



# ANMJ

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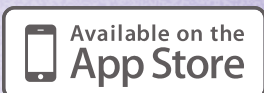
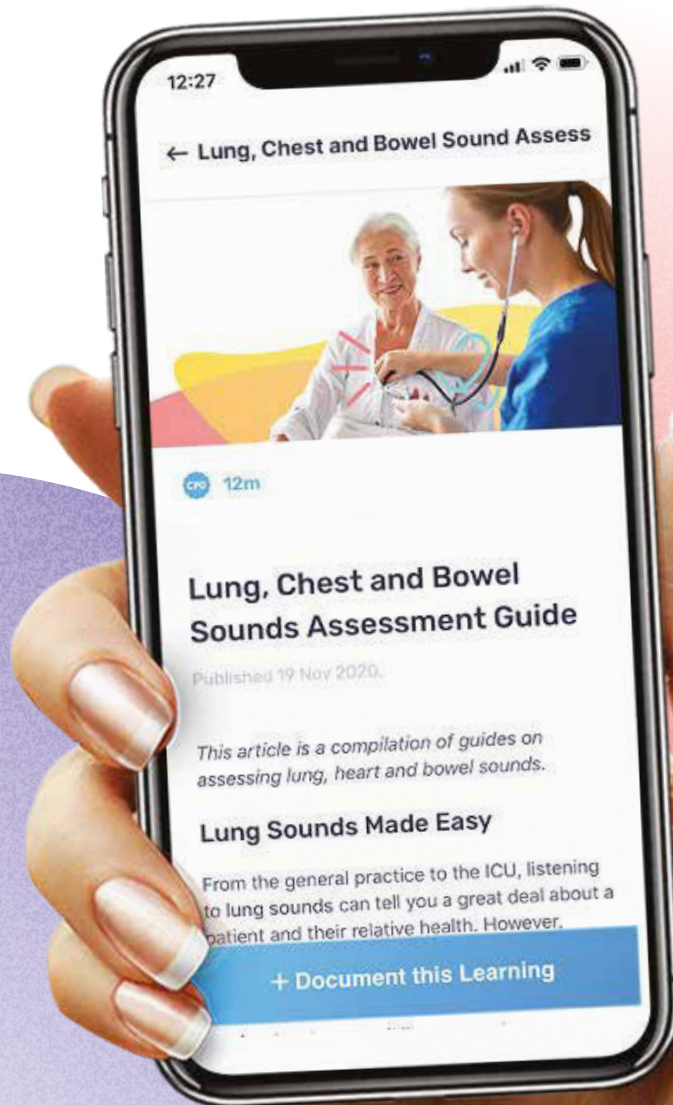
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**Annie Butler**

ANMF Federal Secretary

**As we all know, over the last two decades there has been an unacceptable decline in the quality of care for older Australians, which was clearly, and often painfully, demonstrated in the findings of the Royal Commission into Aged Care Quality and Safety.**

So after years of waiting, older Australians, their families and aged care workers learnt what the 'once in a generation' reform aged care package the Morrison government had promised would provide when the recent federal Budget was delivered.

Regrettably, they were left disappointed when real reform did not transpire – failing older Australians once again.

While the government's reform aged care package has delivered an injection of \$17.7 billion in funding along with several positive measures, which were welcomed, the fact remains too many of the Royal Commission's recommendations have been overlooked.

Quite simply, the federal government's reforms have not gone far enough.

A crucial part of the package is mandated minimum staff to resident ratios from 2023, where staff would be required to provide 200 minutes of care each day to residents, including 40 minutes of care delivered by a registered nurse.

However, not including any requirements for a registered nurse to be on-site at all nursing homes 24/7, as recommended by the Commission, will leave care workers and residents unsupported by nurses' clinical expertise around the clock.

Further, the package excludes an uplift in mandated minimum staff time (also recommended by the Commission), making it unlikely that care will reach the higher-quality level needed by many older Australians.

Instead of guaranteeing safe staffing levels and workloads along with decent wages and conditions for all aged care workers, the package has included a retention bonus for registered nurses only who stay with their employer for at least a year. Dangling such carrots in front of registered nurses in a bid to make them stay or enter the sector is inappropriate, misplaced and dismissive of other aged care workers. Furthermore, it does not build a quality sector that ensures security for the current and future workforce.

The package also includes \$3.2 billion to support aged care providers to "deliver better care and services". Given how some providers have misused funds, it's surprising that this funding comes with no strings attached.

It's clear, this reform package will not guarantee high quality and safe aged care. This is particularly disappointing because this is the government's full response to the Royal Commission, which is ultimately not enough.

We need to do more to ensure all older Australians are treated with dignity and respect and receive the care they deserve. To this end, the ANMF will continue to campaign for real reform – so watch this space.

Further afflicting aged care workers and the sector is the federal government's poor handling of the COVID-19 immunisation rollout in the sector. Along with delayed supplies and community hesitancy, there has been much confusion amongst aged care workers about where and how to get the vaccine and who was responsible for it. Additionally, when writing this editorial, the government had kept no reliable data on who has been vaccinated and there is no central coordination of the process, adding to the perplexity of the situation.

The government promised all staff and aged care residents would be vaccinated in the first six weeks. Yet, 14 weeks on, it's clear this has not occurred.

The government must support workers by funding special leave to manage any reactions. It's also imperative that there is support for facilities and aged care workers to work at single sites. In ANMF's feature this issue, we've detailed more about the vaccine and how Australia has handled its rollout.

Annie

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**Moving state?**

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

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## CONSUMERS NEED MORE CONTROL OF THEIR HEALTHCARE

**A significant number of consumers need more support to feel in control of their healthcare, according to a report commissioned from the Consumers Health Forum (CHF) by NPS MedicineWise.**

The report, *Consumer Health Literacy Segmentation and Activation Research Project*, defined and measured health literacy in Australia and identified gaps which were preventing people from accessing the best possible healthcare.

As part of the project, a survey of more than 1,500 respondents found that approximately one in five consumers:

- Rarely or never felt comfortable asking their doctor, pharmacist or nurse when they needed more information.
- Rarely or never felt comfortable asking the health professional

to explain anything they didn't understand.

- Found the information a health professional gave them always or often confusing.

A further 28% said they found such information confusing sometimes. However, just over 70% of respondents said they always or often felt comfortable communicating on such matters with health professionals.

"We need to increase consumers' capacity to manage and feel in control of their healthcare, including around medicines," said CEO of CHF Leanne Wells.

NPS MedicineWise CEO Adjunct A/Professor Steve Morris said CHF and NPS MedicineWise were working together to build on their collaboration of the past 20 years to ensure consumers are at the centre of quality use of medicines and better health decision-making.

## *Nurse-led home blood transfusions safe and effective, study finds*

**A nurse-led home blood transfusion service was associated with low rates of both individual and system adverse events, a new study undertaken by the University of South Australia, the Royal District Nursing Service and SA Health has found.**

Researchers say the findings confirm that regular blood transfusions can be safely performed for medically stable patients with a chronic health condition in residential homes and aged care facilities.

The joint study investigated 1,790 blood transfusions involving 533 patients in South Australian homes and aged care facilities over a 15-year-period.

Key findings included the system used to deliver blood products to the patients being efficient and safe; less than 1% of adverse reactions, with reactions not serious and able to be managed by a registered nurse; and the gender and age of the patient and their setting not proving a barrier to receiving a blood transfusion at home, nor influencing the risk of an adverse reaction.

Researchers say the findings highlight the growing trend of healthcare being delivered at home. Further investigation is needed to explore the perception of those using the service and supports required to improve the experience.

"Hospitals can be alienating and strange places for older people, especially those who have dementia," UniSA lead researcher Dr Rebecca Sharp said.

"It is better for eligible patients if a trained nurse can go to their home and perform the blood transfusion, following strict procedures.



## Health workers more likely to take rural jobs if they study there or are of rural origin

A study of more than 1,100 nursing and allied health graduates has found the more time students spend on rural placements, the more likely they will stay once they have graduated.

Tracking nursing graduates from Monash University and the University of Newcastle, the Nursing and Allied Health Graduate Outcome Tracking (NAHGOT) study aimed to better understand what influences nursing and allied health students to study in rural and regional areas and, crucially, continue their practice there.

The study, *Destinations of nursing and allied health graduates from two Australian universities: A data linkage study to inform rural placement models*, began in 2019, tracking graduates who completed their degrees in 2017.

Of the 1,130 graduates, 51% were nurses, 81% were female, 62% were aged under 21 at enrolment, 23% came from a rural background, 62% had experienced at least one rural placement, and 23% had over 40 cumulative days spent on a rural placement.

Using data on principal place of practice from the Australian Health Practitioner Regulation Agency, the research team, led by Dr Keith Sutton, from the Monash School of Rural Health, found nurses and allied health workers who were originally from a rural or regional area were 4–4.5 times more likely than urban graduates to practice in a rural area.

Published in the *Australian Journal of Rural Health*, researchers say the findings emphasise the need to increase rural placements in this cohort of health students in a bid to address the rural nursing and allied health shortage and help overcome the health inequities faced by rural Australia.

The long-term study will continue to survey 2017 graduates, following their career trajectory, where they end up practicing, and what proportion end up in rural areas.



## Nursing Now concludes after three years

The Nursing Now global Campaign celebrated its finale last month after three years of raising the status and profile of nursing around the world.

The campaign led by the World Health Organization (WHO) and the International Council of Nurses, also aimed to and empower nurses to tackle 21st century health challenges.

Australia celebrated Nursing Now's conclusion with an event at Parliament House in Canberra.

Hosted by the Australian College of Nursing, nurse leaders dedicated to improving the health sector and the profession, spoke about their tireless

work to influence change in their fields. Topics ranged from the experiences of nurses during COVID-19, the impact of natural disasters, Black Lives Matter and aged care.

Speaking at the event, Nursing Now Campaign Board Member for the WHO's Western Pacific Region, Emeritus Professor Jill White who spearheaded Australia's contribution, said the campaign was about raising awareness and to give nursing a voice. Professor White said she believed that this had been achieved.

"Over time there has been a groundswell in relation to nursing activity in policy and politics and I sense it is our right and our duty to speak publicly and our role to be on boards and on local government."

Other nursing leaders at the event said while there remained much to do, the campaign had provided the platform to create action.

## Hospital activity stalled during early months of COVID-19 pandemic

Years of escalating hospital admissions stalled when the COVID-19 pandemic hit Australia in 2020, a new report from the Australian Institute of Health and Welfare (AIHW) has revealed.

The latest *MyHospitals* update shows there were 11.1 million hospitalisations in Australia in 2019-20, down from 11.5 million during 2018-19.

There were 6.9 million same-day hospitalisations and 4.3 million overnight hospitalisations in 2019-20, representing a 2.1 and 4% decrease respectively from the previous year.

The decrease in hospitalisations was greater in private hospitals, who experienced a 4.5% decrease from 2018-19, compared with public hospitals, which dropped by 1.7%. The larger decrease in private hospitals was influenced by restrictions placed on categories of elective surgeries from March 2020.

The report also revealed that from January to June 2020, there were over 2,600 hospitalisations involving a COVID-19 diagnosis.

Of these, one in four had one or more comorbid chronic conditions such as cardiovascular disease or type 2 diabetes, 225 (8.6%) required a stay in an intensive care unit, and 105 (4%) died in hospital. People aged 65 and over accounted for one third of the hospitalisations and 90% of deaths in hospital for patients with a diagnosis of COVID-19.



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

## Four months after vaccination rollout announced, priority workers left waiting

**It wasn't long ago when the then Prime Minister, Malcolm Turnbull, stood up in Federal Parliament, suggesting that a 60-year-old aged care worker from Burnie, Tasmania should 'aspire to get a better job'.**

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This comment and subsequent attitudes and inactions by the current Morrison government towards aged care workers reveals a sustained and profound disregard for workers in the care industry, particularly private aged care.

When Australia's COVID vaccination rollout was announced in February this year, it was rightly determined that aged care workers would be prioritised in phase 1A, recognising that vaccinating these essential workers would protect workers and prevent the spread of COVID-19 in vulnerable aged care settings. The same settings that experienced so much devastation in 2020.

Federal Health Minister, Greg Hunt announced the vaccination rollout for residents and staff would be made available through residential aged care facilities where they live and work and that it was expected to be complete within six weeks. Four months on, the reality is starkly different.

As of 1 June 2021, just over 50% of private aged care residents have been fully vaccinated, much less is known about the workforce. At a recent Senate Estimates Hearing, the Australian Government Department of Health could not confirm the number of private aged care workers that had been fully vaccinated, as such data was not kept. At best, they offered an estimate of less than 10% of the workforce. In comparison, we have witnessed Victorian state run public aged care homes successfully vaccinate all staff and residents.

Traditionally, Australia has enjoyed high vaccine take up rates. The long established tradition of the Commonwealth securing supply and organising national distribution, while states and territories coordinate vaccine administration, has served us well to date. The decision by the Commonwealth to bypass states and territories and engage private contractors to administer COVID-19 vaccines in private aged care has failed spectacularly. It has also transpired that many of the private companies engaged by the Federal government were never actually contracted to vaccinate staff, only residents. At best, some staff were offered 'left over' vaccines at the end of the day. A dismal and costly failure, both humanly, economically, and from a public health perspective.

The failings of the vaccination rollout compound a workforce that is already marginalised.

A dedicated workforce, predominantly female, of which up to 40% are migrants, very often in precarious employment, who experience chronic understaffing on a daily basis and who are poorly paid. Recent Federal Budget announcements did little to address existing wage disparity or focus immediacy to legislate safe staffing levels and now to further add their list of failings in aged care and their attitudes to workers, they have completely botched the vaccination rollout to private aged care nurses and personal carers despite several announcements promising to do so.

It beggars belief that the Morrison government has learned nothing from the devastating outbreaks in residential aged care in 2020. A reminder that tragically, 685 elderly residents died, 685 families heartbroken and many nurses and carers, who to this day, continue to experience post-traumatic stress from witnessing and responding to these devastating events.

This Federal government who has taken those working in private aged care for granted and has completely failed to respect their valuable work and the care that they provide to those most vulnerable in our community.

If the Morrison government was genuinely committed to fully vaccinating the aged care workforce, they would have authorised the rollout to the states and territories at the very beginning, as the ANMF have been advocating for.

If they honestly respected workers, and were committed to getting workers vaccinated they would create the industrial framework that removes all existing barriers to being vaccinated. This would include easy and equitable access to vaccines, flexibility to access vaccines in paid working time and providing nurses and aged care workers with special paid leave provisions in the event they experience short-term side effects from being vaccinated. It would also provide clear, consistent and tailored communication frequently. The ANMF will continue to lobby for vaccine paid leave provisions in private aged care, some of which already exists in several public sector workplaces.



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# Drive for social justice sparks almost 40 years of supporting workers' rights globally

By Ben Rodin

**The determination of an Australian nurse and committed member of the ANMF to support marginalised workers across the globe helped set the foundations of Union Aid Abroad–APHEDA which has since provided support and justice to many worldwide.**

In 1983 when humanitarian nurse Helen McCue was working in refugee camps and providing nurse education services for the World Health Organization (WHO) in Palestine, she observed the solidarity and aid that Norwegian People's Aid, a trade union organisation from Norway provided for people on the ground.

From her observations, Helen felt the Australian union movement needed to offer similar levels of assistance to their comrades overseas, APHEDA's EO Kate Lee said.

"She was particularly interested in the lives of the nurses in those camps, how affected and traumatised they were, and really felt strongly that the workers needed to be supported as much as the people that they were supporting," Ms Lee said.

On her return, Helen contacted then ACTU President Cliff Dolan and set out her proposal to establish a global justice organisation. With his assistance and the broader Australian union movement's backing, Union Aid Abroad-APHEDA

was born, setting in stone a mission that now encompasses the support of "strong unions and social movements, sustainable development programs, global solidarity and support in times of crisis."

Today, APHEDA works in thirteen locations in Southeast Asia, the Pacific, the Middle East, and Southern Africa in partnership with 39 local unions and community organisations through 30 projects and campaigns.

APHEDA's work has included actively supporting causes such as the Anti-Apartheid movement and the liberation of Timor Leste while also helping those communities in developing countries develop infrastructures that support strong worker's movements.

While a key part of APHEDA's work is assisting with union organising, Ms Lee said the organisation had developed a multi-pronged approach in aiding communities over time. This includes defending and developing women's rights,

climate justice and "the rights of migrant workers and refugees".

Currently, APHEDA is building a movement in Australia to join unionists and campaigners across South East Asia to support their struggle to ban Asbestos and eliminate asbestos-related diseases.

While Asbestos is banned in Australia, Ms Lee said many Asia-Pacific nations continued to use the dangerous material as part of construction activities, creating significant risks for workers on the ground and their families.

"As the markets have shrunk [in Europe and Australia], the Asbestos industry has found new markets, and those markets have been growing until recently," she says, adding that India, Indonesia and Vietnam are among the countries that have experienced increased demand.

"We're up against an industry lobby that's determined to hold on to the very last bit of its market.

APHEDA's campaign, **Asbestos. not here. not anywhere**, which is its flagship concern for the next four years, aims to ban Asbestos in Vietnam, Indonesia, Laos and Cambodia, while also aiding and abetting the global movement for a total ban on Asbestos.

It's a big campaign, and with several other APHEDA projects on the go, Ms Lee says there are plenty of ways for union members to get on board, whether through member, fundraising, education, lobbying or other contributions.

"We want to build a stronger sense of international solidarity," Ms Lee explained.

"We want to develop new ways to do that, and we want to ask all workers and as many unions as possible to be part of that with us."

