ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL
VOLUME 27, NO.5
OCT–DEC 2021

LET'S TALK ABOUT RACISM

INSIDE

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Following on from an extraordinary 2020, this year has also proven just as challenging.

As I write, significant parts of the country remain in lockdown as the nation struggles to control COVID-19 infection rates rampaging across states and territories.

For Victorians, it's an all too familiar situation. But as more Australians are vaccinated, we can look forward to lower infection rates, a reduction in deaths, and a relaxing of restrictions.

Annie Butler

ANMF Federal Secretary

Until that time, the ANMF remains deeply concerned for the health and wellbeing of nurses, midwives and carers working at the forefront of the virus, battling heavier than usual workloads.

Since the beginning of the COVID-19 outbreak, the ANMF has firmly stood by Australia's health workforce and will continue to do what it takes to protect members.

To date, the ANMF has advocated its position on critical infection control and prevention issues and pressured governments and other significant bodies to tackle widespread shortages of PPE.

When it became apparent that the Government's vaccination rollout plan for private aged care workers was problematic, the ANMF met with the Commonwealth Department of Health heads to highlight the importance of proper planning, coordination and on-the-ground implementation.

The ANMF also called for state and territory governments to be immediately and appropriately funded to take over the vaccination rollout in private aged care. The union proposed that the Commonwealth support the program by guaranteeing vaccine supply, providing clear health advice, and delivering funding for additional measures, including special leave for vaccinated workers who experience side effects.

Additionally, the ANMF pushed for paid vaccination leave for aged care and disability workers.

This year has also seen the ANMF call for urgent measures to address significant stress across the entire health system. The ANMF has lobbied for a guaranteed increase in funding for public hospitals with a commitment from the Commonwealth to a 50/50 share of funding with the states to meet increased demand, improve performance and expand capacity.

These are just a few examples of our union's efforts to support members throughout the course of the pandemic. Moving forward, we will continue to do whatever is necessary to support nurses, midwives and carers to keep them safe in all sectors.

Other activities the ANMF has worked on over 2021 include significant reforms in aged care.

For two and half years the ANMF gave evidence about the state of aged care at the Aged Care Royal Commission. In March this year, the Commission released its final report, making 148 recommendations for wide-scale reform of the sector.

While critically, it recognised that meaningful reform, including safe and quality care, could only be achieved through staff ratios with appropriate skills, the Federal Government disappointingly fell short of implementing all the reforms urgently needed in its Budget released in May.

The Government's 'once in a generation' $17.7 billion reform package over five years suggested it would overhaul the sector. However, the package failed to respond to the Royal Commission's request for 24 hour registered nurse on-site presence at every facility, did not accept the recommended uplift in mandated minimum care hours and excluded sufficient transparency and accountability.

Subsequently, the ANMF will continue to campaign to secure safe staffing ratios, increased wages and conditions, better clinical governance, legislated transparency and accountability for taxpayer funds, and registration for personal care workers. So watch this space.

As the journal reaches your mailboxes, we will be preparing for our biennial national conference, where delegates set the future direction of the ANMF for the next two years. Due to the pandemic, delegates will join the conference online which, like for many others, is a new way of sharing our event.

The conference is themed, **powerful and proud**. It's a theme that aptly describes our exceptional nursing, midwifery and carer workforce.

Despite working in incredibly challenging circumstances, your resilience to show up and provide the care that our community needs is outstanding. As a collective, this grit is powerful, and as we stand up to protect our patients, ourselves and each other, we should all be proud of what we have achieved and what we will accomplish in the future.

Finally, as I sign off on the last journal for the year, I would like to take this opportunity to bid you and your families peace, happiness and goodwill over the Christmas break. While the season may look a little different this year, I hope we can all enjoy this time knowing that there will be brighter days ahead.

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Moving state?

Transfer your ANMF membership

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

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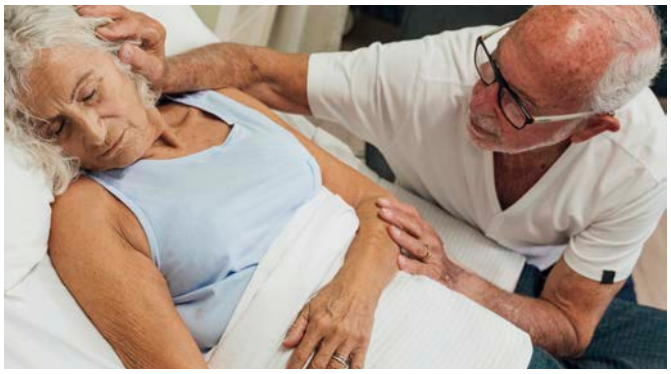
REGULAR COLUMNS

FEATURES

CLINICAL UPDATE

EDUCATION

FOCUS



Study identifies ways to reduce hospitalisations for older Australians

Implementing targeted treatment programs among Australians who undergo an aged care eligibility assessment (ACAT) could help reduce hospitalisations for older Australians, a study has found.

