



# ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 27, NO.3  
APR-JUN 2021

## Remembering the bravery of wartime nurses

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awesomeness**

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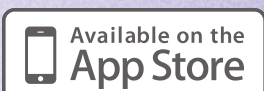
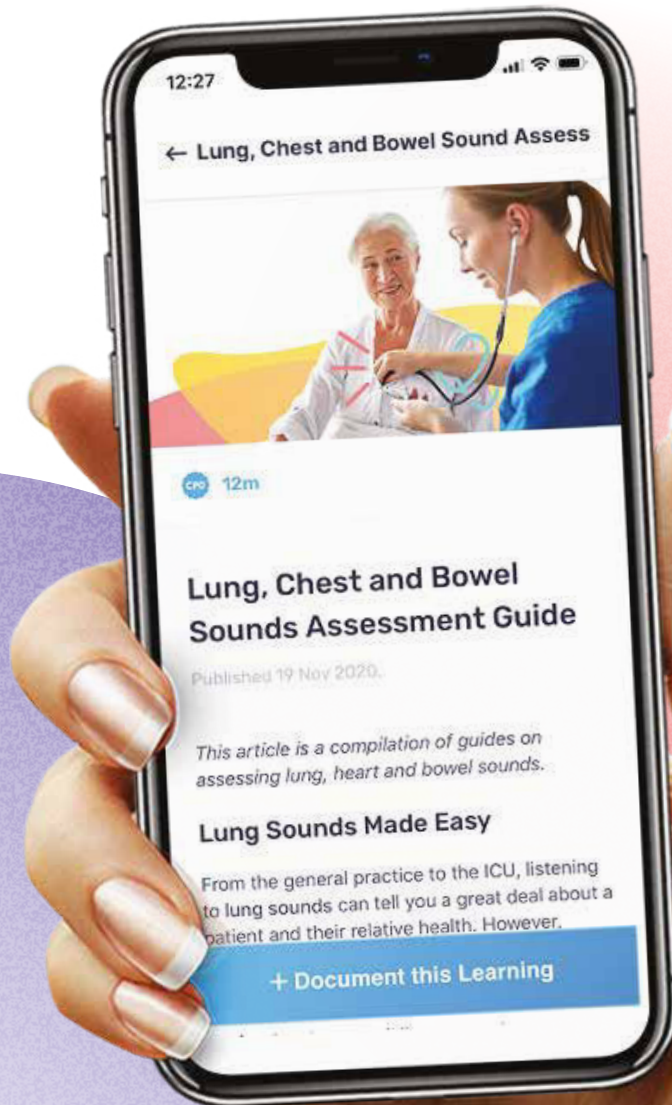
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**Annie Butler**

ANMF Federal Secretary

**After two-and-a-half years of Inquiry, including hearing evidence from nursing home residents and their families, nurses, carers and organisations such as the ANMF, the Royal Commission into Aged Care Quality and Safety's Final Report was tabled in Parliament on 1 March. Its findings are clear: vulnerable elderly Australians will continue to suffer until there is fundamental reform of the aged care system, including mandated minimum staffing levels and skills mix. Now, the Morrison government must act.**

In their report, titled *Care, Dignity and Respect*, Royal Commissioners Tony Pagone QC and Lynelle Briggs AO made 148 wide-ranging recommendations to fix the crisis in aged care.

One of the key recommendations seeks to address understaffing in nursing homes to enable the provision of high quality and safe care.

The Commissioners found Australia's aged care system is understaffed, and the workforce underpaid and undertrained. Too often, there are not enough staff members, particularly registered nurses, in home and residential aged care. Inadequate staffing levels, skills mix and training were the principal causes found for substandard care in the current system.

The report stated that enough staff, with the right skills and time for care, was central to achieving a world-class aged care system.

To get staffing right, the Commissioners recommended introducing mandated minimum staffing levels and skills mix in nursing homes. This would require aged care providers to employ an appropriate skills mix and daily minimum staff time of registered nurses, enrolled nurses and carers for each resident. At least one registered nurse would also be required on site at all times.

Importantly, the Royal Commission also recommended greater accountability and transparency regarding staffing levels. It calls for aged care providers to publicly disclose the direct care staffing hours they provide each day and to specify who is delivering the care, for example RNs or carers.

Other recommendations outlined in the report include national registration of personal care workers, including a mandatory minimum qualification of a Certificate III; a new Aged Care Act that protects the rights of older people; and improved education, training and wages for the workforce.

For many years, the ANMF has campaigned for safe staffing laws in aged care to ensure elderly nursing home residents receive the care they need and deserve. Our body of research includes an evidence-

based staffing and skill mix model that would address chronic understaffing and meet residents' care needs.

The final report also provided the government with funding options to improve the quality of aged care, including higher taxes or a Medicare-style levy. Not surprisingly, the government was quick to pledge a \$452 million package on the day the report was released. Such funding boosts matter little unless they are bound by legislated transparency and accountability measures that ensure billions of taxpayer dollars allocated to providers are actually spent on direct care.

Over the past two decades, there have been numerous reports and Inquiries into aged care calling for reform. Yet, successive governments have failed to take action. There must be no more excuses or delays. Reform must begin now.

To this end, the ANMF's priority is strengthening our campaign for safe staffing laws. Last month, ANMF aged care nurses and carers travelled to Canberra to lobby politicians to fix the crisis in aged care. Several state and territory branches have also held Days of Action to highlight the importance of legislated ratios.

Collective action is vital. We need to mobilise, hit the streets and demand the Morrison government urgently implement the Royal Commission's recommendations.

It's up to them to ensure elderly Australians living in residential aged care are guaranteed high quality, safe, dignified care. It's not too much to ask.

Each day this government delays addressing dangerous understaffing in nursing homes is another day that vulnerable residents suffer.

Annie

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**Moving state?****Transfer your ANMF membership**

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

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### Bees responsible for most venomous bite and sting hospitalisations



Australia is home to some of the most venomous animals in the world – including deadly spiders and 25 of the world's most venomous snakes. Yet, according to a new study released by the Australian Institute of Health and Welfare (AIHW), Australians are most likely to end up in hospital because of a bee or wasp sting.

Over 3,500 Australians were hospitalised due to contact with a venomous animal or plant in 2017-18, the study found. Bee stings caused more than a quarter (26% or 927 cases) of the hospitalisations.

The majority of hospitalisations for bee stings were due to allergic reactions, with bees and wasps responsible for 12 of the 19 deaths related to venomous bites and stings in 2017-18.

Spider bites, led by redbacks and white-tailed spiders, accounted for one in five (19% or 66 cases) of all venomous bite and sting related hospitalisations; while venomous snakes, topped by brown snakes, were responsible for 17% (606 cases) hospitalisations.

Contact with venomous marine animals, such as stonefish and stingrays, accounted for just under 400 hospitalisations and resulted in zero deaths.



### Women with gestational diabetes at risk of Type 2

Women who develop gestational diabetes are ten times more likely to develop type 2 diabetes later in life, research conducted by the University of South Australia in conjunction with the University College Dublin has found.

Lead researcher, UniSA's Kristy Gray says understanding the risks of developing type 2 diabetes post gestational diabetes is essential as prevention was key.

"Women who've had gestational diabetes are ten times more likely to develop type 2 diabetes, but only a third of these women understand that they are at high risk," she said.

"Being overweight is a common risk factor for developing type 2 diabetes, making post pregnancy weight loss important in preventing onset of this disease.

While the study indicated 75% of the women surveyed understood that they were overweight, this knowledge did not translate into a high level of perceived risk, Ms Gray said.

Co-researcher, UniSA's Associate Professor Jennifer Keogh said diabetes prevention strategies must embrace both education and lifestyle.

"Women diagnosed with gestational diabetes often have a young family, which means any interventions need to be considered in line with small children, busy lifestyles and multiple priorities.

"The priority is to educate both women with gestational diabetes, and the health professionals who care for them, to ensure greater communication and boost awareness of the risk factors these women have."



### USE OF OPIOIDS SLASHED FOR PATIENTS WITH ACUTE BACK PAIN

A trial in NSW has resulted in up to a 24% reduction in the number of prescriptions issued for opioids to patients with acute back pain in the emergency department setting.

The results, published in *BMJ Quality and Safety*, could transform the way patients with back pain are treated at hospitals across Australia and help tackle the growing opioid crisis, the researchers suggest.

The randomised trial was conducted across four NSW emergency departments and was led by researchers and clinicians from the Institute for Musculoskeletal Health,

University of Sydney and Sydney Local Health District.

At Canterbury Hospital, opioid use fell dramatically from 61% of patients being given prescriptions to 37% during the four-month trial.

Importantly, there was no increase in pain levels for patients, or any drop in satisfaction with care from patients despite clinicians giving out fewer opioid painkillers.

"Our trial has demonstrated that there is a safer way to treat acute back pain that can easily be adopted by hospitals across the country. With back pain often being a leading reason people visit emergency departments, this new strategy could result in millions of scripts being handed out each year and help tackle the global opioid epidemic," lead author Dr Gustavo Machado said.



## A NEW MODEL OF HEALTHCARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER AUSTRALIANS

Deep-seated resistance to addressing institutional and systemic racism in our health system is thwarting progress towards improving the health and wellbeing of Aboriginal and Torres Strait Islander Australians, according to a new paper.

The paper, *Perspective*, published in *Public Health Research & Practice*, indicated that institutional racism leads to a dismissal of Indigenous knowledges, worldviews and cultural practices that must be incorporated into healthcare provision if we are to close the gap in life expectancy between Indigenous and non-Indigenous Australians.

“When an Aboriginal or Torres Strait Islander person accesses a healthcare service, there is always a level of mistrust and fear. A lot of people forget that our health system was one of the many institutions involved in the ‘Stolen Generation’ that took children from their families and communities – which still happens today. Those stories resonate through our communities.” said lead author Dr Carmen Parter, Senior Research Fellow at the Poche Centre for Indigenous Health at the University of Queensland.

The authors said it was critical that healthcare provision to Aboriginal and Torres Strait Islander peoples incorporates Indigenous worldviews, which can be very different to those of the Western medical establishment.

“When Indigenous knowledges are incorporated into services and programs, research has shown that health outcomes are improved.”

The paper outlines a model of practice where different knowledges and cultures can co-exist, which the authors say could be instrumental in closing the gap in life expectancy by 2031.



## International Medicinal Cannabis Symposium draws closer

A Medicinal Cannabis Symposium featuring international and Australian experts will give nurses and midwives the opportunity to learn more about the drug's emergence as a potential therapeutic treatment for patients across a number of clinical areas.

Sponsored by the Australian Nursing and Midwifery Federation (ANMF), the United In Compassion (UIC) Symposium includes a one-day Nurses Conference, titled *The New Frontier of Medicinal Cannabis Nursing*, where nurses and midwives can hear from experts about the latest research, legislation and developments in the field, and opportunities within the professions.

Medicinal cannabis has been successfully used as a treatment for conditions such as epilepsy, multiple sclerosis and chronic non-cancer pain.

To be held from 13–15 August in Queensland, the Symposium's focus is improving patient access by educating the health workforce

and promoting development of a viable, professional, and patient focused industry.

The event also includes a two-day general Symposium open to the public featuring local and international speakers covering a wide range of topics; a three-day trade exhibition; a gala dinner; and an Australian Medicinal Cannabis Training Day for Health Professionals hosted by the Society of Cannabis Clinicians Australian Chapter.

Confirmed international speakers include Associate Professor Dedi Meiri (Israel), Dr Sue Sisley (USA), Dr Peter Grinspoon (USA), Sarah Flogan RN (Canada), and Lynda Balneaves RN (Canada).

Australian icon Olivia Newton-John and her husband John Easterling will also take part in a Q&A session on Friday, 13 August.

To purchase tickets visit [eventbrite.com.au/e/united-in-compassion-uic-2021-australian-medicinal-cannabis-symposium-tickets-136360434731](https://eventbrite.com.au/e/united-in-compassion-uic-2021-australian-medicinal-cannabis-symposium-tickets-136360434731)



**Lori-Anne Sharp**  
ANMF Assistant  
Federal Secretary

## Federal government's IR Omnibus Bill will see workers worse off

**In December 2020, the federal government introduced the Fair Work Amendment (Supporting Australia's Job and Economic Recovery) Bill 2020 to Federal Parliament. If passed, this Bill will erode workers' rights and bargaining power. Lobbying from unions, including the ANMF, resulted in the Bill being referred to a Senate Committee.**

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The ANMF made submissions to the Inquiry and both ANMF members and officials gave evidence in the Senate hearings, which were held in Townsville, Adelaide and Canberra in February. It is expected that the Senate Inquiry will deliver their report in mid-March.

The federal government claims that the proposed amendment to the Fair Work Act is necessary to create greater job security and assist in Australia's economic recovery post Covid.

In fact, if passed, this Bill will achieve the opposite and do nothing to address the problems of casualisation, wage stagnation and lack of job security. It will erode workers' rights and further shift industrial relations power in favour of the employer.

In short, key concerns of the Bill include:

- The proposed definition of casual employment and inadequate casual conversion clause. Rather than including a definition of casual that reflects common law, the proposed definition would effectively allow employers to designate any future employment as casual simply by stating it as such at the time of employment. This means an employee on commencement of employment could be designated casual, despite working a regular pattern of shifts, effectively, allowing employers to label a permanent job casual. This Bill, if passed, would also prevent courts from assessing whether an employee has been correctly characterised as a casual or is, in fact, a permanent employee.
- Modern Awards – The Bill lists 12 modern awards where it would become possible for part-time workers hours to be increased without any overtime premium. The proposal does not currently include awards covering ANMF members, however, the list of awards can be extended by regulation, giving very broad discretion to the government to include in the future. At a time when it is critical we recruit, value and retain a skilled aged care workforce, this Bill, if passed, would have disastrous consequences in achieving this goal. We know that there is already a high prevalence of low-hour contracts in the aged care sector, forcing many workers to obtain secondary employment or live with the uncertainty of irregular hours from week to week. Further, this

Bill will allow employers to give “flexible work directions” to perform new types of work or at new locations.

- Enterprise Agreements - Overall effect of these provisions seek to make it easier for employers to undercut employment conditions. Employers would not need to inform employees they have started bargaining for a period of one month, this will make it easier for employers to push through bargaining, leaving limited opportunity for genuine bargaining. The Bill will also weaken the approval steps normally required by an employer when seeking approval of Enterprise Agreements from the Fair Work Commission. All of these changes give more power and discretion to employers. It is worth noting that the federal government only recently conceded and removed the section of the Omnibus Bill that would see enterprise bargaining agreements exempt from the Better Off Overall Test (BOOT) for a period of two years.
- Wage theft – Whilst this Bill seeks to criminalise serious wage theft, it does not adequately address the problem of widespread wage theft that exists in Australia. If passed, it would override current superior wage theft laws that already exist in Victoria and Queensland.

We should be aiming to improve wages and conditions, job security and certainty of employment, restore the power imbalance that currently exists rather than seeking to undermine minimum safety nets. This Bill is short-sighted, politically motivated and will do nothing to address the power imbalance that currently exists between employer and employee. If passed, it will do nothing to improve working conditions for Australian workers.

At the time of writing, it's expected that the IR Omnibus Bill will be debated in the Senate the week beginning 15 March. Labor and the Greens oppose the Bill, which is now with the Senate. The ANMF is lobbying to block the passage of the Bill through the Upper House, seeking to persuade the five crossbench senators to oppose the Bill. ANMF will be in Canberra during this week to continue the fight for workers' rights and ensure this IR Omnibus Bill is rejected.



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**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. Healthcare professionals should review the full product information before recommending, which is available from Vifor Pharma on request.

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**James Lloyd**  
ANMF Federal  
Vice President

## Critical thinking in an era of misinformation

**We live in a world where information is easily accessed and consumed. It is thrust upon us constantly and anyone can easily publish an opinion that could potentially be read by thousands of people.**

We are bombarded with a constant flow of information, some of which has contributed to the spread of “alternative facts”. It is all too easy to form an opinion without fully understanding the subject – who has the time? It is easy to be sucked into the vortex of misinformation on social media and some news outlets.

So how do we navigate through this data onslaught? We can use a skill that, inherently, all nurses and midwives have – critical thinking.

Critical thinking is purposeful analysis, logical reasoning, and reflection that provides a framework to care for our patients. It is also known as the process of problem solving and decision-making.