For more information on APHEDA's work and the ways you can contribute as a member of the trade union movement, visit the organisation's website [apheda.org.au](http://apheda.org.au)



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# TOO-GREAT EXPECTATIONS:

## How Australia's aged care COVID-19 vaccination rollout fell short

In February, when the Morrison government unveiled Australia's COVID-19 vaccine rollout plan, aged care workers, along with frontline healthcare workers and quarantine and border workers, were included in the highest priority group, phase 1a, and assured they would get vaccinated at their workplaces within the next six weeks. Instead, two months on, fewer than 10% of the private aged-care workforce had received the vaccine, leaving thousands angry, frustrated and in limbo. **Robert Fedele reports.**

By mid-April, aged care worker Jane (not her real name) was still waiting to receive the COVID-19 vaccine.

In-reach teams were supposed to arrive weeks ago to administer the jab to residents and staff. The federal government's broken promise left her feeling unsettled and upset.

"You're always fearful that you're going to be the one bringing it in [to the facility]," Jane says.

"You just want to be able to say that you've done everything you can [get vaccinated] to protect your residents."

On 16 February, Health and Aged Care Minister Greg Hunt said the vaccination rollout would reach more than 2,600 residential aged care facilities, 183,000 residents and 339,000 staff in coming weeks.

Under the Morrison government's plan, all aged care residents and workers should have been vaccinated by the end of March. The target fell well short.

Opportunistically, Jane secured the Pfizer jab at her workplace on 19 April after vaccines were leftover following the vaccination of residents. Only 20 of the facility's staff were as fortunate.

Jane, an assistant in nursing (AIN) at a private nursing home, counts receiving the vaccine by chance as "not good enough".

"I think it's [the rollout] been very poorly organised," she says.

"We'd been well prepared and put our names forward that we wanted it [the vaccine] and the numbers of which staff members and which residents wanted it was known. We were assured that we were all going to get it, so it was kind of a letdown [to only get it as an afterthought]."

Her colleagues who missed out were told to source the vaccine at their GPs, GP respiratory clinics and dedicated aged care workers clinics. Suddenly, the goalposts had shifted.

"We weren't a priority," Jane reflects.

"They [the government] failed to actually look after our citizens. We had a chance while COVID infections were low to get on top of these vaccinations. They've failed the Australian public once again."

### TOO-GREAT EXPECTATIONS

In January, Prime Minister Scott Morrison labelled the vaccine rollout his key priority for 2021, saying Australians would be "at the front of the queue". The roadmap forecast 80,000 vaccinations per week, four million doses by the end of March, and fully vaccinating the entire population by the end of October.

Marred by logistical failures, supply issues, changing health advice and an ineffective public information campaign, the rollout failed to meet early benchmarks.

"The challenges Australia have had has been a supply problem, pure and simple," Mr

Morrison claimed in early April.

"There was over three million doses from overseas that were contracted that never came."

"The rollout of the vaccine is a debacle," Opposition leader Anthony Albanese countered.

"We now have circumstances whereby just under 20% of aged care residents have been vaccinated. They've stopped promising to rollout the vaccine to aged care staff and are now telling aged care staff to check with their GP."

ANMF Federal Secretary Annie Butler says the delayed vaccine rollout is typical of the Morrison government – good on paper but not great in practice.

"Generally, the Federal government is unskilled at carrying out an on-the-ground task of this scale," Ms Butler says.

"Tragically, we saw their inability to manage private aged care during the COVID-19 pandemic last year and, unfortunately, we have seen a lot of the same mismanagement with this vaccination rollout."

At the beginning, the Federal government made clear they would be solely responsible for the COVID-19 vaccination rollout in aged care.

From the outset, the ANMF tried to work with the government on its planning and execution, including repeatedly questioning how the immunisation workforce would be delivered and complete the task.





The government immediately took a u-turn, outsourcing its responsibility to private companies, including Aspen Medical, Sonic Healthcare, and Healthcare Australia.

Many blame the decision for vaccination delays and layers of confusion in aged care. For example, numerous reports emerged of in-reach teams turning up to nursing homes only to find no vaccines. On other occasions, vaccines had arrived, but in-reach teams were missing.

“Subcontracting out the responsibility for the vaccine rollout in aged care was not taking full responsibility,” Ms Butler argues.

“Effectively, the government privatised an aspect of the public health response to the COVID-19 pandemic. It was unthinkable.”

### ANMF CALLS FOR STATES TO STEP IN

In mid-April, the problematic vaccination rollout in private aged care prompted the ANMF to call for state and territory governments to take over.

In a survey conducted over the Easter long weekend, 86% of ANMF (Vic Branch) private aged care members, including nurses and carers, said they hadn't received a vaccination.

Of those who had, most had grown tired of waiting for workplace vaccinations and got one through a GP.

In another survey of 254 aged care workers, conducted by the United Workers Union (UWU), 60% described the rollout as “very poor”. Asked to rate the rollout, aged care workers gave it an average score of 3.5 out of 10.

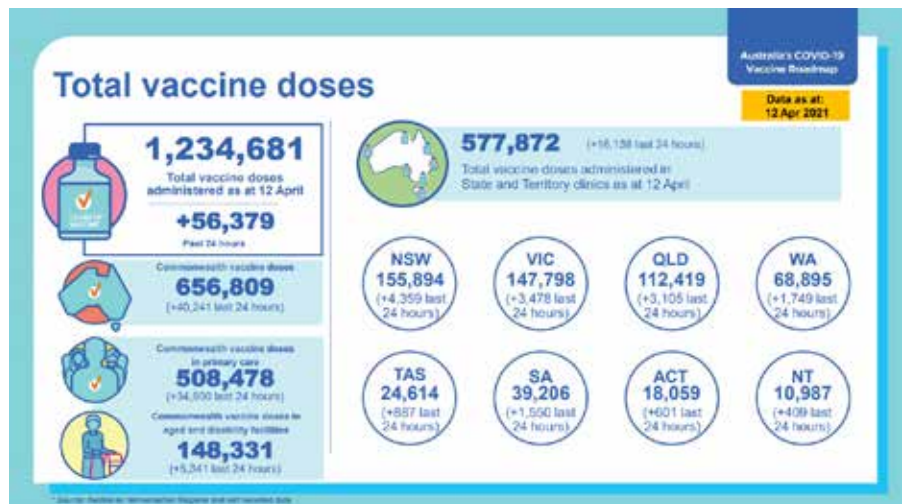
The Victorian state government, responsible for the vaccination of public aged care residents and staff, effectively used a combination of outreach services and hospital vaccination hubs.

“By outsourcing their responsibility under the guise of choice, the Morrison government has abandoned aged care nurses, personal care workers and other staff,” ANMF (Vic Branch) Secretary Lisa Fitzpatrick said.

“For staff to be told to organise their own vaccination makes a mockery of their importance as a 1a priority cohort.”

As the nation's vaccine rollout stalled, National Cabinet began meeting twice weekly to discuss new strategies.

During this time, the ANMF met Commonwealth Department of Health heads responsible for managing the aged care vaccination rollout to highlight the importance of proper planning, coordination and on-the-ground implementation.



The ANMF proposed states be appropriately funded to carry out the rollout in private aged care, with the Commonwealth supporting the program by guaranteeing vaccine supply, providing clear health advice, and delivering funding for additional measures like special leave for workers who get vaccinated and experience side-effects.

### SHIFTING GOALPOSTS

By May, Australia's COVID-19 vaccine rollout had been “recalibrated” and reshaped.

The target to vaccinate the entire population by the end of October was pushed back as the eligibility of new demographics, including Australians aged over 50 in phase 2a, were fast-tracked.

To get the vaccine, private residential aged care nurses and carers were given an increased range of options - state-government-run vaccination clinics, GP clinics, GP respiratory clinics, or dedicated ‘pop-up’ Pfizer vaccination clinics for aged care workers under 50. In-reach vaccinations, and vaccinations undertaken by aged care providers, continued.

Latest advice recommended residential aged care workers 50 years and over get the AstraZeneca COVID-19 vaccine and those under 50, Pfizer.

Ms Butler suggests the aged care rollout improved considerably once state-run vaccine hubs ramped up the effort.

While vaccine supply shortages and changing health advice played a part in the delay of Australia's rollout, Ms Butler believes many of the country's problems stem from poor planning, unrealistic targets and an unconvincing, and largely ineffective, public information campaign.

Put simply, Ms Butler says the Morrison government overpromised and under-delivered.

“Information and how you communicate it is absolutely critical,” Ms Butler says.

“One of the biggest problems we found with the aged care rollout was lack of communication. Aged care workers across the country were confused about so many aspects of the rollout, from which vaccine they should be getting, to when, and how.

“From the beginning, we called for transparency from the government. Our message was clear - if you just tell us the truth about what's actually going on, then we can find ways to help you.”

### NURSE PRACTITIONERS EXCLUDED

It's a sentiment shared by Leanne Boase, president of the Australian College of Nurse Practitioners (ACNP).

Despite pushing to contribute to Australia's COVID-19 vaccination rollout, nurse practitioners (NPs) were excluded.

Ms Boase began raising concerns with the government about the omission back in January after it emerged nurse practitioners would only be able to administer the vaccine if supervised by a general practitioner or “suitably qualified health professional”.

Additionally, NPs working outside the public health system were not covered by the Medicare Benefits Schedule (MBS) for the vaccines, meaning they could not access a rebate.

Ms Boase believes the government missed an opportunity to increase access to vaccinations in settings such as aged care and rural and remote by excluding NPs.

“It was absolute disbelief and disappointment because we've been so engaged and frankly working our backsides off to contribute to this response as best we can, not just from

a clinical sense, but also around the policy table as well,” Ms Boase says.

“When you don’t include all of the stakeholders and all of the health professionals that can contribute to a response, then, naturally, speaking with only one group, you end up with one pathway or only one option and I think that’s what’s happened.”

If the Morrison government had utilised the expertise of nurse practitioners, Ms Boase believes the rollout would have progressed more rapidly and efficiently.

“It’s incredibly frustrating because we all saw what happened in aged care in NSW and in Victoria and we know from experience that they [aged care residents] are our most vulnerable during this pandemic.”

### SOURCING TRUSTED INFORMATION

Australia’s vaccine rollout paused when links between the AstraZeneca vaccine and rare blood clots first surfaced in early March in Europe.

A handful of cases soon emerged in Australia but following careful review, health authorities backed the safety and efficacy of the vaccine due to benefits outweighing risks. However, on 8 April, official advice did change with the Pfizer vaccine deemed the preferred option for Australians under 50.

The problems with AstraZeneca fuelled vaccine hesitancy.

Throughout the rollout, the ANMF’s National Policy Research Unit has produced and updated COVID-19 resources for members in line with evolving evidence. Resources include information on which vaccines Australia is rolling out, their safety, efficacy, and common side effects.

One resource summarises that the benefits associated with COVID-19 vaccine administration outweigh a potentially increased risk of rare blood clots with low platelet counts following AstraZeneca vaccination among people aged under 50. The development of blood clots is extremely rare, affecting 4-6 people per million.

The ANMF supports vaccination as a safe and practical public health program that protects people from, and prevents the spread of many diseases.

Ms Butler says nurses and midwives remain critical to the rollout’s success by getting vaccinated themselves and providing accurate, evidence-based information and advice to their patients and the community about the COVID-19 vaccines that support wider community awareness and uptake.

### GETTING BACK ON TRACK

As Australia’s vaccine rollout gathered pace, it became clear the Morrison government still had a lot of work to do.

Many high-risk groups, including the aged care and disability sectors, had yet to receive the vaccine. Amid low vaccination rates, and government figures revealing more than 1.5 million vaccines were sitting unused in clinics across the country, calls for a more effective communication campaign to highlight the benefits of COVID-19 vaccines intensified.

At a press conference on 17 May, Health Minister Greg Hunt said more than 436,000 vaccinations had been administered nationally in the past week, taking the total to 3.1 million; it took 47 days to reach the first million doses of vaccine.

At the end of April, at the Senate Select Committee on COVID-19, the government confirmed just 37,000 aged care workers had been vaccinated so far within in-reach programs in nursing homes. Now, Mr Hunt said in-reach vaccinations had topped 60,000, while many more aged care workers had attended state-run clinics, or GP clinics, to access the Pfizer vaccine.

The Australian Council of Trade Unions (ACTU) argued the government had walked away from its promise to vaccinate aged care workers at their workplaces and shifted the burden onto them. Workers, many of them casual, would now be forced to choose between getting paid and getting vaccinated due to the uncertainty over financial support from the government if they have to give up shifts or suffer side-effects from the vaccine that prevents them from working.

“Aged and disability care workers were all meant to be vaccinated by now. They are

not. It’s less than three weeks until winter – where is the urgency,” ACTU Secretary Sally McManus tweeted on 13 May.

In early June, under the microscope at Senate Estimates, Minister for Senior Australians and Aged Care Services, Senator Richard Colbeck, conceded he did not know exactly how many aged care workers had been vaccinated and, bizarrely, that he was comfortable with the pace and progress of the rollout.

It soon emerged that companies leading the private aged care vaccination rollout may never have been contracted to provide vaccinations to aged care staff, only residents, with any leftovers to be used on staff.

The astonishing revelations, which emerged amid another COVID outbreak involving private aged care in Victoria, sparked calls for his resignation.

Looking ahead, ANMF Federal Secretary Annie Butler says vaccinating those most vulnerable, including elderly nursing home residents and those working with them, should remain Australia’s biggest priority.

“Older Australian living in nursing homes are most vulnerable to the effects of COVID-19 and that’s why it’s really important aged care workers get vaccinated, so that they can protect residents in their care, their families and the wider community,” Ms Butler says.

“We’re very fortunate in Australia to be rolling out our vaccination program when we don’t have high community transmission but the risk remains ever-present and we must capitalise on the opportunity to get protected against COVID-19.”



Leanne Boase



Annie Butler

# Professional boundaries: Respecting the feelings of residents in aged care

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By Roslyn West

**She called him \*Shorty. He called her \*Smiley. She was one of his nurses in the aged care facility. He was my dad.**

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When I first heard this exchange of pet names I felt slightly uneasy about just how familiar it was. It seemed to border on the unprofessional. But she was warm, radiated youthful joy, brightened my dad's day and of that, I was glad.

Dad was a highly intelligent and compassionate man who excelled in his chosen field but in this last stage of life he had become frail and some dementia had crept in. He had short term memory loss and some confusion at times. He gracefully accepted his declining health and rarely complained. His gentleness shone brightly. He was a compliant and 'easy' client and with a cheeky grin, joked with each nurse that she was his favourite.

But we all knew the truth. His favourite far and away was Smiley.

Then one day in a whispered and excited tone he placed his hand over his heart. He took a folded piece of paper from his chest shirt pocket and handed it to me to read. It was a letter from Smiley. My heart sank. I knew this would not end well.

Smiley told Dad how much she admired and valued him. She told him he provided her more encouragement to study and better herself than her own family ever had, and she finished with, "You are truly a great man ... and will always be in my heart".

He carried that letter next to his own heart for weeks. On face value it was a lovely acknowledgement of how he had positively touched her life but for someone with a slight touch of infatuation on top of worsening dementia it was an invitation to despair.

The letter was the tipping point. He was now in love. It was painful to see his longing for her and his irrational and futile hopes. Mum had died years before when dad was only 51. In more than 35 years since her death he had never had another relationship, such

was his life-long devotion to her. And now ... Smiley.

We all knew that if he still had the cognitive powers of his younger years he would have been utterly humiliated by his declarations of love for a woman more than 60 years his junior but his feelings, which were very real to him, could not be dismissed. When Smiley walked past his door he would beckon her in and his face would light up in her presence. He began to request kisses, and marriage proposals followed. He begged her to sit and hold his hand and talk with him as before. He couldn't understand why she always had to dash off and what had changed.

Then one day I arrived to find tears streaming down his cheeks, his green eyes sad and stormy. Smiley had said goodbye to him on a Friday and on Monday had informed him she was now married. Of course it wasn't true. In her youthful naivety she thought this would solve the problem but of course it only made things worse.

He was devastated. He told me many times they would have made a wonderful couple and could have had a happy life together. His world became dark and sad. Many of the staff thought the whole situation was 'cute' and amusing but my heart was breaking for him. No amount of suggesting that, perhaps it wouldn't have worked anyway given the age difference, would register.

But after her 'marriage' he knew all hope had gone and his grief was deep. And yet, despite his dementia he wasn't stupid and even he could see that her story didn't make much sense. He would ask me, "Where is her wedding ring and why hasn't she shown me her wedding photos as promised?"

Then, again and again, "Did Smiley really get married?" to which I could only answer, "Well that's what she told us". Over time he seemed to become more and more confused



and forgetful. Why couldn't he just forget all about her?

As the weeks passed Dad spoke less and less of Smiley but always remained suspicious about whether or not she had lied to him. Often I caught him looking around for her in the dining room smiling and waving enthusiastically whenever he saw her.

Then in his last weeks Mum once again came into focus for him. He started to believe he had seen mum here and there and was worried about who was looking after the children (the youngest of whom - my brother - was by then, already a grandfather!).





Dad died a peaceful death surrounded by family and will be forever loved and missed.

Was she unprofessional to have called him by a pet name which no one else used?

Was she unprofessional in giving him a personal letter?

Was she unprofessional in lying to him about getting married?

Did she receive enough guidance from management about how best to deal with the situation?

Did she receive enough education in her training and from her employer about what constitutes professional conduct?

Was it ironic that the very one charged with caring for him was the cause of so much hurt?

Did she intentionally hurt him? Of course not. She was a bubbly naive young woman. But with better education and guidance perhaps Dad's suffering may have been avoided or lessened.

As we care for those who are most vulnerable, is it time once again in our training courses and workplaces to discuss what is appropriate and professional for us as nurses and be encouraged to think more about the impact that crossing professional boundaries might have?

Yes it is!

(\*Names have been changed to protect privacy).

#### Author

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# Will voluntary assisted dying see new social rituals evolving?