According to research from the University of South Australia and the South Australian Health and Medical Research Institute, one in five South Australians experience an unplanned hospitalisation or visit to the emergency department within 90 days of undertaking an aged care assessment.

The study, *'Predictors of short-term hospitalisation and emergency department presentations in aged care'*, analysed the outcomes of 22,130 people who had an ACAT, uncovering 25 predictors that identified older people most at risk of being hospitalised.

They include level of frailty, types of medications taken, prior hospitalisation and frequency of after-hours services use.

Lead researcher, Professor Maria Inacio, said the findings suggest ACAT, which 186,000 Australians undertake each year, presents an ideal period to implement programs targeted at reducing hospitalisations for older Australians.

"We can identify moderately well those most at risk of being hospitalised, meaning we can determine the older people who need the most follow up after their assessment," Professor Inacio said.

"If we provide targeted treatment or therapies during this time, we can not only provide better support to older people transitioning to care, but we could reduce overcrowding and ramping in our hospitals as well."

One intervention, for example, could target frailty, Professor Inacio said.

"If we invest in services and care that can help reduce frailty – things like encouraging physical exercise if possible, or comprehensive management with geriatric specialists and appropriate allied health professionals – we could improve older people's quality of life and reduce the impact on our hospitals at the same time."

Record demand for suicide prevention services

Record numbers of Australians are accessing suicide prevention services in a "silver lining" that shows the sector is making a difference, according to a new report released last month on World Suicide Prevention Day.

Suicide Australia's second annual *State of the Nation Suicide Prevention* report showed 84% of suicide prevention services and workers experienced an increase in demand over the past 12 months (August 2020 to August 2021), up 6% from the previous year.

Overall, 27% of Australians reported taking action to seek help from a suicide prevention service.

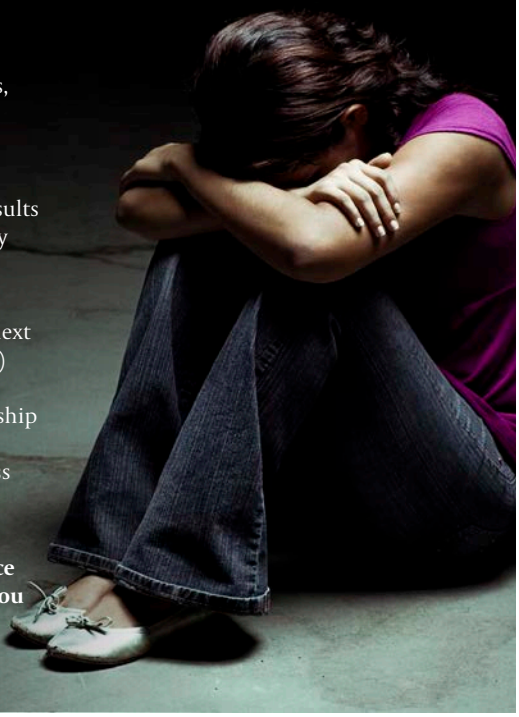
The report found 66% of Australians believe Australia should introduce a standalone Suicide Prevention Act similar to Japan that takes a whole of government, and not just a health approach, to suicide prevention.

Across the community, 29% of Australians reported discussing suicide concerns about themselves or with someone else in the past year. This included young people (18-34) having conversations about suicide (40%) and seeking help (41%) at twice the levels of their parents' generations, 20% and 19% respectively.

The report was based on 283 responses from suicide prevention and mental health sector organisations, as well results from a public survey commissioned by Suicide Prevention Australia.

According to sector respondents, the greatest risk to suicide rates over the next year are posed by social isolation (88%) and unemployment and job security (74%), followed by family and relationship breakdowns (69%), cost of living and personal debt (57%) and housing access and affordability (56%).

To get help 24/7, phone Lifeline on 13 11 14 or the Suicide Call Back Service on 1300 659 467. If you or someone you know is in immediate danger, phone 000 for emergency services.