In a clinical setting, nurses and midwives use critical thinking in all aspects at work. We use critical thinking to analyse patient care related information, weigh up all relevant options and then make decisions in the best interests of our patient. Paired with critical thinking is evidence-based practice, a tool where nurses and midwives integrate research evidence, clinical expertise and best practice to provide optimum care.

We are taught to use critical thinking without second thought. After all, our decisions use the concept ‘patient first approach’.

The use of critical thinking in our profession protects our patients/clients against human fallibility. Nobody is perfect and critical thinking decreases the chance of us making risky decisions, makes us immune to confirmation bias, allows us to distinguish between facts and opinions to assess the credibility of information sources and makes us more likely to be impartial and not subject to group thinking.

But outside of our workplace, we encounter information overload. Social media bombards us with a packaged set of opinions, easily consumed media bites, and latest trends and consumables.

We now contend with fake news. An unhinged person with no qualifications on a particular topic can share their opinions, spread globally via social media, and be considered an expert.

Confirmation bias, a tendency to search for and recall information that supports your own existing beliefs, ensures that these opinions spread widely.

When presented with information, look for scientific evidence to support claims and evaluate the

plausibility of arguments before forming a view. You may, for example, hear that a COVID-19 vaccination is causing side-effects.

Instead of taking this as fact, use critical thinking skills to seek more data. How does it stack up against current scientific consensus by leaders in the field? Have they provided peer-reviewed evidence to support their claims?

People no longer rely on television and print media alone for obtaining news, but increasingly make use of social media and news apps, where it is not easy to distinguish real news from fake news.

Social media facilitates the distribution of user-generated information. This includes hoaxes, false claims, fabricated news, and conspiracy theories. Facebook, for example, will show you messages based on your previous use, what you read, how long you spent reading a FB post, and what videos you looked at. Social media is designed to make you consume content to get money for the ads you see.

So how do you deal with people who have swallowed the fake news, even believing in conspiracy theories, especially in this era of misinformation?

Shouting your evidence does not work, as people will withdraw and refuse to interact. The key is to acknowledge and respect their core beliefs.

For example, if your friend was an anti-vaxxer, acknowledge that they value their health and those of their loved ones. Listen to what they have to say, find common ground and shared values. This builds empathy, which can be used to discuss differing views.

Introduce concepts of searching for proper evidence, seek other views, introduce concepts of the scientific process, and let them progress from denial to acceptance on their own terms.

Critical thinking is a key skill in nursing and midwifery. Think like a scientist: examine, critique, assess and look for evidence in a rational, unbiased manner. This can sometimes be uncomfortable!

“Knowing a great deal is not the same as being smart; intelligence is not information alone but also judgment, the manner in which information is collected and used” – said Carl Sagan

Remember, ask the right questions!

# Global solidarity for nurses on the frontline of COVID-19

**Nurses worldwide continue to fight on the frontlines to safeguard the lives of those affected by COVID-19. Yet tragically there has been 2,262 reported COVID-19 deaths in nurses in 59 countries, according to the International Council of Nurses (ICN).**

At the time of writing the World Health Organization (WHO), affirmed more than 1.6 million people globally had contracted COVID-19, with healthcare workers making up 10% of that total and rising.

By the end of 2020, in California alone, more than 63,000 healthcare workers had contracted COVID-19, resulting in 240 deaths.

Yet despite the statistics, nurses have continued to care for those who have contracted the virus, risking and sometimes losing their own lives as a result. Many work in unsafe and unsatisfactory conditions, which includes lack of PPE, insufficient infection and control policies, scarce access to testing for themselves and patients and inadequate staffing levels.

In 2020, as nurses working in California were battling heavier workloads as a result of COVID-19, hospital administrations sought to implement waivers against safe staffing levels across the state.

"There could not be a worse time to take dangerous steps that will make this crisis more severe, and that will create more tragedies for our communities," California

Nurses Association (CNA) and National Nurses United (NNU) President Zenei Triunfo-Cortez said at the time.

"To roll back the protections Californians fought for years to achieve and defend is a disaster on top of the calamity that is the worst pandemic in a century."

After speaking with the Californian Nurses Association about the issue last year, Assistant Federal Secretary Lori-Anne Sharp said the situation was intolerable.

"As nurses, we stand by and support our overseas comrades and acknowledge their efforts and courage in dealing with this crisis," Ms Sharp said.

As a gesture of support, the ANMF wrote a letter of solidarity to the Californian Nurses Association and National Nurses United. ANMF members also wrote messages of encouragement and support to their American counterparts on the ANMF's Global Nursing Solidarity Facebook page.

"Every day, one nurse can change several patients' lives. United, nurses can and do change the world ... Guys, you band together and fight like blazes for patient ratios, as ratios save lives. Nothing is too big or too

strong if you fight together. Don't let those who only care about profit win," wrote one member.

"My heart aches for the desperate situation that you all are trying to get under control. You are all in our thoughts every moment we step into the doors of our workplaces. Thank you all for being the compassionate people you are," wrote another.

Meanwhile, Californian nurses continued to stage protests against the rollback of nurse-to-patient ratios, arguing the violation of safe staffing at a time when nurses were already at breaking point would lead to more deaths and suffering.

In February, the protests and collective action paid off, with the state's public health department, guaranteeing it would not approve any new expedited waivers of landmark safe staffing ratios and that all existing waivers would end that month.

"This win reinforces what we have learned over the decades in defending safe staffing standards against multiple attacks: fighting back together works," Ms Triunfo-Cortez said.

"But we must continue to stay united and vigilant in protecting and enforcing the safe staffing standards we need to provide the kind of nursing care we know our patients deserve. Because we know this won't be the last time the industry tries to get rid of ratios."

Ms Sharp said it was essential to stand in solidarity with all nurses and midwives whether they reigned from Australia or abroad.

"At this time it's critical we stand by all nurses across the globe to help support them in their endeavours to protect their rights and to stay safe so they can provide the essential care their patients need."



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## ANZAC DAY SPECIAL

### Remembering the bravery of wartime nurses

*"We shall kindle in your hearts a torch whose flame shall be eternal"*

In 1942, a group of Australian Army nurses were gunned down by Japanese soldiers during the Second World War in what became known as the Bangka Island Massacre. The heroism of the fallen, and those who survived, lives on, writes BEN RODIN.



The 23 women, 22 of them nurses, were facing the ocean. After hearing muffled gunshots moments earlier, the realisation dawned on them that they too would meet a similar fate as their fellow soldiers.

They'd done their best: first, to take care of the survivors from the Japanese bombing and, later, attempting to survive by surrendering to the Japanese soldiers that now stood directly behind them, guns in hand.

Stuck on Bangka Island, an Indonesian island near Sumatra that was a Japanese stronghold, the 60-plus survivors had little choice but to defer to the armed forces. It

was clear that the attempt, while noble, was of little use: after cleaning their bayonets, the seven soldiers, executors in the moment, were primed and the bayonets were used to position the women, all Australian nurses, in a line.

Moments later, Matron Drummond, the most senior figure among the women, called out.

"Chin up girls, I'm proud of you and I love you all," she cried.

The 22 Australians marched into the sea, machine gun fire rattling away moments later; 21 of the women, all who had committed to their nursing duties until their last moments, would die on that day.

It was the 16th of February, 1942.

The true scope of the Bangka Island Massacre, one of several attacks on Australian nurses that emerged out of the Second World War, and one of the foundational events that inspired the creation of the Australian Nurses Memorial Centre, didn't transpire until after the war.

The sole survivor of the massacre, Sister Vivian Bullwinkel, didn't leave captivity until September 1945, along with 23 other nurses who had suffered in prison camps for three-and-a-half years across sites located at both Bangka Island and Sumatra.

Yet, while Sister Vivian testified at both the Australian War Crimes Board of Inquiry

in October of 1945, and the International Military Tribunal for the Far East in 1946, much still remains unknown about the massacre, and the conditions that Australian nurses experienced as prisoners of war (PoWs).

Many of the Australian women destroyed their diaries to avoid further adverse consequences while imprisoned, while after their release, the Australian army also confiscated and destroyed several sets of records.

Despite this, an increasing number of raw material and first-person accounts have surfaced in subsequent decades, making details of what happened on that fateful day in 1942 more accessible for Australians.

While the massacre is a testament to the cruelty of war, it actually followed an equally significant moment of conflict between Allied Forces and Japanese Soldiers.

After reports emerged throughout January 1942 about the rape and murder of British nursing staff in Hong Kong by Japanese soldiers, a decision was quickly made by senior officers to evacuate nurses on the SS Vyner Brooke, a 12-passenger boat that was hastily refashioned to carry 300 people.

Departing on 12 February, the boat left with a large cohort of civilians including women and children as well as 65 nurses.

For the nurses who boarded the ship, including Sister Betty Jeffrey, the thought of



leaving some of the wounded men behind weighed heavily. "... we just had to walk out on those super fellows lying there- not one complaining and all needed attention also our young doctors and the senior doctors too. Just had to walk out on them- the rottenest thing I've ever done in my life... we all hated it," Sister Betty wrote in her diary at the time.

The scenes at the wharf before the departure demonstrated the chaos of the moment. As Catherine Kenny wrote in her book *Captives*, the area "was so congested the nurses had to walk the final part of the journey through fire, smoke, constant noise and gunfire and 'indescribable ruin'".

The sense of foreboding was obvious for those on board, including the nurses.

Sister Jessie Elizabeth Simons, writing in her account, *While History Passed*, observed a "gloomy anticipation": "All of us were tensely aware that, omens or no omens, we would be very fortunate to reach our unknown destination unmolested".

While the ship presented its own challenges – a lack of space, humid and hot conditions, and less than ideal nutrition – the first two days of the journey, the 12th and 13th of February, passed without incident.

But as Saturday the 13th passed into Sunday the 14th, bombs began to rain down on the SS Vyner Brooke as it set sail for Sumatra, encountering not only aircraft but warships equipped with machine guns.

Initially surviving, the nurses, passengers and crew experienced less good fortune in the afternoon when the ship was attacked again, this time failing to evade the targeted assault.

The nurses were assigned lines of responsibility and sprang into action. Although the lifeboat supply had been diminished by the attack, nurses worked earlier to ensure passengers could operate their life belt, and in the midst of the attacks, that wounds were treated and attended to.

As evacuation became the only option, the situation turned chaotic, with groups of British servicemen, civilians and nurses dispersing, only to arrive at Bangka Island, an Indonesian territory that was now under the control of the Japanese.

"We had been told to see that every civilian person was off the ship before leaving it ourselves... believe me, we didn't waste time getting them overboard!", Sister Betty noted afterwards in her first-person account of the war, *White Coolies*.

The impact of the attack on the 300-strong group couldn't be understated. Within the nursing contingent alone, 12 of the 65 drowned while making the journey to the shore, and more than half lost their lives by the time the massacre took place two days later.

Sister Vivian Bullwinkel swam to shore alongside Jimmy Miller, an officer on the ship who would later lose his life in the



*Clockwise from left:*

Betty Lawson was one of several nurses who served during WWII, and later was an ANMC board member. She is holding a replica of the ANMC's Florence Nightingale Lamp. Source: Australian Nursing Memorial Centre (ANMC) Archive.

Betty Jeffrey, pictured decades after the war. She passed away in 2000, the same year as Vivian Bullwinkel. Image Supplied by the ANMC Archive.

Vivian Bullwinkel, pictured in uniform after the war. She continued to serve until 1947, when she left the army and enjoyed a long career in nursing. Image Supplied by the ANMC Archive

The original ANMC building, constructed after World War II. Image Supplied by the ANMC Archive.





## FEATURE

massacre, as well as several other nurses and an elderly couple.

When they rejoined with a larger group of around 100 survivors, which included several British servicemen, the decision was made to surrender. While women and children were spared, neither the other survivors, nor the nurses' Red Crosses, engendered any sympathy.

The Japanese soldiers thereafter marched the remaining men out to sea; the nurses, along with one uninjured woman who stayed to care for her husband, soon followed where they were massacred.

However, Sister Vivian found her way back to the island. Lasting for slightly less than a fortnight alongside Private Paul Kingsley, they surrendered once more, arriving in Muntok where she joined several others nurses in internment.

For Sister Vivian, it would effectively be the beginning of a three-and-a-half year sentence, shared with the other women.

By the end of the Second World War, more than 40 nurses who boarded lost their lives, while of the 32 women who were

imprisoned throughout the war, eight lost their lives throughout the internment.

However, as Australian Nurses Memorial Centre (ANMC) President Arlene Bennett notes, the traumas that the women, not just those on the Vyner Brooke, would experience together, bonded them in the aftermath of returning home.

Significantly, the memorial was something that was discussed by the nurses during their shared imprisonment, with the phrase "We shall kindle in your hearts a torch whose flame shall be eternal" becoming an eventual cornerstone for the ANMC.

"The nurses themselves, who were prisoners of war, were very close to each other," Ms Bennett explains, reiterating that they were discouraged from publicly sharing their experiences.

"They were tight because they shared that experience together, but also, when they came home, there was really no debriefing or anything like that... they were told to get home, and just put up and shut up and don't talk about it."

As time moves further away from the horrors, and more comes to light about their experiences, both good and bad, Ms



Bennett says there is much to be learnt from the resilience of the Australian Army Nursing Service workers of the Second World War.

"They got on and they did what they could with what they had, and they didn't have very much," she says.

"They just really put their nurse training to the fore, and they had hope."



*Clockwise from top:*

Matron Annie Sage (who came into the role at the end of WWII) and Betty Jeffrey flank Sister Ida O'Dwyer, a World War I nurse, while visiting the Edith Caville Memorial.

Nurses (from left to right) Beryl Woodbridge, Wilma Oram-Young, Vivian Bullwinkel, Betty Jeffrey, Nesta James flank Ken Brown, one of the pilots flying the rescue planes.

The Official Opening of the ANMC took place on February 19, 1950. Image Supplied by the ANMC Archive.





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## SECURING A WORKING FUTURE FOR NEW GRADUATE NURSES AND MIDWIVES

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**The biggest priority for graduating nursing and midwifery students remains getting a quality job. Since 2014, the Australian Nursing and Midwifery Federation (ANMF) and key industry stakeholders have been investigating the concerning underemployment of nurse and midwife graduates, the causes of which are complex and varied, to ensure all grads have a future, Robert Fedeles writes.**

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The inaugural Graduate Nurse and Midwife Roundtable

All newly graduated nurses and midwives deserve to transition into quality jobs at the end of their studies, ANMF Federal Professional Officer Julie Reeves says.

Regrettably, however, many struggle to find jobs, denying them the opportunity to consolidate theory into practice, and left facing an uncertain future. Forced to look elsewhere, some may be lost to the profession for good.

"There is often a mismatch currently between the number of nursing and midwifery students graduating and employment availability," Ms Reeves explains.

"It's heartbreaking to see one, let alone many new graduate nurses and midwives, miss out on finding a position in a transition program after dedicating three years of their time, money and effort to enter the professions."

In 2014, the ANMF held a National Graduate Nurse and Midwife Roundtable, bringing together over 30 nursing and midwifery leaders and key industry stakeholders to discuss ways of securing employment opportunities for nursing and midwifery graduates.

The Roundtable included representatives of the Council of Chief Nursing and Midwifery Officers, the Nursing and Midwifery Board of Australia (NMBA), the Council of Deans of Nursing and Midwifery, federal politicians, public sector and aged care employees, nurse educators, and, most importantly, graduates themselves.

From the outset, participants acknowledged nurse and midwife graduates not being able to find jobs as a significant problem. Causes were considered complex and varied and it was agreed that further work to address key barriers was required. A Working Group of interested Roundtable participants was subsequently formed to tackle the issue.

A key area of initial focus for the Working Group, which continues to meet twice a year, was sourcing and analysing accurate data relating to graduates, specifically the numbers graduating, registering and seeking work in nursing and midwifery.

After much discussion, the group developed a minimum data set it considered essential in order to make informed projections for future graduate employment.

Five main questions, which remain central several years on, were tabled:

- Numbers of nursing and midwifery student commencements per year in a course leading to registration;
- Numbers of nursing and midwifery course completions per year in a course leading to registration;
- Number of new graduates registered (initial registration) from Australian education providers in a one year period;
- Of new graduates (initial registration) from Australian universities, how many are employed in nursing and midwifery; and
- Number of graduate transition places.

Following the establishment of the Working Group, the ANMF has continued to work closely with a number of government agencies in a bid to collect available data.

It frequently requests information from aged care providers and private hospitals across the country, and Chief Nursing and Midwifery Officers in each state and territory, relating to annual transition/graduate positions for nurses and midwives.