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By Deb Rawlings, Megan Winsall, Lauren Miller-Lewis and Jennifer Tieman

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## INTRODUCTION

Voluntary Assisted Dying (VAD) was legalised in Victoria in 2017, in WA in 2019, with other states and territories following.<sup>1</sup> In clarifying processes and terminology, VAD in Australia refers to someone with advanced disease taking medication prescribed by a doctor who will bring about their death at a time they choose.<sup>1</sup> This is similar to Medical Aid in Dying (MAiD) which is enacted in the USA and Canada.<sup>2</sup> Euthanasia, however, is where someone (a doctor for example) intentionally administers a fatal dose of medication at the patients' request.<sup>3</sup> These acts have the intention of purposefully ending someone's life.

Life rituals are practised in most countries around the globe, described as “a sequence of activities involving gestures, words, and objects performed in a specific place and sequence of time. Rituals encase memories and link the past with the present”.<sup>4</sup>(p471)

Rituals can be found in birth, in coming of age and marriage, as well as at the end of life, with funerals and memorial services marking the ultimate rite of passage.<sup>5</sup> A team of researchers interviewed Canadian nurses on good nursing practice surrounding MAiD, with the concept of ritual emerging as something nurses felt was missing and even enacted themselves when appropriate.<sup>6</sup> Rituals have a very real place in society and in healthcare (for example, annual memorial services), with nurses playing a vital role.

The VAD law was being introduced in Australia at the same time as a team at Flinders University were hosting a Massive Open Online Course (MOOC) on Death and Dying called ‘Dying2Learn’.<sup>7</sup>

The MOOC was freely available and targeted at the general public to introduce dying as a normal part of life, and to encourage open conversations. It was proposed that participants were asked about their thoughts on the possibility of new rituals emerging in relation to VAD being performed. In the 2018 MOOC we included an activity that looked at the social side of VAD, which aligned with the MOOC philosophy and approach of promoting socially constructed learning and conversation, rather than a medically focused curriculum.<sup>7</sup>

## METHODS

This work is taken from the Dying2Learn Massive Open Online Course (MOOC), hosted four times by the CareSearch project. Ethics approval related to the Dying2Learn MOOC was granted by the Flinders University Research Ethics Committee (Project 7247).

## DATA COLLECTION

In week three of the 2018 Dying2Learn MOOC, qualitative data in the form of participant responses to an open-ended activity were collected. The activity invited participants to reflect on what would change for families and friends if people choose to die rather than dying naturally (ie., not via a deliberate act) and what, if any, rituals surrounding this act could potentially emerge: “Let’s reflect on what will change for families and friends if people choose to die rather than dying naturally. Consider the rituals that we have surrounding birth (a baby shower before the baby is born and a christening, naming ceremony or similar after the baby is born). We also talked in Week 1 about people attending or hosting their own wakes. Do you think that these sorts of rituals will emerge in

our society relating to a known date of death? What do you think that these might look like? Remembrance rituals leading up to the day? Something special or significant on the day? Think about what this might mean for those close to the person who has chosen to die. You may like to come up with an idea for a new ritual that could help people to cope with this experience.”

## DATA ANALYSIS

Participant statements (n=508) responding to the activity were extracted from the MOOC learning platform. The data were de-identified, and imported into the NVivo 12 software package, with each statement classed as an ‘open-ended’ response. An inductive approach to thematic content analysis was conducted to identify key themes emerging from the data.<sup>8</sup> The emerging themes were classified into two broad overarching categories, which were related to the question that we posed to participants.

1. General views held in relation to VAD/MAiD.<sup>9</sup>
2. The rituals and funerals envisaged pre- and post-death, with the focus of this paper on pre-death rituals (ie., that may impact on direct care provision).

## RESULTS

The participants were a relatively homogenous group. Most were from Australia (90.4%), female (92.5%), with a mean age of 51 years. Just over two thirds (67.3%) had studied at university and just over three quarters (77.2%) identified as health professionals. Most had cared for someone with a terminal illness, whether in their work (68.5%) or their personal lives (64.0%).



## THEMES

### 1. Living wakes, parties, and celebrations (n=227, 44.7%)

Comments related to celebrations, wakes, parties, or funerals carried out before the person dies were the most commonly reported by participants.

"I wonder if death will go the way of high school graduations, weddings and pregnancy ... I worry that death will come with an events coordinator and a social media platform for likes. Imagine your life being rated by how good your funeral is ... actually, does that already happen? Imagine if the event was all planned and you changed your mind and ruined everything."

"I think when death becomes a choice, many of those dying would do something to "celebrate" their last days."

"I hate the idea of a pre-death party - what if no one turns up??? I don't like a party at the best of times - how will the small talk unfold?"

### 2. Respect for individual wishes (n=120, 23.6%)

Comments around the importance of respecting and honouring the preferences, choices and wishes of the dying individual and their loved ones when it comes to pre-death rituals were also frequent.

"Rituals are very individual and personal to the person and their families."

"I think that rituals would be really important in the case of a known death date. How wonderful for the dying person to be in control, to have the opportunity to create ritual and hold space for themselves and their loved ones."

"I'm not sure how I feel about a death on the calendar, you know, knowing the time and date. But if that is what my family member wants, then I'd support their right to die their way."

### 3. Time with loved ones (n=46, 9.1%)

Comments around the dying individual spending quality time with family and friends, saying their goodbyes, talking, and expressing their love before they die. Comments in this theme are more specific to *spending time together* than celebrating in a one-off event.

"People who have time to come to terms with imminent death gravitate to spending time with loved ones."

"... telling loved ones that you love them."

"Before I enter my end-of-life stage, while I still have my consciousness, I need to have time to say my goodbyes to family and friends so that I can be at peace with my private world."

## DISCUSSION

Participants had conflicting thoughts about VAD itself and about choosing your own date of death, with resulting themes of choice, control, and dignity published elsewhere.<sup>9</sup> In this study, an emerging concept was that social rituals were likely to evolve around VAD in much the same way that they have evolved around most life events (eg, weddings), potentially helping all involved to process what is happening and even to make lasting memories. Rituals are acknowledged as an important part of societies, cultures, and religions,<sup>10</sup> and integral to healing.<sup>11</sup> Considerations around what 'new' rituals may look like have been described by Luddeckens<sup>12</sup> in terms of a "transfer of ritual from one context to another".

As the nurses in Pesut et al.'s study found, VAD almost required the development of ritual or ceremony, with one nurse incorporating her own ritual before the patients' death,<sup>6</sup> perhaps providing a sense of comfort, and helping to sustain them and their colleagues. Ritual may also become important for families in dealing with a complex (and perhaps unwanted) reality whereby they can create value in what is happening, so consideration may be required in how to incorporate rituals

into care when enacting VAD. As one MOOC participant wrote:

*"Rituals are a process of dealing with a hard fact of life. Death is a well-established part of existence and I feel rituals and respect for peoples desires and preferences concerning their own passing is a growing and very important gift that the world at large can offer."* (participant response)

By far the most popular theme from the data is that of living wakes, parties, and celebrations whereby the dying person is present at their farewell. This may translate into a family gathering at the bedside at the time of a VAD death, or immediately before. Respect for individual wishes is a theme that emerged in relation to honouring the dying person's wishes and it is a consideration not only for families who may disagree with VAD, but also nurses for whom it may go against their own beliefs about end of life.

The personal fulfilment theme saw parallels with other work such as bucket lists,<sup>13</sup> and discussions on Advance Care Planning, in relation to documenting your wishes about future healthcare preferences.<sup>14</sup> Time with loved ones was highlighted as important, and parallels work on a virtual 'Before I Die' wall whereby participants in the MOOC cited time spent with loved ones as an

extremely important desire before their death.<sup>15</sup> Leaving a legacy was also found to be important with participants, who provided examples of how this might be achieved. This has also been found in palliative care, whereby people reflect on their illness and their life.<sup>16</sup>

## LIMITATIONS

A main limitation is that this is a specific cohort who are very educated and possibly already well informed about VAD, given their interest in a course about death. Many participants are health professionals, so again may have already formed opinions on VAD.

## IMPLICATIONS FOR NURSES

As VAD is increasingly practised in Australia, social rituals will likely emerge as they have done with other important life milestones. Consider your responses if family or friends want to have music, prayers, candle lighting, or singing, as a known date of death may see family gather and want to be present at the time of death. This is generally not possible with 'normal' dying, as while death is inevitable, family are often waiting on-edge for it to happen with little idea of the actual timing,<sup>17</sup> and with the dying person mostly unresponsive.

#### 4. Personal fulfilment (n=34, 6.7%)

Comments around the dying individual doing things of a personal nature, eg. achieving something or participating in certain activities (going through a bucket list, putting affairs in order), creating things (decorating their coffin), visiting certain places, writing their own eulogy.

"As the dying person, I might like to release balloons into the sky, representing the spirit of my life soon to be lost."

"I would love the opportunity to write my own eulogy ... that way I'm not relying on someone else to write my story."

"... some people are even building and painting their own casket."

#### 5. Leaving a legacy (n=16, 3.1%)

Comments related to the dying individual leaving things behind for others, eg. giving away their possessions, giving gifts to people, or writing letters or notes.

"You may like an aspect of Romani tradition. In our culture things are 'bequeathed' before we die. [...] This gets rid of a lot of burden to those left behind. Also, no disputes as it's all sorted, often years ago."

"I know a lady who purchased gifts for the people that will be left behind so that they would have one last gift from her that had meaning to both of them and that they could keep for the rest of their lives."

"Wouldn't it be wonderful if it were our community practice that, upon hearing of someone's impending death, we all wrote letters to the person, thanking them and relaying our most precise memories and learnings from contact with them."

#### 6. General views on rituals before death (n=19, 3.7%)

Participants expressed their general view on pre-death rituals (whether they think they are important).

"I foresee that our future pre-death rituals will be something warm and positive since nobody wants to go in an ugly way."

"Within the passages of life, birth and death is a very private thing. I'm not sure about rituals and being able to pinpoint the moments of death."

"I do think that new rituals will emerge around "send-offs" for people who decide upon a planned death as opposed to a natural one."

"My imagination is going mad thinking about possible death rituals!! Would you have a "Goodbye" planner like you do a wedding planner? Would an etiquette evolve around who you would have to see in your final days? What if you changed your mind at the last moment?"

There are implications for nurses regarding participation in planning and enacting VAD, as well as for colleagues in the ward/unit who may be drawn into pre-death practices or rituals or into the act itself (pharmacists, doctors, healthcare workers, ancillary staff, etc.), especially if it is a long-term patient. Also to be considered is the choice as to whether to be present or not,<sup>18,19</sup> or on the periphery through supporting family, friends and colleagues.

#### CONCLUSION

Dying by VAD will be seen and experienced increasingly. Understanding the anticipated pre-death rituals and plans surrounding VAD offers important insights for health professionals involved, and for the important conversations likely to unfold with patients and families at this time.

#### Authors

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## Hesitant but hopeful: Empathy for COVID-19 vaccine uncertainty

**Being a health professional is about empathy as much as it is about evidence.**

With the recent announcement of a government deal with the manufacturers of the Moderna mRNA-type (same as Pfizer/Comirnaty) vaccine, Australia may have at least three different COVID-19 vaccines on offer, providing it is approved by the Australian Therapeutic Goods Administration (TGA), by the time this column goes to print.

The Moderna vaccine has demonstrated high efficacy, safety, and effectiveness overseas. In the United States, the Pfizer-BioNTech or Moderna COVID-19 vaccines was 94% effective against COVID-19 hospitalisation after two doses and 64% effective after one dose in adults  $\geq 65$  years.<sup>1</sup>

Elsewhere, I have written in greater depth about how the COVID-19 vaccines work,<sup>2</sup> their effectiveness,<sup>3</sup> safety and side effects.<sup>4,5</sup>

In summary, as we've all heard many times: "the COVID-19 vaccines are safe and effective". This includes the AstraZeneca vaccine, which is still highly efficacious at preventing symptomatic COVID-19, severe and critical disease, and hospitalisation despite reports of extremely rare instances of blood clots.<sup>6</sup>

Perhaps it's a combination of desensitisation to being told repeatedly by experts and politicians (often mutually exclusive) that the vaccines are safe and effective and at once bombarded by media reports of the latest (almost exclusively minute) number of adverse reactions that has resulted in an increasing sense of hesitancy and even antipathy towards the prospect of vaccination.

In my last column, I wrote about risk society and its postmodernist challenge that knowledge claims about reality are problematic and contestable. Within a postmodern risk society, "the evidence" can be disputed and claims of "truth" reproved with "alternative facts". But apart from this philosophical explanation of why people may be ambivalent despite, or even because of, the evidence, what else can explain vaccine hesitancy in more practical terms?

There are many contributing factors to vaccine hesitancy. People with lower incomes and lower levels of education tend to be more hesitant towards vaccination.<sup>7</sup>

Having to attend an unfamiliar setting (ie. a mass vaccination clinic) can also be a factor.<sup>8</sup> Being a member of a marginalised group can also be a factor due to the history and experience of systemic racism, abuse, and neglect.<sup>9</sup> Knowing why people may be hesitant is one thing, but actively and sympathetically addressing it is another.

Hesitancy is perhaps most usefully thought of as a modifiable state rather than a fixed trait. That is, people update and change their opinions and positions regarding their willingness to receive the vaccine based on a complex range of information, influences, and contexts. This can be readily seen in how before COVID-19 vaccines arrived, there appeared to be an immense sense of hope and urgency that was quickly replaced with uncertainty when they finally did.

Being a health professional is about empathy as much as it is about evidence. Championing truth while at once empathising with patients.<sup>10</sup> Patients who aren't across the latest evidence may be understandably concerned – even frightened – by the prospect of experiencing a rare adverse reaction to a new vaccine.

Another part of being a health professional is the responsibility to provide individualised person-centred care and meeting people where they are at. This includes enabling people to make the best decisions for themselves regarding their health and wellbeing while informing them in an understandable manner about the evidence and potential risks while allaying their fears and attempting to empathise with their situation. Nurses are by far the most trusted profession,<sup>11</sup> and a vital source of health information for patients and community members.<sup>12</sup> Health professional recommendation is one of the most effective approaches to increase vaccination.<sup>13</sup>

By understanding why people may be hesitant to receive a vaccine and coming equipped with honest, easy to understand evidence-based information about the benefits and risks of vaccination, nurses can help to shift people from hesitant to hopeful and ensure both the safety and wellbeing of their own patients and the wider community.

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**Naomi Riley**

Federal Professional Officer

## ANMF joins *Thrive by Five* campaign

***Thrive by Five* is an initiative of the Minderoo Foundation campaigning to make Australia's early learning childcare system high quality, affordable and universally accessible.**

Joining the Campaign was an obvious choice for ANMF. Access to high quality, affordable early learning and childcare impacts the health of children, families and communities across generations. Nurses and midwives are affected by inequitable access to childcare. As a female-dominated profession, it is essential we work in unity with other stakeholders to address cross-sectorial gender inequality.

As nurses and midwives, we know how crucial the first five years of a child's life are for optimal growth, development and health into adulthood. Our work with families with infants and young children aims to optimise growth and development for lifelong health and wellbeing.

A well-developed early learning and childcare system would complement this work by recognising the relationship between development, health and education. Childcare must be viewed first and foremost as an opportunity to invest in children's health and development. Every child needs politicians to shift their thinking to view time spent in early learning and childcare as a chance to give all kids a head start in life.

This investment will be repaid with interest. While children are at the heart of the *Thrive By Five* campaign, early learning and childcare reform will have far reaching implications for the broader community. The Campaign highlights the significant economic, social and educational costs that currently exist and follow on from an underfunded and poorly structured early learning and childcare system. Decreased workforce participation, lower educational outcomes, widening gender disparity, and increased burden to care for older Australians, just to name a few.

To explore this, let's take financial security for women as an example. Women are more likely to reduce workforce participation to care for their children and counterbalance childcare costs. They are also more likely to have been earning, and to earn, a lower wage than their male counterparts before and following becoming a parent. Consequently, women's already reduced lifetime earning capacity is compounded by a lack of viable childcare options. By providing early learning and affordable childcare, high quality and accessibility to all, women will gain increased choice over their workforce participation and be more likely to achieve economic independence.

Higher lifetime earnings and increased superannuation contributions for women will not only offer their family additional financial security but also deliver an economic benefit of greater financial independence in retirement. It will also help women to leave an abusive relationship, according to fellow campaign supporter White Ribbon Executive Director Brad Chilcott.

Financial security and employment opens up options for women and creates opportunities for security in the face of family violence. Lastly, this reform enables women to continue to progress their career and for all people in Australia to benefit from the skills and expertise women contribute across all sectors whilst caring for children.

As many nurses and midwives are parents and carers themselves, the *Thrive By Five* campaign narratives around early learning and childcare access and affordability are also relevant. Shift work, rotating rosters, long shifts and night shifts make it difficult for many nurses and midwives to access affordable, quality childcare that aligns with their work hours. The Campaign offers the ANMF the opportunity to highlight the challenges nurses and midwives who are parents and carers experience to balance workforce participation and care responsibilities and lobby in unity with other organisations for a more flexible and universally accessible system.

Recent budget announcements to deliver funding of \$1.7bn to the sector falls short on delivering the reform needed. Governments need to think beyond childcare as a childminding service and embrace the educational, economic and societal benefits that will flow on from investment in early childhood education not just for children, women and families but all people in Australia.

So what can you do to show your support for the campaign alongside the ANMF?

Visit the campaign at [thrivebyfive.org.au](https://thrivebyfive.org.au) and get involved by:

- Signing the petition;
- Signing the open letter; and/or
- Sharing your story about accessing early learning and childcare or the impact of childcare fees on your family and participation in work.



