tragically almost 700 deaths due to COVID-19 occurred in aged care highlighting the widespread deficiencies of the sector in the most heart-breaking way. It is without question that if this had been addressed earlier, much of the distress, pain, and indeed, trauma suffered by residents, their families and the workers who cared for them during the pandemic could have been avoided.

The Aged Care Royal Commission has identified these insufficiencies and, in October 2019, made recommendations to consider including mandated staffing ratios, establishing a new Aged Care Act, compulsory registration of personal care workers and improved wages and conditions for aged care workers. But it has not gone far enough.

The Commission hands down its final report and recommendations at the end of February, and to this end we will continue to speak out and strongly lobby for meaningful and timely change on safe staffing levels, appropriate skill mixes and transparency of funding. We invite all nurses, midwives, care-workers, organisations and the community to join us in the campaign to ensure we finally fix aged care and prevent the tragedies of 2020 from ever occurring again. Let 2021 be the year that the collective voices of nurses and midwives enact real systemic change.

This is just one of ANMF's priorities during 2021. To read what else we have in store head to page 10 of the journal.

We look forward to a promising year in 2021, facing and overcoming the year's challenges ahead together to continue to do the best for all nurses, midwives and carers and the greater community.

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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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REGULAR COLUMNS

FEATURES

CLINICAL UPDATE

EDUCATION

FOCUS

ICN sets theme for International Nurses Day 2021

The theme for International Nurses Day 2021 recognises the impacts of the global COVID-19 pandemic on the health system and nursing profession and how they could be affected in the future.

Announced late last year by the International Council of Nurses (ICN), the theme for International Nurses Day 2021 follows on from previous years, with the overarching theme Nurses: A Voice to Lead, and the sub-theme for 2021 A Vision for Future Healthcare.

Each year, ICN leads the global celebrations for International Nurses Day, which is held on 12 May, the anniversary of the birth of nursing trailblazer Florence Nightingale.

ICN says the global COVID-19 pandemic has shown the world the vital role nurses play in keeping people healthy across the lifespan. While there has been significant disruption to healthcare, they also suggest there has been great innovation that has improved access to care.

In 2021, ICN will focus on the changes to and innovations in nursing and how they will ultimately shape the future of healthcare.

ICN CEO Howard Catton said the pandemic had exposed the weaknesses in many of the world's health systems, the enormous pressure nurses are working under and shone the light on their incredible commitment and courage.

2021 designated as the International Year of Health and Care Workers

The World Health Assembly, the decision-making body of the World Health Organization (WHO), has designated 2021 as the International Year of Health and Care Workers.

Member states announced the decision at the recent 73rd World Health Assembly, saying the theme recognised the dedication and sacrifice of the millions of health and care workers on the frontline of the COVID-19 pandemic.

They also highlighted the critical role of health and care workers in boosting health outcomes and emphasised the urgent need to address persistent healthcare worker challenges.

As part of the tenth anniversary and review of the WHO Global Code of Practice on the International Recruitment of Health Personnel (Code), the World Health Assembly discussed the increasing scale of health worker migration. Member states called for strengthened implementation of the code, particularly in the wake of COVID-19, and urged prioritising support and safeguards for the most vulnerable countries, including greater investment.

The decision reflects a collective vision to support the health and care workforce.

"WHO urges all Member States, International Financing Institutions, Global Health Initiatives and partners to invest in health workforce readiness, education and learning to manage the pandemic, maintain health services and prepare for a COVID-19 vaccine," WHO Director of the Health Workforce Department, Jim Campbell said.

CAMPAIGN TO TACKLE WORKPLACE MENTAL HEALTH EMERGENCY

A joint campaign to encourage action on workplace mental health has been recently launched by the ACTU, Employers Mutual Limited (EML) and WorkSafe's WorkWell Mental Health Improvement Fund.

The initiative is in response to the increasing rates of mental injuries in the workplace. The Mind Your Head campaign aims to raise awareness about mental health hazards like the impact of isolated work, high job demands and violent events so that they're understood and dealt with like physical workplace safety issues like electrical or trip hazards.

The initiative will provide pilot workplaces with the resources and tools they need to identify and address workplace mental health hazards before injury occurs.

The ACTU states that unlike physical hazards, employers often don't identify workplace mental health hazards or put systems and practices in place to address them.

Consequently, workplace mental health hazards injure thousands of workers each year, just like physical hazards, but they often fly under the radar, the official website suggests.

ACTU Assistant Secretary Liam O'Brien said that this had contributed to a mental health emergency in Australia, with

workplace mental health injuries now the fastest-growing type of workplace injury.

"This is the fastest-growing workplace health and safety issue in Australia and that a lot of work was needed to quickly stem the tide.

"It starts with getting employers to treat mental health and safety with the same seriousness that we do physical health and safety," he said.

Find out more at **mindyourhead.org.au**

Report shines light on health and welfare of women in Australian prisons

Most women in Australia's prisons come from disadvantaged backgrounds and suffer poor mental and physical health, a new report from the Australian Institute of Health and Welfare (AIHW) has revealed.

The report, *The health and welfare of women in Australia's prisons*, examines data collected from questionnaires over a two-week period in adult prisons nationally, bar NSW.

The number of women in Australia's prisons grew by 64% between 2009 and 2019. According to the report, many women entering prison come from disadvantaged backgrounds, with one-quarter (24%) of those surveyed saying they were unemployed, while over one-quarter (27%) were in short-term or emergency accommodation in the month before being incarcerated.

Almost one in five women entering prison had a parent or carer incarcerated during their childhood, more than half had at least one dependent child and 25 women gave birth while in custody. More than seven in 10 (72%) women entering prison had previously been incarcerated, with about one in 10 (9%) having been in youth detention.

Most women leaving prison were satisfied with the healthcare they had received, with eight in 10 reporting that their physical health had improved, or stayed the same, while in prison.

"On entry to prison, more than a third (36%) of women reported having been diagnosed with a chronic health condition," AIHW spokesperson Anna Ritson said.

"Among the chronic health conditions, just over one in four women reported having asthma (27%) and around one in 10 arthritis (9%)."

The report found mental health conditions among women in prison were common, with two in three (65%) women reporting they had received a mental health diagnosis before entering prison, and 40% already taking mental health-related medication.

Short-term health impacts of 2019–20 bushfires examined

Emergency department visits for respiratory problems, sales of asthma medication and access to mental health services in NSW regions affected by the 2019–20 bushfires increased significantly according to a report from the Australian Institute of Health and Welfare (AIHW). The bushfire season of 2019–20 saw widespread destruction of land, national parks and property, and tragically, 33 people lost their lives.

The report, *Australian bushfires 2019–20: Exploring the short-term health impacts*, examined some of the short-term health impacts of the devastating bushfires, focusing on the period from September 2019 through to March 2020.

The report used data from NSW emergency departments, air quality monitoring, GP visits, Medicare-subsidised respiratory testing, and pharmaceutical sales data from all states and territories.

Visits to NSW hospital emergency departments for respiratory conditions increased in the 2019–20 bushfire season, compared to 2018–19.

"Some areas of NSW were affected more than others, with emergency department visits rising by more than 50% in the Capital Region (includes Bateman's Bay) during times of peak bushfire activity, and 86% in the Riverina region," AIHW spokesperson Mr Richard Juckes said.

Similarly, some areas of Australia experienced worse air quality than others – Canberra residents experienced the worst air quality in the Territory's history, and on some days, the worst recorded air quality in the world.

Analysis of pharmaceutical sales data revealed that sales and dispensing of asthma reliever medications, including salbutamol, increased in bushfire-affected regions.

In the Coffs Harbour–Grafton region, there were increases of 70% and 43% in sales of inhalers for shortness of breath for the weeks beginning 10 November and 17 November 2019, respectively.

Additionally, there were almost 19,000 bushfire-related Medicare-subsidised mental health services accessed by 5,094 patients (as at 11 October 2020),' Mr Juckes said.

Lori-Anne Sharp

ANMF Assistant Federal Secretary

Good riddance 2020!

As 2020 draws to an end, I am sure many of you are utterly exhausted after dealing with such a challenging year. Not wanting to add further to your exhaustion, my column this quarter, takes a slightly different angle.

I wish to share with you my cherished boiled fruit cake recipe, great to make at Christmas time or any time of the year for that matter.

One of my favourite traditions at Christmas time is to bake fruit cakes and give them as Christmas presents to family, friends, school teachers and neighbours. This recipe, while handed down over three generations has been adapted over the years and I suspect my variation may vary slightly from previous generations. I doubt my late Nan Baker's version was laden in the same abundance of brandy!

Thank you for your extraordinary efforts responding, protecting and caring for the community in this Covid year. It came as no surprise to me that when needed, our workforce stepped up and did an amazing job. I thank you and I know our community does too. Over the Christmas break, I hope you get the opportunity to rest, relax, rejuvenate and spend time with family and friends.

Lori-Anne's celebrated boiled fruit cake recipe

INGREDIENTS

1kg mixed fruit
150g glazed red cherries (optional)
150g butter
1 cup water
1 tbsp golden syrup
I cup brown sugar
1 tin crushed pineapple
4 eggs (beaten)
1 cup sifted self-raising flour
1 cup sifted plain flour
1 tsp bicarbonate soda
1 tsp garum malsala or mixed spice
1 tbsp cocoa powder
brandy
pecans, almonds, walnuts or cherries for decorating (optional)

METHOD

Preheat oven to 170c.

Grease and line with baking paper large round or square cake tin.

Bring mixed fruit, cherries, water, golden syrup, butter and brown sugar to the boil. Simmer for 10 minutes.

Allow to cool before adding the beaten eggs. Add the crushed pineapple. Mix well before adding the remaining dry ingredients.

Depending on your oven bake for 20 min at 170c then 1.5–2hrs at 150c or until testing skewer comes out clean. Time will vary depending if oven is fan forced etc. Allow to cool completely and wrap in glad wrap. I like to douse cakes with a cap or two of brandy every few days before gifting/serving. Cake also freezes very well.

Enjoy comrades

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*In a study comparing iron polymaltose with ferrous sulfate in iron deficient pregnant patients. n=80.

References: 1. Ortiz R *et al. J Matern Fetal Neonatal Med* 2011;24:1–6. **2.** Toblli JE & Brignoli R. *Arzneimittelforschung* 2007;57:431–38. **3.** Jacobs P *et al. Hematology* 2000;5:77–83.

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James Lloyd

ANMF Federal Vice President

Black humour: Use it for the purposes of good and not evil

"*Every time you find humour in a difficult situation, you win*" – Snoopy

Black humour – It's something we are introduced to early in our nursing careers. It is often muttered in tea rooms, at ward Christmas parties or during a post-shift debrief. An outsider listening in might be appalled at what they hear – these are remarks not voiced in polite circles or in public. But dark humour can have positive as well as negative aspects.

Nurses have a few handy traits in our toolbox of skills that allow us to function professionally. First, we are inherent empaths. We feel the pain and misery that our patients experience. Yet we are also thick-skinned. Images, smells and verbal un-pleasantries are deflected by this armour. This protection, to a certain extent, allows us to emotionally deal with the daily tragedies, and minimise the chance of vicarious trauma settling in. But we have another device in our toolbox to employ – black humour.

Black humour is taking a morbid experience and expressing it via a jest. We nurses hear, see, smell and emotionally absorb circumstances that are inherently ghastly. We laugh against fear; however, another outlet may be required. Sometimes the situation is expressed through an emotion, like crying. But often we use macabre humour to express raw grief.

This isn't meant to demean our patients, but is an expression of a coping mechanism against taboo topics. This allows us to smile and laugh and then muster the emotional stamina to move onto the next patient.

Black humour transmutes a distressing event. It transforms a physically or emotionally exhausting incident into a diversion that makes us smile and laugh. This lets us express painful thoughts more easily. Gallows humour allows us to bond and share experiences with our colleagues witnessing the same dire situations. It is a natural human instinct that helps to manage our own mounting stress with a snarky comment. Incidentally, a 2017 study published in the journal *Cognitive Processing* stated that people who appreciate black humour "may have higher IQs, show lower aggression, and resist negative feelings more effectively than people who turn up their noses at it."

But black humour can be taken too far, and from outside hospital walls can be interpreted as cruel and inappropriate. Derogatory comments may be considered as a lack of caring, insensitivity, or an abuse of power and trust between the nurse and patient. People can use grim humour to promote an agenda that is ageist, racist, homophobic or sexist. The danger lies with black humour stereotypes that devalue a patient or worse, dehumanises them. As nurses and midwives, we need to take the person out of the humour and focus on the truth of the circumstances. Otherwise, it can destroy empathy and distort objectivity.

We must remember that our patients are likely experiencing fear, anxiety, and vulnerability. In our profession, we must be aware that our comments, even if innocently expressed, may be interpreted by the public as offensive or even scandalous.

For example, I once had a colleague use the tragic death of a young person as the reason to make a dark humour joke – they were quickly shut down.

Black humour may be acceptable in certain situations, but nurses need to develop their judgement that recognises that it has both a time and a place. Mindful of professional ethics, I would argue that this shows we are human and trying to cope as best we know how. Macabre humour allows us to cope expertly when we witness tragic events and allows us to care for our patients with empathy. Importantly, this allows us to maintain a semblance of control over the endless suffering that we encounter. And ultimately, laughter is still the best medicine.


Credit: UNSW Archives

Vale Susan Ryan – A trailblazer for gender equality and nursing education

By Ben Rodin

The Honourable Susan Ryan AO, former Labor minister and advocate for gender equality, education, and nursing, passed away in September, aged 77.

As the first woman to act as a cabinet minister in a Labor government while serving as a Senator in the ACT for 12 years, Ms Ryan played a crucial role in many pieces of legislation that legally enshrined gender equality in Australian working life, including the 1984 Sex Discrimination Act.

In her post-political career, her work as the Age Discrimination (2011-2016) and Disability Discrimination Commissioner (2014-2016) for the Australian Human Rights Commission helped to ensure rights and freedoms for elderly and disabled Australians.

Leader of the Federal Labor Opposition, Anthony Albanese, said Ms Ryan had left an "enormous legacy."

"She made an enormous difference in terms of removing discrimination on the basis of gender.

"Before Susan Ryan and her legislation, it was possible to be sacked for falling pregnant. You needed to take a fellow in with you to get a loan from the bank to buy a house," he said.

"She's a giant of our movement, a giant of the women's movement as well."

However, it was her 1984 co-endorsement of the transfer of hospital-based training to tertiary nursing education that most significantly affected the trajectory of Australian nurses.

Serving under the Hawke government at the time Senator Ryan in conjunction with the Minister for Health Dr Neal Blewett, and Minister for Employment and Industrial Relations Ralph Willis, federalised nursing education which allowed for nursing training to transition into the tertiary sector.

The complete transition took almost a decade with the last group of nurses to train through the hospital system occurring in 1993.

Since entering the tertiary sector there have been many positive outcomes for the professions, including the body of nursing and midwifery research and knowledge that has been built over the years.

Additionally, entering the sector has allowed opportunities for women to involve themselves in academia more broadly.

ANMF Federal Secretary Annie Butler paid tribute to Ms Ryan's legacy.

"We are all deeply saddened at the passing of Susan Ryan, who dedicated her public life to championing equality and the rights of Australia's working women," Ms Butler said.

"Susan was a brave, inspirational female leader and role-model, who made a significant and long-lasting contribution to Parliament, always fighting hard for gender equality.

"Her tireless campaigning over the years has made Australia a fairer, better place through landmark laws which have protected and promoted women's work and the rights of women in the workplace."

ANMF's priorities 2021

Heading into a year shaped by the global pandemic, the ANMF has determined a list of priorities the union plans to work on during 2021. High on the agenda is protecting nurses, midwives and carers working on the frontline amidst the continuing threat of COVID-19, through sound policy and procedures, infection control and adequate supply of PPE. Mandated safe staffing levels to be instigated immediately in aged care also remains a critical priority for the ANMF. While on the back of the Year of the Nurse and Midwife, the ANMF plans to help strengthen the voices and influence of nurses and midwives. Robert Fedele and Ben Rodin report.

AGED CARE

The COVID-19 pandemic exposed Australia's strengths and weaknesses. Its strength is its health system; its weakness, the aged care system.

When the pandemic took hold in early 2020, the under-resourced and underfunded sector began to buckle. This was no more evident than in Victoria where, tragically, hundreds of deaths occurred in nursing homes during the state's second wave. Later in the year, a special report by the Aged Care Royal Commission into the sector's response to the pandemic found the federal government did not have a COVID-19 plan devoted solely to aged care and that the measures it implemented were 'insufficient' to prepare the sector.

Tellingly, about 70% of all COVID-19 deaths in Australia have occurred in aged care. "By anybody's measure, that's disgraceful," ANMF Federal Secretary Annie Butler says.

The ANMF has been warning successive governments of the dangers of chronic understaffing in aged care for years. In November 2019, the Aged Care Royal Commission's Interim Report, *Neglect*, found Australia's aged care system fails to meet the needs of its older citizens and does not deliver uniformly safe and quality care. Still, the Federal government took no action.

In its final submission to the Aged Care Royal Commission last July, the ANMF's key recommendation reiterated its calls for mandated minimum staffing levels and skills mix, specifically that nursing homes must ensure residents receive an average of 4.3 hours of care per day delivered by a mandated minimum skill mix of 30% registered nurses, 20% enrolled nurses, and 50% personal care workers.

Last October, at the conclusion of hearings, Senior Counsel Assisting the Aged Care Royal Commission made 124 recommendations for Commissioners to consider. They included mandated staffing ratios, establishing a new Aged Care Act, compulsory registration of personal care workers and improved wages and conditions for aged care workers.

The recommendations outline a phased introduction for mandated nursing hours, beginning from 1 July 2022 that stipulate providers must engage registered nurses, enrolled nurses and personal care workers for at least 215 minutes per resident per day for an average resident. The minimum staff time standard requires at least one RN on site at each nursing home, but only for morning and afternoon shifts. Under the recommendations, nursing hours would be increased from 1 July 2024, when at least one RN would be required to be on shift at every facility at all times.

However, Ms Butler said the recommendations failed to address understaffing.

"The recommended hours are not high enough to reach the level of safe and quality care vulnerable older Australians need and deserve.

"We are extremely concerned that the minimum staff time provided by a registered nurse is insufficient and the system cannot wait another four years to ensure there is at least one RN on site at each nursing home at all times."

With COVID-19 shining the spotlight on the issues facing aged care, the ANMF remains committed to capitalising on the broader awareness to guarantee change in 2021.

The Royal Commission will hand down its final report and recommendations at the end of February. Other key dates as the ANMF's campaign for legislated ratios in aged care and skills mix intensifies include May's Federal Budget and the next federal election.

"The community and mainstream media are finally taking notice of the systemic issues in aged care that we've known for years. As a collective, we need to build on that newfound awareness to deliver solutions," Ms Butler says.

"The aged care workforce has held the system together for too long and workers can't sustain their efforts much longer.

"It should not have been allowed to come to this. The government must act now. Most importantly, they must introduce mandated minimum staffing levels and skills mix in residential aged care. We have seen the tragic consequences of understaffing on elderly residents and the buck stops here."

STRENGTHENING THE VOICE AND INFLUENCE OF NURSES AND MIDWIVES

The World Health Organization (WHO) and International Council of Nurses (ICN) designated 2020 the International Year of the Nurse and the Midwife.

The celebration linked with the culmination of *Nursing Now*, a three-year global campaign aiming to raise the status and profile of the professions. Core objectives included empowering nurses and midwives to maximise their voice in health policymaking, encouraging greater investment in the workforce, recruiting more nurses into leadership positions, improving gender equality and driving universal health coverage by supporting nurses and midwives to work to their full scope.

The global COVID-19 pandemic shifted the narrative and nurses, in particular, rallied in response, putting their lives on the line to care for others. Once unsung and undervalued, nurses were suddenly being hailed as frontline heroes for their caring and commitment. The faces of exhausted nurses shielded by masks and goggles dominated media outlets.

On reflection, has the increased exposure of nurses and public goodwill translated to greater representation and meaningful involvement in decision-making and policy? Has it increased understanding of nurses as well-educated, intelligent, qualified professionals providing evidence-based healthcare?