Global Handwashing Day 2021

Global Handwashing Day, dedicated to advocating for handwashing with soap as an easy, effective and affordable way to prevent diseases and save lives, will be celebrated on 15 October.

The 2021 Global Handwashing Day theme is "Our Future is at hand – Let's Move Forward Together".

This year's theme calls on society to work together to scale up hand hygiene and push towards universal access and practice of hand hygiene.

Organisers say the COVID-19 pandemic highlighted the importance of handwashing for reducing the spread of disease and protecting health. Amid the pandemic, three in 10 people worldwide did not have access to a hand hygiene facility in their home, leaving 2.3 billion at increased risk of COVID-19 and other infections.

Handwashing can reduce diarrhael diseases by 30% and acute respiratory infections by up to 20%. It plays an important role in reducing the transmission of outbreak-related pathogens such as cholera, Ebola, shigellosis, SARS and hepatitis E. It is protective against healthcare associated infections and reduces the spread of antimicrobial resistance.

Behaviour change programs must change priorities and focus on the determinants of handwashing, rather than on education alone, to achieve universal hand hygiene, organisers argue. At the current rate of progress, only 78% of people will have access to a hand hygiene facility by 2030, leaving about 1.9 billion people unable to wash their hands.

Moving forward demands collective action, including governments developing and funding country roadmaps towards universal hand hygiene, and donors, businesses, researchers and advocates all playing their part.

More information: **globalhandwashingday.org**

Positive mental health outcomes in cancer survivors linked to pet ownership

Owning a pet may help support mental health in cancer survivors, research finds.

Cancer Council SA research found that living with pets was associated with a higher mental health score.

Out of 160 Australian cancer survivors surveyed more than half were pet owners, with two thirds of cancer survivors having their pets by their side throughout their cancer treatment.

Researcher Dr Joshua Trigg said that the research suggested how important pets were in supporting positive mental health, particularly for those going through cancer treatment.

"Pet ownership can help support positive emotions in cancer survivors, a key factor in positive mental health outcomes," he said.

"Feeling companionship and affection are important to the human experience, and for participating cancer survivors, living with a pet helped to create these positive experiences, supporting mental health."

Over 27 % of cancer survivors surveyed also reported that COVID-19 negatively impacted their activities and relationships to others. With a number of states and territories currently in lockdown, Dr Trigg said that pets can also play an important support role during periods of isolation.

"As the country faces varied stages of lockdowns, mental health continues to be a huge focus, particularly for those who are going through or have recently finished cancer treatment."

Lori-Anne Sharp

ANMF Assistant Federal Secretary

Morrison Government fails to legislate critical recommendations for safer workplaces for women

As we experience significant outbreaks of COVID-19 in NSW, Victoria and the ACT, and our focus is on the devastating impacts the Delta variant is having on our community and our health professionals, you may be unaware that the Morrison Government has missed a critical opportunity to guarantee safer workplaces for women.

Last month, the Morrison Government largely ignored key recommendations from the National Inquiry into Sexual Harassment in Australian Workplaces 2020, *Respect at Work* report. The Inquiry aimed to address and prevent sexual harassment in the workplace, a problem the report found affects 39% of women and 26% of men. The report detailed 55 recommendations, which, if adopted, would essentially make workplaces safer for women.

Key recommendations included a new regulatory model to lead a proactive, preventative approach to sexual harassment in the workplace, with the onus on the employer to implement a "positive duty".

After sitting on the report for over 15 months, (coinciding in the same period, shocking stories stemming from Parliament House of alleged rape and sexual misconduct), the Coalition Government passed the Sexual Discrimination and Fair Work (Respect at Work) Amendment Bill 2021. Regrettably, this Bill addressed just six of the 55 recommendations. Some of the changes included extending the time to make a complaint from six months to two years, extending laws to parliamentarians and their staff and legislating that sexual harassment can be a valid reason for dismissal. Whilst these changes are welcome, they do not go far enough.

The legislation failed to deliver the desperately needed reform required to improve women's safety at work. If the Morrison Government were committed to providing safe workplaces for women, they would have legislated more than just six of the *Respect at Work* recommendations. Most importantly, they would have included those recommendations that would make a tangible difference to the working lives of women which include:

Amending the Fair Work Act to expressly prohibit sexual harassment and introduce a new prompt and easy complaints process. Recognising there should not be an unnecessary burden placed on women who have experienced sexual harassment to endure complex and lengthy complaints processes at their own cost and risk. Amending the Sex Discrimination Act to include a positive duty on employers to take reasonable measures to eliminate sex discrimination, sexual harassment, and victimisation, supported by suitable enforcement and review powers.