Debbie Richards

Federal Industrial Officer

## Government's response to aged care reform remains disappointingly lacking

**The Royal Commission into Aged Care Quality & Safety Final Report found that the aged care workforce is understaffed, underqualified and underpaid. So what has been the government's response to the Commission's recommendations and will it be enough?**

The Final Report the Commission released on 1 March 2021 presented a bleak picture of substandard care and recommended a complete overhaul of the system, with 148 recommendations across all areas, including a new aged care Act centred on the rights of older people in need of care.

The report left no doubt about the scale of rebuilding required to ensure our elderly receive the quality, safe care they require and what we as a community should expect and demand.

The report highlighted that the current aged care system is "understaffed, and the workforce underpaid and undertrained." It was made clear that the provision of high quality and safe care could not be achieved without enough staff with the right skills and sufficient time to provide care. While the Federal government has accepted a number of the Commission's recommendations relating to the aged care workforce, the measures proposed and timetable for implementation do not go far enough and fall well short of what would be required to fix the system.

### Staffing levels and skills mix

The Commission recommended a "minimum staff time standard" for residential aged care of 200 care minutes per average resident per day by 1 July 2022, including a minimum of 40 minutes of care provided by a Registered Nurse (RN). This is to increase to 215 minutes a day by 1 July 2024 with at least 44 of those minutes provided by an RN. In addition, the Commissioners recommended an RN be on site on the morning and afternoon shifts (16 hours per day) by 1 July 2022 and that by 1 July 2024 there should be an RN on site in each facility at all times.

The government accepted the recommendation for a minimum staff time standard which is a good start but leaves residents waiting until 2023 before an 'acceptable' level of care is reached. There appears to be no plan to increase the minimum care time to 215 minutes with at least 44 minutes of registered nurse care and no plan to provide an RN on site 24 hours a day.

### Minimum qualification

The Commissioners recommend that a certificate III be the mandatory minimum qualification required for personal care workers working in aged care. The

government has sidestepped this recommendation stating it will be subject to further consideration in the process of developing a 'Care Workforce Strategy'.

### National registration scheme

The Commissioners recommend a national registration scheme for the personal care workforce that includes a minimum certificate III qualification; ongoing training requirements; minimum level of English proficiency and a code of conduct. While the government's response indicates it is accepting this recommendation "in principle," the detail suggests a much watered down version requiring a pre-employment screening check; a nationally consistent code of conduct and a register of cleared and excluded workers commencing by 1 July 2022.

### Improving pay for the aged care workforce

The Commissioners highlighted the wage gap between aged care workers and workers performing equivalent functions in the acute health sector, noting that past attempts to address the pay discrepancy through providing additional funds to providers with the hope it would go to wages had failed. The Commissioners recommend unions instigate both work value and equal remuneration applications and collaborate with the Australian government and employers in relation to the applications.

The government's response to improving pay and condition of the aged care workforce predictably avoids the wages issue by 'noting' the case before the Fair Work Commission to increase rates of pay in the Aged Care Award. The government has not provided any positive support for increased wages in this sector so far, nor committed to any increased funding specifically tied to improving wages and conditions.

The ANMF's application to the Fair Work Commission to increase rates of pay for personal care workers under the Aged Care Award, and nursing assistants, enrolled and registered nurses under the Nurses Award employed in aged care by 25% is currently in progress.

At the time of writing, our requests seeking collaboration with the Federal government and aged care employer groups in line with the Royal Commission recommendation have been ignored.



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A close-up, high-angle photograph of a person's ear, showing the ear canal and the surrounding skin. The person has dark hair. The image is used as a background for the text.

## Reimagining listening in clinical practice

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By Sean Botha (HS Botha)

**Nurses are regularly confronted with making difficult and critical decisions in fast paced environments. These decisions, in many cases, are life-altering for patients and their families.**

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The most intensive settings where nurses' clinical decision-making are at the forefront of care are Emergency Departments or intensive care. Additionally, nurses are faced with being part of a changing health industry on a global scale. We can thank COVID-19 for throwing healthcare into the virtual space without any warning. This means that clinicians need to be willing to be part of positive change for the health sector, no matter in which country we find ourselves.

How nurses, doctors and other health professionals listen is a significant component of healthcare. A recent research project conducted by Sean Botha<sup>1</sup>, rethinking listening practice, became an integral part of current creative practices. Botha<sup>1</sup>, indicates that the process of listening takes on aural, gestural (physical) and visual dimensions. The study was conducted in the field of music and the researcher found that the art of listening is a universal practice applicable to a variety of professions. The study did not take any clinical or scientific approaches, although, with minimal clinical interference, Botha<sup>1</sup> considered the four major elements our bodies need to make energy in our body.

The body needs oxygen, carbon dioxide, water and glucose to create energy<sup>2</sup>. It is this energy that nurses use to listen and communicate. Every emotion, physical action and behaviour are directly linked to how the nurse listens.

From a creative perspective, Botha<sup>1</sup> considered the work of John Cage.

John Cage<sup>3</sup> was a 20th-century composer who visited Harvard University in search of answers as to whether or not silence truly existed. Cage entered an anechoic chamber and what he found was the opposite of silence. He found sound, he heard the movement of the electricity in his own physical body, which is known to be integral in our neural pathways. He even went on to create a piece of music entitled 4:33" where the pianist would sit in front of a piano and not touch a single note on the instrument. This meant the audience was listening to the rustling of paper, people sneezing, coughing, moving around, the wind outside the performance hall and maybe even the sound of rain. Each sound became music and asked every member of the audience to become acutely aware of their immediate environment. One can even go so far as to say that the audience members became aware of one another's presence.

Nurses become desensitised by the noise they are surrounded with, alarm bells, call bells, heart monitors, people talking in the background and phones ringing. Nurses need to take these sounds they have become accustomed to and place them in "sound capsules" where the ability to listen is not compromised.

Nurses need to re-evaluate how they listen in the clinical space and ignore multiple sound events to obtain an accurate blood pressure reading that will reflect the true status of patients. Nurses need to bring the patient into focus with undivided attention when an in-depth assessment of their mental health status is conducted. Botha<sup>1</sup> suggests that listening practice consists of four major dimensions: what is heard, seen (physical behaviour) and read (patient notes). The fourth dimension is the nurse. This fourth dimension is directly influenced by the type of energy the body creates and is influenced by the type of fuel introduced to the physical body every day.

Nurses' clinical practice can be questioned when technology is involved in patient care. For instance, computers used to document medication administration and write patient notes could interfere with nurses' listening skills. Especially when patient assessments are conducted. Nurses need to know what to focus on and what sounds need to be placed 'on hold'.

Therefore, the nurse needs to differentiate between critical awareness, critical listening, focus and offering emotional support when needed. This is where silence or quiet moments, as described through the work of John Cage<sup>3</sup> and the use of mindfulness, is of critical importance in the clinical setting. The emotional needs of patients are found in what they are not saying, their physical movement or the lack thereof.

The argument for critical listening can be condensed into four points of reference and be of benefit to the clinician. The following four aspects of clinical practise should be considered:

- 1. ENERGY:** Unhealthy food can potentially lead to poor energy, feeling run down and create unnecessary communication barriers. Eating healthy food can potentially improve your attention and awareness in the workplace.
- 2. SILENCE:** True silent moments do not exist in any clinical settings. Nurses and other medical professionals are always surrounded by sound and noise. It is how one works with these occurrences

or moments which will dictate their responses (verbally and physically).

- 3. SOUND:** Know and understand your workspace, become aware, critically aware. Use the sounds you are confronted with to your advantage.
- 4. LISTEN:** Pay attention to how you listen. How much energy do you need to listen to your patients and colleagues? How do you engage with or address the patient's needs? How much information can you obtain by paying attention to the moments when your patient is not talking to you? How is your patient physically moving and behaving? Can you reach out and give your patient extra time when you can see they need you?

Botha's<sup>1</sup> research may have been in the field of music analysis, although the need for progressive clinical practice was identified through ongoing observation of student nurses in the tertiary educational environment.

The health industry needs assistance with improving listening practice in the clinical setting. Botha<sup>1</sup> openly admits to observing the same need in other professional industries such as the arts, and nursing is no different.

The questions to each reader are this: Do you want to be a progressive clinical nurse who listens to patients on a deeper level? Do you want to move from being aware in your workplace to being critically aware? Lastly, do you want to be a critical listener for your patients and your colleagues?

### Author

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# Nurse-led alcohol clinic: Increasing access to drug & alcohol treatment

Melise Ammit and Nick Miles

## INTRODUCTION

The adverse effects of alcohol use account for many hospital presentations and admissions. Excessive intake of alcohol is responsible for 3.3% of the total disease burden in Australia.<sup>1</sup> People who attempt to cut down or quit their consumption due to health concerns can experience barriers and delays in accessing appropriate care.

This paper describes an innovative approach to increasing access to alcohol treatment: a nurse-led clinic that offers safe, evidence-based care.

Provision of nurse-led treatment in a community health environment aligns with the National Safety and Quality Health Care Standards<sup>2</sup> by improving patient experience of care, improving the health of populations and reducing per capita cost of healthcare.

A literature search revealed this stand-alone nurse-led alcohol clinic's uniqueness integrated within a large public Drug & Alcohol (D&A) service.

## BACKGROUND

Approximately 17% of Australians drink alcohol at levels that place their health at risk.<sup>3</sup> Despite levels of risky consumption remaining stable, alcohol-related hospital separations continue to increase. Over 30% of Drug & Alcohol (D&A) treatment episodes are for alcohol, making it the most commonly treated drug in Australia.<sup>4</sup>

Outpatient treatment for alcohol use disorders is a safe and effective option for many people.<sup>5</sup> Ambulatory alcohol withdrawal - home-detox - has the same safety and efficacy profile as inpatient treatment.<sup>6</sup> While anti-craving pharmacotherapies, such as Acamprostate, Naltrexone and Disulfiram, are shown to be effective, they are often underutilised in treatment settings.<sup>7</sup>

Nurse-led models are well received by the community. Specialised nurses are shown to deliver convenient, safe, evidence-based

treatment that meets patients' needs.<sup>8</sup> Research shows that nurses can produce positive health outcomes for patients with a range of chronic health problems and that nurse-led care effectively promotes patient adherence to treatment and patient satisfaction.<sup>9</sup>

## AIMS

- To reduce harms from alcohol use (provide safe, evidence-based outpatient alcohol interventions).
- To minimise barriers in accessing alcohol withdrawal treatment.
- To enhance links between acute services and primary care networks.

## IMPLEMENTATION

The clinic is located in a suburb of Sydney within a large local health district. Alcohol attributable hospital admissions for this area account for 697.7 per 100,000 of population, slightly higher than the state average.

The guiding principles of this clinic are based on Australian government policy recommendations outlined in the *National drug strategy 2015-2025*,<sup>10</sup> and the *Australian guidelines for treatment of alcohol problems*.<sup>11</sup>

Harm minimisation is the central tenet of health policy for substance use in Australia. Harm minimisation comprises of three tiers, including Supply Reduction (policing), Demand Reduction (education) and Harm Reduction (health). Harm reduction is a pragmatic approach based on the acceptance that substance use exists and is likely to continue. Harm reduction means that abstinence may be one of a range of strategies, not the only goal.<sup>12</sup>

This project's procedural guidelines were adapted from existing service delivery models from within Australia and in accordance with state government guidelines: *Identification and treatment of alcohol and other drug issues*, and *NSW Health drug and alcohol withdrawal clinical practice guidelines*.<sup>12</sup>

## SERVICE DESIGN

Located within a community healthcare centre, the nurse-led clinic operates four days a week. Patients can self-refer and referrals from GPs and other clinicians are accepted. The clinic staff consists of one clinical nurse specialist - responsible for intake, screening, scheduling appointments, and daily treatment reviews. A nurse practitioner who provides clinical consultation and prescribing of diazepam withdrawal regimes and anti-craving alcohol pharmacotherapies.

Eligibility criteria require the patient to have no history of complicated alcohol withdrawal, and no use of multiple psychoactive substances, or history of suicidal ideation. People deemed not appropriate due to medical complications, or poly-drug use are triaged to an acute medical service. Reasons for exclusion may also include severe or multiple medical comorbidities, unstable psychiatric issues, and lack of safe and supportive home environment.

## SCREENING AND BRIEF INTERVENTIONS

Brief interventions are a strategy that can offer support to clients prior to treatment entry; they typically target individuals using at risky levels before they develop into abuse or dependence disorders. Brief interventions aim to identify a real or potential substance use problem and motivate the individual to do something about it.<sup>13</sup> Harm reduction and controlled drinking strategies can be delivered either as a one-off intervention or while clients consider further treatment.

## WITHDRAWAL MANAGEMENT

Management of withdrawal is in accordance with clinical guidelines for alcohol withdrawal and includes medication with daily provision of diazepam for four days. Clients are required to attend the clinic daily for blood alcohol, withdrawal and vital

## CLINICAL UPDATE

sign monitoring, blood testing and care coordination and support. Thiamine is also provided to prevent the risk of Wernicke's encephalopathy.

### CASE COORDINATION AND REFERRAL

Clients are offered group and individual counselling and encouraged to attend mutual aid groups such as SMART Recovery and Alcoholics Anonymous.<sup>14</sup> This can occur either before or after the commencement of withdrawal management. Clients can be assisted to enter rehabilitation programs if that is what they would like.

### PHARMACOTHERAPY

Clients can be prescribed medication to help them reduce their alcohol intake and maintain abstinence from alcohol. Acamprosate and Naltrexone are the first-line treatment options in Australia.<sup>15</sup> The well-documented safety issues of Disulfiram can be mitigated by prudent patient selection and supervision of dosing.<sup>16</sup>

### RESULTS

Data was collected within the first year of clinic operation. The sample consisted of 68 people, 64% female and 36% male. The

median age for women was 53 years of age and 45 years for men. (see figure 1)

One-third of referrals to the clinic came from GPs requesting alcohol treatment advice and from people who did not meet outpatient treatment criteria due to a history of seizure, withdrawal complications or poly-drug use. These patients were referred to specialist and inpatient services.

Forty-eight people received treatment at the clinic. Twenty-one people commenced withdrawal treatment, with 85% (n=18) completing the four-day treatment regime. Over half of these people were also prescribed an alcohol anti-craving medication such as Acamprosate, Naltrexone or Disulfiram; 39% reported abstinence at one month.

Twenty-seven people received brief interventions, relapse prevention support, and alcohol anti-craving pharmacotherapy. Of these, eleven remained abstinent and three had reduced alcohol consumption after one month.

Waiting time from intake to the first appointment was less than a week in over 90% of cases. (see figure 2)

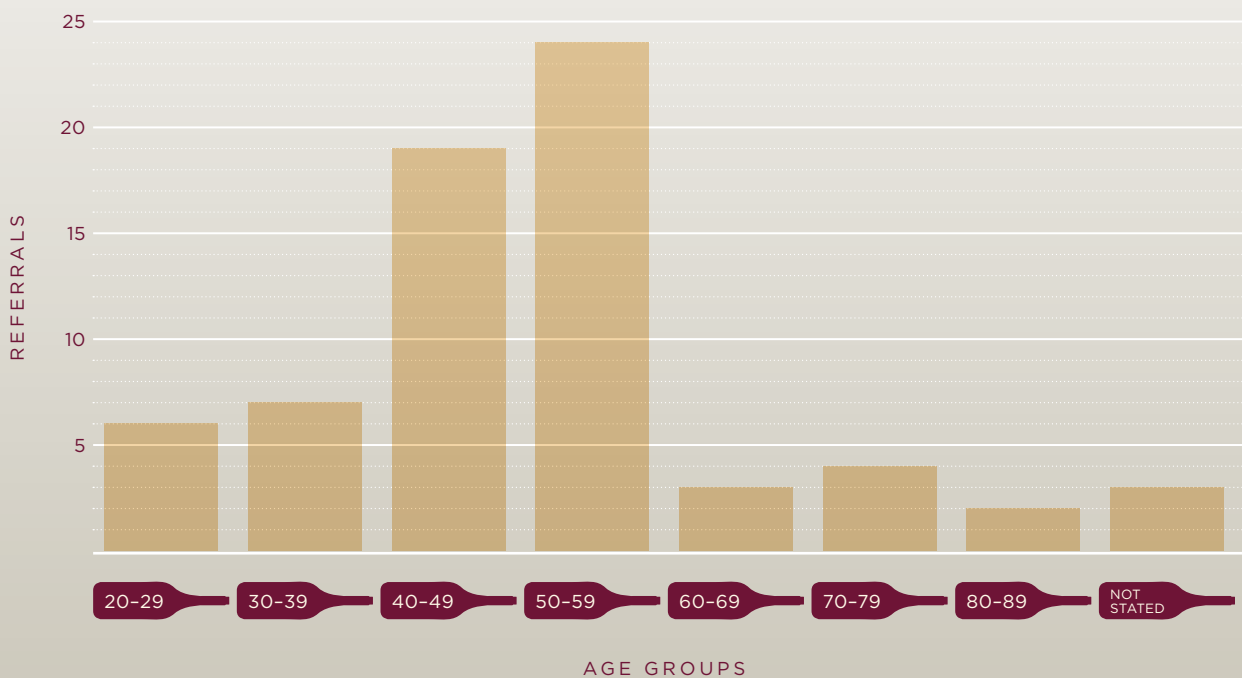
### DISCUSSION

People can experience barriers to accessing alcohol treatment, both personal and organisational. Admitting the need for treatment can be hindered by ignorance of treatment availability or lack of understanding about what treatment entails.<sup>17</sup> Separate silos of care exist and the nomenclature of alcohol treatment and the intake procedure can be confusing; patients are often unsure whether they need 'detox', 'rehab', 'counselling', 'pharmacotherapy', 'a specialist' or all of the above.