Take aged care, for example. Australia's COVID-19 crisis in aged care, especially in Victoria's privately-run for-profit nursing homes, exposed many of the sector's systemic problems. Chief among them was the chronic understaffing and dangerously inadequate levels of qualified nurses and carers with the right skills mix.

The ANMF has known for many years that the country's aged care system is failing older Australians and warned successive governments of the dangers of chronic understaffing. More recently, the union's mounting evidence-based research confirmed the need for mandated minimum staffing levels, including registered nurses on every shift.

As Australia's COVID-19 aged care crisis intensified and, tragically, led to hundreds of deaths, the public and mainstream media became more informed and conscious about the systemic issues which the ANMF has been lobbying to address for decades. It begs the question, why didn't they listen earlier?

"We knew that these weaknesses already existed. We knew about the systemic problems in aged care. The Royal Commission's Interim Report released last year, *Neglect*, confirmed it. But still, nobody took action," ANMF Federal Secretary Annie Butler says.

Ms Butler suspects the lack of responsiveness is tied up, in part, to gender inequality. Caring has traditionally been regarded as the work of women and the voice of nursing, the nation's largest health workforce, is often overlooked.

In 2021, the ANMF is imploring nurses and midwives to capitalise on the increased prominence triggered by the pandemic by getting political and advocating for change.

"We need to strengthen the voice, power and influence of our nursing and midwifery workforce in order to advance the professions, address issues in areas like aged care and ensure all healthcare workers have access to full PPE as the world navigates the COVID-19 pandemic," Ms Butler says.

"Let's take this opportunity to educate the community about what it actually means to be a nurse or midwife. To do this, we need to champion nurses' and midwives' education, commitment, courage, professionalism, research, capabilities and understanding of the evidence that informs our practice."

PROTECTING HEALTHCARE WORKERS FROM COVID-19

When the COVID-19 pandemic hit Australia, nurses, midwives, carers and other healthcare workers quickly adapted and responded to the challenge.

On the frontline, they grappled with issues such as widespread shortages of PPE but courageously continued to carry out their jobs in our hospitals and other health settings despite the threat of contracting the virus hovering.

Recognising that more needs to be done to keep healthcare workers safe during the pandemic, the ANMF has developed a new framework aiming to protect healthcare workers from COVID-19 infection in 2021 and beyond.

It outlines the ANMF's position on key issues regarding infection control and prevention for the protection of healthcare workers during the pandemic, drawing on research evidence, expert guidance and work health and safety (WHS) perspectives to present the union's policy regarding the five principles of infection prevention and control as defined by the World Health Organization (WHO):

- Destroying the infectious agent
- Minimising exposure to infectious sources
- Diminishing modes of transmission
- Defending entry points to the host (including personal protective equipment/PPE)
- Protecting susceptible hosts

The document also outlines recommendations for healthcare workers and employers of HCW's in relation to the five principles.

Regarding personal protective equipment (PPE), for example, the document states there should be sufficient stocks to meet demand, it should be readily accessible when needed, there should be appropriate types and suitable sizes and fits for safe use, and that best practice fit testing, donning, wearing, doffing and disposal should be followed. Further, employers must provide workers with appropriate PPE to reduce their risk of infection and, equally, healthcare workers should be knowledgeable about and follow evidence-based practices to prevent transmission by wearing the appropriate PPE.

The ANMF says healthcare workers are often at the frontline of efforts to control and respond to the pandemic, which places them at greater risk of becoming infected with COVID-19 and unintentionally transmitting it to others.

As such, employers must undertake proactive risk management, including considering what could happen if someone is exposed to COVID-19 and the likelihood of it happening, to determine risk and take action where necessary. Like other infectious diseases, the ANMF says effective evidence-based infection prevention and control strategies and interventions are vital to reducing the risk and impact of COVID-19 within and beyond the healthcare workforce.

ANMF Federal Secretary Annie Butler says that until a vaccine is developed, Australia and the world must learn to live with COVID-19. This demands implementing the strongest protections possible for healthcare workers putting their lives on the line.

"Healthcare workers are on the frontline of the pandemic response and therefore most at risk of becoming infected with COVID-19 themselves or unintentionally passing it onto others," Ms Butler says.

"Due to their higher risk of infection, employers of healthcare workers must ensure that their staff are properly protected. This safeguard maintains workers' own personal health and safety at work, ensures the health and safety of patients and others in the workplace, and ensures Australia has a sufficient workforce to provide safe and effective care to the community as we emerge from the pandemic."

COVID RECOVERY

While the coronavirus continues to remain a threat the ANMF will continue to push for greater support mechanisms for nurses, midwives and carers as the country shifts into "COVID-normal".

As part of this plan, the ANMF will encourage and lobby the federal government to consider the significance of the last year's events, and the issues it has highlighted in both health and aged care.

Jobs and job security for nurses and midwives who work in these sectors will be a key plank of this push, with the ANMF particularly keen to tie this element into the broader national economy recovery.

While there is now unanimous recognition of the havoc the coronavirus can cause in light of Victoria's second wave experience, the ANMF has regularly expressed concerns about the federal government's management of the pandemic from as early as March.

"Many in the public are concerned, confused and searching for answers, as access to important and basic information has not been distributed widely," ANMF Assistant Federal Secretary Lori-Anne Sharp said at the time.

While public confusion about things like school closures and mass gatherings eventually subsided as states and territories implemented plans specific to their residents' needs, it also meant ANMF members had different experiences with regards to workplace Occupational Health and Safety (OH&S).

Even in a state such as Queensland, that eventually achieved elimination, accessing PPE was sometimes difficult, according to QNMU OH&S Officer James Gilbert.

"Clearly there were hiccups, mainly around supply issues: We had the PPE, but it wasn't getting to the workplace," he said in the July 2020 issue of the *ANMJ*.

Meanwhile, in Victoria, when the second wave of the virus hit, it became clear that PPE was one part of a bigger puzzle, as the ANMF Victorian Branch worked with the Victorian government and other stakeholders as part of a taskforce to address health worker safety.

"[…] multiple and complex factors – PPE training, donning and doffing safely, cohosting of positive patients, the space between patients, ventilation in older buildings, and how staff amenities are used — are contributing to the transmission," ANMF (Vic Branch) Secretary Lisa Fitzpatrick said in August 2020.

"Masks are a significant part of the solution, but you must have safe systems and infection control procedures in place as well."

Meanwhile, the $1,500 Pandemic Leave Disaster Payment, a national measure designed to solve a structural workplace issue, failed to address the specific needs of the health workers on the frontline, ANMF Federal Secretary Annie Butler described last year.

"The $1,500 disaster payment is only available if a worker doesn't have sick leave and has been directed by a public health official to self-isolate. This won't stop workers going to work while they're feeling unwell because they can't afford to lose pay," Ms Butler said.

The lack of long term thinking was also laid bare in the federal government's October 2020 Budget, with Ms Butler observing that funding delegated for aged care, a sector devastated by Victoria's second wave, failed to specifically address the private sector's structural issues.

"It's disappointing that there's no action on job security and no action of improving wages and conditions for aged care workers," Ms Butler said.

"If jobs are the cornerstone of the national economic recovery plan, the ANMF is calling on the government to act now and address the dangerously inadequate levels of qualified nurses and care staff working in aged care."

CLIMATE EMERGENCY

While the COVID-19 pandemic has dominated the political and health agenda, the current climate emergency remains a serious threat needing significant and urgent action.

As a key priority for the ANMF heading into 2021, the union is committed to advocating for positive climate action in both the health sector and the broader community and will continue to back a variety of campaigns that agitate for stronger climate leadership from the government.

Last year, the ANMF endorsed the #FundOurFutureNotGas Day of Action on 25 September, where students organised a COVIDSafe series of online and socially-distanced gatherings to protest the proposed use of pandemic recovery funds on gas projects.

The ANMF also joined with other member organisations of the Climate and Health Alliance to call on the federal government to engage with climate change as part of its National Preventative Health Strategy.

Additionally, the ANMF's support for emergency workers, including nurses, midwives and carers, during the horrific 2019-20 bushfire season was also a reminder that many of those on the frontline will often be the first to experience the worst effects of climate disasters.

As we move into 2021, the ANMF will continue its efforts to highlight the health impacts of an ongoing climate emergency whose true scale is still only beginning to just emerge.

It will promote best environmental practice in healthcare, support causes that actively engage in positive climate action, while lobbying the federal government on the need to reduce the country's emissions.

The ANMF believes this is prudent, as while COVID-19 still remains a threat, the growing body of international evidence linking environmental collapse and the emergence of pandemics has ensured that a changing climate will remain a significant public health concern.

This was seen in an August report from staff at the US National Institute of Allergy and Infectious Diseases that suggested recent significant coronaviruses and other infectious diseases have spread, in no small part, due to factors like deforesting, over-crowding, sanitation, and lastly, wet markets.

The report's authors, Anthony Fauci and David M Morens, concluded that with COVID-19 acting as another example of this global trend, human behaviour would have to change.

"COVID-19 is among the most vivid wake-up calls in over a century," they wrote.

"It should force us to begin to think in earnest and collectively about living in more thoughtful and creative harmony with nature, even as we plan for nature's inevitable, and always unexpected, surprises."

In addition to pandemics, mounting air pollution, extreme temperatures and variable rainfall patterns have other significant impacts on the determinants of health, including exacerbation of respiratory and cardiac disease, infections amongst a range of other health issues.

Concurrently, the arrival of US President-Elect Joe Biden is also expected to create significant shifts in that country's climate policies, and it is set to join the EU, UK and other major Asian nations in having a net-zero emissions target.

Australia, by contrast, increasingly appears to be an outlier.

Not only does it not have a net-zero target for 2050, it will rely on "carryover credits" to meet its 2030 Paris carbon targets instead of investing in carbon neutral energy sources, while the aforementioned lack of a climate and health strategy is likely to become an increasing issue for both health workers and patients.

These local and global factors underline the ANMF's already clear belief that immediate climate action needs to be prioritised as part of the union's advocacy going forward, as Federal Secretary Annie Butler earlier forecast in the *ANMJ*'s January 2020 issue.

"Adverse climatic conditions continue to pose significant risk to the health and wellbeing of the community, particularly in those who are most vulnerable. We need to transition to zero emissions energy sources urgently to avoid dangerous and irreversible impact to the environment and health," Ms Butler said.

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

Policy – the need for them to be understood, enforced and practised

Healthcare professionals (HCP) are often involved in providing care to vulnerable people, including the very young, the elderly and those compromised through physical and or mental illness. The use of restraint and seclusion for such vulnerable people has been significantly restricted as a means of control unless deemed to be a necessary measure where it is necessary to use restraint/ seclusion to protect the person from self-harm or from harming others.

Any restriction on a person's liberty of free movement has the potential to infringe on basic human rights and the more restrictive, the more risk there is to the patient. Hence, when seclusion and restraint are employed as a measure to keep the patient and others safe, staff need to be aware that this is highly regulated both through legalisation such as Mental Health Acts the common law, organisational policy and professional standards.

It is imperative that HCP's are familiar with this framework making sure that they both practise within their scope around this and meet the expected standard of care during the period of seclusion or restraint.

In cases where this is not observed the risk for poor patient outcomes is high as in the recent findings in the Inquest into the Death or Ricky Noonan, (2020) where the cause of death was determined to be hypoxic-ischaemic brain injury attributed to cardiac arrest due to choking. The patient choked on a sandwich whilst supposedly under continuous supervision.

The deceased diagnosed with paranoid schizophrenia and depression had a history of suicide attempts and presenting on numerous occasions in an agitated and manic state, often in the context of amphetamine, cannabis and alcohol abuse. Mr Noonan suffered from persecutory delusions involving people wanting to hurt him and had a forensic history in relation to a number of assault charges. He was admitted to an acute psychiatric facility, and during the course of this admission, there were a number of code blacks due to his aggression, which resulted in 16 episodes of seclusion. The final order for seclusion followed him punching another patient in the head for no apparent reason and threatening to kill a nurse.

An important issue in the seclusion policy, in this case, was the need for patients in seclusion to be continuously monitored. However, what was meant by 'continuous monitoring', was unclear amongst the staff resulting in inconsistent practice. Some staff interpreted this policy as meaning that the patient must be sighted and communicated with at least every fifteen minutes. Another view was that CCTV was not a nursing intervention and did not replace the need to do 15 minutely checks, whilst another informed the court that it was just common practice not to continuously view the CCTV monitor but to glance at it every 15 minutes. In the Coroner's view, the intent of the policy was that a very close if not continuous eye should be kept on secluded patients, particularly given there was a requirement to undertake 15-minute sightings of all patients on the ward wherever they were. Therefore, one would have thought that secluded patients would have been subject to a closer degree of scrutiny than the 15-minute intervals that applied elsewhere in the ward.

What was apparent from the CCTV in the nurses' station was that at the critical time all three nurses were present, one looking at a mobile phone or device, one at a computer screen and one at a magazine or computer screen - none of them were watching the monitor. Had they done so what they would have observed was a harrowing account of the patient hunching over, putting his hand to his mouth, apparently coughing and apparently kicking on the door and his eventual collapse onto the floor where he lay motionless on his back.

It was at this point that a nurse glanced at the screen and the alarm was raised. Unfortunately, it was too late and Mr Noonan could not be resuscitated having choked on the food he was left unsupervised to consume.

The Coroner concluded that the observation of the deceased prior to his death was haphazard and inconsistent due to the policy not being understood nor consistently adhered to by staff. The patient who required continuous monitoring in the seclusion room either by direct viewing or by way of CCTV monitoring was 'at best intermittent and superficial and on any analysis unsatisfactory'.

Policies are important documents, however, their value is only realised when they are understood by all staff, enforced and practised. This case serves as an unfortunate example of what can happen when one or more of these criteria are not met.

Reference

Inquest into the Death or Ricky Noonan, (2020) Coroners Court SA.

Kristen Wischer

Senior Federal Industrial Officer

Voice. Treaty. Truth. The Voice to Parliament

The Uluru Statement from the Heart calls for three major reforms to empower First Nations People and to recognise their rightful place as the owners and custodians of the land of Australia.

The first of the reforms is the call for the establishment of a First Nations Voice to Parliament to be enshrined in the Constitution – 'Voice'.

The second is treaty-making between governments and First Nations – Treaty and the third, truth-telling, through a Commission – Truth. These will progress through the establishment of a Makarrata Commission – meaning 'coming together after a struggle'. Establishment of a Makarrata Commission will follow the first step – of recognising the Voice of Aboriginal and Torres Strait Islander people in the Constitution.

The Uluru Statement calls for constitutional reform to ensure that the views of Aboriginal and Torres Strait Islander people are heard in all decision making that affects their lives. Constitutional recognition is permanent and politically strong – it cannot be altered at the whim of changing policy, legislation or the government of the day.

The purpose of the Voice to Parliament is to ensure that when Parliament debates legislation or develops policy that will impact on the lives and rights of Aboriginal and Torres Strait Islander people, there is a place for their voices, opinions and ideas to be heard and properly considered. The Voice to Parliament will be a representative body that will advise the Parliament, but will not veto or block legislation.

The Voice to Parliament will ensure that the Parliament and the government are better and more appropriately informed in its approach to Indigenous affairs policy and law-making. This will lead to better outcomes for Indigenous people that are practical and fair.

The form of the Voice to Parliament is yet to be determined. What is clear is that constitutional recognition will not result in 'a third chamber' of Parliament as some politicians have suggested.

A range of advocates and academics acknowledge that, as with any group within Australian society, there is diversity of opinion, priorities and interests. For this reason, methods of providing an avenue for expressing views reflecting the cultural diversity of views of Aboriginal and Torres Strait Islander people throughout the country are being explored.

Constitutional change can, of course, only occur through a referendum, demonstrating that the majority of Australians support the proposed change. Advocacy for a referendum is being led by organisations such as From the Heart and the First Nation Workers Alliance.

The call for an Indigenous voice to be given formal footing is not new. The quest for recognition has been conveyed in statements and petitions over many decades – from the 1938 Day of Mourning, the 1963 Yirrkala Bark Petition, the 1988 Barunga Statement and now the Uluru Statement from the Heart. Human Rights Commission Social Justice Reports published in 2006, 2008 and 2009 have all recommended a voice for First Nations people.

In 2018 the Joint Select Committee on Constitutional Recognition recommended the Australian government initiate a process of co-design to develop detail for an Indigenous voice. This process was formally commenced in October 2019 with three advisory groups established to develop models to enhance local and regional decision-making and provide a voice for Indigenous Australians to government.

The report from this process is due to be released in early December. Release of the report will open a period of consultation with the broader Australian community.

This will be the opportunity for organisations, individuals and advocacy groups to make submissions in support of constitutional reform. It will be an opportunity to highlight the inequality in our health system and the poorer health outcomes experienced by Indigenous Australians. The argument that health results can be improved when the voice of Aboriginal and Torres Strait Islander people is listened to in any debate about health policy decisions is difficult to resist.

The upcoming consultation as a time to reflect on and celebrate the work done to date by those who contributed to the Uluru Statement of the Heart and to promote the importance of the campaign ahead to see the three tenets of the Statement progressed – Voice, Treaty and Truth.

If you would like to know more about the campaign for constitutional change to recognise the First Nations Voice to Parliament visit:

ulurustatement.org
fromtheheart.com.au
australianunions.org.au/fnwa
indigenous.gov.au/topics/indigenous-voice

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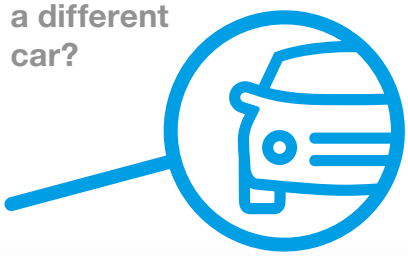

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†Negotiated Smartleasing buying power discount on chosen vehicle may vary.

COVID-19 ICU preparedness – A community-owned not-for-profit hospital experience

By Ashwin Subramaniam, Max Moser, Shae Whyte-Clarkson, Deb Sharp, Amy Brown, Matt Huynh and Gareth James

The following clinical update was written during the second wave of the COVID-19 pandemic in Victoria in August last year. While at the time of publication Victoria had recorded zero cases of the virus for a number of weeks, this paper explains how a Victorian ICU adapted and prepared during this time and may assist other facilities should there be any future outbreaks or pandemics.

INTRODUCTION

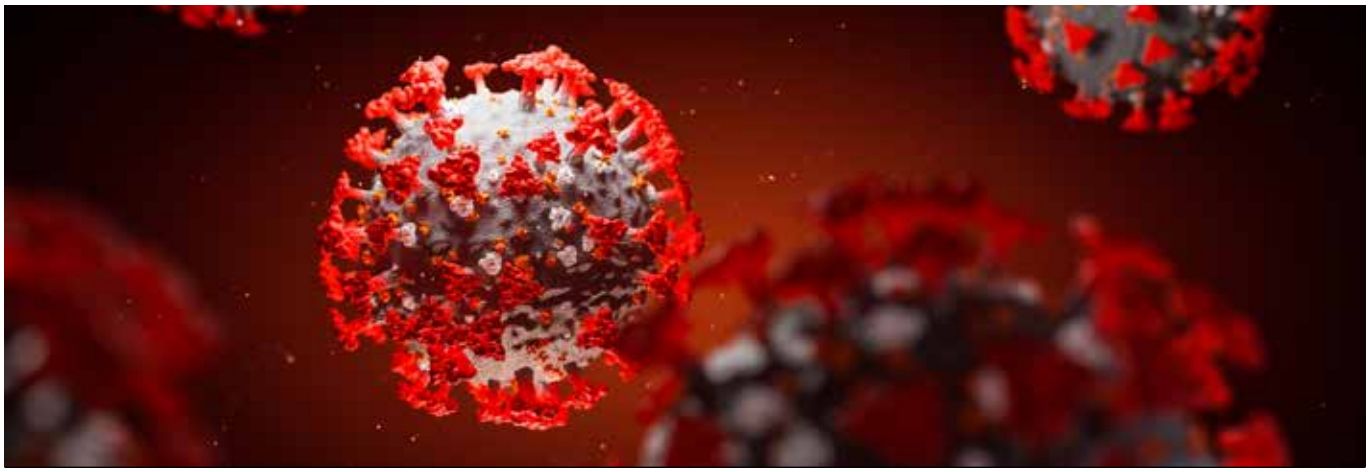
The novel coronavirus disease 2019 (COVID-19) pandemic, caused by the Severe Acute Respiratory Syndrome Coronavirus[2] (SARS-CoV-2) has infected more than 16.[1] million worldwide, with 646,641 confirmed deaths as of 27 July 2020.[1] The COVID-19 pandemic is a complex interaction between biology, human behaviour and governments. Its course is influenced by healthcare, economics, governance, and geopolitics. This pandemic is severely burdening and outstripping healthcare system capacities in many parts of the world,[2] and this time around, Australian healthcare capacities may be stretched. There has been a new surge of cases in Victoria. This rise in cases is likely to continue over the next two to three months. Approximately one third of infected patients become critically ill and require intensive care unit (ICU) admissions.[3] This burden falls especially heavily on ICUs and hence we in The Bays Hospital ICU in the Mornington Peninsula, Victoria enacted plans to prepare for it, as outlined below.