The passing of The Sexual Discrimination and Fair Work (Respect at Work) Amendment Bill 2021 also missed a crucial opportunity to legislate a universal 10 days paid Family Domestic Violence Leave (FDVL) in the National Employment Standards.

A 10-day paid period of leave would assist in supporting women who are escaping violent relationships and improve the woefully inadequate five days unpaid entitlement that currently exists. For many ANMF members under an enterprise bargaining agreement, paid FDVL provisions already exist. Paid FDVL for all is critical to protecting working women to escape an abusive relationship without fearing loss of employment and vital income.

Women of Australia have a right to be safe at work and to thrive in their careers. Women will not be safe if employers only react to sexual harassment rather than taking direct action to prevent it. Proper enforcement powers are needed to stop sexual discrimination and harassment. There must also be a clear prohibition on sexual harassment in the Fair Work Act and powers for the Sex Discrimination Commissioner to initiate their own Inquiries.

Alarmingly, the Morrison Government has ignored the needs of Australian women in workplaces, evidenced by a lack of will to legislate meaningful reform. We can hardly be surprised remembering that this is the same Prime Minister who refused to attend the March 4 Justice Rally and meet protestors, later declaring it a victory for democracy that women could protest without being "met with bullets".

Under the Federal Coalition, we have also witnessed a reduction in funding for women's services and emergency accommodation for abuse survivors and the abolition of the Family Court, driving survivors experiencing FDV and sexual abuse to the mainstream court system. All of these actions adversely impacting women and their families.

We all must continue to pressure the Morrison Government to position Australia as a leader in addressing workplace sexual harassment and family and domestic violence. It is a national crisis. We must demand the full and meaningful implementation of all recommendations from the *Respect At Work* report and commit to gender equality and workplace safety for all.

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Helping to shift government on nuclear weapon usage

By Ben Rodin

ANMF members can play a crucial role as part of the local campaign to end global nuclear weapon usage, according to Gem Romuld, the Director of the International Campaign to Abolish Nuclear Weapons (ICAN) Australia.

Ms Romuld says while Australia isn't yet a signatory to the UN's Treaty on the Prohibition of Nuclear Weapons, nurses (globally) are among those who would benefit from a change in the federal government's position.

"Nurses would be on the frontline of the response to the use of a nuclear weapon, wherever it would be in the world, and it would be impossible to do that in a safe way and in a way that adequately responds to the needs of the moment," Ms Romuld explains.

Ms Romuld says there are both short and long-term ramifications from nuclear weapon usage, with any city centre blast risking lives. At the same time, the impacts of radiation exposure can have significant long-term effects on the lives of those near any blast.

"The stress on healthcare systems is hard to overestimate," she says, Australia's own campaigning has drawn attention to the long-term impacts that previous local detonations have had on Aboriginal and Torres Strait Islander communities, as well as workers who were employed on those sites.

While ICAN Australia's main aim is to get the Morrison government to sign and ratify the UN's treaty, Ms Romuld says there are other actions that the organisation is focused on adjacent to this goal and that ANMF members can support.

The **Quit Nukes Campaign** is one such initiative where concerned community members are encouraged to write to their superannuation funds about whether they invest in nuclear weapon usage as part of a broader campaign to cease investment in nuclear weapons production.

"One of the best things that ANMF members could do right now is to ask for clarity on whether their fund has any investments in nuclear weapons producers and to indicate that they don't want that," Ms Romuld explains.

"There are trillions of dollars in Australian super, and most Australian superannuation funds do have investments in nuclear weapons producers. . .. it's just a small number of companies, and for many funds, divestment would not impact on their returns."

Meanwhile, ICAN Australia wants partner organisations, including the Australian Nursing and Midwifery Federation, to put pressure on both the federal government and the opposition to send representatives to the First Meetings of States Parties concerning the implementation of the UN's treaty, which is scheduled for 22-24 March 2022.

Australia can attend and participate in the meeting, set to occur in Vienna, as an observer despite not yet ratifying the treaty. Ms Romuld says there is plenty of reason for Australia to attend to involve itself in discussions and make statements, even if it can't directly influence any decision-making.

"It's the only progress in terms of a multilateral nuclear disarmament treaty that has come about for decades, so it's a critical piece of law that Australia should be engaging with," she says.

The global ICAN movement, which started in Australia back in 2007 and has received a Nobel Peace Prize, was instrumental in driving the ratification of the UN's treaty, which came into effect in 2017 and had signatures of more than 85 nation-states.