Perhaps most importantly, the ANMF conducts an annual survey of grad nurses and midwives to gauge how many have secured jobs across the professions. Themes to emerge over the years include no offer of employment due to a lack of experience; an inability to secure work without completion of a 'new graduate program; lack of jobs available for new grads; and some grads applying for dozens of positions without success.

Despite the efforts, accessing all relevant and current data has proved problematic, meaning the true extent of the issue remains difficult to measure.

Ms Reeves, Chair of the Working Group, says the reasons why many grads can't find jobs are complex and multifactorial. The problem typically varies



from state to state and from year to year, and is often influenced by dynamics such as government investment. For example, in Queensland in 2015, the Labor government committed to a \$111 million nursing graduate policy that guaranteed all graduates a job for at least a year.

The mismatch between the number of nursing and midwifery graduates and those offered graduate/transition programs is at the root of the issue, Ms Reeves acknowledges. But she adds that simply producing fewer grads isn't the solution. While Australia has a stable number of nurses and midwives currently, with some distribution issues, the industry expects to face workforce shortages over the next decade.

Instead, Ms Reeves says creating more opportunities for grads, such as increasing quality graduate programs backed by greater government investment, must become a priority.

After university places were uncapped many years ago, Ms Reeves says there are minimal policy levers that exist to ensure the number of nursing and midwifery graduates being produced meets current and future demand.

The Working Group continues to push for accurate data but still doesn't have broad access to lots of important information, such as how many third year students will be expected to graduate nationally for Bachelor courses each year.

"At the end of each year we do not have a clear national picture of how many nursing and midwifery students will be graduating and how many graduate or transition places will be available for these graduating students to be employed," Ms Reeves says.

The aim of the Working Group is to bring nursing and midwifery leaders and key industry stakeholders together to identify this sort of information from year to year."

Newly graduated nurses and midwives find jobs in a variety of settings. Many undertake Graduate Nurse/Transition to Practice

Programs in busy acute public hospitals. Others secure positions in the private sector, primary health and aged care, where much needed support and guidance is often lacking.

Ms Reeves says countless evidence shows the importance of nursing and midwifery students putting theory into practice and they need support through this process, such as graduate/transition programs.

However, Ms Reeves points out that formal graduate programs shouldn't be considered the only option.

"There's a myth out there that if you're a graduate and you don't secure a graduate program that you're unemployable. But there's no mandatory requirement for nurses and midwives to have one."

As the Working Group has evolved, it has increased its focus on finding better ways to support new grads who miss out on a job. Many of the ANMF's state and territory branches offer support, such as help with writing CV's and nailing interviews, and the group believes there is scope for it to provide additional assistance.

Working Group member Professor Tracey Moroney, Chair of the Council of Deans of Nursing and Midwifery, and Head of the School of Nursing at the University of Wollongong (UOW), suggests the issue emerged about a decade ago.

"In years gone by, it was fairly easy for students to get a position after they graduated," Professor Moroney says.

"About 10 years ago we started to note that the graduates weren't getting jobs and that it had a great impact on their self-esteem, just the way that they thought about being a registered nurse. Because the perception out there is that we need registered nurses. Some graduates will say to me 'I thought I was needed?'"

Not being able to secure employment can be detrimental for grads.

"If you can't get into work, then the potential for impaired skilled development

becomes greater. The first year after practice is critical for many aspects of career development. Students know how to do things but the first year after graduation helps them consolidate theoretical knowledge to practice."

Like Ms Reeves, Professor Moroney says the notion that every nurse or midwife needs to undertake a transition to practice program to succeed is flawed.

An academic for more than 20 years, her research into transition to practice programs included interviewing grads on their experiences.

"What I found was that students in transition programs didn't get the level of support they needed to be successful. I strongly advocated for us to have a rethink of transition. A lot of people now are discussing what should actually be in a transition program and how we should best support students for career development."

Professor Moroney believes a better understanding of transition programs could pave the way for a redesign so that graduates can funnel into a broader range of healthcare settings if given the right support.

Meanwhile, new legislation slashing the cost of nursing degrees from \$6,804 to \$3,700 is expected to drive more students into the profession and could exacerbate the employment issue.

With data still unclear, Professor Moroney says the government should not have rushed into decreasing fees in a bid to boost the workforce.

Years after the problem was identified, she says many students who invest time and money into getting a nursing or midwifery degree are still not afforded the opportunity to make their mark as registered nurses or midwives.

"We need to understand how many nursing students we actually need. I've advocated for better data and I think that's the most important thing we need at the moment."



### GRADUATE DATA

- In 2019, there were 26,493 undergraduate nursing student commencements in a course leading to registration. The number of commencements have increased by 48% since 2012.
- Midwifery commencements have increased by 33% since 2012.
- Student completions increased by 62% from 10,635 in 2012 to 17,178 in 2019.
- Total enrolment numbers for undergraduate nursing and midwifery programs in 2019 were 74,897, up 55% since 2012. Enrolments increased 5.3% between 2018 and 2019.

Source: Department of Education Skills and Employment, Higher Education Statistics Collection.



**Dr Micah D J Peters**

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

# Evidence and uncertainty in a risk society

**Sociologist Ulrich Beck proposed the notion of ‘risk society’ in 1986.<sup>1</sup> Risk society is characterised by simultaneous production and distribution of wealth/goods and hazards/pollution – manufactured rather than natural risks.**

This leads to uncertainty and mistrust of traditional experts and institutions. This double-bind can be observed through a range of examples; red wine and chocolate are good for you, but may increase risk of illness and death; antibiotics cure disease but overuse may lead to antimicrobial resistance; hospitals treat patients but are also sources of complications and death.

Beck also extended risk society to work, applying the theory to the rise of insecure employment and the growing power of businesses to operate beyond traditional notions of organised labour.<sup>2</sup> Now, stable full-time employment is the exception to the rule with transitions towards casualisation and the ‘gig economy’. While affording workers job mobility and flexibility to work hours that fit in with busy lives, this has resulted in often poorer working conditions, less bargaining power, worse job security and remuneration.

Low-hour contracts, part-time work and heavy reliance on agencies are common practices across the Australian aged care sector. Full-time positions offered by providers are also declining despite known workforce shortages and preferences for continuity of care. Unforeseen implications of insecure work include the eschewal of multi-site work in aged care because of potential risk of transmission of COVID-19. It is unlikely that workers would prefer shifts across different nursing homes if sufficient hours and remuneration were provided at one.

Another contemporary instance of risk society is evident in the rollout of COVID-19 vaccines. Here, the vaccines are viewed both as saviour and as a potential threat; not only due to the possibility (albeit relatively uncommon) of adverse reactions, but also because of a proliferation of conspiracies and misinformation – that the vaccine will alter human DNA or insidiously insert a microchip.

Risk society offers insight into how and why conspiracy theories arise in uncertain and therefore dangerous spaces. Similarly to preoccupations with and fear of excessive government control in discourses regarding the “War on Terror”,<sup>3</sup> conspiracy theories manifest to explain and thereby manage the unknown and threatening by constructing fictitious alternatives now disturbingly prevalent in the “post-truth” world of “alternative facts”.

The COVID-19 pandemic is the perfect storm of risks, buoyed along by uncertainty and a rapidly shifting plethora of competing evidence, opinions, media scaremongering, and government policy.

Today, science is viewed as both the answer to terrifying ambiguity and the source of further questions. Both public and professional anxiety abound regarding what is correct or real versus what might or could be.

Take for instance the debate over whether COVID-19 is transmitted by aerosols. Despite strong evidence suggesting that aerosols have led to infections and outbreaks, a lack of “unequivocal evidence” appears to prevent establishment of policies and processes that guard against the potential for future outbreaks despite knowledge that better strategies and personal protective equipment could be implemented.

Even the commonplace practice of hand hygiene, usually taught to young children by their parents, appears to be difficult to follow by those for whom it should be second nature despite being a leading cause of hospital acquired infection and a cornerstone of the response to COVID-19. Discourse around hand hygiene is replete with misconceptions and scepticism including perceptions that scientific evidence does not support hand hygiene.<sup>4</sup>

What can we do in an increasingly uncertain world so characterised by threats both real and imagined and where knowledge may be argued and contested to such an extent that confusion paralyses progress? Instead of offering further answers, a promising solution could be to enhance the individuals’, and therefore the wider community’s, capacity to critically appraise and evaluate evidence.

Research education and training is vital. With an ongoing mistrust of industry, experts, and government, health professionals should reflect upon and increase their own ability to evaluate and apply evidence by drawing upon the essence of the scientific method and understanding of society as a means of acquiring knowledge and critiquing how assumptions can distort observations and interpretation. This, I propose needs to occur from the very outset of early education and be regularly reinforced throughout development and into professional careers and workplaces.

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## Day of the Midwife and Nurses Day – International bodies set the theme and agendas worldwide this May

**Each year, the International Confederation of Midwives (ICM) and International Council of Nurses (ICN) lead global celebrations for the International days following a theme.**

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The theme for International Day of the Midwife 2021, 5 May, set by the ICM, is *Follow the Data: Invest in Midwives*.

ICM President Franka Cadée said the theme was about leading the ongoing and growing effort to centre midwives as fundamental to improving quality and respectful care and so ending maternal and newborn death.

She said rigorous evidence supporting this statement comes from a growing number of studies such as the *Impact of Midwives Report* and the *State of Midwifery Report* that the ICM, UNFPA and the World Health Organization (WHO) will launch at the World Health Assembly this May.

“We now know that achieving universal

health coverage through midwifery continuity of care could prevent 67% of maternal deaths and 64% of newborn deaths by 2035.

“These findings can’t be ignored, and IMD [International Midwives Day] is the perfect opportunity to bring together midwives, women, regional and international decision makers and donors in a moment dedicated to underscoring life promoting and lifesaving skills of midwives.”

The overarching theme for International Nurses Day, 12 May, is *Nurses: A Voice to Lead*. The sub-theme for 2021 is *A Vision for Future Healthcare*.

The ICN, who set the theme, said the global

COVID-19 pandemic had shown the world the essential role nurses play in keeping people healthy across the lifespan. While there had been significant disruption to healthcare, they also suggested there had 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. As the largest healthcare profession, nurses should play an integral part in planning the future of healthcare.

“We can only achieve this vision of future healthcare by generating new policies that pave the way for this sea-change, and that is another key area IND2021 will seek to focus.”



# Celebrating your awesomeness

**Nurses and midwives will be celebrating their professions across the world this May.**

International Day of the Midwife (IDM), held 5 May, and International Nurses Day (IND), held 12 May, are opportunities to recognise the crucial role midwives and nurses play in achieving high levels of essential care to their patients.

It is also a time to acknowledge nurses' and midwives' awesomeness, individually and as part of a team, when achieving those outcomes.

Nurse & Midwife Support, who are dedicated in providing a national support service to nurses and midwives, could not agree more and have partnered with the ANMJ to help you celebrate your awesomeness with your team.

Thanks to Nurse & Midwife Support, we are giving away a wellbeing food hamper valued at \$250 to a midwife or nurse in each state and territory to share with your nursing or midwifery colleagues.



To enter, head to [mailchi.mp/anmf/win](https://mailchi.mp/anmf/win) and tell us in 25 words or less why your nursing and/or midwifery team is awesome.

**Entries close 30 April 2021.**

**The winners will be drawn 5 May 2021 and will be announced via Facebook 12 May 2021.**

For T&Cs, head to ANMJ's website: [anmj.org.au](https://anmj.org.au)

For more information about Nurse & Midwife Support, head to [nmsupport.org.au](https://nmsupport.org.au) or call 1800 667 877.



## CELEBRATING INTERNATIONAL DAY OF THE MIDWIFE AND INTERNATIONAL NURSES DAY

Thanks to Nurse & Midwife Support, we are giving away a wellbeing food hamper valued at \$250 to a midwife or nurse in each state and territory to share with their nursing and/or midwifery colleagues.

Head to [mailchi.mp/anmf/win](https://mailchi.mp/anmf/win) to enter, and tell us in 25 words or less why your nursing and or midwifery team is awesome.

**Entries close 30 April 2021**



## Aged Care Royal Commission Final Report

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**“A highly skilled, well rewarded and valued aged care workforce is vital to the success of any future aged care system,” states the final report of the Royal Commission into Aged Care Quality and Safety.**







## GREAT FIRST STEP

ANMF (Victoria Branch member), Rebecca Woodfield shared with the *ANMJ* her views on the Royal Commission's recommendations.

Rebecca, who is a residential facility manager, and who has also worked as both a Personal Care Assistant (PCA) and Registered Nurse (RN) across her two-decade plus career in aged care, says the recommendations were a "great first step." However she added that the government needed to commit to adapting the full recommendations made in the report.

"They need to listen and critically go through each of those recommendations, because the recommendations wouldn't be there if this industry was working as it should and providing everything that it could."

Speaking about the Inquiry there was frustration that it had taken two years to identify the issues that were already known.

"... and those that have died in our homes or left the industry through no longer wanting to work in it... we might've been able to keep them; things might've been better for them if we had just started on what we knew already."

Yet positively Rebecca says the Commission has united the sector.

"As individuals [and aged care managers] we've been fighting this broken system-fighting for our residents, fighting for our staff, and this Royal Commission has given that a united voice... and it's louder because we're all saying it together."

The culmination of two and a half years of investigation, the landmark report was released on 1 March.

Titled *Care, Dignity and Respect*, Commissioners Tony Pagone QC and Lynelle Briggs AO (pictured left) made 148 wide-ranging recommendations for fundamental reform of the aged care system.

One of the report's key recommendations calls for the introduction of mandated staff ratios to ensure there are enough nurses and other care staff present at all times in residential aged care.

"In a large number of residential aged care facilities there are not enough workers to provide high quality, person-centred care. In many cases the mix of staff who provide aged care is not appropriately matched to the care needs of older people," the Commissioners wrote.

To address staffing, the Commissioners recommend that the Australian government introduce a minimum quality and safety standard for staff time that residential aged care providers must meet. This would require aged care providers to employ an appropriate skills mix and daily minimum staff time of RNs, ENs and carers for each resident. Once fully implemented, at least one RN would also be required on site at all times.

In their report, the Commissioners suggest the introduction of the Aged Care Act in 1997 removed the obligation of aged care providers to spend a dedicated portion of their government funding on direct care staffing.

"Since 1997, providers are free to judge for themselves what staffing numbers are 'adequate' and what skill levels are 'appropriate'."

Accordingly, another recommendation calls for greater transparency and accountability regarding staffing. If introduced, residential aged care providers would need to report, on a quarterly basis, their total direct care staffing hours provided, as well as specify who is delivering the care, for example, RNs, ENs, or carers.

Other recommendations made by the Royal Commission include:

- A new Aged Care Act that protects the rights of older people receiving aged care
- National registration of the personal care workforce, including a mandatory minimum qualification of a Certificate III
- Legislative amendments to improve provider governance by ensuring independence, accountability and transparency
- Funding options, such as higher taxes or a Medicare-style levy, to meet the cost of delivering high quality care

The ANMF, which has long-campaigned for the introduction of safe staffing laws, welcomed the Royal Commission's recommendations for reform and its acknowledgement that staffing levels and skills mix are linked to quality of care.

ANMF Federal Secretary Annie Butler said it is now up to the Morrison government to take action.

"This government, and many previous governments, have done nothing to address ever-increasing shortages of registered nurses and qualified carers working in aged care," Ms Butler said.

"Without adequate staffing and skills mix, with minimum standards for care workers, nursing home residents have suffered terribly.

"The Morrison government must now act. Every day the government delays taking action to address dangerous understaffing in nursing homes and community care, is another sad day that vulnerable residents will continue to suffer."

Immediately after releasing the final report, the government pledged \$452 million to address immediate priorities in the sector.

While increased funding is crucial, Ms Butler said it would count for little unless directly tied to the provision of care through legislated accountability and transparency measures.

Moving forward, the ANMF's campaign for safe staffing laws is intensifying. Collective action has already included aged care workers travelling to Canberra last month to lobby politicians, and Days of Action across the country.

"The evidence heard throughout the Royal Commission exposed the dangerous levels of understaffing in privately-run nursing homes. The government must now act so that every older Australian can receive high quality, safe, dignified care."