HEALTHCARE WORKERS SAFETY

Healthcare workers (HCW) are at considerable risk for SARS-CoV-2 infection, attributable to working in high-risk departments, longer duty hours, and suboptimal hand hygiene after exposure to patients with coronavirus.[4] A recent study identified that SARS-CoV-2 is widely distributed in the air and on object surfaces with significant environmental contamination in ICU.[5] This implies that stricter protective measures should be taken by medical staff working in the intensive care unit (ICU).[6] To date, 1.4 million HCWs have been infected globally (accounting for 10% of COVID-19 cases).[7] However, the infection rate appears to vary between <1% to 14%.[8-10] Although the reasons may be multifactorial, it is not unreasonable to speculate that variable personal protective equipment (PPE) preparedness may have played a significant role in HCW infection rate. PPE is the cornerstone to preventing HCW infections.[11] Suboptimal PPE training results in PPE breaches, thereby exposing HCWs to SARC-CoV-2 infection.[12,13] Concerns exist amongst HCWs about the overall effectiveness of PPE provided by organisations due to reports of PPE shortage emerging from multiple locations.[14,15]

AUSTRALIAN PANDEMIC PREPAREDNESS

Whilst public health measures aimed at reducing virus transmission are the primary means to reduce the overall disease burden and ICU requirement, guidelines recommend that ICUs undertake a coordinated and staged surge plan to respond to increased demand. In response, Australian ICUs can potentially triple their intensive care bed capacity from a baseline 9.4 per 100,000 to 26.5 per 100,000 population.[16] To mitigate the outbreak, both public and private facilities are preparing surge ICU bed capacity under the looming threat of limited resources. Key measures include cancellation of elective surgeries, and optimisation of workforce. Rapidly upskilling registered nurses and non-intensive care doctors is paramount at this time. The stage-3 lockdown was relaxed on 12 June in Australia. There has been a sudden increase in the number of cases in the last four weeks. Despite reinforcement of stage 3 restrictions for over two weeks and mandatory donning of face coverings in public for the past week, 532 new cases of coronavirus since the day before and a total number of active cases now at 8,696.[17] Moreover, residential aged care facilities are significantly affected with many of the infected residents being moved to acute



hospitals.[18] To make matters worse, about 150 Victorian HCWs are infected.[19]

LOCAL PANDEMIC PREPAREDNESS

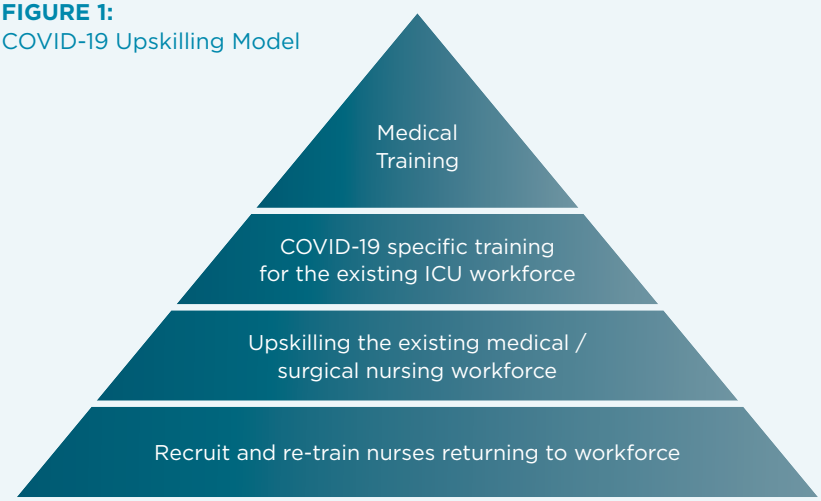
Given the ageing demographic of the facility catchment area (28.6% of the Mornington Peninsula population are older than 65 years of age)[20] and local referral patterns, we in The Bays ICU realised that preparing an ICU for COVID-19 pandemic had numerous requirements. We maintained a high index of suspicion and subsequently implemented screening of all personnel, visitors, and patients entering the facility. This became essential, as the Mornington Peninsula was labelled a "hot spot" with the second highest laboratory confirmed COVID-19 patients in the city of Melbourne.

As a 100-bed community owned, not-for-profit organisation, The Bays Hospital provides medical and surgical care to the Mornington Peninsula area via a Private Healthcare model. In May of 2019, The Bays Healthcare commissioned a six bed ICU to escalate surgical and medical acuity and expand services to the Mornington Peninsula area. In under 12 months, The Bays Hospital ICU is now geared and relatively idle, in anticipation of an influx of COVID-19 cases. Planning has been prepared in collaboration with our regional tertiary hospital – Frankston Hospital (Peninsula Health) in readiness to receive overflow. In addition, our ICU is prepared to care for any existing inpatients who demonstrate symptomology and require screening and treatment as required. A comprehensive assessment of our admission base and vulnerable patient populations was conducted in order to commence primary modelling and assess the impact that COVID-19 may have on our organisation.

Of significant impact was the reduction in all elective surgeries that did not fall into Category 1 (procedures that are clinically indicated within 30 days) or Category 2 (procedures that are clinically indicated within 90 days).[21,22] As a private facility with elective surgery as the predominant revenue stream, this had the potential to threaten ongoing hospital operation. However, assistance from State Government confirmed our role in the COVID-19 health response and ensured continued operation of business with a strategy of providing support for the public health sector.

ICU preparedness: Careful infection control planning governed how patients would be allocated and cohorted. Mapping patient flow ensured access to the required equipment and facilities such as a dirty utility room and negative pressure room, whilst also keeping as much of the department 'non-COVID' as possible. A COVID-only ingress and egress route was established, and policies were drafted to guide transfer of COVID-19 suspected or confirmed cases across the facility. Throughout the ICU preliminary preparations, a core team committed to the ongoing review of emerging clinical literature regarding the management of COVID-19 patients and constantly updating the policies and procedures.

FIGURE 1:
COVID-19 Upskilling Model



Staff upskilling: Anticipating a significant change in our medical and surgical presentations was the driver for our staff training and upskilling matrix. Our human resources are demonstrative of an ICU nursing workforce which is predominantly 'casual' based employment (77%), with only a small proportion being permanent part time (23%). In comparison, a significant proportion of workforce in Frankston Hospital (Public Sector) were permanent (85% overall; 58% part time and 27% full time), with only a minority casual (15%). Furthermore, the majority of this workforce also maintain employment in larger metropolitan tertiary facilities, therefore modelling for ICU staffing and surge capacity identified that our casual cohort of Critical Care Registered Nurses (CCRNs) may be seconded to frontline efforts. These analyses led to a tiered training model as illustrated in Figure 1. A large majority of healthcare organisations have an ancillary workforce that comprises of nurses who have transitioned into non-clinical roles. Re-engaging the clinical capacity of this workforce by facilitating refresher training was necessary in order to fill general medical/surgical nursing requirements. This enabled the organisation to draw upon the current medical/surgical workforce for upskilling and supplementing critical care nursing surge capacity. By cross-referencing job skills and specialty attributes, the organisation identified cohorts of staff who may be fast-tracked into the ICU environment (eg. Anaesthetic RNs, Post-Anaesthesia RNs). In view of social-distancing measures and limitations on face-to-face teaching modalities, staff were directed to online learning modules for delivery of theoretical content, and video practical demonstrations of selected skills. Orientation to environment, equipment, policies and procedures was provided with clear expectations around supervision, roles and responsibilities. On completion of online training, staff were then offered supported 'comfort' sessions in the clinical workplace.

Multidisciplinary simulation training: Focus was simultaneously driven towards training the existing critical care workforce for the anticipated changes in ICU patient care. This strategy was multi-factorial and incorporated clinical training (eg. PPE, ventilation, prone positioning), procedural training (eg. COVID-19 intubations), and alternative patient care models. Risk assessment was conducted via multidisciplinary simulations with regard to COVID-19 intubations. The process involved a core team of intensivists, anaesthetists, and senior CCRNs who collaborated on an ICU plan for intubation. Anaesthetists provided the primary taskforce for all suspected/confirmed COVID-19 intubations supported by the intensivist group and ICU nursing team. The ICU COVID-19 intubation plan was then remodelled to fit the theatre environment, and further modified to facilitate intubations in COVID-19

FIGURE 2:
ICU-preparedness in the Bays Hospital

(Top to bottom)

The arrangement of essential personal protective equipment in the Anteroom necessary for intubation of a suspected/confirmed COVID-19 patient

COVID-19 screening kits in sealed containers (for ease of disinfection). Contents include complete laminated instructions for ward staff on COVID-19 screening; swabs and swabbing protocol; altered MET and Code Blue protocol; donning and doffing protocol with one full set of AGP-specific PPE required for preliminary swabbing; mask for the patient; and clinical care guidelines for ongoing management

Designated case to be taken for the MET/Code Blue. The contents include – altered MET and Code Blue protocol; donning and doffing protocol with one full set of AGP-specific PPE; emergency drugs; nasal prongs; non-rebreather masks, IV pump set with 1L normal saline; AED defibrillator; IV cannula (18G and 20G) and dressing pack; viral filter

obstetric emergencies. In all phases, representatives from each key craft group were incorporated. Ward-based patient deterioration and code blue simulations were also conducted, and processes refined. At every level, simulations were utilised repeatedly to facilitate communication and familiarity across teams.

Contingency plans: The ICU preparedness modelling generated a tiered 'CONTINGENCY' staffing strategy, which would necessitate employing upskilled non-CCRN staff. This represented a significant shift in role for the CCRN from bedside to supervisory in heightened, high-risk circumstances. With an anticipated 30% attrition rate due to COVID-19 exposure or other causes, a back-up intensivist and ICU Fellow roster was drafted. Anaesthetists offered full support to cover ICU, and many surgeons also expressed their willingness to upskill and support the intensive care medical faculty, if required.

Modified rapid response service: The ICU also provide the hospital's Medical Emergency Team (MET) and Code Blue response. The MET/Code Blue policies and procedures were amended specifically to cater for COVID-19 patients. With staff safety as the leading priority, compressions only CPR was implemented for all suspected and confirmed COVID-19 patients with placement of nasal prongs for apnoeic oxygenation and a non-rebreather mask. Cardiopulmonary resuscitation is identified as an aerosol generating procedure, which prompted the removal of bag-valve mask ventilations.[23] MET and Code Blue teams were reduced to three people only (CPR, defibrillation, drugs) inside the patient room with a runner outside the room. Consideration was given to limiting exposure to critical care staff if possible, for conservation of the workforce at this level.

To facilitate early detection of COVID-19 in the inpatient setting, the ICU team reviewed the hospital 'escalation of care' criteria, and implemented changed triggers based on increasing oxygen requirements. Policy mandated that a MET call was to be triggered for any patient requiring >4 L/min oxygen via nasal prongs to maintain oxygen saturations >90%.

COVID-19 screening kits: Given that all admissions take place in a ward setting in the absence of an Emergency Department, the organisation manufactured COVID-19 screening kits to assist staff. These kits were to ensure staff had all the resources immediately available in the event a patient demonstrated symptoms or revealed information which would necessitate screening. Sealed containers (for ease of disinfection) were provided complete with laminated instructions for ward staff on COVID-19 screening, swabs and swabbing protocol, altered MET and Code Blue protocol, donning and doffing technique with a full set of required PPE for preliminary swabbing, mask for the patient, and clinical care guidelines for ongoing management. Feedback from staff was instantaneously positive.

Goals of care: A significant proportion of medical admissions are completed by the ICU Fellow (Registrar), who is the only doctor in the hospital after hours. With significant support from the Medical Advisory and Internal Medicine Committees, the preliminary goals of care discussions were initiated by the ICU Fellows in appropriate patients and then followed up by the admitting VMOs in a timely manner.

End of life care: Consideration was given to the anticipated clinical course of COVID-19 positive patients, and ultimately planning commenced for management and care of the dying patient. As a small private hospital with no mortuary, communications were established with local funeral directors to ensure deceased patients could be facilitated. Policies and procedures were implemented surrounding facilitation of end of life care,

and how to best support family members through the loss of a loved one due to COVID-19 in view of restricted access and maintenance of infection control precautions post-mortem.

Communication, engaging the stake holders – incident control group: There was significant support from executives and the board of directors. An incident control group was formed with key representation from executives, human resources, nursing, medical, infection control, hospitality and engineering divisions. The group continue to meet every day to address key issues with immediate resolutions. The daily news bulletins that were distributed to all hospital staff helped address staff concerns during these stressful times.

Pharmacy preparedness: Medication supply and stock were impacted both directly and indirectly by the onset of the COVID-19 pandemic. Although Therapeutic Goods and Administration (TGA) did not report any COVID-19 related medication supply issues,[24] the hospital faced issues with: 1) supply chain between the sponsors, wholesalers and pharmacies, 2) significant delays in ethical orders of up to five business days and 3) demand-related medication shortages. Fortunately, the hospital's 14-day medication imprest supply policy relieved the stress on medication supply. There was a significant surge in demand for intubation, inotropic and analgesic medications across hospital pharmacies, with medications such as intravenous propofol, midazolam and metoprolol becoming unavailable. Practice guidelines also mandated minimisation of aerosol-generating procedures. As a result, bronchodilators such as salbutamol and ipratropium bromide were administered solely as metered dose inhalers (MDI).[25] The limitations to Category 1 and urgent Category 2 surgeries subsequently allowed the redistribution of these medications to support the expected needs of the ICU, along with sourcing such drugs from alternative wholesalers and sponsors.

Equipment procurement: COVID-19 related supply interruptions were anticipated as early as January 2020. To ascertain possible impact and likelihood of interruptions the team reached out to all critical suppliers and tracked responses. Although historically the hospital only held 10–14 days of surplus supplies due to operational constraints, the stock surplus was increased to a 30-day buffer and six weeks for critical items such as PPE, sanitisers and antiseptic wipes. The hospital team also liaised with alternative suppliers as a contingency and to future-proof the hospital supply options. Daily counts on critical items were commenced to discourage any potential loss due to theft or overzealous use. Processes were amended across departments to conserve stocks and trial use of alternatives. Support services began extensive recruitment and cross training to support anticipated future need with an assumption worst-case principle of potential 70% workforce attrition rate.

SUMMARY

A major incident is said to have occurred when an incident requires an extraordinary response. The COVID-19 pandemic has required an extraordinary response from every employee of every global health service. The scale of an incident is not only defined by the number of 'casualties', but the amount of resources required versus the amount of resources available. Preparedness comes from a thorough understanding of an organisation's resources and a willingness to collaborate and adapt. At some point, hopefully in the not-to-distant future, hospitals will be able to commence the recovery phase. This will involve resolution and planning to progressively return to business as usual, reflection of events during the pandemic and auditing of operational processes. One element that stands out as a clear positive in our minds is the multidisciplinary cohesion and sense of comradery that has increased during this time of uncertainty. This serves as testament to our duty of care and our collective attitude 'we are all in this together'.

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References

1. Coronavirus disease (COVID-19) Pandemic. 2020. (Accessed 21/04/2020, 2020, at who.int/emergencies/diseases/novel-coronavirus-2019.)
2. Remuzzi A, Remuzzi G. COVID-19 and Italy: what next? *Lancet* 2020;395:1225-8.
3. Huang C, Wang Y, Li X, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *Lancet* 2020;395:497-506.
4. Ran L, Chen X, Wang Y, Wu W, Zhang L, Tan X. Risk Factors of Healthcare Workers with Corona Virus Disease 2019: A Retrospective Cohort Study in a Designated Hospital of Wuhan in China. *Clin Infect Dis* 2020.
5. Guo ZD, Wang ZY, Zhang SF, et al. Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020. *Emerg Infect Dis* 2020;26.
6. Ong SWX, Tan YK, Chia PY, et al. Air, Surface Environmental, and Personal Protective Equipment Contamination by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) From a Symptomatic Patient. *JAMA* 2020.
7. WHO. So far, about 10% of all #COVID19 cases globally are among #healthworkers. In: @WHO, ed. 1:29 AM ed2020.
8. Infection and mortality of healthcare workers worldwide from COVID-19: a scoping review 2020. (Accessed June 28, 2020, at medrxiv.org/content/10.1101/2020.06.04.20119594v1.full.pdf.)
9. Muhi S, Irving LB, Buising KL. COVID-19 in Australian health care workers: early experience of the Royal Melbourne Hospital emphasises the importance of community acquisition. *Med J Aust* 2020;213:44-.e1.
10. Lai X, Wang M, Qin C, et al. Coronavirus Disease 2019 (COVID-2019) Infection Among Health Care Workers and Implications for Prevention Measures in a Tertiary Hospital in Wuhan, China. *JAMA* Network Open 2020;3:e209666-e.
11. De Iaco G, Puro V, Fusco FM, et al. Personal protective equipment management and policies: European Network for Highly Infectious Diseases data from 48 isolation facilities in 16 European countries. *Infect Control Hosp Epidemiol* 2012;33:1008-16.
12. Wang J ZM, Liu F. Reasons for healthcare workers becoming infected with novel coronavirus disease 2019 (COVID-19) in China. *J Hosp Infect* 2020.
13. Schwartz J KC, Yen M. Protecting Health Care Workers during the COVID-19 Coronavirus Outbreak – Lessons from Taiwan's SARS response. *Clinical Infectious Diseases* 2020.
14. Rosenbaum L. Facing Covid-19 in Italy – Ethics, Logistics, and Therapeutics on the Epidemic's Front Line. *N Engl J Med* 2020.
15. Kamerow D. Covid-19: the crisis of personal protective equipment in the US. *BMJ* 2020;369:m1367.
16. Edward Litton TB, Shaila Chavan, Yvonne Y Ho, Anthony Holley, Gretta Howard, Sue Huckson, Philomena Kwong, Johnny Millar, Nhi Nguyen, Paul Secombe, Marc Ziegenfuss and David Pilcher. Surge capacity of Australian intensive care units associated with COVID-19 admissions. *Medical Journal of Australia* 2020.
17. DHHS. Coronavirus update for Victoria – 27 July 2020. Department of Health and Human Services: dhhs.vic.gov.au; 2020.
18. Aisha Dow PS. St Basil's empties as Epping home pleads for residents to be moved. *The Age* 2020.
19. Noel Towell MF. 150 Victorian health workers infected as new cases top 300. *The Age* 2020 July 16th 2020.
20. Australia's coronavirus hotspots. *The Guardian*, 2020. (Accessed 17/04/2020, 2020,
21. Elective Surgery wound back to prepare for coronavirus. Victoria Premier, 2020. (Accessed 21/04/2020, 2020, at premier.vic.gov.au/wp-content/uploads/2020/03/200325-Elective-Surgery-Wound-Back-To-Prepare-For-Coronavirus-1-1.pdf.)
22. Health Mo. Australian Government partnership with private health sector secures 30,000 hospital beds and 105,000 nurses and staff, to help fight COVID-19 pandemic. In: Health Do, ed. health.gov.au2020.
23. Recommendations for Rapid Response Teams (RRTs) and Critical Care Outreach (CCO) services in the context of the COVID-19 pandemic. 2020. at www.baccn.org/static/uploads/resources/RRT_and_CCO_COVID-19_Version_1.pdf.)
24. Amdministration. TGA response to coronavirus (COVID-19). In: H.T.G AGDo, ed.: Therapeutic Goods Administration (TGA); 2020.
25. Kutter JS, Spronken MI, Fraaij PL, Fouchier RA, Herfst S. Transmission routes of respiratory viruses among humans. *Curr Opin Virol* 2018;28:142-51.