With ICAN's Australian campaigns continuing to build momentum, focusing on outcomes like treaty ratification and divestment, Ms Romuld says the urgency of nuclear disarmament can't be undersold. She suggests that the current pandemic is a reminder of how concerns labelled as distant can suddenly become all too real.

"The pandemic has also been really instrumental in showing us that things that have potentially a low probability but a high impact — sometimes these things do happen," she explains.

"It's a similar case with nuclear weapons. It is inevitable that whether it's by accident or on purpose, that nuclear weapons will be used again.

"We have an opportunity now to try and prevent that."

More information on ICANW Australia's campaign to end nuclear weapon usage can be found at **icanw.org.au**

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LET'S TALK ABOUT

RACISM

Racism has no place in nursing and midwifery, or in society. Yet it remains common. To stamp out racism, advocates say the professions must acknowledge the problem, confront it head on, and then dismantle it. Robert Fedele reports.

—

Nearly 20 years ago, Lesley Salem was the first Aboriginal person to become a nurse practitioner in Australia. It's a day she'll never forget, for both the significant achievement and, shockingly, the talk amongst colleagues in the tearoom afterwards.

"It was said outright: 'I suppose they had to give one of you (Aboriginal person) a nurse practitioner qualification'," Lesley recalls.

Lesley currently works as a generalist/chronic disease nurse practitioner in Doomadgee, a remote Aboriginal community in far north-west Queensland.

Driven to improve the health disparities faced by Aboriginal and Torres Strait Island People, she has also long been an advocate for standing up against racism across the health system and society.

However, when she first started nursing, Lesley kept her Aboriginality hidden.

A relative told her it 'wasn't worth it' and witnessing the treatment of a very dark-skinned Aboriginal nurse, who was given the worst jobs and made to look after the sickest patients, made it hit home.

Back then, people weren't afraid to be openly discriminatory, Lesley says.

Most of the racism she has faced over the years has been overt. Negative comments like 'Why don't you go and look after your mob if you care about them that much?'

"They're like death by a thousand paper cuts," she says.

"But I guess I cared more about the people I was trying to be an advocate for than myself."

On the wards, Lesley routinely witnessed staff overlooking the symptoms of Aboriginal patients and not providing them with the care they needed.

But she says racism runs much deeper than the clinical setting and isn't always as obvious.

Eight years ago, she stopped ticking the box identifying her as Aboriginal when applying for positons because she wanted to get the job because of her skill-set and not to simply meet a quota.

In another example, Lesley says she was invariably the lone Indigenous voice among dozens when speaking on nursing panels at conferences, and drowned out.

Is progress been made?

Lesley believes so, with racism better recognised than it was 40 years ago when she entered the profession. These days, she suggests people reflect on their unconscious bias and do not act on it so instantly. Young First Nations nurses and midwives are also no longer afraid to call out racism.

"The more of us [Aboriginal nurses] the more we'll tackle racism and put it to rest," Lesley declares.

Acknowledging racism exists within nursing and midwifery is the first step towards addressing the issue, argues Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) CEO Roianne West.

This country always was, and always will be, Aboriginal land. Yet in our own country we deal with racism every day.

Photo credit: Nardoo photography

Lesley Salem (left) and Debra Jackson (right)

"The more of us [Aboriginal nurses] the more we'll tackle racism and put it to rest."

"You'll see it referred to as discrimination, as bias, as bullying, all of these other issues. But they (the nursing and midwifery professions) haven't yet acknowledged racism is an issue."

Racism comes in many forms – structural, systemic, institutional, interpersonal, internalised – and happens in many places.

The Australian Human Rights Commission says racism includes prejudice, discrimination or hatred directed at someone because of their colour, ethnicity or national origin. It can be revealed through racial name-calling and jokes. Sometimes, it is invisible. Other times it is systemic, with groups and organisations putting up barriers for people from particular cultural or ethnic backgrounds.

Professor West questions whether nursing and midwifery, as a collective, is doing enough to acknowledge, address and eliminate racism.

The professions' peaks must make racism a national priority clearly identified and embedded in governance, leadership and accountability processes, she says. They must also promote Aboriginal and Torres Strait Islander health and cultural safety within curriculums, and embed cultural safety across the professions and the health system.

A proud Kalkadunga and Djaku-nde woman, Professor West still experiences racism daily. When she first entered nursing, it was "debilitating".