# Preparing undergraduate nurses to care for people living with HIV infection

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By Denise Cummins and Kurt Andersson-Noorgard

**The human immunodeficiency virus (HIV), although incurable, is now a treatable chronic health condition. Due to effective treatments, which reduce morbidity, infectivity and mortality whilst preserving and restoring immune function, have resulted in people living with HIV (PLHIV) living longer and productive lives. Consequently, HIV in Australia no longer makes news headlines, and many nurses new to the profession may have little exposure to issues related to HIV or have limited experience providing care to PLHIV.**

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There is an estimated 27,545 PLHIV in Australia<sup>1</sup>. As an ageing population, PLHIV may be at risk of increased comorbid health conditions<sup>2</sup> and as such may now receive care from non HIV specific health services including hospital and community admissions and an array of outpatient settings.

In the past stigmatising attitudes from healthcare professionals has been shown to negatively affect medication adherence, access to care and decreased retention to care<sup>3,5</sup>, which can impact quality of life and increase morbidity and mortality.<sup>6,7</sup>

To provide optimal care, nurses need to be aware of current issues facing PLHIV to enhance their experience of the health system<sup>8</sup>.

Studies have provided evidence that nursing students have concerns about HIV. These concerns include: fear of contracting HIV; reluctance to care for people with HIV/AIDS; homophobia; and stigma associated with HIV/AIDS<sup>9</sup>. Evaluation following an education session of first year registered nurses Cummins and Muldoon<sup>10</sup> reported incorrect knowledge of HIV transmission such as transmission by insects. Stravapoulou<sup>11</sup> noted student nurses were concerned with providing care to PLHIV with 65% identifying education as an important factor to improve communication between healthcare provider and the patient.

During tertiary education NSW undergraduate nurses (UGNs) may have the opportunity to attend one of five

community health centres within the boundaries of the Sydney Local Health District (SLHD), NSW, Australia as part of their clinical placement.

Due to a known population of PLHIV already receiving care within SLHD an online education module was designed for UGNs to access at each clinical site.

## OVERVIEW OF THE ISSUE

The purpose of this study was to assess UGNs HIV knowledge and experience whilst on clinical placement in a community setting by evaluating an online education module "HIV and Nursing" developed by specialist HIV nurses for nurses.

## PROJECT OUTLINE

### CONTENT OF MODULE

Dean<sup>12</sup> and Frain<sup>13</sup> both discussed the importance of having clinical experts involved in developing education and the content was reviewed by clinical experts in both the nursing and medical fields. Material in the module included, but was not limited to, general HIV information, HIV transmission, HIV treatment and the importance of medication adherence to prevent drug resistance, legal issues, infection control, first aid and information regarding processes undertaken after an occupational exposure – post exposure prophylaxis, or PEP, which is prescribed and taken within 72 hours to be effective to prevent exposure to HIV following exposure<sup>14</sup>.

Additionally historical information relating to events and information from the beginning of the HIV epidemic (1980s) were included with videos and press releases from that time to provide context for nurses with limited exposure to that period.

HIV related stigma and discrimination was discussed and most importantly three HIV positive speakers were interviewed to share their experience of healthcare services. They were selected to promote diversity of PLHIV, one who identified as a homosexual man, one a female refugee and one a Trans woman, each with unique stories and experiences of stigma within the health system.





## ACCESS

Initially access for UGNs on clinical placement was problematic as they did not have access to SLHD education portal which required employment based approval. To resolve this the authors partnered with staff of SLHD Centre for Education and Workforce Development who placed the module within an accessible section of the education portal with the students requiring only their university details to access. Clinical Nurse Educators who oversaw the UGN placements at each community health centre facilitated this process.

## METHOD

A quantitative, descriptive, pre and post survey design was developed with twelve pre questions and ten post questions. These were designed to explore pre-existing education and experience, knowledge of HIV related issues: eg. stigma and discrimination, infection control and post exposure prophylaxis. Data was examined after a pre-determined period of 12 months.

The UGNs were asked to complete the module during their community based clinical placement. The results will be given as descriptive statistics with percentage and number for each series.

## RESULTS

Seventy pre and post surveys were completed. The students on placement were drawn from four Sydney, NSW, Australian based universities (University of Sydney, University of Technology Sydney, Western Sydney University and the Australian Catholic University).

### PREEXISTING EDUCATION

The amount of education provided regarding HIV varied between universities. No education was provided to 18% (13), 53% (37) received less than four hours, 21% (15) received four to eight hours and 8% (five) received over eight hours. A small percentage (13%, nine) felt prepared to



provide care to PLHIV whilst on clinical placement due to the education they had received from their university. Following completion of the module the participants stated that they felt their preparedness to care for PLHIV had improved, with an increase to 98% (68).

### CARING AND CONCERNS

Twenty three percent (16) said they had previously provided cared to PLHIV; of those who had not 51% (36) were concerned to do so. There was a multi choice question that all respondents could choose multiple responses regarding concerns:

- 70% (49) felt unprepared to care for someone with HIV infection;
- 69% (48) were concerned at having poor HIV knowledge;
- 57% (40) were concerned about HIV transmission to themselves;
- 49% (34) said they felt uncomfortable about how to talk to the person about their HIV infection;
- 41% (29) were concerned about HIV transmission to other people in their life;
- 12% (eight) had no concerns caring for PLHIV; and
- 61% (43) did not know the life expectancy of PLHIV.

### INFECTION CONTROL

Twenty per cent (14) didn't know whether PLHIV had to be nursed in isolation and 32% (23) thought additional infection control requirements were needed. Following completion of the module this declined to 7% (five) regarding need for isolation and 25% (16) requiring additional infection control. Eighty per cent (56) thought that PLHIV had to notify their HIV positive status to their healthcare professional (which in NSW is not the case<sup>5</sup>, although it is advised for optimal healthcare).

### POST EXPOSURE PROPHYLAXIS

Thirty nine per cent (27) had knowledge of PEP prior to completing the education but only 12% (eight) knew how to access PEP. Post-survey knowledge regarding PEP including how to access increased to 98% (69).

### STIGMA AND DISCRIMINATION

All respondents identified that stigma and discrimination were issues for PLHIV, yet 98% (69) reported watching the videos of HIV positive speakers increased their awareness and the impact on PLHIV of this.

### FUTURE CARING FOR PLHIV

Following the education 98% (69) said they felt more prepared to care for PLHIV and that the module increased all the respondents (100%) awareness of issues for PLHIV. Ninety three per cent (65) would recommend the module to their colleagues with 7% unsure.

### DISCUSSION

UGNs had varied levels of education from their university and personal exposure to caring for someone with HIV. Education designed by experts can have a positive impact on the PLHIV's experience of the health system<sup>8</sup>, which can affect access to care.<sup>3,6,7</sup> This online module designed by expert HIV nurses for UGNs to complete resulted in improved awareness of issues for PLHIV and their preparedness to care for PLHIV. This is important as PLHIV contact with other non-HIV clinical areas will increase and may not necessarily be related to HIV infection.

Infection control and additional precautions continue to be matters that nurses consider when relating to HIV transmission as many UGNs thought additional measures were needed and some thought PLHIV required nursing care in isolation. This shows a need to maintain updated information and follow existing infection control policies. Although some nurses had some knowledge of PEP most did not know how to access PEP which is a key measure to prevent occupational transmission of HIV.

Many PLHIV have experienced stigma and discrimination in the health system<sup>3,4</sup>. Although all the UGNs had an understanding of this they said that hearing PLHIV stories increased awareness of the impact of their care behaviours. This is important for PLHIV as stigma and discrimination in the health system can lead to poor access to care and health outcomes<sup>5</sup>. Although UGNs identified many concerns about providing care to PLHIV such as limited HIV knowledge and how to talk to PLHIV, following completion of the module improvement was noted and the vast majority stated they felt better prepared to provide care.

There were some limitations to the survey questions. Current year of education was not asked which may have impacted on the receipt of HIV related education; gender, age or cultural or religious background of the UGNs which may have provided information about their life experience and attitudes, though questions were asked regarding their own experience they had with HIV. We did not explore whether completing the module improved their confidence but the authors felt the improvements in post survey values



noted an increased preparedness to care for PLHIV in the future. Additionally reasons for not recommending the module could be explored<sup>6</sup>.

### OPPORTUNITIES TO ADDRESS

University level education varied and knowledge and experience of UGNs reflects that. There were several key areas that the authors wanted to increase UGNs knowledge such as HIV treatments, current infection control information, how stigma and discrimination can impact care, knowledge of PEP with the aim to support UGNs with information to enhance care for PLHIV.

SLHD covers a large geographical area with five community health centres. The HIV and Nursing Education Module was developed to provide all UGNs attending community clinical placement within SLHD with standardised education regarding HIV.

Pre-survey knowledge on infection control and isolating PLHIV was not current from a clinical perspective regardless of education at undergraduate level, this remained for a minority of the UGNs. This may be due to an imbedded cultural belief around the acquisition of HIV that can be combated by the provision of information from trusted and credible sources. A key objective was to improve knowledge of PEP and how to access PEP for any future risks of occupational HIV transmission and results reflected that knowledge had improved for UGNs.

Surveys following completion of the module showed improvements in UGNs knowledge and belief that could provide improved, non-discriminatory nursing care to PLHIV.

### CONCLUSION

Improved knowledge and awareness of issues relating to HIV can have a positive impact on PLHIV. Every nurse can improve the experience of PLHIV within the health system. Completion of specific HIV education can prepare UGNs to be that nurse.

### Acknowledgement

The authors would like to thank Keiran Harvey from CEWD, SLHD for his support and assistance with developing the Module LMS platform; the staff of Positive Speaker Bureau, NSW and the three positive speakers whose stories showcased the lived experience of PLHIV.

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**Daniel Crute**  
Federal Industrial Officer

## ANMF win against employer attacks on Award

**In January 2020, the Australian Industry Group (Ai Group), representing several private hospital associations, made an application to reduce the rate of pay for casual nurses, midwives and nursing assistants employed under the Nurses Award.**

Ai Group argued the Award was ambiguous and/or uncertain concerning the rate payable to a casual employee for work performed during overtime, weekends and public holidays.

Their preferred interpretation of the Award would have meant casual employees working during these times would be paid less.

In the alternative, Ai Group argued that amending the Award was necessary to meet the Modern Awards objectives.

While most ANMF members work under a collective agreement, some still rely on the Award to determine their terms and conditions of employment, including their rates of pay.

This is particularly the case for ANMF members working in the private sector for employers such as medical practices, day hospitals, specialists' clinics etc.

For other members, the Award is important because any collective agreement is assessed against the conditions within it to ensure it passes the Better Off Overall Test (BOOT).

The ANMF Industrial Team vigorously defended the application before a Full Bench of the Fair Work Commission.

We were able to demonstrate that the case law on the matter was in our favour.

The QNMU Branch of the ANMF had a Full Bench decide a similar issue in their favour concerning the rates of pay for employees covered by an enterprise agreement for Domain Aged Care' less than two years ago.

If Ai Group had been successful in their claim, it would have meant significant decreases in pay for

casuals working overtime, weekends and public holidays.

While this case was largely fought on technicalities and legal argument, there would have been 'real world' consequences for some casual ANMF members with their rates of pay reducing when working unsocial hours.

It would have meant that casuals employed under the Award would have had the following percentage decreases in pay:

- Saturday and first two hours of overtime  
Monday–Saturday: 6.68%
- Sunday: 8.57%
- Public holidays, overtime after two hours  
Monday–Saturday, all overtime on Sunday: 10%
- Overtime on public holidays: 12%

For further information comparing the pay role breakdown for casuals employed under the award go to [anmj.org.au](http://anmj.org.au)

In January 2021, the FWC handed down its decision in the matter, rejecting the Ai Group's case in its entirety.<sup>2</sup>

With respect to the argument that the Award was ambiguous and/or uncertain the FWC rejected that there was any ambiguity or uncertainty. With respect to the Modern Awards objectives, the FWC noted that the Ai Group's submissions were "largely unsupported by evidence" and this lack of evidence was "fatal to Ai Group's case".<sup>3</sup>

Hopefully, this decision will dissuade other employer groups and employers from having another attempt to undermine Award conditions, at least for the foreseeable future.

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1. ANMF v Domain [2019] FWCFB
2. [2021] FWCFB 115
3. Ibid., at [79]

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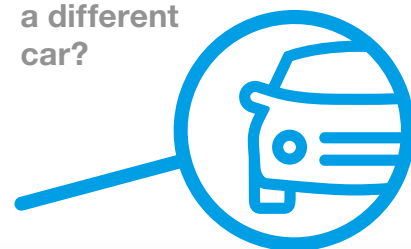
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†Negotiated Smartleasing buying power discount on chosen vehicle may vary.



# Palliative Care provision during COVID-19 – Reflections of Clinical Nurse Consultants

By Anita Haines, Kirsten Mitchener, Loretta Williams, Marianne Phillips, Fiona Grimaldi and Margaret Shaw

**The COVID-19 pandemic presented unprecedented challenges for healthcare services. The provision of the Palliative Care Consultancy Service at Western Health, a major metropolitan health service in Melbourne, Australia, was no exception.**

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During 1 April – 30 September 2020, a retrospective audit revealed a total of 65 deaths from COVID-19, with 50 patients referred to the Palliative Care Consultancy Service. The majority of these patients (41) were seen by Clinical Nurse Consultants (CNCs).

There are many rewards of palliative care nursing; not least of which is the human connection to patient, carer/family and relationships built with care providers.

COVID-19 necessitated significant changes in this practice as CNCs navigated new ways of working as separate teams and communicating with families via virtual interactions.

To reduce risk of COVID-19 transmission to other wards and limit the impact of team exposure; CNCs divided into two working groups at two separate sites and only worked on the COVID-19 wards for two weeks at a time. Cross campus travel was forbidden.

Staff on the COVID-19 wards faced significant pressures and challenges. The CNC's role became focussed on imparting decades of skills in minutes. CNCs endeavoured to prepare junior doctors for discussions regarding end of life care and handling emotive conversations. Palliative Care provision for COVID-19 patients focused on ensuring teams knew how to access prescribing guidelines available online, providing symptom management and end of life care, whilst supporting ward staff.

A major challenge for the CNCs was donning personal protective equipment (PPE) and switching to time limited interactions with patients dying from COVID-19. Repeated visits were often performed indirectly with the nurse caring for the patient and through observation.

Patients dying from COVID-19 were frequently referred late in their illness. The median time from referral to death being three days, leaving little time to build up any rapport with families. Most families

were negatively impacted by hospital visitor restrictions with a majority of patients dying alone.

PPE became a visible barrier between patients, families and hospital staff. Families who visited were not familiar with donning PPE and were often afraid and anxious of becoming infected.

CNCs are experts in preparing families for dying and face-to-face bereavement support. This practice was impacted during COVID-19 as visiting bans and restrictions led to more virtual interactions. Treating teams and social workers took on the role of providing updates to families. Further contacts with families from the CNC team were met with varied responses and were often filled with anger at visitor restrictions.

CNCs found it confronting to be repeatedly exposed to the level of loneliness and distress many patients on COVID and non-COVID wards expressed. Many had no visitors throughout their admission, and CNCs noted that wearing PPE was restrictive as patients were unable to see facial expressions or a comforting smile.

During the pandemic, palliative care consultancy referrals grew by 33%, not as a direct result of COVID-19, but a sicker patient demographic and decrease in length of hospital stay. The focus turned to rapid referrals and discharges to community services for symptom management and end of life care at home.

Daily debriefings became the norm across the organisation and weekly cross campus team meetings were conducted via Zoom. CNCs at each campus noted increased bonding within their site team during the uncertainty. Virtual meetings led to a loss of camaraderie and heightened isolation, with each team relying on each other rather than the overall team for support.

One CNC had to self-isolate at home, which required a role change to data entry, referral writing and virtual multidisciplinary team meetings, and led to feelings of guilt and disconnection from the team.

CNCs noted numerous stressors during the pandemic from working with heightened levels of patient, family and staff emotional distress, constantly changing guidelines and working environment. Repetitive actions of removing clothes and shoes and showering on arrival home for fear of becoming infected and bringing COVID-19 home, social isolation, and home schooling, had a cumulative effect on CNC stress levels.

Repetitive COVID screening whenever patients on non COVID wards exhibited COVID-19 like symptoms or failed to divulge potential exposure, also heightened anxiety.

Learnings from the pandemic were the need to build greater connections across separated teams and staff working at home and to focus more on self-care.

Positively, existing relationships with the Aged Care Team and COVID-19 wards strengthened during the pandemic through shared clinical responsibilities, collaborative education sessions and mutual support.

We wish to acknowledge our clinical colleagues at WH who continue to provide dedicated care to patients during the pandemic and beyond. Caring for patients dying from COVID-19 remains a privilege.