Rasa Kabaila

Rasa Kabaila is a Nurse Practitioner working in community mental health (acute care service) Mid North Coast LHD.

Implementation of an innovative nurse led service to support treatment for depression in primary care (OptiMA2)

Overwhelming evidence shows that achieving early full remission in depression is crucial as residual depressive symptoms are the strongest predictor of early relapse and are strongly associated with poorer functional outcomes.

Additionally early full remission can reduce the indirect costs associated with depression.

However, evidence also demonstrates that primary care clinicians are not optimising timely treatments for their clients that experience depression which has resulted in the failure to achieve early remission.

Further, evidence shows, that when clients with moderate to severe depression seek secondary care they are also not receiving the specialist care they require.

To address this issue in the Mid North Coast Local Health District, we instigated a trial, known as the OptiMA2 study, to help extend specialist care into primary care. The OptiMA2 model assists GP's to optimise their treatment for clients presenting with moderate to severe depression. It involves using Nurse Practitioner led care pathways, supported by an online system capturing patient rated outcomes, to optimise treatments.

To examine the feasibility and acceptability of the care pathway a study was instigated using qualitative research techniques, quality improvement science and co-design methodology.

WHY ENGAGE IN THIS RESEARCH ACTIVITY?

I chose to engage in this research activity because my role in the project allows me as a Nurse Practitioner to work to my full scope of practice and fill service gaps within health.

Within my Nurse Practitioner role in this project, I have enabled GP's clients to access timely, specialist and holistic care. This in turn, bridges the gap between primary health and public health. As this project is a quality improvement project in the Mid North Coast Local Health District and having gained research ethics approval, I am able to demonstrate the ability and contribution of a Nurse Practitioner. My hope is that this project will further show why more Nurse Practitioner positions are needed in healthcare.

STUDY PROCESS

The OptiMA2 study is a mixed method pilot service implementation study, utilising: literature reviews on service implementation models; service data gap analysis; qualitative interviews and focus group methodology.

As part of the research, I have set up and run the Nurse Practitioner depression clinic where I assess and treat all clients. Care plans are discussed and shared collaboratively with clients, psychiatrists and referring GP's.

Working collaboratively with the research team, Richard, Sarah, Pia and Rob, we met weekly to discuss progress and how the care model can be improved. This process is ever evolving through using quality improvement develop tools such as driver diagrams and Plan Do Study Act (PDSA) cycles through the Quality Improvement Data System (QIDS).

OUTCOMES AND RECOMMENDATIONS SO FAR

From July-October 2020, 12 clients were referred to the clinic. Out of the 12 clients, the first three clients have reached remission in less than three months. Six of the clients have only recently had their initial assessment. Two clients decided not to join the trial and one client is yet to be seen.

Barriers to clients joining the clinic or being seen for their treatment in a timely way have been work and caring responsibilities, not wanting to attend any more appointments (or fill out more paper work) as well as difficulties reaching the client by telephone.

In September 2020, Pia and Rob ran a focus group for the initial cohort of clients and GP's to obtain qualitative feedback about their experiences in the OptiMA2 study. Pia's role was important as she has a special ability in knowing which questions to ask client's about their experience pertinent to the OptiMA2 clinic, given her own personal experience as a healthcare consumer.

The initial focus group for clients produced positive feedback; the clients felt that this clinic should have been made available years ago. The clients felt listened to, cared for and appreciated the time that was invested in their appointments, especially during the initial assessment (which is crucial in formulating the best treatment plan possible).

Constructive feedback from the clients related to the online system where they felt that some of the questions were difficult to answer.

The initial GP focus group's feedback was positive. The GPs stated they had come to better understand and appreciate the Nurse Practitioner role and felt they had a pathway to timely specialist mental healthcare that was demonstrating positive clinical outcomes.

Continually engaging and educating the local health workforce on the longer-term value of this pathway will be an important part of embedding it in a sustainable way. In addition, once this clinic expands, more Nurse Practitioner positions are required to sustain the client numbers.

IMPLEMENTATION AND EVALUATION

Co-investigator Medical Student, Robert Oakeshott from the UNSW Rural Clinical School recently completed a clinical report of the findings of the OptiMA2 trial through UNSW.

The research team has provided a presentation discussing the OptiMA2 trial at Grand Rounds in the Mid North Coast Local Health District. As the Nurse Practitioner, I am still seeing clients who have been referred to the OptiMA2 study, the final results have not yet been analysed.

The results of the OptiMA2 trial will focus on the qualitative analysis of the co-design process to implement the initial care pathway.

The research team intends to submit findings of OptiMA2 through scientific journal publication as well as disseminating research findings through oral presentation and poster presentation at academic conferences within Australia and internationally.

OptiMA3 will be the next stage of this research project, in which we are in the process of writing for ethics approval. OptiMA3 will examine the cumulative clinical outcomes to consider if increased rates of remission are achieved and search for potential predictive factors to individualise treatments for depression.

The long term goal for this clinic is to support the development of community based care-extender models, including specialist nurses, pharmacists and GPs, to extend specialist mental health expertise to larger primary care populations where the greatest burden of mental illness occurs.

The research team for this project includes:

Coordinating Principal Investigator: Dr Richard Tranter, Psychiatrist & District Medical Director for Mental Health, Mid North Coast LHD.

Co-investigator: Rasa Kabaila, Nurse Practitioner Mental Health Nurse, Mid North Coast LHD.

Co-investigator: Dr Sarah Mollard, General Practitioner, Five Star Medical Centre, Port Macquarie.

Co-investigator: Pia Latimer, Peer worker, Mid North Coast LHD.

Co-investigator: Robert Oakeshott, Medical Student, UNSW Rural Clinical School.

Rasa, Pia and Rob

Palliative Care

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

By ANMF Federal Education Team

The World Health Organization (WHO) defines palliative care as: "An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

PALLIATIVE CARE

- provides relief from pain and other distressing symptoms such as vomiting and shortness of breath;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness; and
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications." (WHO 2020).

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows:

- Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family;
- It begins when illness is diagnosed and continues regardless of whether or not a child receives treatment directed at the disease;
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress;
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited; and
- It can be provided in tertiary care facilities, in community health centres and even in children's homes." (WHO 2020).

This definition and description of palliative care indicates that, contrary to earlier definitions, individuals with diseases other than cancer that have a terminal phase and are progressive in nature would benefit from the philosophy underpinning the palliative approach.

These include chronic obstructive pulmonary disease (COPD), Alzheimer's disease, AIDS, heart failure and acute massive cerebrovascular accident, to name a few.

The individual receiving palliative care is an important partner in the planning of their care and managing their illness.

When people are well informed, participate in treatment decisions and communicate openly with their doctors, nurses and other health professionals, they help make their care as effective as possible.

Care planning is an important process in ensuring the individual's wishes, in relation to their care, are met.

Palliative care is active care. It anticipates problems that might arise, and aims to minimise the impact of the progressing illness so that the person can live life to the fullest.

No one professional can deliver all of the elements of care. Palliative care requires the

cooperation and participation of a range of healthcare providers.

WHAT IS A PALLIATIVE APPROACH?

The underlying philosophy of a palliative approach is a positive and open attitude towards death and dying.

The promotion of a more open approach to discussions of death and dying between the care team, the client and their families ensures identification of their wishes regarding end-of-life care.

It is vital to be aware of and understand the individual's cultural and spiritual beliefs to address their needs in an appropriate and acceptable manner.

A palliative approach is not confined to the end stages of an illness.

A palliative approach provides a focus on active comfort care and a positive approach to easing an individual's symptoms and distress.

In most western societies, discussion of death and dying creates discomfort.

This distancing response to death and dying is reflected in poor communication about the topic, limited resources directed to this specialty area, and minimal education about how to provide supportive end-of-life care.

DIGNITY

Promoting a person's sense of dignity is central to a palliative approach, and dignity and quality of life are vital links in this approach. Several researchers have explored what people's views on quality of life means to them as their death approaches. Themes identified include having adequate pain and symptom management, avoiding inappropriate prolongation of dying, relieving burdens, achieving a sense of control, and strengthening relationships with loved ones.

People may hold different views about what dignity means, and in the face of progressive illness or the ageing process,

the meaning of dignity may change over time. It is also important to note that the team's perception of dignity may differ from that of the individual. The best way to understand what dignity means for the individual is to ask them and their family what are the most important factors for him or her concerning dying with dignity.

TALKING ABOUT PALLIATIVE CARE

Talking about dying is hard and it is sad. However, death is inevitable and the better prepared for our death, the easier it will be on the ones left behind.

It is also important to talk about death so everyone involved can prepare well.

If people do not have the opportunity to talk about dying and understand their rights when they die, we run the risk of the person, their families and carers, experiencing a difficult death. We need to talk about dying to become advocates for good palliative care and a comfortable death for all Australians (Palliative Care Australia 2020).

FAMILIES AND A PALLIATIVE APPROACH

A family member can be considered as any person who is part of the central core in the support network of an individual, including non-family carers.

For some family members, this may be their first experience of a palliative approach or their first experience of impending death. They need an opportunity to have privacy to attend to such matters as:

- Treatment decisions;
- Family member's history; and
- Tensions that may surface at this time (eg. relationships, financial concerns).

The family will also require education on how a palliative approach works and an explanation of the signs of impending death to reduce their fears.

Research undertaken to evaluate the effectiveness of a palliative approach has suggested that a palliative approach may be at least of equal value and may often be of more value to the family than to the dying person.

The evidence suggests that families value not only technically competent physical care but also regard emotionally sensitive care as especially important.

Families appreciate good communication with those who provide care to their family member, affirmation from the care providers that the families input is valued and permission from care providers for families to withdraw at times from the caregiving situation.

Families describe the importance of time with the team, being kept informed about their loved one's condition and being treated as if they have an active and equal role in the care planning process.

Specific palliative approach interventions found to be helpful to families include:

- access to 24 hour medical and nursing advice (not always possible in rural and remote areas);
- use of family conferences to obtain and share information;
- attention by the team to the loved one as a whole person; and
- competent pain management and comfort measures.

The family's trust in the team is essential, helping them build a satisfactory partnership with them. By entering into a caregiving partnership with the team, some family members can express their love for the client through contributing to their care.

Therefore, if a person is admitted towards the end of their illness trajectory or ageing process, the team need to help the family build a satisfactory partnership as members of the team.

To build this trust and fulfil family's needs, extra time and good communication skills are required from all members of the team.

References

Palliative Care Australia (PCA) 2020b: talking about palliative care. palliativecare.org.au/talking-about-palliative-care#

World Health Organization (WHO) 2020: Definition of palliative care. who.int/cancer/palliative/definition/en/

Burning out: Workforce mental health and COVID-19

Writing for the next year's first issue of *ANMJ* at the beginning of November has always been a challenge. This year it's a struggle.

Dr Micah D J Peters

Director of the ANMF National Policy Research Unit (Federal Office) based in the Rosemary Bryant AO Research Centre, UniSA Clinical and Health Sciences, University of South Australia.

Coming into the final straight of the year one can't help but feel a little exhausted and that it's time for a deserved break.

For many, however, 2020 has been exhausting like no other – this is especially true for nurses, midwives, and care workers who have been working tirelessly in the very year when we were meant to be celebrating their contribution to global health and advocating for a stronger influence at political and policy-making tables.

As Emeritus Professor Jill White was quoted in the last issue; "the campaign hasn't been quite the celebration that we had hoped it would be" and while there's no doubt that 2020 has well and truly thrust nurses into the spotlight, the intensity and pressure of the International Year of the Nurse and the Midwife has been a lot to bear.

Burnout is an occupational phenomenon (rather than a medical diagnosis) that arises as a result of continuing, unsuccessfully to manage work-related stress. Three dimensions are typically experienced; emotional exhaustion, depersonalisation or cynicism in relation to one's work, and depleted work efficiency. These signs echo some symptoms of clinical depression and the two presentations can sometimes be confused or coexist; burnout increases the risk of depression (Informed Health, 2020). Comparing the results of a 2019 survey with earlier 2017 results, the Rosemary Bryant AO Research Centre found that even before the pandemic, the nursing, midwifery, and carer workforce in South Australia appeared to be overextended with increasing severity of emotional exhaustion and depersonalisation on the Maslach Burnout Inventory (Corsini et al. 2018).

We recently closed our latest 2020 survey with a national sample of over 13,000 participants and anticipate seeing these findings amplified and apparent among staff working interstate where the pandemic and lockdown responses hit the hardest. This prediction is strengthened by recent findings of high levels of anxiety, burnout, and depression amongst Australian healthcare workers during the pandemic (ABC News, 2020).

Elsewhere, I have emphasised the need for a stronger focus on mental health in relation to COVID-19, making particular mention of the importance of the health and aged care workforce and our most vulnerable members of society (Peters and Bennett, 2020).

There are signs that the 'second wave' of mental health and wellbeing impacts of COVID-19 and the recession is now upon us and that this new tide of challenges will most detrimentally affect women, the unemployed, marginalised groups, and disadvantaged younger people (McGorry, 2020). Mental health systems were stretched before the pandemic, and without greater investment and consideration regarding how a surging number of people who need assistance, care, and treatment can be effectively responded to is at risk of buckling and allowing many to fall through the cracks. There is also a need for the mental health system to look to better protecting and caring for its own workforce as well as staff in the wider health, aged care, and maternity care sectors due to the impact of burnout, stress, and mental ill-health and wellbeing.

There are a number of strategies that are effective for addressing burnout (de Oliveira et al. 2019); resilience training can teach professional approaches for managing cognitive behaviour and enhancing resilience. Meditation, mindfulness, and yoga can also be effective in supporting reduced emotional exhaustion and depersonalisation. Formal mental health programs and physical and mental exercise programs can also be effective.

It will be vital for sectors to examine how they are working to address, prevent, and respond to burnout in their workforces and for political decision makers to recognise that protecting Australia's largest workforce. Thus the community requires immediate and sustained attention and not a pathway back to economic stability focussed on industry, manufacturing, and infrastructure. Indeed, the October Federal Budget did not contain much in the way of funding or support for health and aged care with little to nothing for those in the public sector.

Looking forward, 2021 brings ample opportunity and hopefully a lot less stress and strain than 2020. We look forward to the Royal Commission into Aged Care Quality and Safety's final report, hopeful that our recommendations regarding mandated staffing levels and skills mixes are heard and put stronger minimum requirements forthwith. We also look forward to the possibilities offered by the next election, which at the latest will be in 2022, giving us time to hone our campaigns and evidence to advocate for you on the national stage.

Please look after yourselves and your colleagues in 2021 knowing that it was your work that prevented an even worse crisis in 2020. While the International Year of the Nurse and the Midwife wasn't a celebration, it was a huge demonstration of how important you are.

For support:

Nurse & Midwife Support:
1800 667 877 or
nmsupport.org.au
Lifeline: 13 11 14 or
lifeline.org.au
Beyond Blue:
1300 22 46736 or
beyondblue.org.au

References

ABC News. 2020. Coronavirus pandemic causing anxiety, burnout in most of Australia's healthcare workers. Available online: abc.net.au/news/2020-10-16/survey-of-healthcare-workers-mental-health-issues-coronavirus/12772062

Corsini, N., Adelson, P., Anikeeva, O., Ramsey, I., Peters, MDJ., Sharplin, G., Eckert, M. 2018. Nursing and Midwifery Workforce Climate Survey 2017. University of South Australia. Available online: library.unisa.edu.au/

de Oliveira SM, de Alcantara Sousa LV, Vieira Gadelha MDS, do Nascimento VB. 2019. Prevention Actions of Burnout Syndrome in Nurses: An Integrating Literature Review. *Clin Pract Epidemiol Ment Health*. 2019;15:64-73. doi.org/10.2174/1745017901915010064

McGorry, P. 2020. Mental health and COVID 19: are we really all in this together? *Medical Journal of Australia*. [E-pub] mja.com.au/journal/2020/213/10/mental-health-and-covid-19-are-we-really-all-together

Peters MDJ and Bennett M. 2020. The mental health impact of COVID-19. *Australian Journal of Advanced Nursing*. 37(4):1-3. doi.org/10.37464/2020.374.317

Avoiding diabetic ketoacidosis in perioperative and procedure settings

By Gillian Ray-Barruel and Kathryn Kerr

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) are a relatively new class of oral medications for the treatment of type 2 diabetes. While they are particularly helpful for managing blood glucose in diabetic patients with cardiovascular comorbidities, they also come with side-effects and potentially life-threatening risks. This article describes how to safely manage these patients when fasting in perioperative and procedure settings.

INTRODUCTION

Almost one million Australian adults self-reported a diagnosis of type 2 diabetes in 2017–2018 (4.9% of the total population) (ABS 2019). In addition, an estimated 500,000 people are living with undiagnosed type 2 diabetes.

Populations at higher risk of type 2 diabetes include Aboriginal and Torres Strait Islander peoples; non-indigenous people over 40 years with high blood pressure, overweight, or family history of diabetes; young people who are overweight or obese; history of gestational diabetes; polycystic ovarian syndrome with obesity; and those over 55 years of age (Queensland Health 2015).

Diabetes is a chronic metabolic disease characterised by high blood glucose levels and disturbances of carbohydrate, fat, and protein metabolism (Queensland Health 2015). Without careful blood glucose control, patients with diabetes are at risk of vascular complications, including retinopathy, peripheral neuropathy, myocardial infarction, cardiovascular disease, renal disease, and stroke (Queensland Health 2015).

Many people diagnosed with type 2 diabetes take oral hypoglycaemic medications to regulate their blood glucose. In recent years, a new class of oral hypoglycaemic drugs has become available. Sodium-glucose co-transporter 2 inhibitors (SGLT2i) are licensed for the treatment of type 2 diabetes in Australia, with some off-label prescribing for type 1 diabetes mellitus. This drug class includes dapagliflozin, empagliflozin, and ertugliflozin, and may also be given in combination with metformin, sulfonylurea, or both (ADS 2020).

This education update provides information about SGLT2i medications, which is particularly relevant for nurses caring for patients who need to fast for surgical or day procedures. Some references are included for further reading.

BENEFITS AND RISKS

SGLT2i medications reduce renal tubular glucose reabsorption and increase excretion of glucose and sodium, resulting in lower blood glucose and osmotic diuresis (Waylen and Riedel 2019). A systematic review and meta-analysis identified dramatic benefits in diabetic patients taking these drugs, with a reported 23% reduction in cardiovascular-related morbidity and mortality, and a 45% reduction in progression of renal disease (Zelniker et al. 2019).

Metabolic benefits have also been reported, including weight loss (Fleming et al. 2020). Such benefits make these drugs particularly useful for diabetic patients with cardiovascular comorbidities. However, these drugs are contraindicated in patients taking loop diuretics or with chronic kidney disease (estimated glomerular filtration rate [eGFR] < 45 ml/min/m^2) (ADS 2020).

Unfortunately, SGLT2i medications also come with documented side-effects and risks. Adverse effects may include dehydration, dizziness, postural hypotension (associated with volume depletion), increased risk of genitourinary infections, and lower extremity vascular insufficiency (ADS 2020; Waylen and Riedel 2019). If any of these side-effects are evident, patients may be at increased risk of falls.

A potentially life-threatening complication is euglycaemic diabetic ketoacidosis (DKA), particularly when patients taking SGLT2i medications have been fasting due to illness or before a surgical procedure. Case studies have reported diabetic patients taking SGLT2i drugs who have developed severe acidosis requiring admission to a critical care unit (Fleming et al. 2020). Most of these patients had normal or mildly elevated glucose levels, but severe ketoacidosis, a condition called euglycaemic DKA.

DKA is caused by an absolute or relative insulin deficiency, which ordinarily leads to hyperglycaemia (BGL >13.9 mmol/L); however, patients taking SGLT2i medications have increased glycosuria, so their blood glucose levels may be within normal limits (Fleming et al. 2020).