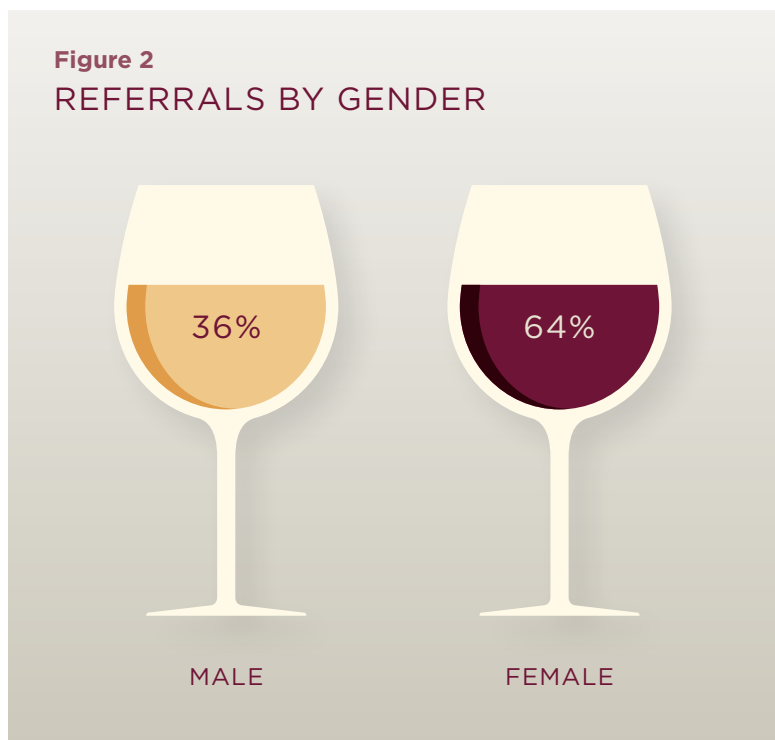
These barriers are diminished within this nurse-led model. Patients are able to self-refer to the clinic - a GP referral is not required - and the nurse who answers the initial phone call can advise on appropriate treatment options and make referrals, even if the person does not meet the clinic criteria. The small, dedicated staff allocation allowed for scheduling flexibility and continuity of care as the intake nurse is the same nurse who provides clinical treatment.

Ease of referral, short waiting times, and satisfaction in meeting treatment goals are the main areas of positive feedback. This reflects current research that shows nurse-led clinics are associated with high levels of patient satisfaction and are effective in

**Figure 1**  
**REFERRALS BY AGE**



**Figure 2**  
**REFERRALS BY GENDER**



improving treatment accessibility and enhancing patient health outcomes.<sup>18-19</sup>

Outpatient withdrawal is an acceptable first step treatment for alcohol dependence.<sup>20</sup> The high completion rate of 'home detox' episodes and resultant abstinence at month are comparable to inpatient rates and demonstrate that primary care nurse clinics can deliver cost-effective, safe evidence-based care that relieves hospital burden.<sup>21</sup> Furthermore, the clinic nurse practitioner (NP) is able to diagnose, treat and prescribe for patients without medical oversight.<sup>22</sup> The autonomy inherent in the NP role allows for flexibility of care that enhances a person-centred focus that promotes patient adherence to treatment.

The dominant cohort of females aged 45 to 60 presenting to the clinic is significant. Recent statistics from the Australian Institute of Health and Welfare demonstrate the emergence of hazardous alcohol use in midlife women.<sup>23</sup> This female age group most likely to exceed the lifetime risk guidelines for alcohol consumption are also the least likely to seek treatment.<sup>24</sup> While men often exhibit denial of their drinking, women tend to exhibit guilt and shame. This has implications for future

alcohol treatment planning; research suggests that gender-sensitive approaches can redress the current imbalance of male-dominated service providers.<sup>25</sup> Feedback from women indicated satisfaction with both accessibility and acceptability of treatment, citing discreet location of clinic, appointment flexibility, female clinician and gender-relevant referral pathways as positive factors.

## CONCLUSION

Nurses play an important role in delivering comprehensive patient-centred care in primary care settings, and nurse practitioners can manage complex circumstances, including specific pharmacotherapy and treatment. Outpatient alcohol models have been shown to be as effective as inpatient treatment regarding safety and outcomes; they are cost-effective and reduce barriers such as stigma. Nurse-led clinics are well received by the community and are an acceptable option for women and those less likely to seek alcohol treatment.

## Authors

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# Professional dominance and the oppression of the nurse: The health system hierarchy

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By Hannah Ferguson and Dr Judith Anderson

The healthcare system has come a long way from its traditional roots of hierarchal and subservient relationships between physicians and other healthcare professionals.<sup>1</sup>

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The nursing profession is one that is often perceived, even by nurses, as the caring profession, and often stays removed from the political scene. Together these features contribute to its ongoing struggles with subordination and power dynamics between themselves and other healthcare professions, predominately medicine.<sup>2</sup> (When one profession holds dominion over another, it silences the other, creating oppression; the nursing profession are often regarded as an oppressed group.<sup>3</sup> The following paper analyses, through personal reflection, oppressed group behaviours of the nursing discipline within the context of patriarchal oppression.

## THE INCIDENT

A 23 year old male, was transferred to the medical ward from the emergency department (ED) following a mechanical fall from a bicycle. Imaging reports showed two fractured ribs with no other underlying injuries; however, the patient complained of significant pain and therefore a cumulative dose of 100mcg fentanyl intravenously, 25mcg fentanyl subcutaneously and 5mg oxycodone had been administered in the ED. The patient was awaiting a head CT\* to rule out head injury. The patient appeared drowsy but orientated and the Registered Medical Officer [RMO] in attendance stated they were not concerned regarding the amount

\*Computed tomography scan

of pain relief administered, advising to let the patient “sleep it off”. Later I noticed the patient’s lips looking blueish. I was able to rouse him by calling his name, his colour returned, and he was orientated to his surroundings. Oxygen saturations were 90% trending up and respiratory rate 11. I applied oxygen 2L/min via nasal prongs believing pain relief to be the cause and notified my Team Leader [TL] and RMO.

The RMO assessed the patient and requested that I remove the oxygen as the patient had been “oxygen free in ED and it is counter-productive in people who do not need it”. I explained that I was concerned the patient’s oxygen requirements were unmet as I had witnessed his lips turn blue to which the RMO responded ‘allegedly’. My TL in attendance explained I was a new nurse and that they would assist me with the patient’s ongoing care. I removed the oxygen from the patient but kept the oximetry on to monitor oxygen saturation. The patient drifted off to sleep and the alarm bells on his oximetry rang, I attended the patient again: he was blue around the lips, his oxygen saturations 76%. I called for assistance but was able to rouse the patient using painful stimuli, my TL witnessed this episode and initiated



a MET call. The patient's oxygen saturations trended up to 95% on RA but my assessment was that he needed oxygen. The RMO came to examine the patient who was again orientated and chastised me in front of the MET team for continuing to apply oxygen on a patient who did not need it. At this point the TL had escalated the situation to the bed manager.

I voiced I was not comfortable leaving the patient oxygen free as he continued having apnoeic episodes. The bed manager removed the oxygen stating they would observe the patient. The patient drifted off to sleep again and the oxygen saturations began to drop. The bed manager attempted to rouse the patient using both voice and painful stimuli but was unsuccessful, oxygen saturations were 65% on RA. A MET call was commenced, airway management initiated, and oxygen applied; the patient woke up. The MET team assessed the patient a second time, this time agreeing that the patient was narcotised on the background of the cumulative dose of fentanyl and oxycodone.

### PROFESSIONAL DOMINANCE

Benoit et al. p. 475<sup>4</sup> defines professional dominance as 'the way in which certain professions control the content of their work (autonomy), define limits of the work of others (authority), and act as state-supported experts regarding the public's health (altruism)'. The incident described demonstrates a power dynamic between the RMO and the nurses where dominance was asserted over the registered nurse, TL and the bed manager. For centuries the medical profession has monopolised the design of healthcare, holding a disproportionate amount of power in relation to the delivery of care with other healthcare professionals collectively submitting to their authority.<sup>2,5</sup> Whilst healthcare has progressed significantly by moving towards care models that utilise a team-based approach, the surrender of power does not happen overnight.<sup>15</sup>

### NURSES: THE OPPRESSED GROUP

Nurses are the largest group of healthcare workers and yet continue to struggle to develop our political voice.<sup>6,9</sup> There are many factors that have influenced nurses as an oppressed group; in particular class and gender.<sup>7</sup>

Nurses are viewed as being inferior to medical doctors and also inferior as women (gender) in a patriarchal society.<sup>7,8</sup>

Women represent approximately 90% of the nursing and midwifery workforce meaning women, by sheer numbers, should have a larger voice in terms of healthcare delivery.<sup>9</sup> However, medicine has historically been associated with men and although women have increased their representation within this workforce to approximately one third, medicine and nursing continue to be gendered workforces.<sup>10</sup>

Historically nurses adopted the working-class pseudonym of 'hand maiden' being present to

make the doctor's job easier. This pseudonym has continued to have an impact on professional autonomy, even after the transition of nursing education into universities.<sup>3</sup>

Congruently, women are raised in a patriarchal system that views them as 'less' and creates injustices as a result of gender.<sup>11,12</sup> The patriarchy sets values which are to be considered the 'norm' and to break from oppression requires us to assimilate the image of the oppressor.<sup>3</sup>

On reflection of the incident presented we can see nurses continue to be an oppressed group, as neither registered nurse, team leader nor bed manager challenged the RMO on their direction. All removed the oxygen even against their better judgement. It was not until the patient's condition significantly deteriorated and other medical professionals agreed that the appropriate care was given.

### OPPRESSED GROUP BEHAVIOURS

Oppressed groups exhibit behaviours that are toxic to a workplace. Stanley states 'Powerless groups, who are unable to act against their oppressors or feel unable to change their circumstances, commonly vent their frustration on the least powerful within their own group'. p. 3210<sup>11</sup>

It is widely recognised that nurses, as a group, report in-house aggression, lack of unity, fear of authority and change, low self-esteem and horizontal violence.<sup>3,8,13</sup>

The consequences of these behaviours negatively affect patient outcomes.<sup>14,15</sup> Whilst the incident described focuses on the actions of a registered nurse and an RMO, it also highlights the lack of unity within the nursing team. With each apnoeic episode I escalated I was told I was wrong, and my nursing peers were either silent or agreed with the RMO. I was frustrated at how the events were handled and how I was spoken to, yet failed to voice that appropriately and professionally. Instead, I cried in the medication room and was passive aggressive toward the TL who originally questioned my assessment.

I have learnt a lot from the incident and feel as though I have been able to grow and mature as a nurse. I use myself now as a catalyst for creating a positive work environment, ensuring that after each shift I thank my team individually for a 'good shift' and recognise the part each team member played. Tillott et al.<sup>15</sup> recognises this philosophy, by discussing the importance of empowerment and engagement with one's work peers as a necessary step to eliminating workplace hostility and oppression.

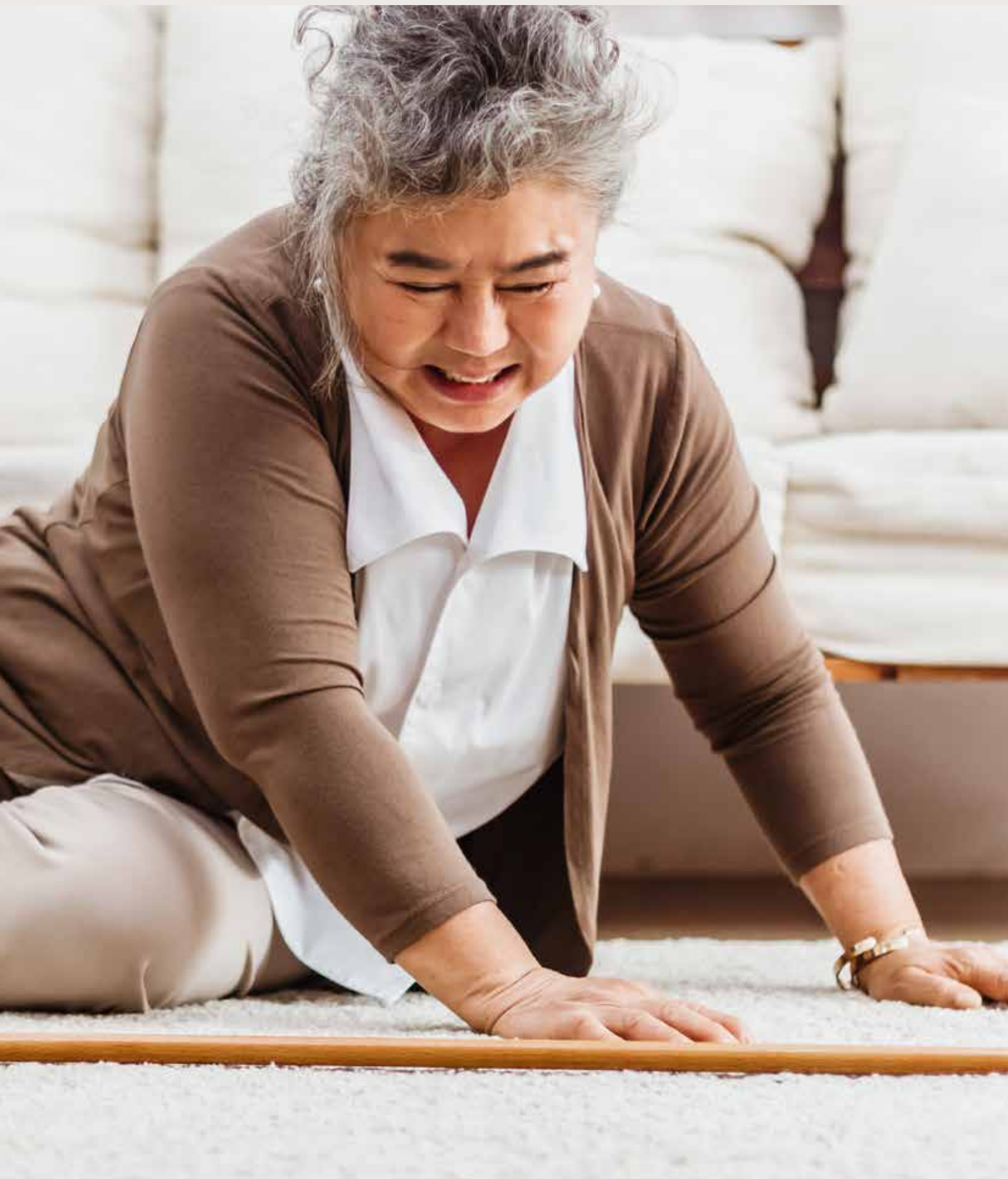
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# Falls Prevention

By ANMF Federal Education Team

**Falls can impact an individual in many ways. These impacts can cause physical injuries, have negative social consequences and induce psychological distress. Therefore falls prevention programs are essential to decrease the risk of an individual falling and experiencing these negative effects.**

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

The World Health Organization (WHO) defines a fall as 'an event which results in a person coming to rest inadvertently on the ground or floor or other lower level'.<sup>1</sup>

Any falls-related injuries are classified as fatal or non-fatal, with most falls being within the non-fatal category.

Although most falls are non-fatal, worldwide 37.3 million people require medical attention every year due to falls.

- Worldwide, falls are the second leading cause of death resulting from accidents of unintentional injuries
- People over 65 years of age have a higher risk of falling
- 30% of Australians over the age of 65 experience at least one fall per year
- In Australians aged over 65 years, falls account for 40% of all injury-related deaths
- With the population ageing, the number of people experiencing falls is also expected to rise.<sup>2</sup>

There are many different injuries associated with falling.

#### These include:

- Cuts and abrasions
- Soft tissue damage and bruises
- Fractures
- Head injuries

The hip and thigh are the most commonly injured areas following a fall that require hospitalisation.

Most hip fractures (91%) are caused by falls, and they are one of the most common reasons for hospital admission.

Hip fractures cause increased morbidity and increase the risk of death for the individual. They can also increase the likelihood that

the individual will need to be admitted into a residential aged care facility following their fall and injury.

Wrist fractures are also a common injury following a fall due to the instinct to use your hands to break your fall. These injuries can be severely debilitating for the individual and result in a decrease in their level of independence.

People who have fallen can also develop a fear of falling and lose confidence in their ability to walk. This can then reduce their independence and consequently their quality of life. An increased burden can then be placed on their family and caregivers to undertake more care responsibilities for the individual.<sup>2</sup>

#### FACTS

- Falls can occur in all age groups and in all environments.
- Adults over the age of 65 are more at risk of falling due to both environmental risk factors and personal risk factors.
- The more risk factors an individual has, the more likely it is they will fall.
- Both genders are at risk of falls equally. However, some studies have shown that males are more likely to suffer from fatal falls than females.
- Increased length of stay in a hospital setting increases falls risk.

#### RISK FACTORS

Falls commonly result from a combination of risk factors as 'the risk of falling increases with the number of risk factors that are present'.

The number of risk factors increases as a person ages.

Risk factors can be classified in a number of ways. One of the well-known methods is to classify them as either personal (intrinsic) or environmental (extrinsic).

Personal risk factors include individual characteristics such as age, gender, ability and health conditions.

Environmental risk factors refer to hazards found in and around the home and public places, such as uneven surfaces and the lack of hand or grab rails.<sup>3</sup>

#### THE IMPORTANCE OF FALLS RISK SCREENING AND ASSESSMENT

Falls risk screening and assessment tools identify patients at an increased risk of falling. They then prompt us to implement strategies to help decrease this risk of falling.

Screening can determine whether a person has a low or high risk of falls and assessment of risk can inform prevention strategies.

Currently, the National Standards require that all patients have a documented falls risk screen on admission to hospital and on transfer between settings.

Experts emphasise that drawing on our clinical judgement can be equivalent if not superior to using these types of tools. Given this, we should consider the following patients as having a higher risk of falling:

- Aged 65 and over.
- Aged between 50 and 64 who are at higher risk of falling (according to clinical judgement) due to an underlying condition, for example, Parkinson's disease, stroke, early-onset dementia.
- All inpatients admitted following a fall.<sup>4</sup>

Falls risk assessments should be completed on those who have been determined at high risk of falling from the falls screening tool.