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# A lasting legacy: ANMF (Vic Branch) Assistant Secretary Pip Carew bows out

By Robert Fedele

**A fierce advocate for ANMF members for almost 20 years, ANMF (Vic Branch) Assistant Secretary Pip Carew retired in February.**

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Pip Carew was studying a Bachelor of Arts at university when she stumbled into nursing.

To make ends meet, she took up a part-time job as a cleaner at an aged care facility and quickly became inspired by the nursing staff's quality of care.

"I just loved the way the nurses looked after the residents," Pip recalls.

"It was quite influential for me, seeing how the aged care facility was run so beautifully. It was a small facility and a real team. I was attracted to the way nurses provided care and the work that they did."

With a newfound passion, Pip changed tack and set out on the path to becoming a registered nurse, undertaking her training at the Alfred Hospital.

During her clinical career, she worked across several diverse settings, including public and private hospitals, community health, neurosurgery and aged care.

Looking back, her experience working at a nursing home in the 1990s and determination to speak out to improve the rights and working conditions of staff, as well as the quality of care for residents, laid the

foundation for a future career and leadership roles with the ANMF (Vic Branch).

Disturbed by the working conditions and inadequate level of care at the aged care facility, Pip, with her ANF organiser's support, raised the issues with management, rallied staff, and stood up to drive change.

Some of the issues included heating not being put on overnight until nursing rounds were carried out; staff having to get residents up at 5 am to begin washing them; and food being locked up after 6 pm, meaning residents were often left hungry.

Complaints reported by Pip to the authorities added to investigation material and ultimately there were sanctions imposed against the nursing home and a federal police investigation into its financial practices regarding Commonwealth funding.

Taking action was Pip's first connection with the ANF and she says the support of her organiser left an indelible impression.

"She was really supportive and I thought 'wow, what a great job and what a difference it has made to me'. I would love to do that too."

Pip became a Job Rep in 1997 and was appointed to Branch Council in 1999. She began working for the ANF (Vic Branch) as an information officer, then became an organiser in 2001.

In her role as an organiser, which spanned almost a decade, Pip endeavoured to pay it forward by providing members with the same level of support and assistance that she was afforded.

She says the role demands the ability to develop meaningful relationships with members, as well as management, across a variety of workplaces, to improve working conditions for staff and outcomes for patients.

Pip was elected Assistant Secretary in 2010, describing the opportunity to lead Victorian members as a privilege.

"It's been such a great privilege to be part of a great team," she says.

"Working with Lisa [Fitzpatrick] and Paul [Gilbert] has been terrific over the last ten years. Their passion for the work and their commitment to the members has really influenced me.

"Being involved with the Branch and Branch staff in our unified objectives, working for nurses, midwives and carers has also been a great privilege. As a nurse myself, I know the effort and commitment it takes, and sometimes the sacrifice, with the shift work that you do and the difficulties the profession presents in so many clinical areas. It shows you just how important [our work] really is and it makes such a big difference to people's health outcomes. It's just been a really great thing to do and I couldn't have wished for a better working life."

During her career with the ANMF (Vic Branch), Pip represented members throughout several enterprise bargaining negotiations, including the current 2020-24 EBA campaign.

Her leadership and influence during the 2011-2012 general public sector 'Respect our Work' EBA campaign to save nurse/midwife patient ratios, where the then Baillieu/Napthine Coalition government tried to replace nurses and midwives with nursing and midwifery assistants, ranks among the most memorable.

"When you start an EBA campaign you know you have to go through a number of different processes and that there's always going to be an end, but we didn't anticipate the hurdles and difficulties," she says of the nine-month campaign.

"The longer something goes on, it's a strain for everyone. It's a strain for the ANMF staff who are out there supporting members in the workplace and a strain for members



Pip gives petitions to the then Health Minister David Davis



Pip with ANMF Vic Branch Assistant Secretary Paul Gilbert and ANMF Vic Branch Secretary Lisa Fitzpatrick

in the workplace who have to maintain momentum and the conviction.”

The ANMF (Vic Branch) won the fight to protect nurse/midwife patient ratios and Pip says the campaign continues to serve as a reminder of the power of the collective.

“The members were just so fantastic. They are just so committed to ensuring patients receive the best possible care. The campaign was about keeping our nurse/midwife patient ratios and the fortitude and strength members showed was a real boost for the ANMF and staff. Being out there with our members to achieve that outcome was really inspiring.”

In retiring, Pip also leaves behind a strong legacy when it comes to the ANMF (Vic Branch’s) leadership and commitment to reducing the state’s health services’ environmental impact.

With support from ANMF (Vic Branch) Secretary Lisa Fitzpatrick, Pip helped establish the branch’s annual Health and Environmental Sustainability Conference.

The conference aims to promote how sustainability initiatives can improve current health practices and mitigate healthcare services’ environmental footprint. At the conference, members learn

new ways to reduce waste and promote sustainability in their workplaces and communities.

“When you work in hospitals, you see the waste and you just know it’s not sustainable and that there are better ways of doing things. The response from members, who similarly were aware of the impact of healthcare on the environment, and how that could be improved, has been very motivating.”

At a national level, Pip has contributed her support across a number of the ANMF’s core campaigns, such as the push for mandated aged care ratios, as well as its advocacy for broader causes, like marriage equality and climate change.

She lists aged care as a priority and believes meaningful change can occur in the sector.

“Over the last 20 years I’ve been involved with the ANMF, I’ve watched the decline of private aged care, with the substitution of registered nurses leaving the profession impacting clinical care. We understand the difficulties we would have had if we hadn’t been able to retain nurse/midwife patient ratios in the public health system and the impact on quality of care. The momentum is there for aged care and I’d love to be around to see that change happen.”

As Australia’s largest union, Pip is filled with pride that the ANMF’s voice and influence continues to grow. She says members are the union’s biggest asset.

“We’re only as strong as our members,” she says.

“The more members you have, the better outcomes you can get. My message to those who are members is recruit in your workplace, particularly in workplaces like aged care, where we have the opportunity to really enhance outcomes for the people who are working there and for the residents living there. For those who aren’t members, join up and be part of the change.”

Reflecting on her career with the ANMF (Vic Branch) after announcing her retirement, Pip says the best part was working as part of an effective and influential team to achieve important outcomes for members, headed by historic nurse/midwife patient ratios.

“I feel very fortunate because I’m leaving when I still love the job. It’s a really good time for me to leave and I’ll certainly be keeping in touch and following the issues from afar that are really important to us, like mental health and aged care.”



# Asthma Management

By ANMF Federal Education Team

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**Asthma is a common chronic condition that affects the airways. People with asthma experience episodes of wheezing, shortness of breath, coughing, chest tightness and fatigue due to widespread narrowing of the airways.<sup>1</sup>**

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

Asthma affects about 11% of the Australian population. That equates to approximately 2.7 million or one in nine Australians.<sup>2</sup>

Asthma attacks can come on gradually or quickly. When asthma occurs as an acute attack, the airflow restriction can be life-threatening. Each year approximately 400 people in Australia die from asthma.<sup>3</sup> Therefore, skilled patient education is vital for effective asthma management.

Asthma is a common inflammatory disease of the airways. It is debilitating and potentially life-threatening, rising in incidence and has no cure.

Normally the airways are open and relaxed, allowing air to easily move in and out. People with asthma have sensitive airways that are primed to react to triggers in the environment, leading to an asthma attack. These triggers vary between different people.

#### **Triggers include:**

Pollen, dust mites, mould spores, the common cold, thunderstorms, aspirin, obesity, sinusitis,

viral exposure in children, work-related asthma, gastroesophageal reflux disease (GERD), exercise, food, pet dander, bushfire smoke and environmental irritants such as cigarette smoke and pollution.

Asthma is a condition in which the airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, wheezing when the person exhales and shortness of breath.

For some people, asthma is a minor nuisance. For others, it can be a major problem that interferes with daily activities and may lead to a life-threatening asthma attack. Asthma can't be cured, but its symptoms can be controlled.<sup>4</sup>

#### **In clinical practice, asthma is defined by the presence of both of the following:**

1. Excessive variation in lung function; and
2. Respiratory symptoms that vary over time and may be present or absent at any point in time.<sup>5</sup>

#### **The pathophysiology of asthma is complex and involves the following components:**

- Airway inflammation;
- Intermittent airflow obstruction; and
- Bronchial hyper-responsiveness.<sup>6</sup>

**The underlying cause of asthma is not completely understood, however evidence suggests that the risk of developing the disease may be significantly increased by:**

- A positive family history (indicating genetic predisposition to the disease);
- Presence of allergies, such as atopic dermatitis or hay fever;
- Environmental factors such as exposure to allergens/cigarette smoke;
- Lifestyle – active and passive smoking;
- Obesity; and
- Genetic factors (eg. genetic predisposition to allergies).

#### **Morbidity and mortality may be significantly decreased with:**

Appropriate diagnosis, patient education, use of appropriate drug therapy, identification of triggers and reducing contact with them, self-monitoring of signs and symptoms, regular medical review and having a written asthma action plan.

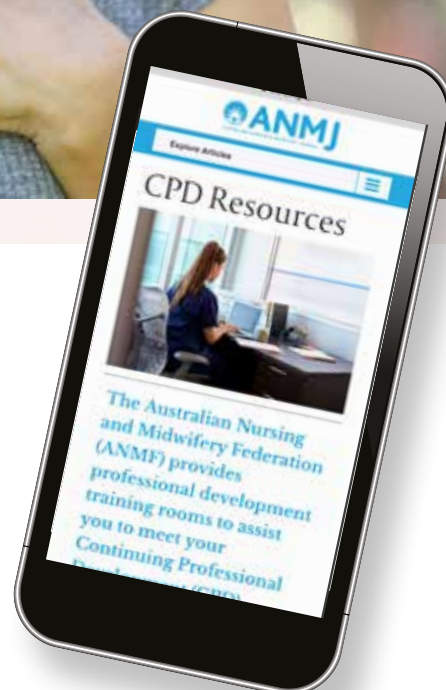
Unfortunately, only one in four people aged 15 years and over have a written asthma action plan. The good news is that 67% of children (under 15) do have an asthma action plan.<sup>7</sup>





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**3 HOURS  
CPD**

**The following information is a snap shot from ANMF's Asthma Management tutorial available on the Continuing Professional Education (CPE) website.**

The complete tutorial will give you three hours of CPD and covers the following topics: Asthma facts, pathophysiology, etiology, epidemiology, signs, symptoms and triggers, clinical presentation, diagnosis, prognosis, patient education, asthma and allergy, asthma medications, medication administration, spirometry, peak flow meters, asthma action plan, complications of asthma, respiratory assessment, acute asthma attack, first aid for asthma.

To access the complete tutorial go to [anmf.cliniciansmatrix.com](http://anmf.cliniciansmatrix.com)

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

For further information, contact the education team at [education@anmf.org.au](mailto:education@anmf.org.au)

[anmf.org.au/cpe](http://anmf.org.au/cpe)



**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*

## Poor clinical governance leads to a 10 year disqualification

**A recent tribunal finding against a Director of Nursing is a timely reminder to those in supervisory positions that they may share accountability when their staff fail to provide safe and competent care – particularly where there is evidence of a lack of good governance and clinical leadership.**

Following the discovery of a cluster of stillborn and newborn deaths at the Bacchus Marsh Hospital (run under the authority of the Djerriwarrh Health Services (DjHS)) in 2015, an external review of obstetric services was conducted. This review identified 'catastrophic and unprecedented systemic governance failings within the service' including a recurrent issue of staff misinterpreting Cardiotocography (CTG) used in fetal surveillance, highlighting a workforce inadequately skilled in this area.

As a result, a number of notifications regarding the professional conduct of several medical officers, nurses and midwives were made to the Australian Health Practitioner Regulation Agency.

The investigation of the professional conduct of two midwives resulted in findings of professional misconduct in relation to their lack of knowledge and skill in their practice. A third investigation focused on the conduct of the DON, Mrs Meek – which also found professional misconduct regarding her failure to provide adequate leadership and clinical governance in the service.

In 2005, Meeks, an RN and midwife for more than 20 years, was appointed to a senior leadership role at DjHS, and continued on in executive roles from 2008. As the DON, she was responsible for ensuring that reliable and safe high quality nursing and midwifery practice and patient care was provided by staff which met the professional codes of conduct and practice standards as published by the NMBA. The DON's responsibilities included monitoring performance, identifying gaps in effectiveness and taking action when gaps were identified. It was noted that both the health service management team and the midwifery management team – which included the DON, were responsible for ensuring the midwifery workforce were skilled in CTG.

The investigation into the DON's practice during these adverse events resulted in four allegations against her concerning her failure to perform her role according to the standard expected in that she:

- Should have been aware of the lack of knowledge and skills of the midwives involved in cases where there were adverse outcomes and should have taken steps to ensure these knowledge deficits were identified and addressed, particularly as she had been advised some staff had not completed required online training in this area and took no steps to ensure this was done.

- Failed to take adequate steps to ensure there was a midwife competent in fetal surveillance monitoring in the birthing suite on each shift. Although the DON was not responsible for the actual roster, her lack of robust oversight of midwives successfully completing the fetal surveillance training enabled them to be rostered to the birthing suite without having demonstrated competency in CTG.
- Shared both operational and professional accountability to ensure that the only admissions to the unit were suitable at the level of the capacity of the DjHS and failed to have clear written guidelines addressing admission or transfer criteria to be implemented for maternity cases of less than 37 weeks that were compliant with the Maternity Capability Framework.
- Failed to provide professional leadership through adequate peer and multidisciplinary review and conduct robust investigations of adverse events such as perinatal deaths when her position carried an express duty to undertake such investigations and to ensure appropriate action was taken, including the implementation of practice recommendations.

The external review identified systemic failings in the Obstetric service of DjHS at the time, however despite this expert opinion, concluded there were many warning signs that should have triggered the DON to take action that would have improved clinical safety and ensured the service had a suitably skilled workforce, as well as identifying the need to take robust action to address performance issues and gaps in the service.

It is clear each staff member is responsible for ensuring they have the knowledge and skill to perform their role and will be held accountable for failing to do so. However, as this case demonstrates effective leadership and clinical governance skills are necessary to oversee all components of a service and when these are deficient, and fail to address systemic issues, patient safety is put at risk.

The Tribunal considered the DON's conduct a serious abrogation and departure from her professional duties and obligations, which constituted professional misconduct issuing a reprimand and a 10 year disqualification from practicing as a nurse or midwife.

### Reference

Nursing and Midwifery Board of Australia v Meek (Review and Regulation) [2021] VCAT 68.





## Nurse-led remote HITH program provides safe and effective care for patients with COVID-19

By Doris Vella, Meagan Thomas, Jason Pak, Karen Aarons, Raja Devanathan and Belinda Scott

**The SARS-CoV-2 (COVID-19) crisis presented an unprecedented challenge to the Australian health system. From initial identification in December 2019 in Wuhan, China, its spread has been exponential. In Australia, confirmed cases grew from 25 at the start of March 2020 to over 6,000 six weeks later.'**

Available medical evidence and modelling at that time suggested that mortality rates would be high and ICU bed capacity overwhelmed.<sup>23</sup>

Based on health advice, the Australian government's response was to expand health system capacity, such as increasing ICU capacity and cancelling elective surgery, as well as to slow the spread of the virus by measures such as widespread testing and by restricting travel, social gatherings and business activity.

But amid these broad responses to the pandemic, there was little direction given

to frontline health providers on how to manage individual cases of confirmed infection in the early months. Given that a confirmed case carried an infection that was highly infectious, potentially severe, and with significant occupational, social and public health implications, this was no small matter.

### REMOTE MONITORING MODEL OF CARE FOR COVID-19

Djerriwarrh Health Services (DjHS), a peri-urban health service West of Melbourne, responded to the need to both expand bed

capacity and to safeguard the occupational health and safety of staff by adapting their Hospital In The Home (HITH) program into a dedicated program for remote clinical monitoring and managing of confirmed COVID-19 cases.

The HITH COVID program began in March 2020. COVID positive cases from the health service's fever clinic were automatically referred to the HITH COVID program by the health service's doctors who also informed the patient and notified the Department of Health and Human Services (DHHS).

Once a patient was admitted to the program, they were provided with a thermometer, pulse oximeter and comprehensive COVID information pack by courier.