The risk of DKA increases for patients who are dehydrated, have been fasting, have undergone bowel preparation for a procedure (colonoscopy or surgery), have gastrointestinal or systemic illness, or an active infection. Therefore, surgical and procedure nurses need to understand this new class of drugs, be alert to the signs of DKA, and understand how to manage these patients. Signs and symptoms and biochemical parameters of DKA are listed in Table 1.

PRIOR TO THE PLANNED PROCEDURE

The pre-operative visit or phone call should identify patients who are taking SGLT2i medications and advise them on cessation. Patients should also be provided with written information about when they should cease these medications.

The nurses can provide this in the endoscopy unit, or a pharmacist or nurse in surgical outpatients, depending on the hospital.

For patients undergoing elective surgery or procedures requiring bowel preparation or prolonged fasting, SGLT2i medications should be ceased at least three days pre-procedure (two days prior to and the day of surgery/procedure) (ADS/NZSSD 2020). For day-stay procedures (including gastroscopy), SGLT2i can be held for the day of the procedure (ADS/NZSSD 2020).

Any diabetic patient who is fasting for a procedure should have their blood glucose levels strictly monitored, and adjustments to other diabetic medications may be required. Fasting before and after the procedure should be minimised, where possible.

TABLE 1 – Diabetic ketoacidosis – what to look for

SIGNS AND SYMPTOMS (may have one or more)	BIOCHEMICAL PARAMETERS
• Abdominal pain • Nausea • Vomiting • Fatigue • Drowsiness • Confusion • Thirst, dehydration • Tachypnoea • Ketone breath (smells like acetone) • Unexplained clinical deterioration	• Metabolic acidosis pH < 7.3 • Blood ketone levels > 1.0 mmol/L with or without hyperglycaemia • Base excess – 5 mmol/L on arterial or venous blood gases • Blood glucose levels may be within normal limits (4–7.8 mmol/L)

RACGP/ADS, 2018; Waylen & Riedel, 2019

MANAGEMENT IN THE PERIOPERATIVE AND PROCEDURE SETTING

For a patient with a history of taking SGLT2i medications, blood glucose and blood ketone levels should be obtained on admission to the hospital or procedure unit. Urine ketone tests may be inaccurate when patients are taking SGLT2i drugs, therefore blood ketone testing is preferred (RACGP/ADS 2018). Hourly blood glucose and blood ketone level monitoring are strongly recommended during the admission. However, in the case of short sedation procedures, like gastroscopy and colonoscopy, monitoring on admission and again in the recovery unit is considered adequate. Blood ketone levels must be measured because urine ketone levels are unreliable in patients taking SGLT2i medications (ADS/NZSSD 2020).

If the procedure is uneventful and the patient displays no evidence of DKA, SGLT2i medications should be restarted 24 hours after the patient is eating and drinking their normal diet (Waylen and Riedel 2019).

If the patient taking SGLT2i medications requires urgent or emergency surgery, the medications should be withheld as soon as the decision is made to proceed with surgery (Fleming et al. 2020). As a precaution, the patient should be admitted post-operatively to a high-dependency or critical care unit for close monitoring of blood glucose and blood ketone levels (Waylen and Riedel 2019).

WHAT TO DO IF THE PATIENT DEVELOPS DKA

DKA is an acute medical emergency. If a patient who has been taking SGLT2i medications develops abdominal pain, nausea, vomiting, drowsiness, confusion, tachypnoea, or fatigue, the nurse should suspect DKA and obtain immediate medical attention (ADEA, 2020). An urgent finger prick test for capillary glucose and ketones should be followed up with a venous blood gas (Fleming et al. 2020). If the patient's blood ketones are > 1.0 mmol/L and base excess –5 mmol/L, treat the patient for DKA, even if blood glucose levels remain normal (4–7.8 mmol/L). The patient should be transferred to the critical care unit and managed with specialist care (rehydration, insulin, and monitoring as per the DKA protocol) (ADS/NZSSD 2020). Once the patient has been stabilised, the medical team should consult with an endocrinologist prior to resuming the SGLT2i medications.

A diabetes nurse specialist should be consulted to provide diabetes education prior to discharge from hospital and follow up in the community, as needed (ADEA 2020).

As a patient safety precaution, all surgery and day procedure units should have a policy outlining the recommended management of fasting diabetic patients prescribed SGLT2i medications, including education for staff detailing how to recognise and manage DKA.

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References

Australian Bureau of Statistics (ABS). 2019. National Health Survey, 2017–18. ABS cat. No. 4324.0.55.001. Canberra: ABS. aihw.gov.au/reports/diabetes/diabetes-snapshot/contents/how-many-australians-have-diabetes/type-2-diabetes Accessed: Sept 2020

Australian Diabetes Society (ADS) and New Zealand Society for the Study of Diabetes (NZSSD). 2020. *Periprocedural diabetic ketoacidosis (DKA) with SGLT2 inhibitor use*. anzca.edu.au/resources/professional-documents/statements/ads_alert-update Accessed: Aug 2020

Australian Diabetes Educators Association (ADEA). 2020. *Clinical guiding principles for sick day management of adults with type 1 diabetes or type 2 diabetes: A guide for health professionals*. ndss.com.au/wp-content/uploads/clinical-guide-sick-day-mngt.pdf Accessed: Oct 2020

Australian Diabetes Society (ADS). 2020. *Australian type 2 diabetes management algorithm*. t2d.diabetessociety.com.au/documents/86Nzztb4.pdf Accessed: Oct 2020

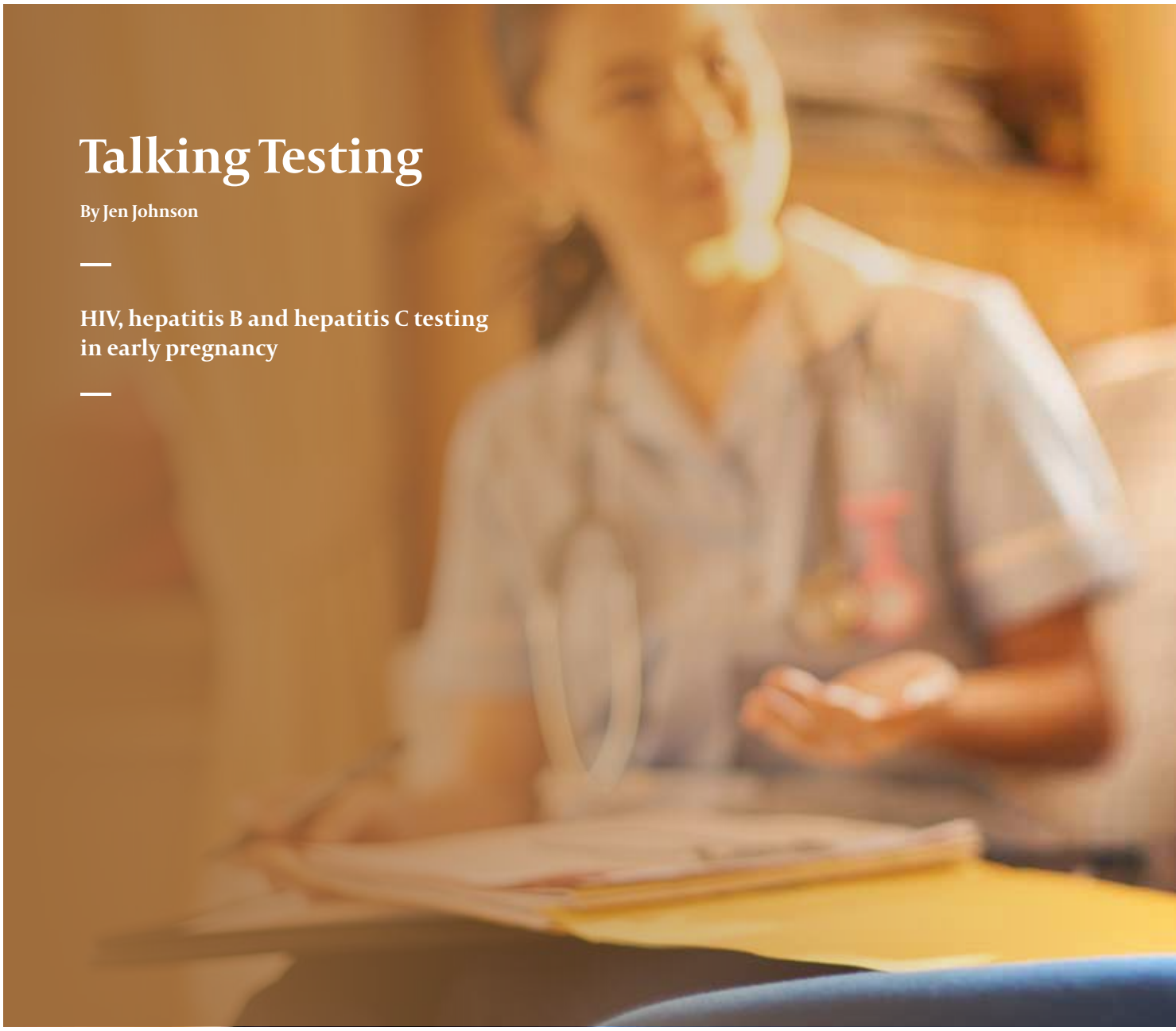
Fleming, N., Hamblin, P.S., Story, D., and Ekinci, E.I. 2020. Evolving evidence of diabetic ketoacidosis in patients taking sodium-glucose co-transporter 2 inhibitors. *Journal of Clinical Endocrinology and Metabolism*. 105(8):1-12.

Queensland Health. (2015) *Chronic conditions manual: prevention and management of chronic conditions in Australia*. 1st edition. The Rural and Remote Clinical Support Unit, Torres and Cape Hospital and Health Service, Cairns. publications.qld.gov.au/dataset/chronic-conditions-manual Accessed: Oct 2020

Royal Australian College of General Practitioners (RACGP) and Australian Diabetes Society (ADS). 2018. Emergency management of hyperglycaemia in primary care. https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Management-of-hyperglycaemia.pdf Accessed: Oct 2020

Waylen, A.L. and Riedel, B. 2019. Sodium-glucose co-transporter 2 inhibitors in the peri-operative period: A warning to all clinicians. *BJU International*. 123(Suppl 5):6-7.

Zelniker, T.A., Wiviott, S.D., Raz, I., Im, K., Goodrich, E.L., Bonaca, M.P., Mosenzon, O., Kato, E.T., Cahn, A., Furtado, R.H.M., Bhatt, D.L., Leiter, L.A., McGuire, D.K., Wilding, J.P.H. and Sabatine, M.S. 2019. SGLT2 inhibitors for primary and secondary prevention of cardiovascular and renal outcomes in type 2 diabetes: a systematic review and meta-analysis of cardiovascular outcome trials. *Lancet*. 393(10166):31-39.



Talking Testing

By Jen Johnson

HIV, hepatitis B and hepatitis C testing in early pregnancy

BACKGROUND

Global, national and state targets have been set to eliminate HIV, hepatitis B and hepatitis C as public health priorities by 2030.

Testing for HIV, hepatitis B and hepatitis C is currently standard practice in Australian pregnancy care (Australian Government 2019). Antenatal testing for HIV and hepatitis B is universally recommended (Australian Government 2015; Australian Government 2017). Detection of these infections in early pregnancy can minimise the risk of transmission to the baby. Hepatitis C testing should be offered to all pregnant women, and is recommended for women with risk factors for hepatitis C. Detection of hepatitis C during pregnancy is unlikely to reduce the low risk of transmission during birth, but can inform decision making related to infant testing, safe breastfeeding and treatment prior to the next pregnancy (Australian Government 2016).

Midwives play a critical role in ensuring that guideline-based HIV and viral hepatitis screening occurs during early pregnancy (Australian College of Midwives 2017). However, there are limited opportunities for midwives to gain the knowledge, skills and confidence required to initiate testing discussions at the first antenatal visit.

In 2017, the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University initiated a broad consultation with community and health practitioners focussed on identifying 'best practice' in HIV and hepatitis pre and post-test discussions in the current era of highly effective treatments (Johnson and Lenton 2017).

In the same year ARCSHS, Mercy Health and La Trobe University's School of Nursing and Midwifery collaborated in the design, delivery and evaluation of a midwifery education intervention which showed that short educational interventions about antenatal HIV and viral hepatitis screening

could result in longer-term improvements in clinical practice (Johnson et al. in press).

Drawing on these two projects, this article offers midwives best practice guidance in the process of initiating antenatal HIV, hepatitis B and hepatitis C testing discussions and gaining informed consent.

TALKING TESTING

Informed consent and voluntary testing are central to Australian HIV, hepatitis B and hepatitis C public health policy (Australian Government 2018). National HIV and viral hepatitis testing policies define informed consent for testing as a process by which the healthcare provider establishes that the person agrees to be tested based on understanding the procedures and the reasons for testing, and is able to assess the personal implications (Australian Government 2017).

A key challenge in the antenatal context is that these tests are a small part of the detailed clinical assessment and maternal health testing process that is recommended at the first antenatal appointment. Time pressures are ever present, and pregnant women are asked to give and receive a lot of information at this appointment.

The following checklist is a guide for midwives to gain informed consent for HIV and viral hepatitis testing at the first antenatal booking visit. We also offer some suggested wording for each checklist item to assist midwives' confidence in initiating these discussions.

TALKING TESTING

Checklist for informed consent

- ✔ Reasons for discussing testing during pregnancy
- ✔ Confidentiality and notification
- ✔ Testing history
- ✔ Basic information about each virus, and each test
- ✔ Stigma sensitive discussion about risk and transmission
- ✔ Partner testing
- ✔ Prepare for test result

REASONS FOR DISCUSSING HIV AND HEPATITIS TESTING DURING PREGNANCY

Informed consent requires an understanding of the reasons for and benefits of testing. However, discussions about HIV and viral hepatitis, particularly in relation to sexual and drug use history, can be difficult for some patients. This can be heightened during pregnancy.

It is important to begin by normalising testing as much as possible, while at the same time acknowledging that people's histories and health beliefs may impact on their experience of talking about testing for HIV and viral hepatitis.

It is helpful to know where to find bilingual written information (healthtranslations.vic.gov.au)

TALKING TESTING

Reasons for discussing testing during pregnancy

It is recommended that all pregnant women are tested for HIV and hepatitis B. Treatments are available which can greatly reduce the chance of HIV or hepatitis B being passed on to the baby.

We also recommend testing for hepatitis C, especially if there's been a risk for hepatitis C.

Talking about HIV and hepatitis testing can be quite personal. These are conversations we have with every pregnant woman at her first antenatal visit.

You do not need to tell me about your personal history to have the tests, but there are lots of support services available.

CONFIDENTIALITY AND NOTIFICATION

While confidentiality will have been explained at the beginning of the appointment, it may be worth reiterating how sensitive health information and privacy is managed.

It is also important for people being tested to understand that HIV, hepatitis B and hepatitis C are notifiable infections, which means that in the event of a positive test result health information is shared with the state health department for epidemiological and surveillance purposes.

TALKING TESTING

Confidentiality and notification

Before we go on, I'd like to remind you that what we talk about is private and confidential.

If any results are positive, some details are sent to the health department for public health purposes. This information is kept securely within the health department. Is that OK?

TESTING HISTORY

Many women have their HIV, hepatitis B and hepatitis C serology done by their GP in very early pregnancy (Kwan et al. 2012), though many will not remember any detailed discussion or be aware of the results. The role of the booking midwife is to deliver these results, and then to determine whether any further testing is needed.

There will be a significant minority of women who have never been tested for HIV, hepatitis B or hepatitis C.

Enquiries about testing history begin the process of assessing and building health literacy.

TALKING TESTING

Testing history

Have you ever been tested for HIV, hepatitis B or hepatitis C? If so, when?

How was that experience for you? Did you receive the results?

Have you been vaccinated against hepatitis B?

BASIC INFORMATION ABOUT EACH VIRUS AND EACH TEST

Provide basic information about HIV, hepatitis B and hepatitis C. Wherever possible, use open-ended questions, and support patients to understand and be able to act on any health information that is given.

The window period is a critical concept in antenatal testing because a single test at a single time point is not always enough to rule out infection. Women need to understand that repeat testing is recommended if there have been any recent risks during the window period.

TALKING TESTING

About HIV and the HIV test

What is your understanding of HIV?

HIV is an infection that affects the immune system. Without treatment, HIV causes very serious health problems. HIV treatments are excellent now and people with HIV can live as long people who don't have HIV. Treatments can also stop HIV transmission to others, including from mother to baby.

Results of the HIV blood test will be either positive or negative. A positive result would mean that you have HIV.

A negative result would mean that you do not have HIV, but the test does not detect recent infections. Another test may be needed if there have been any risks in the last six weeks.

The standard HIV test is a combination antibody/antigen test, and the window period is six weeks. In other words, it can take up to six weeks for markers of the HIV virus to show on the test.

TALKING TESTING

About hepatitis B and the hepatitis B test

What is your understanding of hepatitis B?

Hepatitis B is an infection that affects the liver. Many people around the world have hepatitis B. Hepatitis B can cause serious liver problems, including liver cancer. These problems can often be avoided with regular check-ups and treatment if needed. Most people with hepatitis B got it at birth or as small children, and often other people in the family have it too. Vaccination can protect people who don't have hepatitis B. We recommend that all newborns are vaccinated against hepatitis B.

The blood test shows if someone currently has hepatitis B or not.

(If anti-HBs is offered:) If you do not have hepatitis B, the test can tell if you have protection against future infection. You are protected if you have had hepatitis B previously or you've been vaccinated.

The test does not detect very recent infections. Another test may be needed if there have been any risks in the last three months.

Consider providing some specific prevalence information, such as, "In many Asia-Pacific countries more than one in ten people have hepatitis B" (Ott et al. 2012).

Testing protocols for hepatitis B vary across agencies. The RANZCOG guidelines recommend universal screening using the hepatitis B surface antigen (HBsAg) test (Troung and Walker 2019). The Australian National Hepatitis B Testing policy adds: if possible, also perform surface antibody (anti-HBs), to assess the need for vaccination (Australian Government 2018).

Midwives have a role supporting pregnant women to make decisions about childhood immunisation (Australian College of Midwives 2017). This includes discussing the recommendation that babies receive the hepatitis B vaccination within the first seven days of life, and preferably within the first 24 hours (Australian Technical Advisory Group on Immunisation 2018).

TALKING TESTING

About hepatitis C and the hepatitis C test

Hepatitis C is an infection that affects the liver. People can have hepatitis C for many years without symptoms. Treatment can cure more than 95% of people, however, these medicines are not used in pregnancy. Without treatment, hepatitis C can cause serious liver problems and sometimes liver cancer.

The blood test looks for current or past hepatitis C infection by checking for antibodies. Results will be either positive or negative.

A negative result for hepatitis C antibodies means you do not have hepatitis C, but the test does not detect recent infections. If there have been any risks in the last three months, a follow up test may be needed.

A positive result for hepatitis C antibodies means you have had the hepatitis C virus at some time in the past. Another test is needed to see if you still have the virus.

Curative hepatitis C treatments are now available on the Australian Pharmaceutical Benefits Scheme; however, these have not yet been shown to be safe in pregnancy. The risk of vertical transmission is 5% (Robinson and Canadian Paediatric Society Infectious Diseases Immunization Committee 2008), and women diagnosed in pregnancy can begin treatment workup during pregnancy and undertake treatment prior to their next pregnancy.

Two blood tests are required to confirm a hepatitis C diagnosis. The first line test is HCV-Ab, and positive serology is indicative or past or current infection. Positive serology should be followed up with HCV/RNA (PCR) to confirm current infection (Australian Government 2016). It is estimated that 25% of people with hepatitis C antibodies have not had a confirmatory HCV/ RNA test (Kirby Institute 2018).

Some people with a history of injecting may have difficulty with vein access, creating a major barrier to testing and treatment (Madden et al. 2018). Experienced phlebotomists, such as those working in busy testing centres, will be equipped with strategies to optimise vein access.

STIGMA-SENSITIVE DISCUSSION ABOUT RISK AND TRANSMISSION

These discussions may be embarrassing or difficult for some patients due to stigma and shame, specific cultural norms, or fear of discrimination in healthcare settings. Stigma is a major barrier to testing, care and prevention (Jones et al. 2014; Stone 2015; Knight et al 2016; Broady 2018).