Any member of the multidisciplinary team can use falls risk screening and assessment tools.

The individual undertaking the assessment needs to understand and administer the tool, interpret the results and make any referrals as required.

Education needs to be provided to healthcare professionals before undertaking the use of the tool to ensure it's used correctly.

#### PREVENTING FALLS - WHAT NURSES CAN DO TO HELP PREVENT FALLS?

Nurses play an important role in preventing falls. They are often the ones recognising a change in the patients' falls risk status and communicating this change to other healthcare team members.

#### Nurses can:

- Ensure preventing falls is part of routine care for older patients and others who have identified risk factors.

## EDUCATION

- Ensure targeted and individualised falls prevention care plans are in place for older adults in hospital and others who have identified risk factors.
- Participate in coordinated discharge planning for the patient.
- Screen and assess all patients for their risk of falling and identify high-risk patients.
- Educate and discuss falls risk and falls prevention with staff, the patients and their carers.
- Orientate the patient to the bed area, room and ward.
- Ensuring the bed is at an appropriate height and the room is free from clutter or spills.
- Adequate lighting.
- The patient knows where their personal belongings are and can access them safely.
- Floor surfaces are clean, dry and not slippery.
- Ensure handrails are available to the patient.
- Use a non-slip mat when in the bathroom.
- Supervise the patient as required.
- Place any items the patient may need within easy reach, therefore eliminating the need for them to stretch to reach something and possibly fall.
- Place the call bell within the patients reach.
- Ensure that all walking aids are within reach of the patient.



- Ensure the patient is wearing the appropriate footwear.
- Organise physiotherapy review for patients with mobility difficulties.
- Ensure they know how to use any assistance devices such as walking aids.
- Place high-risk patients within view of the nurses' station.
- Consider hip protectors and alarm devices for those at high risk of falling.
- Lock wheelchair, bed, commode and shower chair brakes before transfers.
- Ensure they have any sensory aids needed and these are in working order.<sup>2</sup>

It is important to consider all intrinsic and extrinsic risk factors that can increase the risk of falls for the patient.

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**3 HOURS  
CPD**

**The following information is a snapshot from ANMF's Falls tutorial on the Continuing Professional Education (CPE) website.**

The complete tutorial will give you two hours of CPD and covers the following topics: Falls facts, outcomes of falling, NSQHS Standards, risk factors, screening and assessment, risk assessment tools, preventing falls, restraints, hip protectors, communication, flagging, multidisciplinary teams, successful programs, what happens when a patient falls and incident reporting.

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

## Keeping the person's best interests in mind

### A fundamental right of patients in healthcare is the right to consent to and refuse treatment.

When the patient lacks legal capacity to make decisions, it is common practice for a legally appointed substitute decision-maker to decide on their behalf. However, determining what is in that person's best interests can be difficult when family hold their own strong views about the matter. This issue was recently considered in three similar cases in English Courts.

All cases relate to a next of kin's refusal to give consent for their relative, who lacked legal capacity to make decisions, to receive the Covid-19 vaccine. Primarily all three had similar concerns regarding the vaccine with some slight variations. In each case surveying the whole canvas of evidence available, the courts made a declaration that the person should receive the vaccine despite strongly held family views to the contrary. The first of these cases is reviewed here.

Mrs E lived in a care home, was 81 years of age had schizophrenia and dementia. Upon learning of the home's offer for her to receive the Covid-19 vaccination, her son (W) refused to give consent. This led to a court application by her legal representative for a declaration under the Mental Capacity Act 2005 that it would be lawful and in Mrs E's best interests to be vaccinated.

Whilst W did not disagree with the vaccine in principle, he held the view that it was not the right time for his mother to receive it. This objection was based on his 'scepticism about the efficacy of the vaccine, how quickly it had been developed, whether it had been adequately tested on the cohort to which his mother belongs, and, importantly, whether his mother's true wishes and feelings have been canvassed' (para 15).

The risk matrix: The judge for the case, Jayden J noted that Mrs E was living in a country with one of the highest death rates per capita in the world, due to Covid-19. He further noted the risks that compounded Mrs E's vulnerability: she was in her 80's, lived in a care home with confirmed positive cases of Covid-19, had Type II diabetes, lacked capacity to understand how Covid-19 can be transmitted and like many others in her position, would be challenged by the rigours of social distancing restrictions.

Jayden J acknowledged the global context of the virus and the particular risks in aged care homes: "I recognise that the world faces the challenge of an alarming and insidious virus. Nobody can possibly have missed the well-publicised and statistically established vulnerability of the elderly living in care homes... I take judicial note of the particularly high risk of serious illness and death to the elderly living in care homes (para 17)".

Jaydyn J was satisfied that Mrs E lacked legal capacity to make decisions about her health and respected W's right to hold his own views. Nonetheless, he also made it clear that it was Mrs E's approach to life that was to be considered in this process and not that of her son. Hence, his role was to as far '... as is reasonably ascertainable, [determine] her past and present wishes and feelings, the beliefs and values that would be likely to influence her decision if she had capacity, and any other factors she would be likely to take into account if she were able to do so' (para 13).

It was noted that prior to her diagnosis of dementia, Mrs E had willingly received influenza vaccines and in 2009, the vaccination for swine flu. In Jaydyn J's view, this indicated that if Mrs E had capacity and was given the choice, she would choose to be vaccinated in line with the public health advice and would accept the offered Covid-19 vaccine. And so, given that there was a 'real and significant risk to her health and safety were she not to have the vaccine administered to her (para 17)" it was declared to be in her best interests to receive the vaccination as soon as possible given the Covid-19 breakout in the home.

In making this finding, Jayden J acknowledged how difficult deciding what is in the patients' best interests can be for family members where love and concern can obstruct rather than focus objectivity in decision making. However, he was clear that the Court has a protective role – to respect and promote the persons' autonomy. It must undertake an objective evaluation of what is in the individual's best interests without confusing the voice of others, no matter how unimpeachable their motivations, with the persons own voice. A position that perhaps mirrors that of health professionals advocating for their patients.

In the court of protection in the matter of the Mental Capacity Act 2005 and in the matter of E [2021] EWCOP 7;

Two other cases on this matter: In the court of protection in the matter of the Mental Capacity Act 2005 and in the matter of V [2021] EWCOP 14; NHS Tameside & Glossop CCG V CR [2021] EWCOP 19



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## Suicide: A recreation approach to prevention

**With suicide an increasing global health concern, increasing priority is being placed on developing effective prevention strategies.**

As suicide is the leading cause of death for people aged between 15–44 years of age<sup>1</sup> a demand for strategies to combat this escalating and worrying health concern is pivotal.

With the emergence of therapeutic recreation as an effective tool in promoting protective factors, including an increased sense of belonging, social inclusion and physical health benefits for individuals living with mental illness,<sup>2</sup> more research is being developed on its effectiveness on suicidality.

Over the last decade alone, suicide rates have increased at an alarming rate. The causes of suicidality can be varied and individualised. However, they can be primarily categorised into proximal stressors and triggers, genetic factors and psychiatric illness.<sup>3</sup>

Past and current strategies aiming to reduce suicidality, including the education of primary healthcare workers, pharmacotherapy, psychotherapy, media reporting of suicide and population education, have been proven to be individually effective. However, evidence supporting their effect in combination with alternative therapies is emergently promising.<sup>4</sup>

Therapeutic recreation includes but is not limited to multiple activities, including arts and crafts, dancing, music, high rope challenges, engaging with nature and sports. It encompasses a recovery-oriented and strengths-based approach to empower individuals to overcome challenges and create social relationships. This, in turn, has been proven to cultivate an individual and community sense of resilience, with

participants reporting improvements in social self-esteem and significantly lower feelings of depression following engagement with therapeutic recreation activities.<sup>5</sup>

Cogan et al.<sup>6</sup> identify modifiable risk factors associated with suicidality, including feelings of hopelessness, poor self-confidence and isolation. A study on Recovery Camp, an initiative that brings together people with a lived experience of mental illness and health students for a week-long therapeutic recreation camp, found participants reported improved self-confidence, had stronger social connectedness, felt they had more of an ability to meet challenges and overcome fears as well as a positive increase in mood.<sup>7</sup> Further studies have also found a significant reduction in suicidal ideation, depressive thoughts and increased self-determination following engagement in therapeutic recreation with nature-based challenges and activities.<sup>8</sup>

With current evidence suggesting that a multi-disciplinary and combination therapy approach is the most effective in reducing suicidality, incorporating therapeutic recreation has proven to have its place in providing an initiative that encourages positive reinforcement and promotes current strategies.

Across a range of age groups and illnesses, therapeutic recreation is becoming a leading tool for recovery-oriented healthcare and is becoming an intervention that could have a promising effect on a devastating national and global health crisis: suicide.

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Sarah Littlejohn

## The struggle of being a carer and mother during COVID

**I consider myself an easy going, adaptable person who can usually see both sides of an argument – but negotiating through the healthcare system during a pandemic was next level.**

**M**y name is Sarah and have been a nurse and midwife in the public sector for 12 years. I am a mother of 16 month old Ella, and was the primary carer to my partner Tony.

Tony received a terminal cancer diagnosis in September 2018. I became the voice of reason to him and spent many days negotiating his care with him – he was stubborn and strong willed. I was soon coordinating his multiple appointments with oncologists, surgeons, stoma nurses, imaging, radiotherapy and day oncology units – all whilst working full time. Six month later I became pregnant.

We got into a rhythm of treatment and appointments – it was our new normal and we managed as best we could. Like any illness we had a few hiccups along the way – couple of steps forward then a couple of steps back – we took it in our stride. December 2019 saw the birth of Ella – we were besotted with her. We were however acutely aware that our time together was limited, and specifically that current treatment was appearing ineffective. When Ella was four days old further investigations showed we were right-so a change in treatment (again!!)

Then Coronavirus emerged and it sent us into a spin. What impact would this have on Tony if he got it? What about Ella? So much uncertainty. Specialist appointments were moved to Telehealth – definitely a positive from COVID. Tony's blood results were indicating an amazing response to treatment – he was even looking at returning to archery – his favourite hobby. We were emerging from the first lockdown feeling relatively positive, and given restrictions were easing and the virus seemed under control within the community, Tony was sent for his CT scan to assess the treatment. All indications pointed towards a great result.

Our world collapsed the day after his scan following a call from his oncologist to tell us that not only was there little change to the existing tumours, there was a large metastasis in his skull. His chemotherapy stopped and he was to have radiotherapy to his skull for symptom relief (recent severe headaches) – his

prognosis was poor. We weren't out of lockdown for long in Victoria before restrictions tightened again – this was the start of an exceptionally challenging time for managing COVID restrictions while still being a mother, partner and carer.

As a nurse I understood the balance of individual patient needs with those of the broader community within a hospital setting. Our first challenge was Tony's radiotherapy and his planning appointments. Due to COVID restrictions I was unable to take our breastfed five month old to the appointments, and I had limited people available who could just wander around outside the hospital with Ella while I accompanied Tony – appointment lengths were unknown so difficult to leave Ella at home. As a result, Tony attended these appointments on his own. Our next challenge was an ED visit as Tony had neurological symptoms – again I was unable to bring six month old Ella with me while I supported Tony, and provided crucial information to clinicians about his illness, treatment and symptoms – he had become completely dependent upon me to provide this information.

What real risk did an infant in a carrier really pose to other patients? (I am aware these guidelines have subsequently changed from DHHS, but a mother/baby dyad at the time was not allowed). Stage 4 restrictions were well and truly in force by now-those who were able to care for Ella while I was supporting Tony, were getting nervous about travelling further than 5km from their home – it was a legitimate reason, but it still made them nervous. On this occasion family looked after Ella, but had to leave the hospital with her – again due to restrictions. Over the next couple of hours I was becoming increasingly anxious about being separated from Ella, but needed to stay with Tony.

Over the next few weeks the difficulties were around having adequate support at home while managing the side effects of radiation, recommencing chemo and trying to provide quality of life for Tony – we weren't allowed to visit family and friends, he couldn't do anything apart from sit at home and watch the world go by. Our final, and probably most significant challenge came in August when the time had come,





Tony and Ella

following rapid deterioration, for Tony to go into a palliative care unit. Our closest unit wouldn't allow Ella to visit her dad under any circumstances (she was nearly eight months old), so I declined to have him admitted there – I would rather struggle at home with him. Another unit was found that would happily allow Ella to visit her dad. Tony was admitted on Friday afternoon

and peacefully passed away on Saturday at lunchtime with Ella and I by his side.

I supported the need for strict restrictions to manage the COVID outbreak, I acknowledge the need for rules to be in place 'for the greater good', however there are some very significant, unintended outcomes of these restrictions. I shouldn't have had to choose between being a carer and being a mother,

nor should I have had to choose between having Tony appropriately cared for and him seeing his daughter in his final days.

#### Author

*Sarah Littlejohn is Associate Midwifery Unit Manager at The Royal Women's Hospital. Sarah holds both a Bachelor of Nursing and Bachelor of Midwifery.*

FOCUS

A teal-colored circle graphic that serves as a background for the main title text.

MENTAL  
HEALTH &  
DRUG AND  
ALCOHOL

## Pregabalin and Gabapentin: The risk of harm and death

By Olivia Sonneborn

Gabapentinoids, such as Pregabalin and Gabapentin, are used internationally in pain management, neurology, psychiatry and primary healthcare but also have a potential for misuse.<sup>1</sup>

Increasing levels of both prescriptions, growing black market accessibility and related fatalities have been reported from a range of countries, with growing numbers in Australia since 2015.<sup>1,3</sup>

Gabapentinoids are thought to possess GABA-mimetic properties, with potential actions on the dopaminergic 'reward' system, as well as reversing tolerance to opioids.<sup>1,4</sup> A portion of these drugs are prescribed "off-label" against anxiety, non-neuropathic pain, mood instability, insomnia and withdrawal symptoms from recreational drugs.<sup>1</sup>

The vast majority of the cases reporting self-administration of Gabapentinoids have a positive history of addiction to traditional psychoactive substances, mostly alcohol, benzodiazepines and opioids, and are using significantly higher doses than is clinically advisable.<sup>2</sup>

The risk of death from concurrent opioid and benzodiazepine use is well documented;<sup>5,6</sup> however, this risk looks to escalate with the addition of Gabapentinoid (anticonvulsant) misuse in Australia.



In 2018, there were 7.3 unintended drug induced deaths per 100,000 people in regional areas, 0.6 per 100,000 related to anticonvulsant drugs.<sup>3</sup> Whilst the rate of deaths from Gabapentinoids is low, the increase since 2015 has been dramatic (See image below). Females of early middle age are considered the highest risk for intentional drug overdose.<sup>7</sup>

The side effects from Gabapentinoids, notably Pregabalin, are dizziness, visual disturbance and somnolence.<sup>4,8</sup> Patients taking Gabapentinoids are exposed to these side effects, as well as the side effects of their often-concurrent opioid and benzodiazepine agents, which may include sedation and respiratory depression. Despite their side effects, Gabapentinoids effectively manage pain relating to spinal surgery, joint arthroplasty, and amputations.<sup>4</sup> There is robust evidence that opioid users or multiple drug users select to use Gabapentinoids due to their

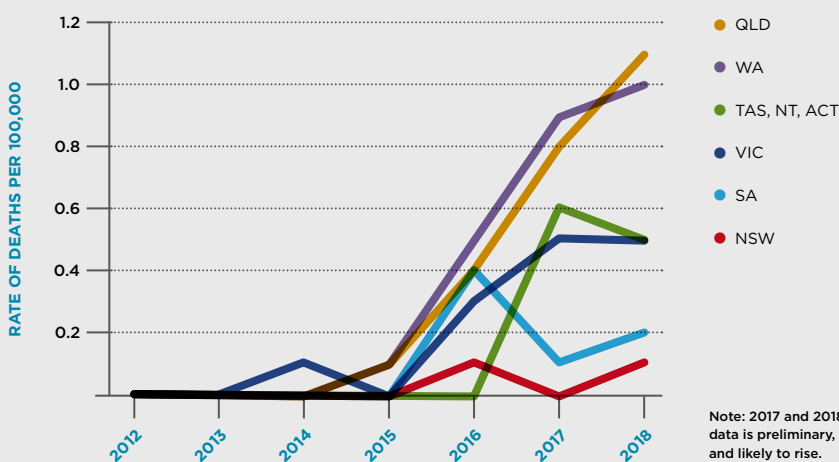
ability to boost an euphoric high and reduce withdrawal symptoms while producing only a few adverse effects. Pregabalin is the preferred anticonvulsant agent, as it is absorbed more rapidly and has a greater bioavailability than Gabapentin.<sup>2</sup>

In patients with a history of substance use disorder (SUD) and especially in patients with an opioid use disorder, Gabapentinoids (notably Pregabalin) should be avoided or administered with caution.<sup>2</sup> Healthcare staff need to consider and assess the development of adverse effects from concurrent use of sedating agents, including opioids, benzodiazepines, alcohol and Gabapentinoids, and consider appropriate pharmaceutical use in the safety of patients and the community.

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Unintentional drug-induced deaths involving anti-convulsants by state, 2012-18, as a rate per 100,000 population



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## Improving access to therapeutic mental healthcare in Emergency Departments

By Timothy Wand

Providing effective mental healthcare in Emergency Departments (ED) is a fundamental expectation, as EDs increasingly become the first point of contact with health services for people in mental distress.

In response to the growing number of people presenting to EDs with mental health-related concerns, a nurse practitioner (NP)-led extended hours mental health liaison nurse (MHLN) team was established in the Royal Prince Alfred Hospital (RPAH) ED in Sydney NSW in 2012. This team has subsequently been evaluated.