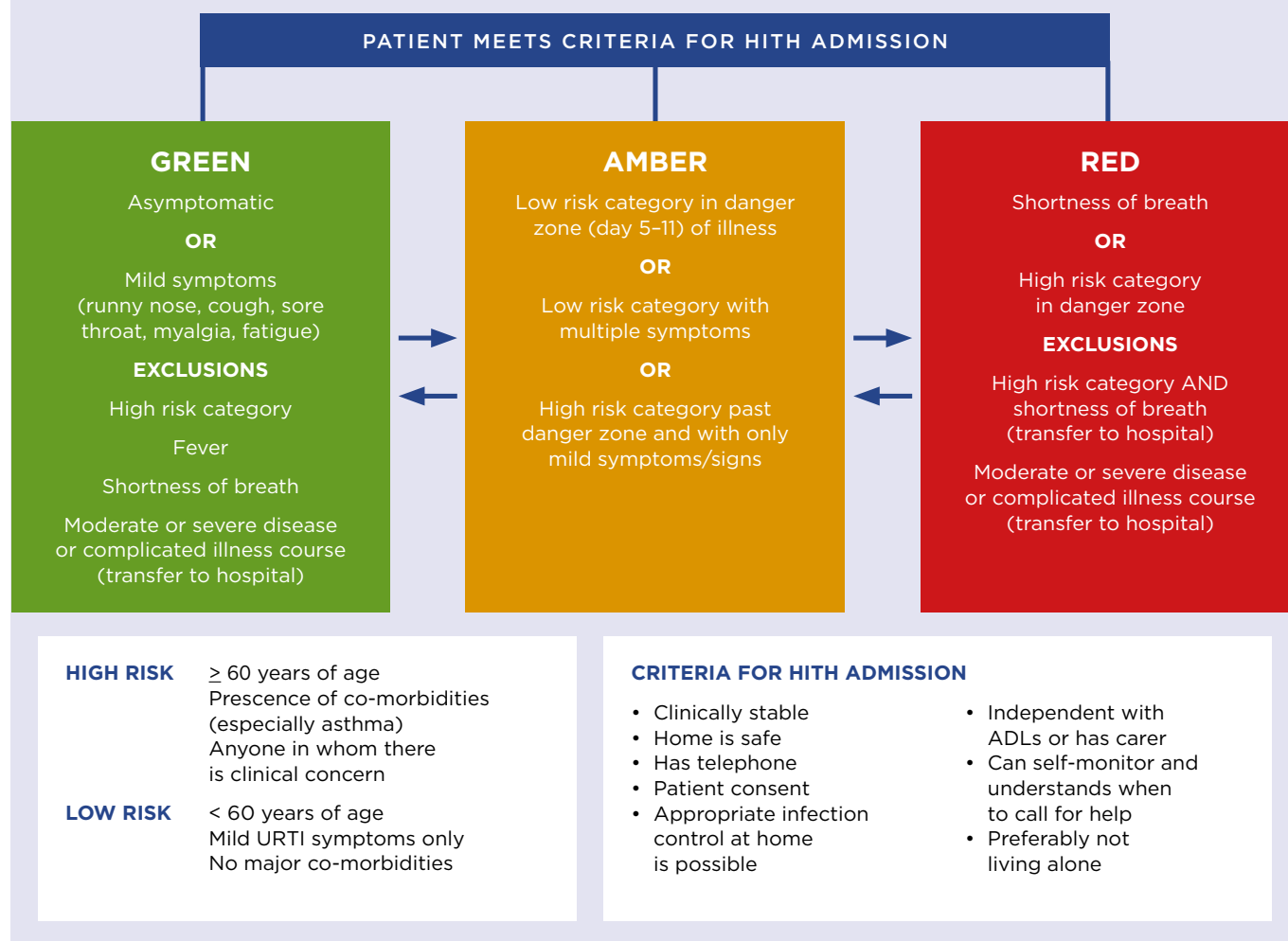
Assessments were undertaken by telehealth. At the initial admission assessment, the patient's symptoms, co-morbidities, presence of close contacts, and the suitability of their home for self-quarantine were assessed.

Education was also provided on how to use the provided equipment, isolation requirements and the symptoms of deterioration that they needed to monitor for.

Patients had daily review assessments to monitor their symptoms, vital signs and general wellbeing. Acute deterioration or deteriorating trends detected by nursing staff were escalated for medical review and/or transfer to a tertiary hospital.

Daily reviews by nursing staff continued until discharge from the program, which occurred once the patient had no or

FIGURE 1: TRIAGE CATEGORIES



minimal symptoms and had received medical clearance from DHHS.

### EVOLUTION OF THE PROGRAM

The program evolved to meet increasing demand. In the beginning, all admissions were made by the newly appointed HITH general practitioner (GP) and all reviews by the HITH program coordinator.

As admissions rapidly increased, HITH staffing was augmented by nurses redeployed from elsewhere in the health service, such as theatre.

To improve patient safety, a 'traffic light' triage system of patient risk assessment was developed.

Referrals were triaged by the HITH program coordinator using the triage tool to assign a risk category to the patient. Consultations were then tailored to the risk rating. Red and amber category patients received at least twice daily phone reviews and regular

consults with the GP. Green category patients received daily reviews with a nurse.

### See fig.1: Triage categories

Experience soon showed that patients who deteriorated did so between day five to 10 of their illness, especially if there was pre-existing asthma. The protocols were adjusted so that between day five to 10, green zone patients may be moved to the amber zone, depending on their symptoms, while amber and red zone patients had an increase in the frequency of their observations and clinical reviews.

An escalation protocol, triggered by specified clinical conditions or alteration in clinical parameters, was developed and aligned to the track and trigger clinical deterioration tool used in the health service. The protocol involved the nurse escalating any deterioration to the medical staff for patient review. At this point,

options included an urgent GP telehealth consultation, transfer to Urgent Care for a physical assessment, or immediate transfer via ambulance to a tertiary hospital.

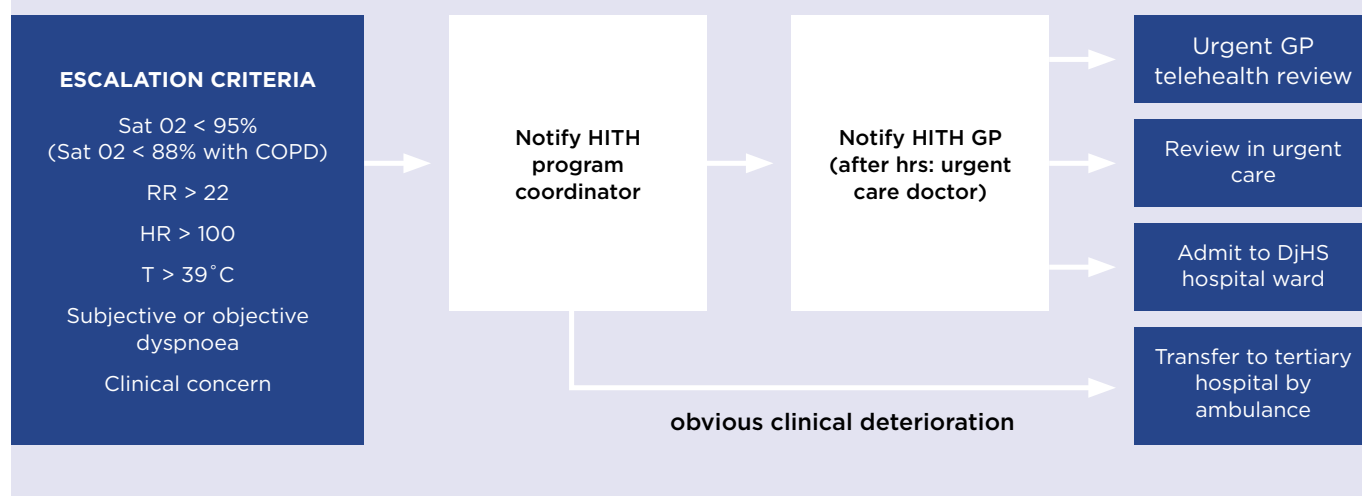
### See fig. 2: Clinical deterioration protocol

Although the program was able to be led and operated by only nurses, a generalist doctor helped by providing care for patients' multi-faceted medical issues (such as COVID-related symptoms and complications, chronic disease issues and mental health problems) and by helping to discriminate which deteriorating patients warranted transfer to hospital.

Nurses were able to discharge green zone patients who met discharge criteria. Red and amber zone patients were discharged by the GP. A DHHS clearance certificate, which may be issued after discharge from HITH, was required before patients could leave quarantine.



FIGURE 2: CLINICAL DETERIORATION PROTOCOL



## OUTCOMES

A total of 416 patients were treated over the program's six-month course, the largest number of confirmed COVID patients managed by any health service in the Western Metropolitan region.

The program was successful in detecting clinical deterioration. Eight percent had deterioration significant enough to require transfer to a tertiary hospital. Of the patients transferred, 12% required ICU admission and 55% were admitted to a tertiary hospital ward. There were no deaths.

Anecdotally, the patient experience of the program was quite positive. Many reported that they felt supported as the program also delivered many tailored non-clinical benefits that enabled patients to successfully quarantine to limit the spread of infection and to adhere to COVID regulations.

Food packs and regular medications were delivered to isolated patients. The details and wellbeing of household members were monitored. Hotel accommodation was arranged with DHHS if home quarantine was not possible. Patients' GPs were kept informed. Patients had access to advice on matters such as when they could return to work and when household members need to self-isolate or be tested.

## DISCUSSION

The remote management model of the DjHS COVID program made it easy to scale up program capacity. Prior to the pandemic, the DjHS HITH program was a small team with restricted capacity for community nursing visits for issues such as wound care and intravenous antibiotics for uncomplicated infections. With remote monitoring, the program expanded to a peak of seven nurses, HITH program manager and one GP providing daily contact to 150 patients.

Additional benefits of DjHS's remote management program was to conserve public hospital beds, protect staff and conserve personal protective equipment.

In hindsight, a remote monitoring model, with pathways for clinical deterioration, is the obvious way to manage confirmed cases of COVID-19. A similar remote monitoring model would also be suitable for managing other infectious diseases where patient contact is to be minimised, such as tuberculosis, gastroenteritis outbreaks or other novel respiratory infections.

A similar nurse-led remote monitoring model would also be suitable for monitoring chronic diseases with an established symptom profile, where regular monitoring is of benefit, requiring a minimum of simple to use monitoring equipment. Suitable chronic diseases include diabetes, COPD, asthma, heart failure and chronic pain. Given that chronic disease is common, with half of Australians estimated to have one or more chronic conditions,<sup>4</sup> there is a lot of potential in a remote monitoring model. This is especially so given that regional and remote areas have a higher burden of disease and poorer access to healthcare,<sup>5</sup> whereas delivery of a remote monitoring model is not limited by geography.

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Bree Green

Federal Professional Officer

# Infant formula manufacturers at it again

**Research has clearly identified breastmilk as the ideal nutrition for optimal growth and development, with numerous health-protecting qualities for both mother and infant widely established.<sup>1</sup>**

It is also recognised that there are circumstances where breastmilk substitutes are medically indicated or the preferred choice for families. Whilst the promotion of breastfeeding is an inherent and essential component of practice for midwives and nurses caring for families during early infancy and childhood, we also have a responsibility to provide evidence-based education and support to all families regardless of infant feeding method. Understanding and complying with the regulation of marketing of breastmilk substitutes supports both a positive breastfeeding culture, and accurate, clear information regarding breastmilk substitutes for the families who use them.

The ANMF advocate for strategies that promote a positive breastfeeding culture, and also respect and support families regardless of infant and child feeding choice. To this end, the ANMF recently responded to a consultation on the re-authorisation of the *Marketing in Australia of Infant Formulas: Manufacturers and Importers (MAIF) Agreement*, which is due to expire in 2021. The Australian Competition and Consumer Commission (ACCC) were reviewing a request they had received for the current MAIF Agreement to be re-instated for a further 10 years.

In Australia, the MAIF Agreement acts as a code of conduct for industries manufacturing breastmilk substitutes such as formula, regulating their ability to market their products and interact with the public and healthcare providers. This Agreement was adopted in Australia in response to the World Health Organization (WHO) *International Code of Marketing of Breastmilk Substitutes* (The Code), which aimed to protect the provision of breastfeeding. The Code recognises that there is a legitimate market for breastmilk substitutes where infants don't breastfeed but also seeks to ensure that breastmilk substitutes aren't marketed or distributed in preference to breastfeeding.

Our response to the ACCC highlighted several issues with re-authorisation of the MAIF Agreement. These included:

- The inconsistency of re-instating the Agreement for 10 years with the recently released *Australian National Breastfeeding Strategy (ANBS), 2019 and beyond*, which identified an immediate review of the MAIF agreement as a priority action area;
- The inadequacy of the current Agreement, as it only partially adopts The Code and hasn't been revised to include any subsequent World Health Assembly Resolutions such as those relating to advertising toddler milk;

- The widening gap between the Agreement and The Code enabling formula producers to access and market to the public and health professionals via social media platforms; and
- The ineffective complaints handling process when a company is in breach of the Agreement.

Breastfeeding education for health professionals is widely available however, education and understanding about the use and regulation of marketing of breastmilk substitutes is lacking. Midwives and nurses are in the optimal position to ensure that families receive accurate, evidence-based information on infant and child nutrition. The ANMF argued in our submission to the ACCC that, for midwives and nurses to perform this role, governments need to invest in transparent, independent research and education on the composition and use of breastmilk substitutes, as well as implement tighter restrictions on their marketing by manufacturers.

Achieving the changes required to ensure the MAIF Agreement complies fully with The Code will take time. Despite this, nurses and midwives can promote a positive breastfeeding culture and still support the proper use of breastmilk substitutes, by understanding and adhering to The Code and promoting the ANBS.

So what can you do?

- follow the national Breastfeeding Friendly Health Initiative, and the WHO, 10 steps to successful breastfeeding;
- don't support industry marketing or messages;
- don't accept gifts, samples or resources from industry representatives;
- don't support the use of any one breastmilk substitute brand over another;
- make sure breastmilk substitutes aren't advertised in your organisation; and
- seek out research on the use of breastmilk substitutes, which isn't influenced by manufacturers, to inform your practice.

If you identify a breach of the MAIF Agreement, you can make a complaint to the Australian Government Department of Health at: [www1.health.gov.au](http://www1.health.gov.au), so we can all keep the infant formula manufacturers honest.

To read the ANMF submission to the ACCC go to: [anmf.org.au/documents/submissions/ANMF\\_response\\_to\\_ACCC\\_re\\_INC\\_application\\_MAIF\\_agreement\\_30\\_November\\_2020.pdf](http://anmf.org.au/documents/submissions/ANMF_response_to_ACCC_re_INC_application_MAIF_agreement_30_November_2020.pdf)

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# Enhancing breast care nurses' involvement in treatment decision-making for women with breast cancer

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By Jing Liu, Dr Sharyn Hunter, Jiemin Zhu, Regina Lai Tong Lee and Sally Wai-Chi Chan

**Apart from radical mastectomy and breast-conserving surgery, more options are available today to women with breast cancer, such as neoadjuvant therapy, breast reconstruction and prophylactic surgery.**

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## INTRODUCTION

As treatment options become more complex, many women with breast cancer found it was challenging to make treatment decisions. In this context, the National Breast Cancer Centre (NBCC), Australia advocates providing appropriate and comprehensive supportive care to patients by a multi-disciplinary healthcare team during the treatment decision-making.<sup>1</sup>

## ROLES OF BREAST CARE NURSES

Breast Care Nurses (BCNs), also referred to as Specialist Breast Nurses, specialise

in breast cancer. The role of BCNs is well developed in Australia. The NBCC Australia proposed competency standards for BCNs in many aspects of breast care during diagnosis, treatment and follow-up.<sup>2</sup> They are well positioned to support women to make effective treatment decisions.

There are substantial differences in the BCNs workforce across countries.<sup>3</sup> Patients living in less-developed countries have limited resources to seek support from BCNs because such a position is not well established. For example, in China, due to the late introduction of this position, the

large numbers of women with breast cancer had no specialised nursing support.<sup>3</sup> Even in countries with BCNs, there are factors, such as workload, time constraints and lacking in skills, which limit BCNs ability to fulfil their role in helping women make a treatment decision.<sup>4</sup>

Further, research suggests BCNs do not play an active role in women's treatment decision-making process.<sup>5,6</sup>

A qualitative study in the US found only one in 39 patients recalled receiving emotional support and helpful information in understanding treatment choices from a BCN.<sup>5</sup> A literature review from Jordan demonstrated that BCNs had a small role in either information disclosure or treatment decision-making.<sup>6</sup>

## POTENTIAL STRATEGIES TO ENHANCE BREAST CARE NURSES' INVOLVEMENT

The power imbalance among healthcare team members might prevent other team members, such as BCNs, to play an active role in treatment decision-making.<sup>6</sup> Hence, BCNs' roles need to be clarified by the healthcare team, particularly emphasising their function in information support and psychosocial care.