Direct questioning about practices associated with transmission, such as unprotected sex or sharing injecting equipment, is not required for antenatal testing and may cause discomfort for both the clinician and the patient (Johnson and Lenton 2017). Rather than asking a list of prescribed questions, midwives can use respectful, non-judgemental language to explain transmission and then invite questions.

Choose terms that minimise the blame and shame, for example, 'unprotected sex' instead of 'risky sex' or 'unsafe sex', and 'people who use drugs' instead of 'drug abusers' or 'drug addicts'.

Be aware of cultural sensitivities around discussing sexual practices. If there is discomfort, it may help to mention sexual transmission briefly and provide further detail in written format.

TALKING TESTING

Stigma-sensitive discussion about risk and transmission

HIV can be transmitted through sexual fluids and blood. It is mainly passed on during condomless sex (vaginal and anal), and through sharing injecting equipment. HIV can also be transmitted during childbirth and breastfeeding.

Hepatitis B is also passed on through sexual fluids and blood. It is mainly passed on at birth. Babies often get hepatitis B at birth if their mother has hepatitis B.

Hepatitis C is only passed on through blood. This can happen when blood from someone with hepatitis C enters another person's bloodstream. This is often the result of unsterile injecting of drugs, including steroids. It can also be passed on through unsterile medical,

dental, tattoo and piercing procedures. Sexual transmission of hepatitis C is very uncommon.

Hugging or sharing food or cutlery *cannot* transmit HIV, hepatitis B or hepatitis C.

Would you like us to talk a bit more about how these viruses are passed on?

PARTNER TESTING

Many pregnant women will have sexual partners with whom they have unprotected sex. Midwives play a critical role in exploring whether the test window period is complete, which means focusing on any recent risks (six weeks before the HIV test date and three months before the hepatitis B and C test dates). It is therefore recommended that current sexual partners go through a parallel testing process with their own doctor to reduce the risk of virus transmission later in the pregnancy.

TALKING TESTING

Partners

Your test results may not be the same as your current or previous partners'. We recommend partners have their own tests to be sure of their status.

PREPARING THE PATIENTS FOR THE TEST RESULT

It is important to explain when and how the results will be given.

Despite the availability of treatments, many people are concerned about the possibility of a positive result. It may be useful to give women the opportunity to explore these concerns and discuss available supports.

TALKING TESTING

Patient is prepared for the test result

An HIV positive result can be distressing, but excellent treatments can be commenced immediately.

If this test shows that you have hepatitis B, regular check-ups, and treatment if needed, can help to avoid liver problems.

HIV and hepatitis B treatments are safe in pregnancy and can prevent these viruses from being passed on to the baby. Treatments also help people to stay well and enjoy a normal lifespan.

If the testing shows you have hepatitis C, new treatments can cure up to 95% of people. Treatments are not safe in pregnancy but the risk of transmission to the baby is low. Ideally, treatment would be given before the next pregnancy.

How do you think you would manage if any of these results were positive? Who are your supports?

There are also community-based support services.

Hepatitis Australia National Infoline 1800 437 222 for details of local peer support, information and support services. **HIV Peer Support organisations** operate in each state and territory, contact NAPWHA 1800 259 666 for more information.

INFORMED CONSENT

In closing the discussion, it is important to reiterate the need for follow-up testing if there is any chance that testing occurred during a window period.

Informed consent is "a person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved" (Medical Board of Australia 2014).

TALKING TESTING

Informed consent

Do you have any questions or anything you'd like to talk more about?

Do you want to have these tests? I can order them today. It's your choice.

CONCLUSION

The normalisation of HIV, hepatitis B and hepatitis C testing in all healthcare settings is essential for increasing rates of diagnosis and reducing late diagnosis. This checklist has been developed to enhance midwives' knowledge and confidence in the process of initiating HIV and viral hepatitis testing discussions at the first antenatal visit.

By supporting women to understand the testing procedures and the reasons for testing, and to assess the personal implications, midwives can be satisfied that their patients are giving their informed consent to be tested.

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References

Australian College of Midwives. 2017. Position Statement for Immunisation. Canberra

Australian Government. 2015. National Hepatitis B testing Policy. Australian Government Department of Health, Canberra.

Australian Government. 2016. National Hepatitis C Testing Policy. Australian Government Department of Health, Canberra.

Australian Government. 2017. National HIV Testing Policy. Australian Government Department of Health, Canberra.

Australian Government. 2018. National Hepatitis B Strategy. Australian Government Department of Health, Canberra.

Australian Government. 2018. National HIV Strategy 2018-2022. Australian Government Department of Health, Canberra.

Australian Government. 2019. Clinical Practice Guidelines: Pregnancy Care. Australian Government Department of Health, Canberra.

Australian Technical Advisory Group on Immunisation. 2018. Australian Immunisation Handbook. Canberra.

Broady, T.R., Cama, E., Brener, L., Hopwood, M., De Wit, J., and Treloar, C. 2018. Responding to a national policy need: development of a stigma indicator for bloodborne viruses and sexually transmissible infections. *Australian and New Zealand Journal of Public Health.*

Johnson, J., Carr, C., Flood, M., and McDonald, S. in press. Talking testing: Impact of a training intervention on midwives' antenatal HIV, hepatitis B and hepatitis C screening practice *Women and Birth.*

Johnson, J. and E. Lenton. 2017. HIV and hepatitis pre and post test discussion in Victoria: Consultation report. Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Victoria.

Jones, L., Atkinson, A., Bates, G., McCoy, E., Porcellato, L., Beynon, C., McVeigh, J., and Bellis, M.A. 2014. Views and experiences of hepatitis C testing and diagnosis among people who inject drugs: Systematic review of qualitative research. *International Journal of Drug Policy* 25(2): 204-211.

Kirby Institute. 2018. *HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018.* UNSW, Sydney.

Knight, R., Small, W. and Shoveller, J.A. 2016. HIV stigma and the experiences of young men with voluntary and routine HIV testing. *Sociology of health & illness*, *38*(1), pp.153-167.

Kwan, K.S., Giele, C.M., Combs, B., and Mak, D.B. 2012. Improvement in antenatal testing for sexually transmissible infections and blood-borne viruses in Western Australian hospitals, 2007 to 2010. *Sex Health* 9(4): 349-354.

Madden, A., Hopwood, M., Neale, J., and Treloar, C. 2018. Beyond interferon side effects: what residual barriers exist to DAA hepatitis C treatment for people who inject drugs? *PloS one* 13(11): e0207226.

Medical Board of Australia. 2014. *Good medical practice: a code of conduct for doctors in Australia.* Melbourne

Ott, J., Stevens, G., Groeger, J., and Wiersma, S. 2012. Global epidemiology of hepatitis B virus infection: new estimates of age-specific HBsAg seroprevalence and endemicity. *Vaccine* 30(12): 2212-2219.

Robinson, J. and Canadian Paediatric Society Infectious Diseases Immunization Committee. 2008. Vertical transmission of the hepatitis C virus: current knowledge and issues. *Paediatrics & Child Health* 13(6): 529-534.

Stone, R. 2015. Pregnant women and substance use: fear, stigma, and barriers to care. *Health & Justice* 3(1).

Troung, D.A. and Walker, P.S. 2019. Management of Hepatitis B in pregnancy. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Melbourne.

Julie Reeves

ANMF Federal Professional Officer

How digitally capable are you?

As the digital world explodes, digital health is part and parcel of every nurse and/or midwife's lives, whatever our role. While many will enthusiastically embrace this change and believe they excel at using digital health technologies, or at least feel capable, some nurses and midwives may wonder if their digital capability is sufficient.

Until now, there hasn't been a way for nurses and midwives in Australia to objectively assess their proficiency against a digital capability framework.

The *National Nursing and Midwifery Digital Health Capability Framework* (NNMDHCF) was released by the Hon. Greg Hunt, Minister for Health, on 28 October 2020. It was developed by the Australian Digital Health Agency in conjunction with the Australasian Institute of Digital Health.

The Australian Nursing and Midwifery Federation (ANMF) were also part of the framework development and chaired the project's advisory committee.

The development of the Framework was a collaboration, with representation from the Australian Primary Health Care Nurses Association, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, the Australian College of Nursing, the Australian College of Midwives, Chief Nursing and Midwifery Officers, the Nursing and Midwifery Board of Australia, the Australian Nursing and Midwifery Accreditation Council, Consumers, and the Digital Health Cooperative Research Centre. The professions of nursing and midwifery are the first in the country to develop a digital capability framework specifically focused on the needs of these professions. The next profession to develop a framework is medicine.

Although challenging at times, chairing the advisory committee was deeply rewarding, working towards a common goal alongside nursing and midwifery colleagues. It makes me proud to be part of a profession that works together to advance and progress not only the individual nurse or midwife but the professions as a whole. I believe we've made this progress by developing a framework that is evidence-based, accessible, and easy to use.

The NNMDHCF was not designed to be used as a punitive measure nurses and midwives have to meet, but instead was developed as a guide to enable nurses and midwives to identify their capability level and provide clarity as to how to enhance their skills.

The digital capability framework consists of five domains:

- Domain 1 Digital Professionalism;
- Domain 2 Leadership and Advocacy;
- Domain 3 Data and Information Quality;
- Domain 4 Information-enabled Care; and
- Domain 5 Technology

Person-centred, safe, quality and connected care are at the heart of the NNMDHCF, with each domain having three sub-domains with four related capability statements. Completing a self-assessment using the framework, guides nurses and midwives to identify their current capability level as being either formative, intermediate or proficient across the domains.

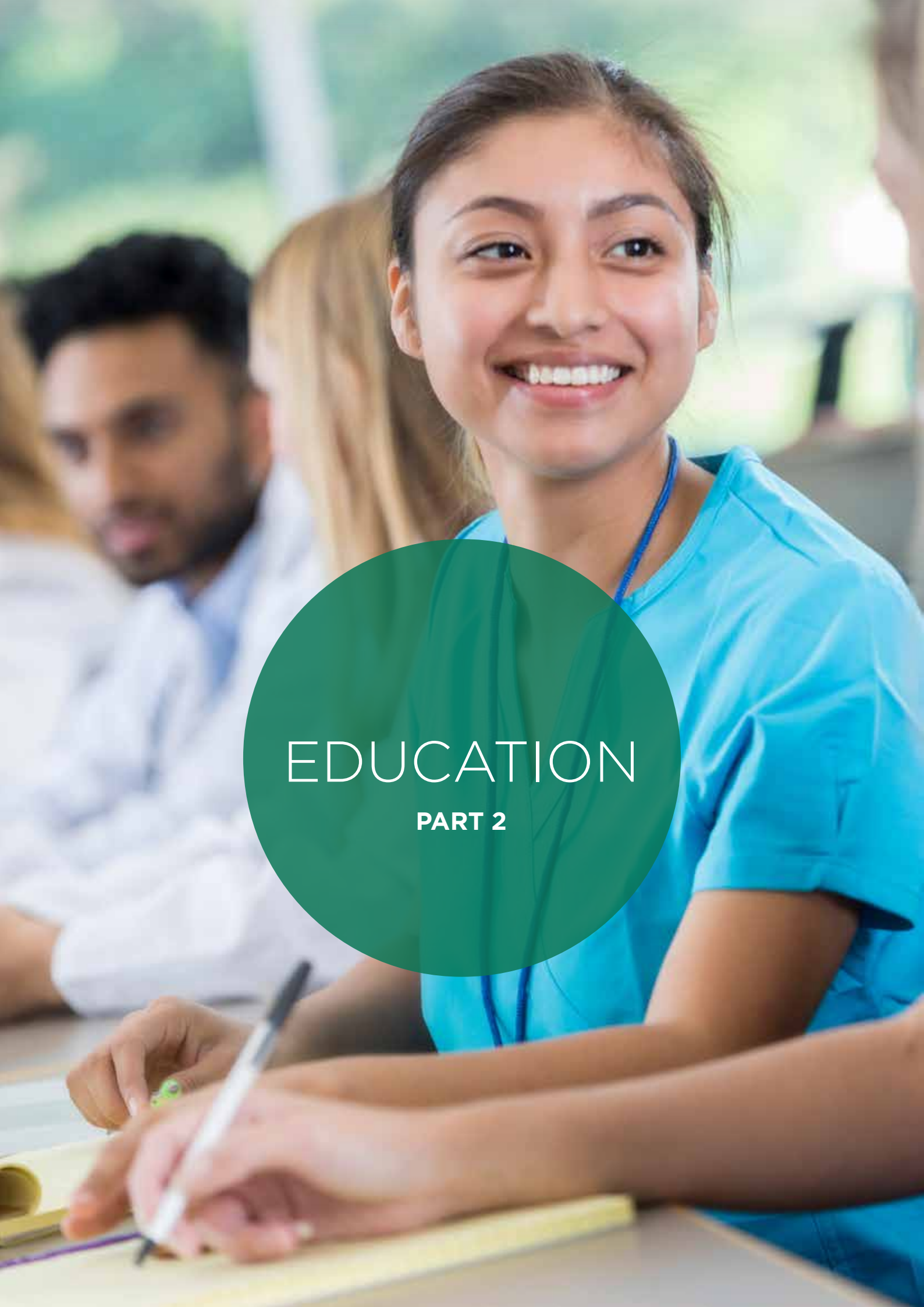
It's important to note that a nurses' or midwives' digital capability will be significantly impacted by the level and kinds of digital technologies they access in the workplace. A nurse working in a health service with minimal access to digital technologies, for example, will be unlikely to achieve a level of proficiency across all domains, or a midwife working in a health setting that's introducing a new electronic medical record may only be able to achieve a formative level in some of the domains.

The NNMDHCF is freely available to all nurses and midwives on the Australian Digital Health Agency's website at the following link: **digitalhealth.gov.au/about-the-agency/workforce-and-education**

There are also a number of resources to assist nurses and midwives to use the NNMDHCF, including case studies and an organisational flow chart that helps you to identify the digital level of the health service or setting you work in.

I encourage you all to use the framework to identify your digital capability - you might be surprised to identify you are further advanced than you thought you were. If you do note areas where you could improve, I would suggest you add these to your continuous professional development plan for next year.

The use of digital health technologies is ever-increasing, and digital capability is proving to be essential in improving health outcomes. The people for whom we provide care are also increasingly expecting digital technology advancement to be a part of their healthcare delivery. As the largest health workforce, nurses and midwives should be at the forefront of leading digital health technology. Get involved and engaged in advancing digital health!



EDUCATION

PART 2

We're in this together: Peer mentorship group in nursing education

By Tracey Moroney, Grant Kinghorn and Bonnie Dean

Mentorship is a well-established professional development strategy for nurse educators. Peer mentoring however, has been shown to be effective for building connections and sense of community amongst colleagues (Kensington-Miller 2019).

Mentorship programs can support educators through exposure to new ideas, critical self-reflection, professional growth and enhancement of relationships (Hundley et al. 2020). Balanced with the need for more continuous informal and just-in-time learning support amongst peers (Gabriel & Kaufield 2008).

The *Develop-MenTaL network* is a peer mentoring group that focuses on development and reciprocal mentorship for teaching and learning at a regional University. The purpose of the group is to share ideas and support members through the development of interactive, informative and best practice teaching strategies that supports student learning. Engagement between members occurs during regular catch-up sessions to identify and discuss common teaching and learning challenges and achievements with the group, drawing on their collective wisdom and experience to facilitate sessions.

In addition, the group utilises an online messaging platform, so members can engage and share resources or seek just-in-time support. Through these activities, the group strives to promote professional learning support, encouragement and practice sharing.

In 2020, the COVID-19 pandemic presented many challenges for the provision of higher education, including reimagining curriculum to be taught entirely online. For some staff, the pivot to remote learning was particularly challenging and required immediate understanding of and engagement in technology-enhanced learning pedagogies.

The *Develop-MenTaL* mentor group proved vital and provided a collegial space for academics to test and discuss new ways of supporting students through remote learning. The group responded with relevant, just-in-time and collaborative learning (Gabriel & Kaufield 2008) which lead to a strengthening of relationships (Kensington-Miller 2011) and a sense of reciprocity and solidarity – that we're in this together. The notion of learning together, especially when forced into isolation, was advantageous (Ambler, Harvey and Cahir 2016), especially when attempting and embracing new approaches to teaching. Overall, through professional support, interactions and reflections, the group provided immense support during a time of uncertainty.

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References

Ambler, T., Harvey, M. & Cahir, J. 2016. University academics' experiences of learning through mentoring, *The Australian Educational Researcher*, 43(5), 609-627).

Boud, D. 2006. Situating academic development in professional work: Using peer learning, *International Journal for Academic Development*, 4(1), 3-10.

Gabriel, M.A. & Kaufield, K.J. 2008. Reciprocal mentorship: an effective support for online instructors. *Mentoring & Tutoring: Partnership in Learning*, 16(3), 311-327.

Hundley, B., Anstey, L., Cruickshank, H. & Watson, G. 2020. Mentoring faculty online: A literature review and recommendations for web-based programs, *International Journal for Academic Development* (first online).

Kensington-Miller, B. 2019. 'My attention shifted from the material I was teaching to student learning': The impact of a community of practice on teacher development for new international academics, *Professional Development in Education* (first online).

Virtual simulated learning environment in postgraduate studies: The introduction of telehealth

By Melissa Robinson-Reilly and Pauletta Irwin

Telehealth has been widely accepted in the urban setting with the COVID-19 pandemic to provide virtual healthcare, instead of face-to-face clinic consultations, which may become the new normal (Wong et al. 2020).

Leading the way to prepare capable, future-proofed graduates, for some years now, the School of Nursing and Midwifery, University of Newcastle has delivered a telehealth simulation as part of postgraduate course work. The simulation has been shown to foster a positive learning environment – where clinical skills are developed in an engaging and supportive environment.

As part of a health assessment course, students conducted a comprehensive health assessment utilising a virtual platform. The purpose of this simulation was to assist learners to develop the skills associated with formulating a differential diagnosis. With the overall aim to differentiate between normal and abnormal trajectories of common health problems, students were required to use appropriate questioning techniques to elicit the information they needed to complete the assessment (Robinson-Reilly et al. 2020).

Students were provided short case scenarios that were portrayed by a standardised patient via the simulated telehealth platform. After their questioning, it was anticipated that students could provide the differential diagnosis. Due to time constraints, in a tag team approach, students would only explore one aspect of the health assessment or systems review sequence. This allowed other students in the group to observe for patient cues that may unmask recent symptoms and enable them to seek more detail.

The use of the virtual simulation platform was not without real-time issues. Students were required to adapt and complete the assessment. This was an unanticipated learning outcome though one that was in itself positive.

At the time the telehealth simulations were initially developed, these were considered an innovative approach that would ultimately meet the needs of healthcare delivery in rural communities. The global pandemic however, now necessitates a rethink of contemporary education on a much broader scale. There is an opportunity for higher education to lead changes in educational practice and refine the intent of simulation that utilises virtual platforms in which healthcare is now being delivered. Strengthening tertiary education curricula to align with healthcare delivery built upon telehealth simulations, contributes to the acceptance currently and in the future (Fisk et al. 2020).

On reflection, telehealth technologies have shown endless education possibilities at the postgraduate level. Demonstrating for the students, how health assessment can occur via a virtual platform not only in rural but also in urban contexts.

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References

Fisk, M., Livingstone, A. and Pit, S.W. 2020. Telehealth in the context of COVID-19: Changing perspectives in Australia, the United Kingdom, and the United States. *Journal of Medical Internet Research*, *22*(6), p.e19264.

Robinson-Reilly, M., Irwin, P., Coutts, R. and Slattery, N. 2020. Adding telehealth simulation into NP programs. *The Nurse Practitioner*, *45*(3), pp.44-49.

Wong, Z.W. and Cross, H.L. 2020. Telehealth in cancer during COVID-19 pandemic. *The Medical Journal of Australia*, p.1.

Double the possibilities with a double degree

By Maria Murphy and Lisa McKenna

Every generation of students reports their expectations for outcomes when undertaking a nursing degree. Students who enrol in double degrees have previously been identified as seeing the merit of undertaking such degrees for possibilities conferred in their graduate careers (Yates et al. 2020; Hickey et al. 2012).