The evaluation identified substantial benefits associated with this model of care for patients and the ED.<sup>1,2</sup> Following the success of this trial, the NSW Ministry of Health sponsored a multi-site project to test this model of care in different ED contexts.

The mixed-methods project involved a 12-month re-evaluation of the MHLN service at RPAH (a major city hospital; 80,000 presentations a year), in conjunction with the implementation and evaluation of this model of care in two settings in rural NSW, site B (a rural hospital; approximately 50,000 presentations a year) and site C (a regional base hospital; approximately 35,000 presentations a year). No additional resources were provided to the rural sites participating in the project. Sites were required to re-configure current resources to align with the model of care and agreed to provide cover from 07:30-2200 seven days a week.

The key principles of the model of care established at RPAH and tested across the two rural sites are listed below:

- A nurse practitioner (or clinical nurse consultant) as clinical lead to a designated team of specialist MHLNs based in the ED on an extended-hours basis, seven days a week.
- Available to see patients (of all ages) with undifferentiated mental health, drug health, mental distress and behavioural problems as close to the point of triage as possible.
- A close working relationship with the ED nursing and medical team.
- A complementary relationship with the psychiatry service. This includes not having to discuss patients with a psychiatrist.
- A coordinated system of referral and follow-up.



### KEY FINDINGS

The MHLN teams demonstrated safe and responsive care. Patients were seen promptly, there was a reduction in ED length of stay, a low admission rate, minimal did not waits and effective follow-up. There were 3,843 patients seen over the 12-month evaluation period. Triage category three presentations (urgent) accounted for 49% of MHLN team workload. The majority of presentations were:

- undifferentiated mental health problems (n=1,549, 40%);
- suicidal/self-harm (n=661, 17%); and
- drug and alcohol/toxicology (n=342, 9%).

The median wait time from triage to MHLN involvement was 66 minutes at RPAH and 47 minutes across the rural sites. The median time spent in ED for discharged patients was 4.8 hours at RPAH and three hours across the rural sites. This constituted a reduction in ED length of stay for all sites.

There were zero 'did not waits' at RPAH and only four across rural sites reported following MHLN team intervention.

Despite the high acuity, the percentage of patients seen by MHLN teams and subsequently admitted was low (8.6% at RPAH and 36.3% for the rural sites). At RPAH, 27% of patients seen were triage category 2 (potentially life-threatening) and 57% were triage category 3 (urgent). Only one adverse event (SAC 2 incident) related to MHLN teams, reported by one rural site.

From surveys conducted with ED patients (n=58), emergency and psychiatry staff (n=52), MHLN teams were rated highly for promptness, the intervention provided, and competence and professionalism. Patients valued the therapeutic qualities of the MHLN role, especially *being listened to and understood* and being involved in decisions about their care and follow-up. Ninety-five percent of staff and 85% of patients recommended the model be implemented in other emergency settings.<sup>3</sup>

### SUMMARY

The model of ED-based MHLN care developed at the RPAH was successfully translated to two rural sites. Based on a set of key principles, this MHLN service is potentially transferable to various EDs. Incorporating the MHLN team within the ED structure achieves integrated care in the recognition that mental health is a core business for EDs.

Integrating the MHLN teams within the ED has greatly improved the therapeutic experience for people presenting in mental distress. The model of care also provided much needed support for ED and psychiatry staff. Our research confirms the safety, responsiveness and effectiveness of the ED-based model of MHLN care. The MHLN service enhances the relationship between EDs and mental health services by working in more collaborative ways, with the clinical governance of the MHLN team under the ED and the patient at the centre of care.

### Author

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## 'Comfortably NUM': Mindfulness program for Nurse Unit managers

By Chris Dawber

### BACKGROUND/RATIONALE

A six-session experiential program, based on an existing mindfulness program and developed by Consultation Liaison and Midwifery Services, aimed to encourage mindfulness practice to build resilience and stress management skills.

This pilot project was initiated as a collaboration between the Consultation Liaison Psychiatry Service and Executive Director of Nursing & Midwifery at Sunshine Coast University Hospital.

Six nurse unit managers (NUMs) participated in the program. Ironically, some participants were unable to attend all sessions due to clinical work demands.

The evaluation was conducted using a 'Day to Day' Mindfulness inventory and an evaluation tool constructed for the purpose. Participants were also invited to provide qualitative feedback.

### RESULTS

The Mindfulness Inventory indicated that NUM's quite frequently struggled to remain mindful during their working day. Particular areas of note related to a lack of emotional awareness (*I could be experiencing some emotion & not be conscious of it till some time later*), and environmental awareness (*I tend to walk quickly to get where I am going without paying attention to what I experience along the way*).



Chris Dawber, with two of the Comfortably NUM participants Sara Leberter (left) and Deanna Nicholls

Pre and post-self-evaluations indicated that the program contributed to an overall increase in participants' understanding, appreciation and practice of mindfulness.

Qualitative responses further supported the benefits of the program:

- I had very little understanding of what mindfulness meant in practical terms. I found that I had a much-improved ability to control my reactions during stressful moments. I was able to channel some of (the) skills (attended five sessions)*
- I received a lot of benefit from the sessions for my own personal development, in being able to "calm" myself... I think it should be strongly encouraged in hospital culture; including exec levels, but needs to have the resources to support such an initiative... many more NG7's could benefit from them however, communication around the offer could be improved (attended six sessions)*
- I found these sessions very beneficial – gave me confidence and understanding to undertake mindfulness and also allowed staff attending to come together in a forum that... built relationships and allowed time to breathe. (attended five sessions)*

### CONCLUSION

Participating NUM's reported gaining a greater understanding and appreciation of the benefits of mindfulness and its role in stress management however, ironically, competing work demands made it difficult for some to attend all the sessions.

The program has been continued, with a recommendation for more effective advertising and practical support for participants to attend.

### Acknowledgements

Amber Jenkins (Midwife), Suzanne Metcalfe (Executive Director – Nursing and Midwifery), Corinna Green (Quality Improvement Facilitator), Dr Luigi (Gino) Medoro (Psychologist), Sharlene Wilson (Surgical Nurse).

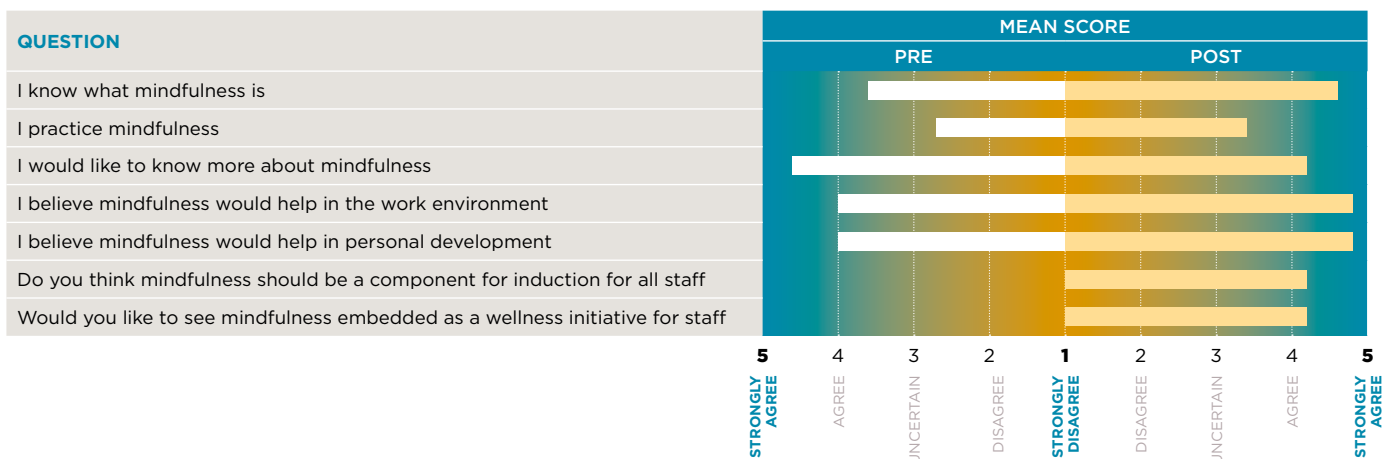
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Chris Dawber, MHN Cred, Ma MH Nursing, Ma MH: psychotherapy, Cert Dev Psych. Values: the personal and interpersonal aspects of healthcare and the special role that nurses and midwives play in balancing the 'business of healthcare' with compassion and humanism.

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Table 1: Pre/Post Evaluation



## Methamphetamine in the family: Looking below the Iceberg

By Douglas Greg Gordon, Kylie Russell and Dr Tracey Coventry

Methamphetamine use leads to frequent presentations to Australian hospitals and emergency departments; intoxicated patients, psychosis, cardiac and neurological issues are painfully common causes of presentation and admission.<sup>1</sup>

Indeed, Methamphetamine use is a significant issue worldwide,<sup>2</sup> impacting heavily on all aspects of society, from law enforcement to healthcare and has far-reaching impacts on social relationships and families.<sup>3</sup> Australia has one of the highest levels of methamphetamine use in the world per capita. Methamphetamine related hospital admissions doubled between 2018-2019, and account for 8.6% of all drug-related hospital admissions with the higher purity crystalline form of methamphetamine, colloquially referred to as "Ice", being the main form of the drug used.<sup>4</sup>

In recent years, these issues have gained the attention of health researchers, but limited effective treatments for methamphetamine use have been demonstrated, and those treatments offering some promise often have a high level of relapse after completion.<sup>5</sup>

With significant media attention on the drug use itself, it is easy to forget that families are also directly affected, and the impact of this difficult to treat drug extends through several family generations, while the emotional rollercoaster of living with a user can cause a sense of grief and loss for families.<sup>6</sup> Nonetheless, nurses and midwives working with methamphetamine users in crisis (often with medical or mental health issues) may have limited engagement with family members, through lack of time or due to a focus on the complex issues associated with management of the patient themselves.<sup>7</sup>

Families have been shown to have an important role when a family member is using drugs; this can be either positive or negative, but to date, this has received scant attention, specifically in relation to methamphetamine.<sup>8</sup> This is arguable because research into various treatments has often neglected the families of methamphetamine users or grouped them with other drug users.<sup>8</sup> In many ways, methamphetamine is unique regarding



Douglas Gordon (author) pictured

the cyclical nature of its use, with extreme ups and downs for users, often over several weeks at a time.<sup>9</sup> Past studies have focused on drug use as a whole, grouping methamphetamine with heroin, cannabis, or alcohol, rather than exploring the unique issues associated with methamphetamine.<sup>8</sup>

The authors of this paper are undertaking a unique study in Western Australia, with a specific focus on the families of methamphetamine users. Each participant is invited to take part in four interviews over a year. Family members can be with or without blood ties and are referred to in the literature as the 'primary group'<sup>3</sup> around the user; the goal is to describe the experiences of these families. The findings will help health professionals – working with methamphetamine users in various settings to understand what families experience and provide meaningful insight into specific interventions that may be useful for the treatment of both families and methamphetamine users.

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## An empathic shared learning community fosters positive mental health

By Elissa-Kate Jay, Lorna Moxham and Dr Christopher Patterson

Nurses need to address their own mental health needs to thrive and provide the best possible care to those they serve. It is widely known that burnout is a risk for nurses and that self-care skills are desirable, an issue that has become very apparent during the COVID-19 pandemic.<sup>1</sup>

The stressors of nursing, many of which are unanticipated, can lead nurses toward unsupported coping methods, including alcohol and drug misuse, or can precipitate mental illness.<sup>2</sup> Unsurprisingly, good mental health and personal wellbeing for nurses promote human connection, positive feelings, greater job satisfaction, and quality care.<sup>3</sup> Therefore, mental health education covering these issues is recommended for all nursing students irrespective of the area of nursing they will enter.<sup>4</sup>

One such mental health clinical placement, advantageous for all future nurses, is examined in an arts-based study by Jay, Moxham, and Patterson.<sup>5</sup> Findings suggest that a residential learning community comprised of nursing students and people with lived experience of mental illness results in affirmative experiences for the student nurse. These positive experiences promote connection, optimism, and wellbeing, all important attributes to foster mental health and clinical safety. Findings imply that student participants learn through their immersion the importance of fostering best possible mental health.

It is noteworthy that a residential mental health learning experience demonstrates to nursing students that a community can accept vulnerability and enable conversations about mental health symptoms.<sup>6</sup> These are important abilities for nurses interacting with those they care for and with each other in workplace environments. Taylor et al.<sup>3</sup> use the expression “organisational empathy” in relation to mental health resilience. They identify that collective groups such as created on this residential placement can make beneficial differences to improve the empathy levels shown amongst members, developing positive mental health.

Despite nursing training having traditionally focussed on technical clinical skills whilst minimising mental health skills<sup>7</sup>, a more holistic approach is now required. The Mental Health Nurse Education Taskforce report states that “mental health theory and practise is an essential foundation for all nurses, irrespective of their domain of practice.” McCann et al.<sup>4</sup> with authors such as Thew<sup>8</sup> highlighting that positivity and teamwork are relational skills which are as important in nursing workplaces as technical skills.

Universities are called to provide clinical placements to teach students teamwork, empathy and self-compassion in the context of mental health. The artwork feedback (see Figure 1 as an example) from participants in Jay et al.<sup>5</sup> study suggests that a residential, supportive learning environment is just the place to foster positive mental health in students, which will benefit their future RN selves and workplaces. Further research could explore what mental health recovery means to nurses personally in their own clinical practice.

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Figure 1: Canvas artboard from the shared learning residential camp May 2018.



## Carers of people with severe mental illness: Who cares for the carers?

By Zahra Almoaber

Living with a serious mental illness (SMI) can generate many challenges and contribute to a disabling life compared to other illnesses. Such significant disabilities, resulting from issues such as severe anxiety, suicidal intent and psychotic episodes, can mean that people with SMIs often require support from informal or formal caregivers, such as close relatives or friends, to assist with everyday living.<sup>1</sup>

Given the increasing number of people experiencing mental health issues, the need for carers has increased<sup>2</sup> but who cares for the carers?

Notably, 12% of the Australian population are informal carers who provide unpaid care to family members or friends with a physical, emotional or psychosocial disability or chronic health condition.<sup>3</sup> These carers undertake significant responsibilities due to the changes in life circumstances and fluctuating symptoms among individuals with SMIs.<sup>4</sup> Therefore, the role of carers is very important in helping and supporting people with SMIs.

Major caring responsibilities that are often exacerbated by the lack of respite result in what is termed 'carer burden' and can lead to carer burnout. Carer burden occurs because of overwhelming caring responsibilities, which are physical, financial

and social.<sup>5</sup> Carer burden can be considered from both objective and subjective perspectives. The objective perspective is related to the person's behaviour and how it affects the carers' health, financial, and social activity. The subjective perspective refers to the carers' reactions, such as feelings of loss or embarrassment.<sup>6</sup> The latter is significant given the ongoing stigma that mental illness still carries.

Carers may also face their own emotional challenges during care; for example, 40% of carers for people with SMIs themselves have mental health issues.<sup>7</sup> Caring for people with SMIs can therefore impact the carers' own health and wellbeing due to increased stress levels. Stress can lead to cardiovascular disease, cancer, depression, or chronic anxiety. Additionally, it can affect leisure activities because carers are often unable to engage in recreational activities due to their caring responsibilities.<sup>8</sup>

Providing care for a person with a complex condition such as an SMI can cause stress for even the most resilient person. Encouraging and assisting carers in engaging in self-care and feeling comfortable asking for help if needed will assist with the burden of care that can feel overwhelming. Nursing practice is holistic, and, in that regard, nurses need to be aware of including 'carer care' into their practice.

### Author

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## ‘Making’ time for mental health

By Zoe Hinge, Jessica Grozdanov, Dr Christopher Patterson, Dr Dana Perlman and Lorna Moxham

Throughout 2020 and continuing, COVID-19 highlighted the negative impacts of social isolation on people’s physical health and significantly on mental health.<sup>1</sup>

As social restrictions eased, it became increasingly apparent that people desired to re-engage and once again find a sense of purpose. While the national restrictions and feeling of isolation limited face-to-face and/or large group mental health supporting experiences like Recovery Camp (RC), a new and innovative program brought together people with a lived experience through a joint program run with RC and the University of Wollongong (UoW) Makerspace.

### WHAT IS A MAKERSPACE?

A Makerspace is a collaborative workspace specifically set up for building, learning, exploring and sharing ideas housed around a central task(s). Makerspaces are engaging and have a variety of ‘maker’ equipment designed to help each participant create their ideas and include 3D printers, laser cutters, heat-press, hand tools, power tools and/or sewing machines. The ‘maker’

mindset is about creating and exploring individual interest and not developing builder specific skills (eg. competency in using a 3D printer). The original intent of a Makerspace was to facilitate skills in various fields such as science, technology, and math<sup>2</sup> to help with critical thinking skills and boost self-confidence and self-esteem.<sup>3</sup>

### RC AND UOW MAKERSPACE EXPERIENCE

The UoW Makerspace is a public creative space providing ‘makers’, both new and experienced, with access to tools, equipment and training. The atmosphere combines enjoyment and learning fostered by an inclusive, vibrant, supportive and exploratory physical environment and educational team. Jess Grozdanov and her team facilitated the combined RC-UoW program. Jess is an engineer and possessed a depth of content knowledge that she easily answered all of our extremely technical questions and guided the group to work appropriately and safely with the expensive and potentially complex machinery. In addition to the UoW Makerspace staff, participants within this program were community members with a lived experience of mental illness and mental health nurses who worked collaboratively throughout the entire program.

The RC-UoW Makerspace program has successfully run twice in 2020-2021, with new intakes scheduled in April, June, August

and October. Thirteen people ranging in age from 21-65 with mental health issues have attended the program to date. Some participants came with their support workers and/or carers and travelled from all over the Illawarra, Western Sydney and the Campbelltown area. The program met weekly for three hours once a week for three weeks. While this program has run twice, the most recent experience focused participants on building a clock.