Women should receive informational and psychosocial support from a BCN before treatment decisions.





Training programs, containing cancer treatment planning modules, might help increase BCNs' knowledge and skills to support treatment decision-making, such as Breast Cancer Distance Education<sup>7</sup> and EdCaN program in Australia.<sup>8</sup> BCNs should be provided with opportunities to attend similar programs.

The McGrath Foundation, a national program in Australia, was established in 2005.<sup>9</sup> Patients could access an assigned BCN via this program and receive one-to-one contact for professional informational support, emotional comfort and lifestyle guidance without a referral. This program has had considerable achievements in enhancing patients' experience as well as cost savings for the healthcare system.<sup>9</sup>

This program is a great example of BCNs' efforts to provide every aspect of breast care to patients, similar programs could be developed by other countries, by which BCNs in other countries could make a more significant difference.

The role of BCNs should be expanded in both developed and less-developed regions, such as increasing BCNs workforce, which could potentially promote their involvement and improve support. Since there is no uniform guideline regarding BCNs' role in decision-making, additional research is needed to provide evidence for developing their roles and promoting their functions in supporting treatment decision-making.

## IMPLICATIONS FOR PRACTICE

It is essential for BCNs to be actively involved in women's breast cancer treatment decision-making process. Four strategies may be useful:

- increasing the clarity of role;
- leveraging breast cancer support programs;
- strengthening knowledge and skills; and
- expanding the nursing workforce.

More robust studies concerning the roles of BCNs are called for to provide, evidence-based strategies for optimising BCNs' development.

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A man and a woman are practicing yoga on a wooden bridge in a park. The woman, on the left, has white hair and is wearing a white long-sleeved shirt and grey pants. The man, on the right, has a beard and is wearing a white t-shirt and light grey pants. Both are in a tree pose (Vrikshasana) with their hands in a prayer position (Anjali Mudra). The background features large trees, a green lawn, and a wooden fence. A large blue circle is overlaid on the image, containing the text "MEN'S & WOMEN'S HEALTH".

# MEN'S & WOMEN'S HEALTH





## \$8.5 million to continue long-term women's health study

**Australia's Longitudinal Study on Women's Health (ALSWH) will continue for another three years after the government committed \$8.58 million for the project late last year.**

"For a quarter of a century, the ALSWH has played a leading role in nurturing our understanding of how health issues impact on the everyday lives of women, how women negotiate these issues, and the ways in which women engage with the health system," Minister for Health, Greg Hunt, said.

"The study has been integral in guiding national approaches to developing services and supports that are tailored to women's needs, and provide the best means of realising improved health outcomes for women, at all stages of their life."

"The new funding will allow the study to continue to fulfil this important function at a time where improvements in the women's health space are being prioritised in response to the *National Women's Health Strategy 2020-2030*," he said.

"The views of everyday women have never been more valuable. Having such a robust and internationally renowned mechanism for informing national Policy on women's health is incredibly important.

"The study follows more than 57,000 women who are broadly representative of the entire Australian population, spanning four generations," Minister for Women, Marise Payne said.

"The three original cohorts were women born in the years 1921-26, 1945-51 and 1973-78. A new cohort of more than 17,000 women born in the years 1989-95 – who were then aged 18 to 23 years old – was added in 2013.

"As well as continuing the study, the additional funding will finance a project to improve the representation of women from South East Asia, North East Asia, and Southern Asia. This will focus on women in the two younger cohorts, who are currently aged 25 to 31 years old and 42 to 47 years old," Ms Payne said.

Partners in the ALSWH, the University of Queensland and the University of Newcastle will assess:

- Physical and emotional health – including wellbeing, major diagnoses, symptoms;
- Use of health services – GP, specialist and other visits, access, satisfaction;
- Health behaviours and risk factors – diet, exercise, smoking, alcohol, other drugs;
- Time use – including paid and unpaid work, family roles and leisure;
- Socio-demographic factors – location, education, employment, family composition; and
- Life stages and key events – such as childbirth, divorce, widowhood.

During 2020, the ALSWH also conducted a series of surveys and reports on women's experiences of COVID-19. They include information on living arrangements during the pandemic, involvement in paid work and home-schooling, and general health and wellbeing.

The information will help assess the impacts of COVID-19 on Australian women, the government has stated.



### Overcoming obstacles during COVID-19 to support men with prostate cancer

The Union for International Cancer Control (UICC) has revealed its member organisations in 55 countries, including civil society, hospitals, research centres and patient support groups, income and organisational activities are under significant pressure.

The union, which conducted a survey with over 100 members, revealed that almost three-quarters of respondents had reductions in their income of anywhere from 25 to 100% in 2020 and similar



projections for 2021. The Prostate Cancer Foundation of Australia (PCFA) has also been impacted, with the cancellation of community events and major fundraising activities.

Professor Jeff Dunn AO, PCFA's CEO and President-Elect of UICC said the organisation was working hard to overcome the obstacles of healthcare in a time of coronavirus.

"COVID-19 has changed the way we do things, requiring us to innovate in order to maintain our support of the 220,000 Australian men and families living with prostate cancer in this country."

Professor Dunn said one of their significant achievements was fast-tracking the establishment of a new Prostate Cancer Specialist Telenursing Service, the first of its kind in Australia.

"This simply wouldn't have been possible without the support of the cancer care community and the many thousands of Australians who give so generously to keep our work going."

Dr Cary Adams, UICC's CEO, said the oncology professionals' response throughout the pandemic had been heroic, providing an opportunity to find new ways of treating one of the world's most deadly diseases.

### Let's talk about Men's Health Week – 14–22 June 2021

**Why is Australian male health so in need of attention? Why work on men's health?**

According to Men's Health and Information Resource Centre it's because the health status of males in most countries, including Australia, is generally poorer than that of females.

More males die at every stage through the life course, more males have accidents, more males take their own lives, and more males suffer from lifestyle-related health conditions than females at the same age.

Meanwhile, men are less frequent visitors to general practitioners, and the perception is that they don't care about health or that health services are not well-prepared to interact with men effectively.

#### Men's Health Week

Men's Health Week was started in the United States by the US Congress in 1994 to heighten awareness of preventable health problems and encourage early detection and treatment of disease among men and boys.

In Australia, there were small and localised Men's Health Week events in Victoria and then in New South Wales from about 2000 onwards.

In 2002, the 2nd World Congress of Men's Health was held in Vienna and brought together six leading men's health organisations including MHIRC to run international events in June each year, just before the United States and the United Kingdom Father's Day.

#### The Vienna men's health declaration

The Vienna Declaration set out to establish:

- Recognising men's health is a critical issue and that there are health issues which only affect men;

- Promoting awareness of men's approach to health;
- Changing the way healthcare is provided to be more sensitive towards men's needs;
- Creating school and community programs which target boys and young men; and
- Connecting health and social policies to pursue men's health goals better.

In Australia, Men's Health Week provides a platform for challenging and debating key issues in men's health and to raise the profile of men, their health outcomes and health needs around the country each June.

The Men's Health and Information Resource Centre says their approach celebrates men's strengths, their contributions, and the important role they play in society.

For more information go to: [menshealthweek.org.au](https://menshealthweek.org.au)



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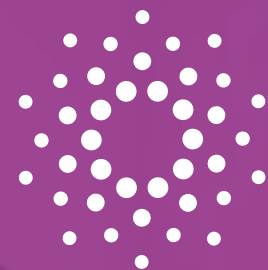


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## We're so 'o-vary' close to a cure

**We're so 'o-vary' close to a cure, says Ovarian Cancer Australia (OCA) Researchers who believe they've never been closer to improving treatment for the nation's deadliest female cancer.**

Currently, one woman dies every eight hours from the disease.

Ovarian cancer is the deadliest yet most underfunded female cancer in Australia. Currently, only 46% of women diagnosed will survive past five years. However, according to Ovarian Cancer Australia, 2021 is the year of hope as researchers believe they've never been closer to a breakthrough.

"Recent advances in our understanding of the disease have left us more optimistic than ever before that new treatments will be found for women with advanced ovarian cancer," said Professor David Bowtell one of Australia's leading translational ovarian cancer researchers.

"We now know that ovarian cancer is not one disease, but a spectrum of related diseases with unique genetic characteristics. This is creating the potential for developing more effective, personalised treatment options for women living with the disease."

Over 1,500 women are diagnosed with ovarian cancer each year in Australia and one woman dies every eight hours from the disease. That's three each day. And for around 70% of those with advanced disease who do achieve remission, the disease will come back.

"We need more evidence and more resources to improve the lives of the women with this horrific cancer," CEO of OCA Jane Hill explained.

Most women are diagnosed with ovarian cancer at an advanced stage, mainly because signs and symptoms are vague and are commonly experienced by many women. A lack of an effective screening test also makes early diagnosis incredibly hard.

For Chloe Spitalnic, this is what happened. At only 22, the Masters' student is much younger than the average female diagnosed with ovarian cancer.

"I was diagnosed with stage 3 low grade serous ovarian cancer in August 2020, two

weeks into Melbourne's stage 3 lockdown. It was a complete shock to be diagnosed with ovarian cancer, especially as there is no history of cancer in my family. I had never really heard of ovarian cancer affecting young women, making the whole experience quite isolating and scary," Ms Spitalnic said.

"I initially called my GP after a few days of pain in my abdomen, which I just shrugged off as normal body pains. I was very fortunate that my GP had treated ovarian cancer patients in the past and referred me to get an ultra-sound. A few months later and I've gone through two surgeries and four rounds of chemotherapy, but I'm determined not to let this get in the way of my Masters, and I'm happy to say I've managed to continue studying and even squeezed in an exam during this period too."

"From my experience, it's extremely important to listen to your body and always seek medical advice, no matter how minor the issue may be. I think as a country, we need to increase awareness of ovarian cancer and educate women of all ages that this cancer does not discriminate against age," Ms Spitalnic said.

## Australian longitudinal study on male health

The Australian Longitudinal Study on Male Health, also known as the Ten to Men Study, is a longitudinal population-based study which focuses on building a strong evidence base in male health. The study aims to inform the National Male Health Policy, programs and initiatives that promote males' health and support.

The study, *Ten to Men*, refers to the age range of the men and boys in the study – from 10 years old to adult men, began in 2011.

The study intends to follow participants over time, as they transition through the different stages of life, and examine health and lifestyle.

Around 16,000 Australian males aged 10 to 55 years across three age groups: boys aged 10 to 14 years; young males aged 15-17 years; and adult males aged 18-55 years. Parents of boys aged 10 to 14 years are also being interviewed.

The study is currently collecting data in its third wave. Health topics examined in this wave include:

- Demographic and background information;
- Health conditions;
- Sleep;
- Disability;
- Diet;

- Exercise;
- Mental health;
- Natural disasters and pandemics;
- Sexual health;
- Risk-taking;
- Drugs, alcohol and smoking;
- Health service use; and
- Relationships and support.

Details of the *Ten to Men Study* can be found at [tentomen.org.au](http://tentomen.org.au)



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Photos courtesy: Would Youth International

## Maternal health in Kenya made possible through an Australian health centre

By Christian Marchetti

**Imagine if you or your partner were about to give birth, and you could not access any healthcare whatsoever for yourself or your baby?**

This was a reality for mothers in western Kenya until 2013 when the Australian based charity, World Youth International's Odede Community Health Centre, was opened. Before 2013, around 70% of women in Odede gave birth in unsafe conditions, under the supervision of untrained midwives or female relatives.

It was estimated that one in five women lost their lives due to birthing complications in this region.

To help break the cycle of poverty within impoverished communities, World Youth International identified women needed adequate access to healthcare to experience healthy pregnancies, and deliver healthy babies.

The need for a safe Health Centre with trained midwives and nurses was a necessity.

Since the Health Centre's opening, maternal healthcare outcomes for women in the

region have significantly improved. In the 2019/2020 financial year, 696 women received antenatal care, 170 received postnatal care, and 137 babies were delivered safely.

Recently World Youth International opened a new Maternal Health Centre at the facility, which is furthering the positive impact that the Health Centre is having on the community.

This new facility means even more women in Kenya can access care and children can have the healthiest start to life as possible in already vulnerable circumstances. The Maternal Health Centre is situated adjacent to the Odede Community Health Centre and is currently staffed by two full time trained nurses. It will ensure women are progressing smoothly with their pregnancies and then receive support after giving birth as they embrace motherhood.

Last year, the Odede Community Health Centre was one of Kenya's first medical facilities to roll out a childhood vaccine for malaria prevention.

With Malaria being one of the most prevalent health issues in many Kenyan villages, this vaccination program will have a long-term impact on these communities and take the country closer to eradicating Malaria.

Fred Mito, the Director of the Odede Community Health Centre, has seen the devastating impact the illness has had on his community.

"Malaria is the biggest disease to burden the community of Odede every day. It keeps recurring and affects all people across the ages and genders. The most vulnerable

are the children and expectant mothers. It reduces the ability of families to work on their farms and produce food for their households. Children miss school quite often as they remain home, sick with Malaria," said Fred.

"If malaria rates reduce, the families' economic status would significantly improve, children's school attendance would improve, and this would translate into a better future."

Nurse Shakila from the Maternal Health Centre is confident that this vaccine is the best preventative measure against Malaria.

"This vaccine is a much stronger preventative method than getting parents to use mosquito nets properly in their homes. This is surely the best way to protect children from the deadly Malaria. Hopefully, a vaccine can be developed to give to expectant mothers too," said Shakila.

As a result of the pandemic, many health professionals recognise the extra help these vulnerable communities need and are keen to travel as soon as possible. Despite the current travel restrictions, World Youth International has continued to receive new applications for their Nurses in Action programs. When Australian nurses and midwives can travel internationally again, they will have the opportunity to spend time working alongside the local health professionals in the new Maternal Health Centre and assisting with the roll-out of the malaria vaccination program.

Kasia is an Australian Perioperative Nurse currently studying a Masters of Public Health and Tropical Medicine. She recently applied for the Nurses in Action program.

"When deciding to pursue a career in nursing, my main reason was to give back and try to help in alleviating inequities locally and around the globe. Whilst studying, I saw an advertisement for the volunteer program," she explained.

"If I could help in even the slightest way, especially now with the added stresses of the coronavirus, I definitely can't deny that it would be a personally life-changing experience."

If you're also passionate about giving back and want to plan future trips, particularly when some of the communities World Youth International work within will need more support than ever, consider signing up in advance to the Nurses in Action program. The program will run again when travel restrictions ease. More information about the Nurses in Action program can be found here [worldyouth.org.au/volunteer/nurses-in-action](https://worldyouth.org.au/volunteer/nurses-in-action)

#### About World Youth International

World Youth International is a registered charity which has facilitated meaningful volunteer opportunities for more than 3,800 Australians and provided access to basic services such as healthcare and education for more than 40,000 people across the globe. At the heart of all our work is a commitment to community-led, sustainable development projects, and a belief in the power of volunteers to create real impact. Our vision is to educate, empower and inspire positive change within the global community through the legacy of our founder, the late Robert Hoey.

World Youth International is committed to:

- Creating innovative and exciting opportunities for people to live life passionately and contribute to the global community; and
- Enhancing quality of life, strengthening communities and reducing poverty through sustainable development projects.

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#### Author

Christian Marchetti is the Marketing & Communications Intern at World Youth International



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## Building the therapeutic alliance with men

By Simon Tyler

**There are significant issues when it comes to men and seeking support for mental health difficulties.**

Research by Spendelow<sup>1</sup> suggests a stark gender disparity and indicates that men are significantly less likely to see a psychologist in comparison to women.

Furthermore, investigation also suggests men have greater drop-out rates than that of women, with men regularly opting to not continue treatment following initial consultation as seen in research by Pederson & Vogel.<sup>2</sup>

Understandably, this is of great concern, as while research shows the prevalence of mental health conditions in men is not as prolific as that for women, many serious outcomes that are associated with mental health difficulties are significantly higher in men, such as suicide, drug and alcohol dependence and violence, as reported by Mahalik & Rochlen.<sup>3</sup>

Fundamentally, this suggests that while there may not be as many diagnoses of mental health conditions in men, presence may be far greater than currently understood and men may be choosing to deal with their mental health difficulties by themselves rather than seeking professional help.