Completing two concurrent degrees takes less time than completing two degrees separately and is attractive, leading to two qualifications.

A cross-sectional study undertaken in regional NSW reported double degree students saw their study program as exciting and different (Hickey and Harrison 2013).

The School of Nursing and Midwifery at La Trobe University offers two double degree options in its suite of undergraduate learning options. The long-established Bachelor of Nursing/Bachelor of Midwifery program, and more recently, the Bachelor of Nursing/Bachelor of Psychological Sciences which commenced in 2019.

The four-year degree equips graduates with both a nursing and psychological sciences degree.

Clinical placement in nursing occurs in every year of the double degree. Partnerships with several international organisations enable students the option of international exchange for their clinical practicum as a member of a student cohort.

The dual degree pathway prepares graduates to register as a Registered Nurse with the Australian Health Practitioner Regulation Agency (AHPRA).

The course enables graduate employment opportunities in government and non-government organisations in the non-profit and for-profit sectors. The outcomes will be highly valued in both metropolitan and rural settings. The course attracts students who are particularly looking for educational, professional practice and research career flexibility.

Traditional paths have been regarded as a thing of the past in the published literature (Berg et al. 2010), however, longitudinal follow up of double degree students is scarce. Follow-up will help to identify the career and lifestyle choices of double degree graduates and inform resource and recruitment planning for health services and university providers.

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References

Berg, J., Grant, A., Johnson, V. 2010. When callings are calling: Crafting work and leisure in pursuit of unanswered occupational callings. *Organization Science, 21*(5), 973-994.

Hickey, N. & Harrison, L. 2013. Career choices and destinations of rural nursing students undertaking single and double degrees in nursing. *Australian Journal of Advanced Nursing, 30*(4), 32-39.

Hickey, N. Sumsion, J., Harrison, L. 2012. Why nursing? Applying a socio-ecological framework to study career choices of double degree nursing students and graduates. *Journal of Advanced Nursing* 69(8), 1714– 1724. doi: 10·1111/jan.12029

Yates, K., Birks, M., Coxhead, H., Zhao, L. 2020. Double degree destinations: Nursing or midwifery. *Collegian* 27, 135-140. doi. org/10.1016/J.COLEGN.2019.07.004

As a learning modality simulation complements theory within nursing curricula

By Joannet Hardenberg, Indrajeetsinh Rana and Kathleen Tori

In recent years the climate of expanding digital communication and simulated learning resources have provided universities with the opportunity to embrace technology when developing nursing curricula.

A migration from face to face, didactic style lecturing has seen the expansion of interactive online activities that can be embedded within subject interfaces to augment the more traditional theoretical knowledge delivery.

Educational outcomes, including theory consolidation, are enhanced when students take part in simulation activities in a stepwise manner moving from single practice stations through to guided case scenarios prior to full immersive simulation sessions. Increasingly, sophisticated learning modalities such as high-fidelity simulation scenarios can be incorporated if in-depth experiential learning is desired. Pedagogically, simulation has developed as an integral component of nursing education, contributing effectively to student learning (Cant and Cooper 2017; Hardenberg et al. 2019; Hardenberg et al. 2020), and is offered to nursing students worldwide.

Robust simulation activities, while a proven effective pedagogy is dependent on the ability to represent an authentic clinical environment, including the ability to integrate technology such as electronic health records (Anderson et al. 2019). Effective simulation provides opportunities for nursing students to practise technical skills in a safe environment and allows for non-technical skills such as critical thinking, communication, cultural humility, clinical decision making and reflection on practice to be undertaken before proceeding on clinical practice (Anderson et al. 2019).

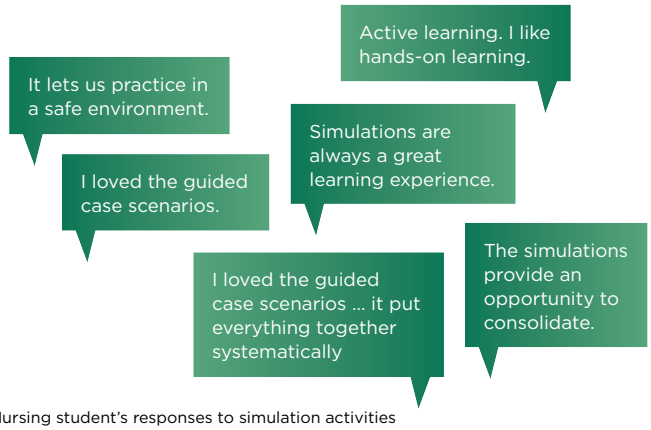
The learnings undertaken in a clinical simulation environment translate to the real-life clinical environment and supports the student in not only their assessments of practical skills but also their confidence when faced with real life practice.

Enhanced knowledge, confidence and practical skills acquisition remains a goal of nursing simulation, and research purports that all three components are markedly improved after simulation activities (Hardenberg et al. 2019).

High-fidelity clinical nursing simulation environment

For example, critical care nursing participants appreciated the opportunity to take part in simulation activities as part of their formative and summative assessments, and while acknowledging increased stress before taking part in the activities, all could see the value of simulations and agreed that the simulation activities complemented theory well.

The simulations offered the opportunity to develop technical aptitude and to consolidate understanding of clinical concepts in a scaffolded fashion. Moving from the single task procedural practice stations through to the more advanced clinical problem-solving activities gave the students multiple practice opportunities to hone both technical and non-technical skills. As each student's practice and confidence levels evolved, they were exposed to increasingly complex immersive scenarios. The students appreciated the gradual build up to the higher intensity scenarios and their feedback at the end of the course was very positive.



Nursing student's responses to simulation activities

Attainment of simulation outcomes is however, dependent on the type of intervention and the simulation resources used to encourage immersion of the students (Hardenberg et al. 2019). While it is acknowledged that high-fidelity simulations are resource intensive, well-constructed simulation with clear learning goals will continue to provide students with valuable opportunities to practice their clinical skills in a safe environment- where if mistakes are made, become learning opportunities. Further research in the field of simulation linking clinical interventions used in simulation with the learning outcome may serve as a guide for constructing successful simulations.

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References

Anderson, M., Hetzel, S., and Diaz, D. 2019. Simulation in advanced practice education: Let's dialogue!! *Clinical Simulation in Nursing*. 26: 81-85

Cant, R., and Cooper, S. 2017. Use of simulation-based learning in undergraduate nurse education: An umbrella systematic review. *Nurse Education Today*. 49: 63-71

Hardenberg, J., Rana, I., and Tori, K. 2019. Simulation exposure improves clinical skills for postgraduate critical care nurses. *Clinical Simulation in Nursing*. 28: 39-45

Hardenberg, J., Rana, I., and Tori, K. 2020. Evaluating impact of repeated exposure to high fidelity simulation: Skills acquisition and stress levels in postgraduate critical care nursing students. *Clinical Simulation in Nursing*. [In press]

Managing resident to resident assault in residential aged care homes

By Julie Ellis, Louise Ward and Fergus Campbell

The Age on Wednesday 13 November 2019, reported that "Elderly residents are dying in violent assaults carried out by fellow patients..."

It also suggested that "A lot of these situations can be averted with a consistent approach, good training and skill set among staff..."

One such approach is **SEARCH**: **S**upport, **E**valuate, **A**ct, **R**eport, **C**are plan and **H**elp to avoid this occurring (Ellis et al. 2014).

The SEARCH approach involves:

Support residents involved in the incident. Physical injuries must be attended immediately. Support must be provided for residents involved in and/or who have witnessed an event because violence can be upsetting for all.

Evaluate the situation and environment to identify those directly or indirectly involved in the incident, (both victim and perpetrator), any risk factors or precipitating events. The initial evaluation is to identify immediate actions required and then:

Act immediately. The actions taken will depend on the type of incident and the environment where the incident occurred. If the incident is occurring, verbally attempt to stop the incident; use non-threatening body language and a calm, firm tone of voice. If a verbal request is not successful, physically separate residents, ensuring staff are not injured in the process. A call for help from staff may also be necessary. An assessment of the residents for physical harm would then occur.

Of importance is the manner in which the staff approach the residents: showing concern and empathy with appropriate facial expression and calm language, avoiding patronising or humiliating confrontational language, blaming or displaying strong emotional reactions, such as shock, disgust or embarrassment.

Report all incidents of aggression and assault and document. Many incidents of assault are currently not reported. The reporting of incidents must be encouraged by all levels of management.

Care plans must document interventions or strategies to manage and/or avoid or minimise incidents of aggression and assault. Ensuring the safety of all residents is the goal. Every incidence of aggression and assault should be documented, with clear, specific interventions ensuring a consistent approach.

Help to avoid incidents of assaults is the role of all staff, who need to be actively involved in the discussion and development of management strategies, and care plans. An acute awareness of the physical environment and the interactions between residents is important.

In many situations, aggression or assault are ignored by staff as it is not identified as serious, often perceived as normative, and rarely reported, leaving residents at potential risk. This approach provides clear steps to follow to help avoid these risks.

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Reference

Ellis, J.M., Teresi, J.A., Ramirez, M., Silver, S., Boratgis, G., Kong, J., Eimicke, J.P., Sukha, G., Van Haitsma, K., Pillemer, K.A. & Lachs, M.S. 2014. Managing resident to resident elder mistreatment (R-REM) in nursing homes: the SEARCH approach, *The Journal of Continuing Education in Nursing*, vol. 45, no. 3, pp. 112-121.

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The value of mutual support and reflection in confronting the impacts of the bushfires

By Tameeka Mulquiney

At the end of December 2019, my role as a lecturer in midwifery took an unexpected turn. I was receiving numerous emails from students studying a Graduate Diploma in Midwifery requesting extensions and support due to the bushfires which were raging in New South Wales.

The fires had impacted students as they had lost access to power supply, water supply, experiencing forced evacuations and felt compelled to fulfil their roles as volunteer firefighters.

The situation the students were facing was clearly illustrated on the news and reinforced through emails and phone calls from students. It became clear very quickly how devastating this situation was for the students and for Australia.

In my role as a midwifery lecturer, I frequently talk to the clinical educators at the hospitals, and this heightened my insight into the challenges these students were facing clinically, academically and most importantly personally.

Every academic support possible was provided to these students acknowledging their ever evolving and dangerous situations with the main focus for students to stay safe during this time.

The bushfires crisis continued to worsen, and the fires were now impacting my family and me in my Victorian rural hometown.

Evacuation was not an option as it was unsafe to do so, and I found myself in the position many of the students had faced. A phone call from a student just a week before saying she had to be evacuated as her family had no power or water, quickly crossed my mind. I knew that my family and I were confronting the same dangerous situation.

In retrospect, throughout this daunting time, the challenges of teaching midwifery had been tested. Staff stepped in to take over my lecturing role and provided students with the support they needed.

Clinical educators involved in workplace learning provided the individual, clinical support for the students.

The relationships between the university, the hospitals and the student midwives proved invaluable in ensuring learning continued and obtaining positive outcomes were achieved for all stakeholders.

One month after the fires, a compulsory residential school was scheduled. Not only was it beneficial to see the students again, but it also provided the opportunity for an informal debrief to reflect on the challenging times many of us faced in the holiday period of 2019.

After the residential school, it was not uncommon for emails to be received to "check-in" on how students and university and clinical staff were coping post bushfires. Reflection is a major part of education for midwives and usually relates to the clinical components of their studies, however students and staff all naturally engaged in reflection to support each other through the personal and professional impacts of this challenging and potentially life-threatening period. The reflection involved the lived experiences we all shared, and provided the opportunity to synthesise self-awareness and critical thinking (Fenech 2016) on a personal as well as professional level; a unique experience for us all.

Six months on, and the students have powered ahead despite the impacts of the bushfires. The challenges we faced were confronting from both personal and

professional levels, however the education these students were provided within this time was invaluable. Students working in clinical settings gained some valuable knowledge in prioritising care, transferring women and babies, and how to work in a crisis; critical skills that these students will use throughout their careers as midwives. Adapting to situations outside of the norm did occur but were managed through the support from students, university staff and clinical educators, and the positive relationships we had between all proved invaluable. Many of these students have now graduated and will never forget the bushfires of 2019/2020, and neither will I.

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Reference

Fenech, G. 2016. Critical reflection in midwifery practice: the protection motivation theory. *Reflective Practice, International and Multidisciplinary Perspectives*. 17(3): 308-316.

Innovative learning options for midwives

By Samantha Davies and Janice Butt

The Department of Nursing and Midwifery Education and Research (DNAMER) at King Edward Memorial Hospital (KEMH) in Perth, Western Australia (WA) utilises a range of teaching and learning modalities to provide continuing professional development for nurses and midwives.

eLearning has emerged as a useful strategy to increase accessibility to education, improve self-efficacy and knowledge, ensure cost effectiveness while promoting learner flexibility and interactivity (Sinclair et al. 2016).

In the last ten years, DNAMER has developed over 20 eLearning packages in response to meeting mandatory requirements, contemporary clinical practices, and "lessons learned" from safety and quality investigations. The recent COVID-19 pandemic has further highlighted the need for alternative education pathways such as eLearning which DNAMER was uniquely prepared for.

DNAMER aims to improve patient outcomes, promote patient safety and support quality healthcare by providing free access to most of our eLearning packages. Since 2011 these packages have been accessed by more than 85,000 users both nationally and internationally with selected packages attracting 1,500 or more users each year. Further evidence that other health services highly regard the packages has been demonstrated by frequent requests to access and utilise for their own staff. All packages are continually evaluated with an emphasis on learner satisfaction and learning needs, ease of navigation and links to additional resources. Some examples of these packages will now be outlined.

Breastfeeding education modules were developed to assist our health service to achieve Baby-Friendly Health Initiative (BFHI) Accreditation. BFHI aims to protect, promote and support breastfeeding globally with improvements in breastfeeding education associated with better breastfeeding outcomes (World Health Organization 2017). The packages; breastfeeding works, breastfeeding introduction and health benefits first released in 2011 and most recently updated in 2019, have been accessed by over 20,000 users. The breastfeeding challenges module is due for release at the end of 2020. Other health services access the modules as part of their own preparation for achieving BFHI accreditation.

The Safe Infant Sleeping package was developed in response to a state-mandate for the completion of an education program for health professionals to reduce the incidence of sudden unexpected death in infancy (SUDI) (Western Australian Department of Health 2019).

Completion data is retained and requested by the Coroner as part of WA SUDI investigations. This package produced in collaboration with Red Nose was first created in 2011, updated in 2018 and has been accessed by over 4,000 users.

Sepsis is one of the leading causes of death in hospitals worldwide, with delayed recognition and treatment associated with high mortality rates, significant morbidity and high healthcare costs (Clinical Excellence Commission 2020). In response to a recent KEMH root cause analysis and a recommendation for improved education, an eLearning package on Adult Sepsis was released.

The package provides an opportunity for health professionals to update their knowledge, implement best practice principles, correctly utilise local observation response charts and sepsis management pathways. The package focuses on both maternal specific and general principles of sepsis and aims to promote early recognition and treatment of, to improve patient outcomes.

Links to the packages are available from wnhs.health.wa.gov.au/For-health-professionals/Staff-resources/WNHS-Education-Hub/Self-directed-learning/2019WNHS-and-other-health-services-self-directed-eLearning

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References

Clinical Excellence Commission. cec.health.nsw.gov.au/keep-patients-safe/Sepsis (Accessed June 2020)

Sinclair, P.M., Kable, A., Levett-Jones, T. & Booth, D. 2016. The effectiveness of internet-based e-learning on clinician behaviour and patient outcomes: A systematic review. *International Journal of Nursing Studies. 57:70-81*

Western Australian Department of Health. Safe Infant Sleeping Standard. Perth: Health Networks, Western Australian Department of Health; 2019.ww2.health.wa.gov.au/-/media/Files/Corporate/Policy-Frameworks/Clinical-Services-Planning-and-Programs/Policy/Safe-Infant-Sleeping-MP/Supporting/Safe-Infant-Sleeping-Standard.pdf (Accessed June 2020)

World Health Organization. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO. who.int/nutrition/publications/infantfeeding/bfhi-implementation/en/ (Accessed June 2020)

Collaboration – the key to success in transitioning to online learning

By Anthony McGillion, Lauren Parkinson Zarb, Hosu Ryu, Cindy Hoang, Rachel Cross, Karen Lawrence, Maria Murphy, Catina Adams, Fergus Campbell, Gayle McKenzie, Ruby Walter, Jacqueline Johnston, Jen Austerberry

It was Michael Jordan who claimed that there was 'no I in Team' – this seemed logical until Dominic Thiem advanced to the final of the Australian Open.

We should have suspected, at that point, that 2020 was going to present some surprises.

Following initial concerns in January 2020 that a new virus may affect travelling international students, the World Health Organization had, by March, declared the outbreak of novel coronavirus (COVID-19) as a pandemic.

With the state of emergency declared, physical distancing meant that the campus was closed to students and staff. Within one week, over 900 subjects were moved to the online environment and the School of Nursing and Midwifery leadership team led the redesign to ensure that academic and clinical standards were maintained to equip current and future nurses and midwives.

What followed was a collaboration between academic (metropolitan and rural schools), technical (Ed-tech were amazing), La Trobe Learning and Teaching (LTLT), professional and administrative staff, industry partners and our students. We even developed a new language such as 'you are muted', 'are you still there', 'is that your cute dog' and 'I appear to have lost connectivity'.

The experience felt like an accelerated version of the original Tuckman model of forming, storming, norming, performing and adjourning (Bonebright 2010).

If only we had read the O'Neill et al. (2013) text on my bookshelf about developing online environments in nursing education seven years ago.

However, we learned that students valued compassion and calmness, how we engaged with them as humans and how we maintained our sense of humour.

This was a healthy challenge for the team – one of our lucky academics faced the challenge of transforming her course material within days of starting her job.

Online learning portrays images of professional actors and well-rehearsed lines; the reality was enthusiastic professionals with no acting experience or scripts, writing on a whiteboard with a mouse (what, no chalk?) and using a tool previously thought to be for meetings as a teaching medium.

The team developed innovative ways of practising skills such as hand hygiene and communication skills; these were learnt in the online classroom before performing assessments on those they live with, such as students performing assessments on those they live with, providing video evidence of skill achievement.

We have learned about connection – and not just internet connectivity; it has been about interdependent connections between students, the teaching team and school leadership. It has also been about student agility and a reminder to us about the privilege that knowledge sharing is. This unique time has taught us many things – workforce preparation of nurses and midwives requires so much from so many – however, it is not only about transferring knowledge – it is about important human connection.

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References

Bonebright, D.A. 2010. 40 years of storming: A historical review of Tuckman's model of small group development. *Human Resource Development International*. 13(1):111-120.

O'Neil, C. A., Fisher, C.A. and Rietschel, M.J. 2013. Developing online learning environments in nursing education. 3rd edn. Springer Publishing Company.

Collaboration photo – from top left to right: Fergus Campbell, Hosu Ryu, Anthony McGillion, Rachel Cross, Jennifer Austerberry, Karen Lawrence, Gayle McKenzie, Catina Adams, Lauren Zarb, Maria Murphy.

Nursing education programs during the COVID-19 pandemic: Adapting BBV and STI education to meet evolving needs

By Olivia Dawson, Courtney Smith, Phoebe Schroder and Melinda Hassall

The novel coronavirus (SARS-COV-2) which leads to COVID-19 illness poses unprecedented challenges to the delivery of health services to people affected by blood borne viruses (BBVs) and sexually transmissible infections (STIs).

These challenges affect both nursing service provision and the way education providers upskill and increase the capacity of the nursing workforce.

Recognising the need to support nurses to work to their full scope of practice to effectively test for, treat and manage BBVs and STIs during COVID-19, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) has adapted its education programs to better utilise various online learning methodologies and platforms.

Converting existing nursing curricula to online delivery has provided ASHM with the opportunity to rethink the learning experience, drawing from evidence to deliver effective and engaging online learning to the nursing workforce.

Adult learning is underpinned by several principles, including that adults are internally motivated, self-directed, practical, and goal and relevancy-oriented (Knowles 1984). ASHM has looked to these principles when adapting its '*STI and BBV nursing: An introduction*' and '*Hepatitis C nursing*' programs to an online environment. Adapting longer format courses to online delivery has necessitated consolidation of information and prioritisation of key messages – some information previously delivered by a facilitator instead provided as self-directed learning. ASHM has developed activities with direct relevance and applicability to nursing practice, including practical case-based scenarios which guide nurses to evidence based online resources to support critical thinking and analysis.