Before beginning this experience, each participant identified a set of goals they wanted to achieve during the three week program. Goals were not limited to completing a clock, they included learning new skills, time management, getting out of comfort zones by interacting, public speaking, group work, setting priorities, decision making and having fun. While a clock has the simple task of telling time, the overarching intention of the program was that the complex design and development aid in facilitating positive mental health concepts (eg. resilience, personal challenge, self-efficacy) and Makerspace learning (eg. new skills, enjoyment, collaboration). At the beginning of this activity, creative juices from all participants started to flow as everyone thought about their designs, which included ideas around textures, materials and mode of the build. Clock designs ranged from geometric, gothic, a fruit bowl, an orangutan, a unicorn, an hourglass and a guitar.



Proud graduates of the Recovery Camp at Makerspace Program



UoW Makerspace will be running future 'making' programs in Wollongong. Information can be obtained by contacting [zoe@recoverycamp.com.au](mailto:zoe@recoverycamp.com.au)

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With the design for each participant decided, we developed a cardboard prototype. This was an impressive process for both the group and individuals as there was continuous chatter, collaboration amongst everyone and a sense of awe with how creative each person's design/prototype was. The social side of these experiences is very important, particularly after the continuous social isolation and lack of peer-to-peer engagement during the COVID pandemic. The program showed that even a small gathering of people who are placed in a setting that allows for the sharing of ideas and thoughts can be meaningful. Once each cardboard prototype was completed, it was time to turn the models into reality. Participants were taught and supported to program the various Makerspace equipment like the 3D printer, heat presses, laser cutters, etc. for each clock pattern to be created.

As time ticked by, participants' clocks were beginning to take shape. Every week the group added to the design while considering the aesthetic elements such as fonts, sizes of clock numbers, layering effects and the working mechanical components.

By week three, each clock was complete and to use the term amazing would be an understatement. All participants were thrilled with what they had created and felt a sense of accomplishment in being part of every step and decision. All clocks are bespoke - totally individual - and are proudly displayed in people's homes or given as gifts. RC evaluated the program via a survey, and the goals that participants set at week one were met. These findings supported the positive benefit that the combined RC and UoW Makerspace program had on each participant during these trying times. Recovery Camp and



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**What about me?  
Collaborating with  
mental health consumers  
about risk assessment**

**By Ed Aquin, Lorna Moxham and  
Dr Christopher Patterson**

In mental health settings, risk assessment involves undertaking a review of the person and focuses on evaluating the potential for harm to themselves or others. Current activities regarding risk evaluation and safety planning continue to be an essential aspect of mental health service delivery from a medicalised model perspective.<sup>1</sup>

Clinical descriptions and mental health consumer language about risk or safety factors may not easily correspond. Differing and competing agendas can exist between consumers, carers, management and clinicians in approaches to addressing mental health risk.<sup>2</sup> This can be especially evident when an individual is placed under compulsory treatment to mitigate clinical perceptions of perceived risk. Given the significant impact of a compulsory admission, the voice of the consumer regarding the risk assessment process is an important one to hear, yet it is a voice that is silent. To date, there is nominal literature related to consumers' lived experience of a risk assessment that led to compulsory admission.

A broader understanding of the experience of having a risk assessment performed which led to involuntary admission is important to both mental health consumers and clinicians for mutual understanding, increased collaboration and promotion of improvements to this area of practice.

Drawing upon the consumer experience will help inform mental health risk assessment practices and encourage active inclusion, information sharing and partnership between consumers and clinicians.<sup>3</sup> Given that mental health risk assessment and treatment activities are often undertaken without the consultation of mental health consumers, mental health services need to improve consumer involvement in risk assessment processes.

Healthcare trends regarding personal recovery call for collaboration and partnership between clinicians and individuals with mental illness, whereby the person's voice is included in decision making and goals related to treatment. Mental health consumer participation and co-production activities for service development and provision are vital for improving mental health services.<sup>4</sup>

In this context, the authors will be undertaking a phenomenological study to explore and represent the consumers' voice regarding their lived experience of having a risk assessment. The hope for this study is to



inform further collaboration between mental health lived experience expertise and clinical expertise. It is anticipated the study will form the groundwork for developing future risk assessment tools and teaching frameworks. Co-production and active engagement with consumers align with national safety and quality standards and better health outcomes for the population. It supports the notion of personal recovery by empowering consumers to have their voices heard and valued by meaningful engagement, active participation, and enabling changes to current practice through active collaboration.

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## Safewards: A nursing model of care

By Matthew Bentley and Thea Hopkinson

In 2014, Professor Len Bowers and his colleagues<sup>1</sup> who are based in the United Kingdom, developed the Safewards Model of Care for acute mental health units.

It looks at the origins of conflict and aims to reduce the rates of conflict (behaviours that can result in harm) and containment (staff methods of managing acute units that can also be restrictive or coercive) through the generation of 10 interventions. This model has been shown to make mental health units safer and a more therapeutic environment for the service users and the healthcare team.

Positive words	Discharge tree
Talk about meetings	Breaking BIG news
Reassurance	Getting to know each other
Soft words	Calm down methods
De-escalation	Clear mutual expectations

These interventions target identified originating domains, which are the aspects of inpatient units that have the potential to create 'flashpoints' that may result in conflict or containment. By identifying these flashpoints, staff can utilise these interventions to plan, support and engage with the young person.

The whole treating team are encouraged to attend the *Talk about meetings* each morning. These meetings are led by the young people on the ward and focus on peer support. The *Get to know you* intervention asks both the young people and healthcare team members to provide some social information about themselves, such as their hobbies or pets, to facilitate building a therapeutic relationship during an acute admission. The *Discharge tree* intervention asks the young person to write a message of hope and support on a leaf and is placed on the tree before they are discharged. Young people are able to see these messages of hope when they first arrive at the unit.

The child and adolescent acute mental health units at the Queensland Children's Hospital have been implementing this model of care and are already seeing some positive outcomes. The nursing team have



been enthusiastic and proactive when incorporating this model into their clinical practice. Some qualitative data collected from the nursing team specifically referred to a change when they engage with the young person, and their families including statements like:

"change my wordings to align with the model."

"by staying calm during conflict, by being safe, respectful and empathetic in all interactions."

With the support of the education team and the Safeward champions, the nurses have been implementing the interventions and adjusting their language into their clinical practice with positive effects when managing difficult situations and forming therapeutic relationships.

CHQCYMHS provides a specialised acute mental health service that supports young people and their families during a very stressful and difficult time in their mental health journey. Our hope is that continuing to implement this model of care will assist in reducing the amount of conflict and containment used on the units, resulting in a safe and therapeutic space to support their recovery.



### Authors

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## The function of the Safe Assessment Space

By Wendy Hall

In St Vincent’s Hospital, Sydney, a Mental Health Safe Assessment Space has been a recent addition to the refurbished Emergency Department.

It consists of two bedrooms and four chair areas (surrounded by curtains for privacy). It has its own WC and shower room plus two camera monitored interview rooms where patients and their supporters can be assessed in privacy. The area is situated in the Acute Space of the Emergency Department (ED) though it is an independent locked area.

It offers dedicated specialist mental health staff, skilled at de-escalating those in distress, who now have access to a comforting environment with food, drink and medication if required. Those waiting to be seen have access to hospital wifi, can read, listen to music, contact advocates, gain access to a social worker or sleep. Anti-ligature fixtures make the area safe and the way into the area is close to the entry points to ED, so that patients do not have to walk or be transported through a large department to get to the space. While waiting for mental health assessment, patients will have a full physical health assessment done by ED staff.

Voluntary patients under the Mental Health Act can leave when they want. Occasionally, if clinical staff judge that they are a danger to themselves or others they will be scheduled under the Mental Health Act 2007, but this is rare. Those brought in under a section of the Mental Health Act must wait for assessment and decision-

making to their future pathway. Due to the Safe Assessment Space (SAS) being a locked area, AWOLS have decreased since its introduction.

### HOW THE SAFE ASSESSMENT SPACE BENEFITS PEOPLE WHO PRESENT FOR MENTAL HEALTH REASONS

The SAS fulfils several useful purposes; it keeps people safe while waiting to be seen, thus mitigating risk. There has been a number of suicides in Australian hospital emergency waiting rooms in recent years because desperately distressed people have been kept waiting in an environment that is noisy and unsuitable for them.'

It helps take pressure away from already busy ED staff. Triage staff, in particular, would often have had concerns before the existence of the space about having to monitor people waiting to be seen by the mental health team.

The SAS also ensures the person requesting or in need of mental health input can be in the hands of experienced mental health clinicians who are there to treat them, rather than be in a busy area where they would be lower on the list of priorities. They can shower and clean up or be given access to educational information about their mental health condition. They can request to use sensory equipment that the unit has access to and has known efficacy in improving mood.<sup>2</sup> Examples of what are used are adult colouring books, glow in the dark eggs, sensory blankets, gel balls.

### THE STAFFING OF THE UNIT

The unit is staffed and open 24/7. Staff include a consultant psychiatrist, psychiatric registrars, JMOS, psychiatric clinical nurse consultants, a nursing unit manager, clinical nurse specialists, a clinical nurse educator and highly skilled psychiatric RNs and EENs.

### THE LOCATION OF THE SAS

The SAS is in close access to the PECC (Psychiatric Emergency Care Centre) itself, a six bedded specialist short-stay unit. It has a good working relationship with the PANDA (Prescribed and Non-Prescribed Drugs and Alcohol) unit which also works to take pressure off ED staff.

The New South Wales government and the Agency for Clinical Innovation (the New South Wales body that works with Health Departments to design and promote better healthcare solutions) sees mental health safe assessment spaces as best practice for Emergency Departments.<sup>3</sup> They elevate safety with both staff and patients favouring them overall for their specialist objectives, comfort, safety and helpfulness to the waiting patient.

### Author

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(from left to right)  
1-2 Team members of the Mental Health Safe Assessment Space  
3 Brandon Smith Nursing Unit Manager



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CRICOS No. 00233E

**ASSIST-Linked brief interventions to reduce hazardous substance use in primary care settings**

By Dr Shirley McGough and Karen Heslop

**INTRODUCTION/BACKGROUND**

Co-occurring mental illness and substance use is associated with poorer health outcomes, treatment noncompliance, higher relapse rates and more hospitalisations. The World Health Organization (WHO) Alcohol Smoking and Substance Involvement Screening Test (ASSIST) version 3 (V3) is a brief, valid and reliable screening instrument that assesses the use of psychoactive substances.<sup>1</sup> Eight questions cover tobacco, alcohol, cannabis, cocaine, amphetamine, sedative, hallucinogen, opioid and ‘other’ drug use, misuse and abuse. Screening and personalised feedback regarding the risk score and associated health problems allow the nurse to engage the person in a non-confrontational way and effectively get clients at moderate risk, particularly to change their substance use.<sup>2</sup>

**AIM**

This pilot feasibility study aimed to determine whether ASSIST-Linked brief interventions effectively reduce hazardous drug and alcohol use in people with an identified mental disorder and comorbid alcohol or substance use who attend a nurse-led primary health clinic.

**METHODS**

People referred to the clinic and screened at low or moderate risk of hazardous alcohol or substance use were invited to participate in the study and offered brief interventions outlined by the ASSIST<sup>2</sup> and followed up after one month to determine the effectiveness of the intervention, see figure 1.

**FIGURE 1: STUDY DESIGN**



To evaluate the effectiveness of the brief intervention, participants completed scales indicating their readiness and confidence to change their substance/alcohol use behaviour and the ‘Stages of Change Readiness and Treatment Eagerness Scale’ (SOCRATES) V8. The 19-item scale is designed to assess the readiness for change under three scale scores; Recognition, Ambivalence and Taking Steps. Ethical approval to conduct this study was obtained from the institution’s HREC.

**DATA ANALYSIS**

Analysis of variance (one-way ANOVA) was used to determine the differences between scores before and after the brief intervention. A p-value of <0.05 was used to determine statistical significance. A 2-point difference in SOCRATES sub-scale scores and a 1-point difference in visual analogue scores was considered clinically significant.

**RESULTS**

Fifteen participants participated in this study, seven males and eight females aged 20–62 years (M=34.7, SD 13.8). Tobacco (53.3%) and opioids (63.3%) were used moderately amongst participants. Amphetamines and inhalants were used at lower levels (93.3%), with alcohol used at low levels by 80% of participants. There was low-level use of benzodiazepines, cannabis and hallucinogens. Following the intervention, despite low statistically significant pre-post improvements noted, there was a significant clinical improvement with reduced use (from moderate to low use) for tobacco (n=6), cannabis (n=2), hallucinogens (n=4), and opioids (n=3). See table 1.

**TABLE 1: RESULTS**

Although a small sample size was included in the study, it demonstrated the feasibility of the ASSIST and is now included as part of a comprehensive assessment for all people that come through the clinic.

**IMPLICATIONS FOR PRACTICE**

To date, few studies have evaluated the use of the ASSIST and associated brief interventions in people with mental illness

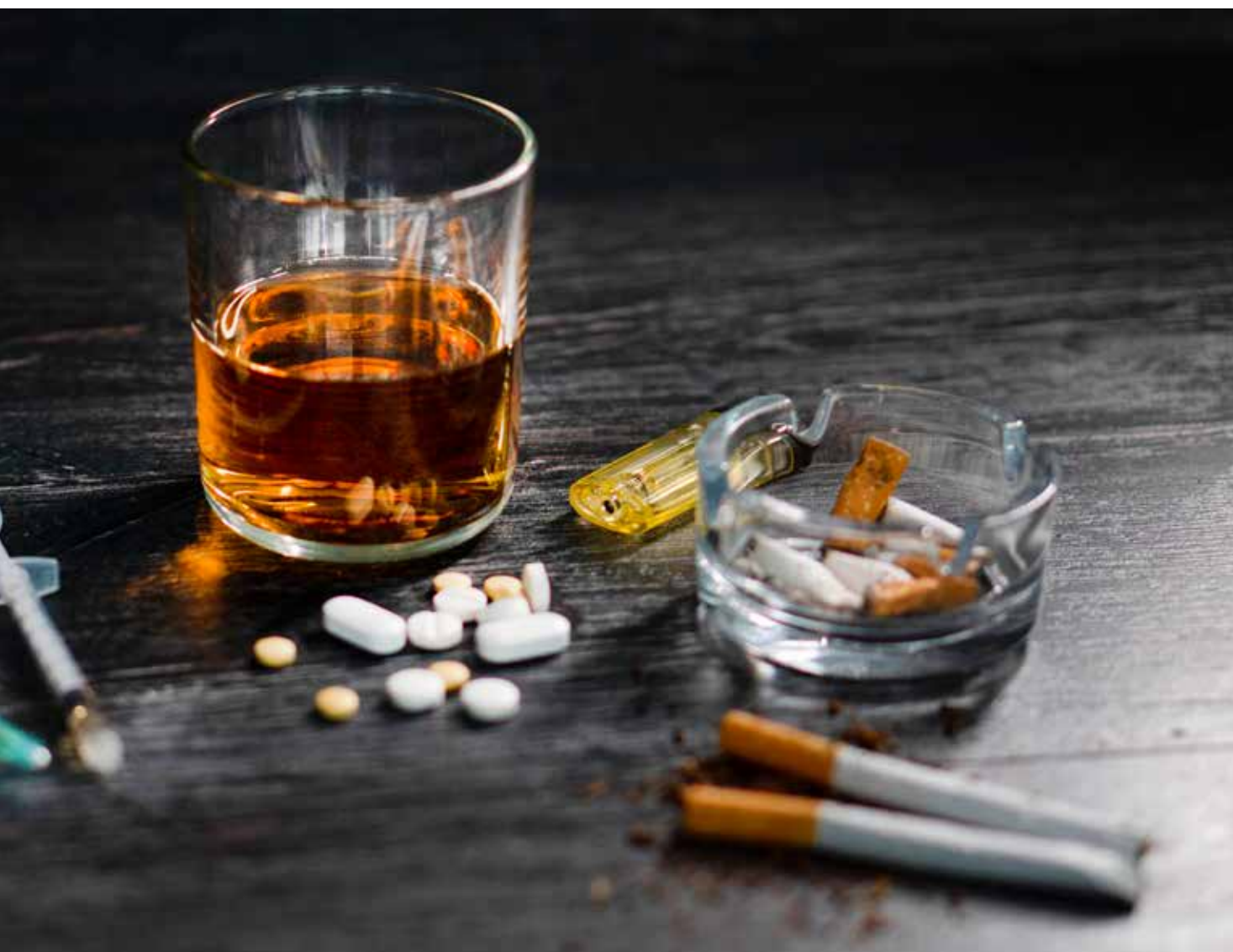


in the primary care setting. Nurses working in primary healthcare are well-positioned to provide screening and brief interventions for people experiencing co-occurring mental disorders and substance use.

**FUNDING**

This study was funded by Research Development Scheme Grant, Curtin School of Nursing, Midwifery & Paramedicine, Curtin University.





**TABLE 1:  
RESULTS**

Substance	Pre-intervention				Post-intervention			
	LOW		MODERATE		LOW		MODERATE	
	n	%	n	%	n	%	n	%
Tobacco	7	46.7	8	53.3	13	86.7	2	13.3
Alcohol	12	80	3	20	15	100		
Cannabis	15	100			13	86.7	2	13.3
Cocaine	12	80	3	20	15	100		
Amphetamines	14	93.3	1	6.7	14	93.3	1	6.7
Inhalants	14	93.3	1	6.7	15	100		
Benzodiazepines	15	100			15	100		
Hallucinogens	15	100			11	73.3	4	26.7
Opioids	7	46.7	8	63.3	10	66.7	5	33.3

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*Associate Professor Karen Heslop (PhD, RN. MHN), Curtin University*

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## CONGRATULATIONS!

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