This information highlights the need for better understanding of what psychologists can do to get men to access and continue treatment services.

However, as Seidler and colleagues have suggested,<sup>4</sup> many suggestions for why men do not seek psychological help are directed at an individual level and their failures in this space, rather than what psychologists can do to change this narrative. For example, as seen in Addis & Mahalik<sup>5</sup> regular professional commentary focuses on men's adherence to traditional masculine norms such as self-reliance and stoicism, as reasons for why they do not seek psychological support when they are experiencing mental health challenges. Furthermore, Mahalik and colleagues<sup>6</sup> have shown men regularly shoulder the blame for not continuing treatment, with suggestion that their preference for treatment methods that do not align with traditional approaches their issue rather than that of the psychologist. Despite this narrative, there is a simple but

significant area that psychologists can and need to improve to ensure men uptake and upkeep psychological support.

The therapeutic alliance has been defined by Bourdin<sup>7</sup> as the "collaborative relationship between patient and therapist in the common fight to overcome the patient's suffering and self-destructive behaviour." The importance of the working relationship between a psychologist and client has long been understood with early psychotherapists, such as Rogers<sup>8</sup>, outlining its significance in obtaining positive treatment outcomes. More recently empirical evidence has further highlighted the importance of the therapeutic alliance with studies such as Ardito & Rabellino,<sup>9</sup> demonstrating an effective therapeutic alliance may be as, or more, valuable to positive client outcomes than the treatment modality used during sessions. Ardito & Rabellino,<sup>9</sup> suggest there to be three key components to the therapeutic alliance being

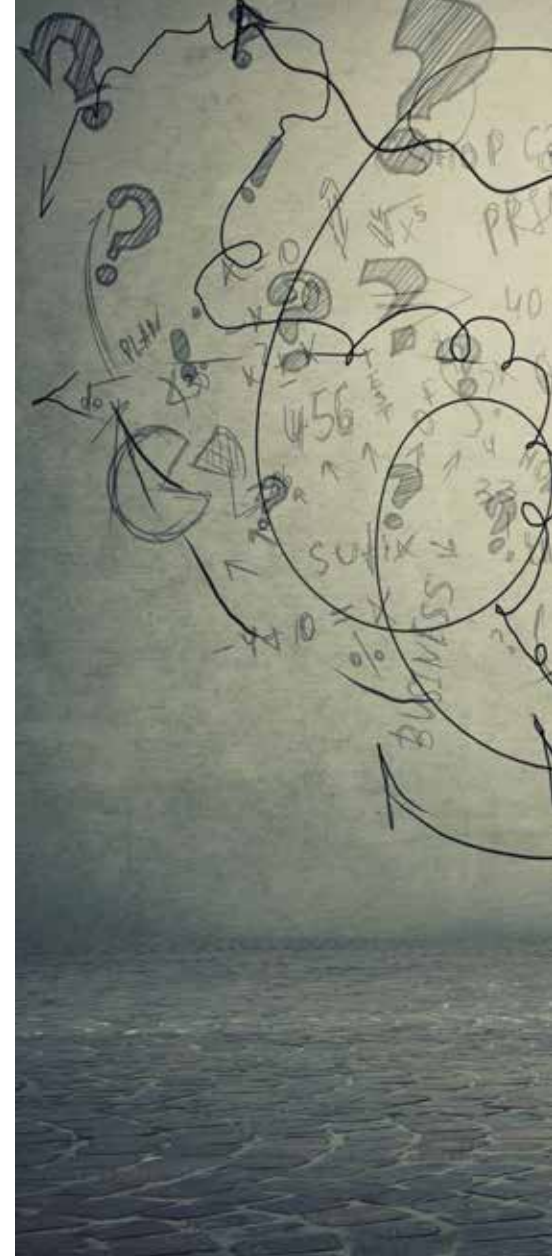
1. goals of the treatment
2. agreement on the tasks
3. development of a personal bond made up of reciprocal positive feelings.

However, despite the long term understanding of the importance of developing and maintaining an effective working relationship between a psychologist and client, it would seem some principals central to its development are discounted by psychologists when dealing with male clients.

A major component of the therapeutic alliance is collaboration with a need for significant focus on the mutual agreement on treatment methods and subsequent outcomes. Unfortunately, men often reported that this does not occur for them, with regular dismissal of their desires for the direction of their treatment. For example, men display a preference for psychotherapy methods that place significant focus on action and overall goals as opposed to therapy of an emotional disclosure format, as reported by Seidler and colleagues.<sup>10</sup> Men regularly report that talking and disclosing emotions often makes them more frustrated and doesn't help with the day-to-day as outlined by Kingerlee.<sup>11</sup> While research suggests that men and women may experience similar positive outcomes from emotional disclosure therapies, to develop an effective therapeutic alliance, psychologists should consult with their clients about what treatment methods are desired and they are willing to engage in. Therefore, Johnson and colleagues<sup>12</sup> suggest by not understanding that men may prefer practical forms of

assistance, with a focus on the development of action based coping strategies, (as opposed to therapeutic approaches heavily focused on emotional vulnerability and empathic communication), psychologists may be compromising their ability to form a therapeutic alliance. Additionally, they may also hinder client access and retention.

In addition to the above, the formation of an effective therapeutic alliance with male clients is dependent on the development of a working relationship with attributes of trust and positivity. The need to create an environment that feels safe and non-judgmental is vital. However, it has been commented that psychologists often fail in this when dealing with male clients with both settings and the language used not facilitating these feelings, as reported by both Bedi & Richards and Englar-Carlson.<sup>13,14</sup> Seidler and colleagues<sup>10</sup> have suggested that psychologists need to utilise a more casual environment and approach, breaking the elitist stereotypes often associated with psychologists. Furthermore, there has been suggestion that trust can be developed in





men through ensuring they are treated as individuals rather than just a number or tick box exercise. For example, research by Seidler and colleagues<sup>15</sup> show men often report that they do not develop effective therapeutic alliances due to the feelings that they are not recognised and understood as individuals. Psychologists who focus on and remember personal details and topics important to the client, are suggested by Seidler and colleagues<sup>15</sup> to develop stronger working relationships with male clients and increase the likelihood of treatment continuance, fundamentally developing an effective therapeutic alliance.

In short, the need to develop effective and long-term therapeutic alliances with men who seek psychological services is a necessity. However, there is a significant need for clinicians to self-reflect on their approaches to developing the working relationship with men in this space and change the narrative that men are the main contributor to the issues faced in men accessing and continuing psychological treatment. Clinicians being aware of male clients' preferences and

desires for treatment goals and outcomes and ensuring they modify their traditional approaches to settings and language, will inevitably lead to better therapeutic alliances positively influencing male client retention and treatment efficacy.

#### Author

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## Plan International calls for fair distribution of COVID-19 vaccines to avoid 'setback' to women and girls' rights

**Failing to distribute safe and effective COVID-19 vaccines to low and middle-income countries could lead to a profound setback to girls' and women's rights, Plan International has warned.**

According to the child rights and humanitarian organisation, governments should act to ensure all countries can deliver effective immunisation programs, which are widely seen as key to systematically lifting lockdowns and kickstarting economic activity.

Research by Plan International has found that girls and young women are disproportionately vulnerable to the secondary impacts of COVID-19 and that economic downturns, job losses and school closures have worsened existing gender inequalities.

Dave Husy, Director of Programs for Plan International Australia said that the pandemic had pushed poorer countries to the brink of disaster, with girls suffering the worst consequences, from dropping out

of education to child marriage and sexual violence. Without equitable distribution of vaccines, girls and women would continue to lose out the most.

"After a year like no other, the approval of multiple safe and effective COVID-19 vaccines and the start of immunisation campaigns in several countries is something to be celebrated. For many, it is the beginning of a return to normal life.

"But unless the vaccine is fairly distributed across the world, women and girls' rights will be at risk. Whether by putting them at increased risk of becoming victims of domestic or sexual violence, or being married against their will, the pandemic has already unravelled decades of progress on gender equality.

"If developing countries are unable to roll out COVID-19 vaccination programs at scale, countless girls and young women will continue to face the dangers associated with lockdown. This would be a huge step backwards for equality, and we therefore urge power-holders worldwide to ensure fair access to the vaccine."

Gender-based violence has soared during the pandemic. It is feared that an additional two million girls have been subjected to female mutilation/cutting this year due to missing school and disruption to prevention programs, according to the UN.

It is also feared that difficulties in accessing modern contraceptives could result in up

to seven million unintended pregnancies over six months of lockdown and that there could be an additional 13 million child marriages.

In a landmark survey of 7,000 girls across 14 countries earlier this year, Plan International also found that nine in ten (88%) have experienced anxiety during the pandemic, with rates higher among those in lower-middle and low-income countries.

Plan International is urging governments worldwide to ensure that low and middle-income countries receive an adequate supply of COVID-19 vaccines, and include vulnerable and excluded groups in vaccination campaigns, irrespective of income, including people who are refugees or have been displaced from their homes.

The organisation also stands ready to support immunisation campaigns by using its existing network in program countries in Latin America, Africa and Asia to raise awareness and support health facilities with supplies such as personal protective equipment (PPE).

Since the outbreak of the novel coronavirus pandemic in March 2020, Plan International has supported communities and countries as they respond to the virus and its knock-on effects.

*Plan International Australia is a charity for girls' equality that tackles the root causes of poverty, support communities through crisis, campaign for gender equality. The organisation helps governments do what's right for children and particularly for girls.*



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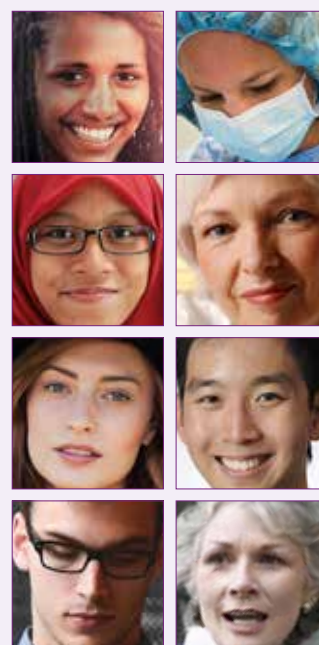
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## The experience of a pre-admission centre: Does a stitch in time save nine?

By Elizabeth (Eilish) Hoy, Hazel Maxwell, Sarah Burston and Kim Walker

Pre-admission services are administered in facilities both nationally and internationally in different ways, some are nurse-led, some are anaesthetist led and others are telephone pre-admission centres.<sup>1-6</sup>

Most literature examines the benefits of the pre-admission visit to a facility<sup>5,7-10</sup> or focuses on patient satisfaction alone<sup>11,13</sup> rather than the perceived and real benefits, to the patients who attend them, the medical and nursing staff who use them and the nursing staff who deliver them.

This research was carried out to examine the effectiveness of a Pre-Admission Centre (PAC) in a tertiary training hospital from the perspectives of patients, both male and female, surgeons, anaesthetists, and registered nurses. The study explored PAC processes and structures to pursue excellence in patient care, safety, and satisfaction. A mixed-methods approach was used. The quantitative component used secondary data already collected by the organisation. The qualitative component consisted of semi-structured interviews,

a focus group, and patient surveys that identified the PAC's perceived impact for elective surgical patients, visiting medical officers, registered nurses, and anaesthetists.

The data from surveys, along with the interviewed participants and focus group suggests that the PAC is effective as it increases the quality of healthcare provided in terms of safety, efficiency, and organisation of surgical risks. It is effective in screening patients providing early detection and communication of risks which allows for appropriate action to be taken in a timely manner. The PAC is a timesaver for anaesthetists, and registered nurses at ward level on the day of surgery and can alleviate fear and anxiety, provide preoperative information and education, may reduce length of stay and can reduce cancellations on the day of admission.

The study was unique in that all stakeholders' experiences were explored not only patient satisfaction. The Pre-Admission Centre provides screening and early detection of risks for male and female patients who are having large and complex procedures and identifies strategies in conjunction with anaesthetists and surgeons to mitigate harm.

### Author

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## Grants on offer to advance gender equality for Queensland women

The Queensland government has opened up a grant program to help advance gender equality for women.

The *Investing in Queensland women* program has committed \$540,000 through two rounds of funding each year, with grants of up to \$15,000 awarded to successful applicants to deliver community initiatives, including projects that prevent and respond to domestic and family violence and sexual assault.

Minister for Women and the Prevention of Domestic and Family Violence Shannon Fentiman said the grants would help address issues that affected women's

status and roles in our community, and restricted women's full participation in the opportunities that Queensland offers.

"These grants will support community-driven events and strengthen partnerships across Queensland communities, no matter how remote," Ms Fentiman said.

"The *Investing in Queensland women* program will bring together a number of funding initiatives that will ensure grants are flexible and readily available to applicants across the state.

"Our aim is to promote and protect the rights, interests and the general wellbeing of Queensland women and girls and support them to fully participate in the economic, social and cultural opportunities our great state has to offer.

"Eligible organisations can submit an application in each round of grants, with categories consisting of up to \$5,000, \$10,000 and \$15,000 amounts for initiatives."

Community-driven initiatives and activities can include targeted campaigns or events, such as workshops or training, or the development of community resources to promote and respond to a particular issue.

"Support groups that may face multiple levels of disadvantage or identify as more vulnerable, are especially encouraged to apply.

"This includes Aboriginal and Torres Strait Islander people, people with a disability, people identifying as LGBTIQ+, people from culturally and linguistically diverse backgrounds, people in rural, regional and remote communities, and young and older people."

Applications for round 2 funding will open on 1 July 2021.

For more information or to apply for a grant visit: [justice.qld.gov.au/initiatives/grants-for-queensland-women](https://justice.qld.gov.au/initiatives/grants-for-queensland-women)



## Engaging fathers through childbirth education programs: Optimising mothers', fathers' and babies' health outcomes

By Anita Thomas, Marie Treloar and Karen Wynter

**The World Health Organization has declared engaging fathers as a priority for all maternal health services.<sup>1</sup>**

Evidence suggests that men want to be actively involved parents.<sup>2</sup> However, most services aren't actively engaging them.<sup>3</sup> Engaging fathers in maternity care is associated with long-term health benefits for fathers, their partners and children.<sup>4</sup>

Many parents find themselves locked into traditional, unequal, gender-based parenting roles, eg. mothers are 'primary carers' and 'experts' and non-birthing parents (usually fathers) are 'support'. Adherence to these expectations sets up long-term family patterns detrimental to both parents' health and social wellbeing.<sup>5</sup> Childbirth and Parenting Education (CBPE) programs present a unique opportunity

to engage men and women as equals in the journey to parenthood. Developed by Carrington Health (CH), *Baby Makes 3* (BM3) is an evidence-based, award-winning education and social change initiative, targeting long-term, gender-based attitudes and social norms about parenting. BM3 aims to build mutual understanding and respectful relationships among first-time parents, and capacity for gender equality promotion among antenatal and postnatal services.

Since 2018, a key focus of BM3 has been embedding gender equality messages and activities into existing CBPE programs.

Between October 2019 and March 2020, 16 CBPE educators from six public antenatal services participated in training; 616 parents attended their programs. Feedback included: "CBPE programs are a great opportunity to introduce gender equality messages of healthy and respectful relationships" (Educator); "Equality is the foundation of a relationship" (Parent); "Parenting is not just mum's responsibility but also dad's responsibility" (Parent).

Due to COVID-19 restrictions, CBPE classes at participating services were replaced with online options. CH developed short (6-15 minutes) modules to be included as a component, for parents to watch together, during or between classes. They covered relationship changes, expectations of new parents, equitable approaches to parenting, and effective communication.

Educators observed that these modules often prompted father-initiated discussions – a positive outcome given the challenges of actively engaging men in parenting programs.<sup>6</sup> Many educators have indicated they will continue to embed the modules as a tool to generate conversations between parents post COVID restrictions.

### Authors

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## CARTOON COMPETITION



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Send your caption to **FUNNYCAPTION@ANMF.ORG.AU**

Go to **anmj.org.au** for terms and conditions. Competition closes 10 May 2021

### CONGRATULATIONS!

***Julia Worthington***

**for your winning entry.**  
A \$50 Coles/Myer card is on the way to you. Thank you to all who entered our funny caption competition in the last issue of the *ANMJ*.

The *ANMJ* staff had a great laugh at all the funny entries. Unfortunately there can only be one winner.



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