Cherie Bennett (Clinical Nurse Specialist, Sydney Sexual Health) and Donna Tilley (Nurse Practitioner, Western Sydney Sexual Health Centre) remotely presenting ASHM's "STI & BBV Nursing: An Introduction" course to a cohort of nurses from around Australia

A key benefit of these adaptations is increased reach; participants are not restricted by geographic location, and the maximum number of participants is dictated by ideal facilitator-to-learner ratio rather than room size or budgetary restraints.

The number of nurses educated in one online *STI and BBV nursing* course was 3.3 times greater than a typical face-to-face course. It included nurses in rural and remote areas who may otherwise not currently have access to STI and BBV education.

Increased reach also allows a greater diversity of participants; adults bring life experiences and knowledge to learning experiences, and the online environment provides nurses with a unique opportunity to engage with and learn from their peers from all over Australia.

However, online learning is limited by its lack of opportunity for informal networking; future courses could explore including designated networking time at the end of the meetings, with 'icebreaker' activities designed to encourage conversation.

The COVID-19 pandemic has made adaptation to online learning necessary for nurses and education providers. As restrictions are lifted in Australia, face-to-face education opportunities will return, reintroducing unique benefits like networking. However, the nursing workforce, having adapted to online learning, may seek out 'blended' learning opportunities which encompass both face-to-face and online activities. Education providers like ASHM have an opportunity to ensure that flexible and self-directed online learning are readily available to complement rather than replace face-to-face learning.

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References

Knowles, M. et al. 1984. *Andragogy in Action. Applying Modern Principles of Adult Education*. San Francisco: Jossey-Bass.

New program focuses on chronic disease and healthy ageing

By Tony Wells

Australia is faced with the twin health challenges of an ageing population (AIHW Sep 2018) and rising rates of chronic disease (AIHW June 2018). To address this, the Australian Primary Health Care Nurses Association (APNA) has developed a new education program for nurses.

It shows how to incorporate and apply the concepts of chronic disease management and healthy ageing within a primary healthcare setting, so nurses can empower patients to age well and thrive.

As the largest workforce in primary healthcare (AIHW 2020), nurses are well placed to do this.

The program was launched in early 2019 with a series of face-to-face workshops around the country in Darwin, Mt Isa, Ballarat, Cairns, Melbourne, Dubbo, Narooma, Mackay, Townsville and Wollongong.

Due to the COVID-19 pandemic, APNA has moved to a fully online program, including a four-part recorded workshop with interactive exercises and videos. This will allow more nurses to participate, regardless of location.

Education is delivered over 12 months, with 50 hours of online learning which can be tailored to a nurse's individual needs through a self-assessment tool, and supported by an online community of practice where nurses can engage with fellow participants, share ideas and support each other.

The course design recognises that primary healthcare nurses – particularly solo nurses in general practices – often find it hard to get time and funding to attend CPD. APNA has created a flexible course structure so nurses can complete it how they want and when they want.

So far, 294 nurses have registered as participants. They are building skills and confidence across a variety of topics including diabetes, asthma, dementia and how to optimise health as people age.

APNA's Chronic Disease Management and Healthy Ageing Program is funded by the Australian Government Department of Health.

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References

Older Australians at a Glance, AIHW, 10 September 2018 aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians

Australia's Health 2018, AIHW, 20 June 2018 aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents

A profile of primary health care nurses, AIHW, 12 May 2020 aihw.gov.au/reports/primary-health-care/a-profile-of-primary-care-nurses/data

Interprofessional Education: How important is this for health students

By Christina Parker, Sandra Johnston and Karen Theobald

Interprofessional Education (IPE) occurs when two or more professions learn with, from and about each other, with an aim to improve collaboration and lead to increased quality of care (World Health Organization 2010).

As professional accreditation increasingly requires the inclusion of Interprofessional Education in undergraduate curricula (Australian Nursing and Midwifery Accreditation Council 2019), this provides a window to view what presently exists. Interprofessional education is increasingly recognised in the preparation of a collaborative workforce to address the complex needs of today's patient.

It is essential that undergraduate health students understand the need for effective collaborative healthcare teams and how to optimise the knowledge and skills of different team members.

However, embedded IPE where students from different courses learn in the same environment is not a common teaching and learning approach used routinely in Australian health courses. The significance of this is that newly graduated health professionals may not feel empowered to make appropriate referrals for complex client conditions and thus not be in control of their own health practice.

In 2019, QUT implemented an interprofessional approach to the delivery of an elective wound care unit within the Bachelor of Nursing course. Lectures were delivered from experts in the fields of dietetics, psychology, podiatry and wound care. Nursing students were taught in combined classes with undergraduate students from podiatry, pharmacy and exercise and nutrition science health disciplines, and worked together to resolve patient clinical cases. The implementation of this course as an interprofessonal learning experience was evaluated.

IPE of wound care in clinical labs

Following ethical approval, a survey was conducted, and students were emailed a link to complete the online survey. All (n=23) students who answered the post-course survey agreed that all health professionals should be educated to establish collaborative relationships with members of other health professions, that health professionals should collaborate on interprofessional teams and that part of the curriculum should include health professional students' involvement in teamwork with students from other health professions, to enhance understanding of respective roles. Qualitative interpretations identified two themes, suggesting that IPE encouraged a more holistic and a more patient-centred approach to learning.

> *'Patient-centred care: Providing care that is respectful of, and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Interprofessional care is to give patients the best evidence-based treatment available. Different professionals have their own expertise, as a result, working interprofessionally helps us learn from each other, which can improve patient's outcomes (mentally and physically better)'.*
>
> ***Student 2, post survey response***

The outcomes of this innovative IPE teaching strategy confirmed that a structured program of Interprofessional Education within Faculty of Health courses promoted student understanding of Interprofessional Education and provided evidence to support the continuation of a structured program of IPE.

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References

Australian Nursing and Midwifery Accreditation Council. 2019. Registered Nurse Accreditation Standards. Retrieved from anmac.org.au/sites/default/files/documents/registerednurseaccreditationstandards2019.pdf

World Health Organization. 2010. Framework for action on Interprofessional education and collaborative practice. Retrieved from who.int/hrh/resources/framework_action/en/

The role of midwives in testing for HIV and hepatitis in early pregnancy

By Jen Johnson

Australian pregnancy care guidelines state that testing for blood borne viruses (BBVs) should happen at the first antenatal visit to prevent mother to child transmission of hepatitis B and HIV, and for maternal and neonatal case identification of hepatitis C (DoH 2019).

BBV testing guidelines and legislation have changed over time as the efficacy of treatments has improved. Midwives play a critical role in ensuring that guideline-based HIV and hepatitis screening occurs during early pregnancy.

Current RANZCOG and Department of Health (DoH) guidelines for HIV and hepatitis antenatal screening are broadly in alignment, however, this has not always been the case. DoH policies did not align with RANZOCG's earlier recommendations for universal screening for HIV and HBV until 2006 and 2011, respectively (Hunt 2002; DoHA 2006; DoH 2012; DoH 2019).

Similarly, DoH antenatal hepatitis C screening policies have leaned toward risk-based screening (DoH 2012), whereas RANZCOG guidelines have generally emphasised discussing testing with all women (RANZCOG 2020).

Since the early days of the HIV epidemic, Australian states and territories have legislated certain information be provided at the time of HIV testing and following the return of positive test results.

In some jurisdictions, such as Victoria, previous legislation required that healthcare workers (including midwives) complete specialised training before they could initiate testing. These restrictions emerged during a time when HIV was largely fatal, and specialised 'pre-test counselling' was seen as necessary to support people through the decision test (Johns 2016). Improvements in HIV treatment and care mean that HIV is now a chronic manageable condition, and shorter pre-test discussions are sufficient to gain informed consent.

Midwives are central to ensuring BBV testing is completed in early pregnancy. Booking midwives need to locate and interpret any BBV serology that may have been done by the GP in very early pregnancy, ensure women are given their results, and importantly check whether follow-up testing is needed.

Where BBV serology is incomplete at the booking visit, midwives need to initiate testing discussion and gain informed consent for testing. Informed consent for BBV testing means that the person being tested understands the test itself, the virus, the possible results, and the benefits and risks of testing (Johnson and Lenton 2017).

Effective short educational interventions, designed and delivered by content experts, are needed to ensure that midwives can give women and their partners' adequate information and recommendations which support the decision to screen for HIV and hepatitis in early pregnancy. Collaborations between BBV community organisations, clinical services and knowledge translation practitioners can facilitate the development and delivery of targeted training that builds midwives' competency in this area.

One such example of an effective training intervention was recently devised and conducted by the Australian Research Centre in Sex, Health and Society at La Trobe University and Mercy Hospital for Women. For more information about the content of the training intervention, the evaluation results, or to learn more about best practice in antenatal BBV testing, please contact j.johnson@latrobe.edu.au

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References

Department of Health. 2006. National HIV testing policy. Canberra: Australian Government Department of Health.

Department of Health. 2012. National Hepatitis C testing policy. Canberra: Australian Government Department of Health.

Department of Health. 2019. Clinical practice guidelines: Pregnancy care. Canberra: Australian Government Department of Health.

Hunt, J.M., and Lumley, J. 2002. Are recommendations about routine antenatal care in Australia consistent and evidence-based? *Medical Journal of Australia*. 176(6):255-9.

Johns, D.M., R. Bayer, and A.L. Fairchild. 2016. Evidence and the politics of deimplementation: The rise and decline of the "counseling and testing" paradigm for HIV prevention at the US Centers for Disease Control and Prevention. *The Milbank Quarterly*, 94(1): p. 126-162.

Johnson, J. and Lenton, E. 2017. HIV and hepatitis pre and post-test discussion in Victoria consultation report. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2020. Management of Hepatitis C in pregnancy – Clinical Statement. Melbourne. Viewed 25/6/20. URL ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Management-of-Hepatitis-C-in-Pregnancy-(C-Obs-51).pdf?ext=.pdf

Spencer, J.D., Tibbits, D., Tippet, C., Mead, C., Kaldor, J.M., Dore, G.J. 2003. Review of antenatal testing policies and practice for HIV and hepatitis C infection. *Australian and New Zealand Journal of Public Health*. 2003; 27(6):614-9. doi: 10.1111/j.1467-842x.2003.tb00608.x.

Helen Skouteris

RE team at MCHRI

Upskilling midwives to support healthy lifestyle during preconception and pregnancy

By Helen Skouteris and Cate Nagle

Over half of Australian women enter pregnancy overweight or obese (McIntyre et al. 2012).

Excessive gestational weight gain (GWG) above US Institute of Medicine (IOM) recommendations (Rasmussen and Yaktine 2009) occurs in over 40% of pregnancies in Australia and in developed countries internationally (Goldstein et al. 2017), with every kilogram above IOM recommendations increasing adverse maternal and foetal outcomes by ~10% (Goldstein et al. 2017).

Preconception higher body mass index also independently increases pregnancy complications (Cheney et al. 2018). The need to optimise lifestyle health in preconception and pregnancy is therefore well understood; yet translation of this knowledge into practice has been limited (Skouteris et al. 2015). Key barriers include confidence, knowledge, and motivation of healthcare professionals, underpinned by insufficient training in lifestyle modification during undergraduate training (ie. university courses, Kothe et al. 2019). We have been awarded a National Health and Medical Research Council Centre of Research Excellence in Health in Preconception and Pregnancy: The Prevention of Maternity (CRE HiPP 2020- 2024). One goal of CRE HiPP is to develop accessible, low cost, capacity building interventions to up skill pre-service and health professionals. We have developed six short professional development modules for undergraduate midwifery students; these include:

- **MODULE 1** – Introduction to healthy lifestyle & pregnancy care guidelines
- **MODULE 2** – Healthy lifestyle at preconception & SMART goal setting
- **MODULE 3** – Healthy lifestyle in pregnancy & readiness for change and goal modification
- **MODULE 4** – Healthy lifestyle in complicated pregnancies
- **MODULE 5** – SMART goal setting for improving healthy lifestyle in complicated pregnancies and readiness for change and goal modification in complicated pregnancies
- **MODULE 6** – Leadership in midwifery

We plan to pilot test these modules prior to dissemination to universities that provide entry to practice midwifery courses early in 2021.

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References

Cheney, K. et al. 2018. Population attributable fractions of perinatal outcomes for nulliparous women associated with overweight and obesity, 1990-2014. *Medical Journal of Australia.* 208(3):119-125.

Guelinckx, I., Devlieger, R., Beckers, K., and Vansant, G. 2008. Maternal obesity: pregnancy complications, gestational weight gain and nutrition. *Obesity Review.* 9(2):140-50.

Goldstein, R.F. et al. 2017. Association of gestational weight gain with maternal and infant outcomes: a systematic review and meta-analysis. *Journal of the American Medical Association.* 317(21):2207-25.

Kothe, E., Bailey, C., Weiner, C., Nagle, C., Nowson, C., Hill, B., McPhie, S., Savaglio, M., and Skouteris, H. 2019. An investigation of Australian midwifery curricula for obesity management and health behaviour change. *Nurse Education in Practice.* 36:54-57.

McIntyre, H.D., Gibbons, K.S., Flenady, V.J., and Callay, L.K. 2012. Overweight and obesity in Australian mothers: epidemic or endemic. *Medical Journal of Australia.* 196(3):184-8.

Rasmussen, K., and Yaktine, A.L. 2009. *Institute of medicine and national research council committee to reexamine IOM pregnancy weight guidelines. Weight gain during pregnancy: reexamining the guidelines.* 2nd edn. Washington DC: National Academic Press.

Skouteris, H., Huang, T., Millar, L., Kuhlberg, J., Dodd, J., Callaway, L., Forster, D., Collins, C., Hills, A., Harrison, P., Nagle, C., Moodie, M., and Teede, H. 2015. A systems approach to reducing maternal obesity: The Health in Preconception, Pregnancy and Postbirth (HiPPP) Collaborative. *Australian and New Zealand Journal of Obstetric Geynaeocology.* 55(4):397-400.

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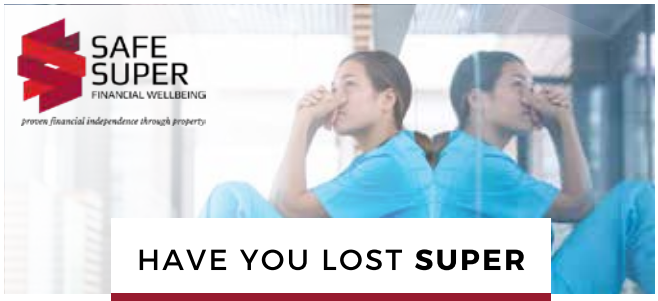

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LIFE WITHOUT BARRIERS

Evan Plowman

Krishna Lambert

Meeting the challenge of social distancing in nursing education

By Evan Plowman and Krishna Lambert

Online learning widens participation, increasing access to education. Learning online is appealing to students who are located rurally, who have family to support and students who are required to work while studying (Schwartz 2019).

Research commissioned by the World Health Organization (WHO) found online learning modalities were equivalent in achieving learning outcomes compared with traditional face to face teaching (Al-Shorbaji et al. 2015).

Other research suggests online courses without a face to face component may lack the ability to develop the necessary knowledge, skills and attitudes required for safe practice (Schwartz 2019). Although there are undergraduate Bachelor of Nursing programs offered entirely online, in most cases, curriculums use a blended approach; comprising of online learning activities (synchronous and asynchronous), and face to face learning.

In response to COVID-19, the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University transitioned all internal classes to an online/blended modality. The majority of learning has been delivered with online synchronous sessions, with some use of asynchronous learning and intensive face to face simulation learning, which we delivered when social distancing requirements were eased.

In our experience, this blended mode of learning requires more organisation and discipline on behalf of the learner to work through the theoretical content before attending Residential School, whereas the 'traditional' on campus learner relies more on the academic to ensure progress is being made throughout the semester. Transitioning students who are accustomed to this level of support has required intentional curriculum modification, with the design of appropriate online activities and extra support in preparing students for online classes, specifically, IT support.

Despite challenges the transition has posed, synchronous online meetings have provided the students with the opportunity to develop an understanding of the rationale and sequencing of a skill independent from the psychomotor capabilities. For example, we applied the clinical reasoning cycle theoretically to a case scenario before subjecting the students to the hands-on practice, which will occur during face to face simulation learning. The extra layer of support provides continuity between the learning and the practising.

Students who opt for an on campus learning mode do so because this suits their personal learning style. While online learning is not a new concept, the transition of students who prefer face to face contact has been challenging but also presented unanticipated benefits.

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References

Al Shorbaji, N., Atun, R., Car, J., Majeed, A., Wheeler, Atun, R., .Žolger, D. 2015. *eLearning for undergraduate health professional education: A systematic review informing a radical transformation of health workforce development*. World Health Organization

Schwartz, S. 2019. *Educating the nurse of the future – Report of the independent review into nursing education*. health.gov.au/sites/default/files/documents/2019/12/educating-the-nurse-of-the-future.pdf

Maria Murphy

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Clinical schools: The university away from the university

By Maria Murphy, Lee MacDonald, Jacqueline Johnston and Marcia George

Worldwide, universities have varying degrees of affiliation with healthcare facilities. La Trobe University was the first higher education provider in Australia to establish Clinical Schools of Nursing co-located within hospital settings.

The Alfred Clinical School was established in the early 2000s. Over the next decade, three additional clinical schools were established at Austin, Northern and Melbourne Health in Melbourne.

Each clinical school comprises both administrative and academic appointments contributing to both undergraduate and postgraduate programs.

Strong emphasis is placed on the importance of sessional academics with relevant postgraduate qualifications, being prioritised from the clinical partner to teach in the study programs.

Undergraduate students are now allocated in Year 2 and Year 3 of their Bachelor of Nursing studies to a Clinical School. To review the student experience, a qualitative study by Watt and Pascoe (2013) identified that graduate nurses viewed the Clinical School model as "the university away from the university" (p. 26), helping to minimise the theory-practice gap.

This model requires an investment of time, resources and effort from both the university and affiliated hospital alike (Watt and Pascoe 2013; Scanlon 2009; Fetherstonhaugh et al. 2008). A potential return for the affiliated hospital is that the students may choose to participate in the hospital's Graduate Nurse Year program and ultimately continue their career at that hospital (Scanlon 2009).

A potential return for the students includes being part of a smaller group and getting to know classmates and academics easily within the larger university community. Thus, enabling students to form friendships more easily, and to familiarise themselves with the clinical school environments and routines, as well as the academic and teaching staff.

Strong communication between students and staff in the Clinical School has been the catalyst for interventions to support clinical placement (Watt et al. 2011, Watt et al. 2013) and undergraduate students

(McDonald et al. 2019). Supporting the development of critical thinking, knowledge and skills graduates require, for contemporary practice, coupled with the need for securing quality clinical placements was the genesis for the university away from the university.

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References

Fetherstonhaugh, D., Nay, R., & Heather, M. 2008. Clinical school partnerships: The way forward in nursing education, research and clinical practice. *Australian Health Review*, 32(1):121-126.

La Trobe University. STARS Learning & Teaching Conference. 2019. Peer mentoring in nursing – Improving retention, enhancing education. McDonald, E. Manessis, R. & Blanksby, T. Melbourne. La Trobe University.

Scanlon, A. 2009. How do university clinical school of nursing graduates choose their graduate nurse year program? *Australian Journal of Advanced Nursing* (Online), 26(2): 34-38.

Watt, E., Murphy, M.C., MacDonald, L., Pascoe, E., Storen, H., & Scanlon, A. 2013. An evaluation of a structured learning program as a component of the clinical practicum in undergraduate nurse education: a repeated measures analysis. *Nurse Education Today*, 36:172-177.

Watt, E., Murphy, M.C., Pascoe, E., Scanlon, A., & Gan, S. 2011. An evaluation of a structured learning programme as a component of the clinical practicum in final year bachelor of nursing programme: A pre-post-test analysis. *Journal of Clinical Nursing*, 20(15-16):2286-2293.

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