"There's a lot of people that drop out of nursing and midwifery because of racism whereas there's a lot of Aboriginal and Torres Strait Islander nurses and midwives and Aboriginal and Torres Strait Islander nursing and midwifery students who persevere because of the racism," she explains.

In 2019, a report by the New South Wales Nurses and Midwives' Association (NSWNMA) examining the experiences of NSW culturally and linguistically diverse nurses and midwives found one in four nurses and midwives experienced racial discrimination monthly.

Titled the *Cultural Safety Gap*, nurses and midwives who completed the survey came from 100 different CALD backgrounds, with the most common being Indian, Filipino, African, Chinese and Nepalese. Nurses and midwives who identify as Aboriginal and Torres Strait Islander also completed the survey.

The main form of racial discrimination was stereotyping, with 54% of respondents being subjected to stereotyping based on their culture, language or appearance.

"Workers with strong foreign accents seem to be taken less seriously than others. It is harder for them to be valued by their colleagues," a respondent said.

"I have people tell me I'm not dark enough to be Aboriginal, that maybe I'm Greek or Italian instead," another said. "Then there are the staff who come out with the generic all Aboriginals stuff. That we drink too much, smoke too much, don't work and get everything for free."

Professor West points out that the racism experienced by Aboriginal and Torres Strait Islander Peoples is distinct and requires a different response because of the unique historical and political impacts on Aboriginal and Torres Strait Islander Peoples.

"My Peoples sovereignty has never been ceded," Professor West explains.

"It has never been handed over, nor given up. This country always was, and always will be, Aboriginal land. Yet in our own country we deal with racism every day."

Racism was a prominent topic at CATSINaM's 'Back to the Fire' National Conference Series this year.

"The core theme that keeps coming up is the experience of racism and not feeling supported," Professor West says.

"Most people are looking outwards to our patients whereas we're saying racism is not acceptable within our professions."

Both CATSINaM and the Australian Nursing and Midwifery Federation (ANMF) support the 'Racism. It Stops With Me' campaign, which promotes the National Anti-Racism Strategy, launched in 2012, which focuses on collective action against racism in all its different forms.

The ANMF developed its first Reconciliation Action Plan (RAP) in 2009.

The ANMF's RAP commits to work to address health inequalities experienced by many Aboriginal and Torres Strait Islander people and keeping the issue on the national agenda.

The ANMF's RAP September 2020 – September 2022 Action Plan includes promoting positive race relations through anti-discrimination strategies, including developing, implementing and communicating an anti-discrimination policy and educating senior leaders on the effects of racism.

Importantly, ANMF branches such as the NSWNMA are actively supporting members to take action against racism.

The union's guide for members who experience racism includes challenging the person about their actions and reporting the racism to management. The union offers its support throughout the process and encourages members to escalate

complaints to the Australian Human Rights Commission and Anti-Discrimination NSW as required.

Professor West says change starts with increasing the number of First Nations nurses and midwives graduating from nursing and midwifery programs and working in the health system.

Aboriginal and Torres Strait Islander nurses and midwives make up just 1% of the workforce, with experiences of racism contributing to the low numbers.

Racism also contributes to 30% lower completion rates among Aboriginal and Torres Strait Islander nursing and midwifery students, a gap that has remained the same for 20 years.

Embedding Aboriginal and Torres Strait Islander and cultural safety training is another key strategy vital to recognising and addressing racism.

In 2018, the NMBA, with the help of CATSINaM, developed new Codes of conduct for nurses and midwives that require taking responsibility for improving the cultural safety of health services and systems for Aboriginal and Torres Strait Islander clients and colleagues. Under the codes, they must provide care that is 'holistic, free of bias and racism'.

A year later, CATSINaM secured $350,000 in federal government funding to develop Australia's first online cultural safety training course for nurses and midwives delivering frontline care to Aboriginal and Torres Strait Islander people.

Set to be launched on National Close the Gap Day in March next year, the training will support all nurses and midwives to meet the standards of their Codes of Practice, embed cultural safety in the health system, and help close the gap in Aboriginal and Torres Strait Islander health outcomes.

In 2020, the global Black Lives Matter movement, which resonated with the Aboriginal deaths in custody movement closer to home, helped re-ignite the national conversation about racism.

Positively, the spotlight translated into influential research and an upsurge in lobbying.

One paper, led by registered nurse and midwife Dr Lynore Geia, *A unified call to action from Australian nursing and midwifery leaders: Ensuring that Black lives matter*, featured 100 nursing and midwifery leaders calling for the need to embed meaningful Indigenous health curriculum in nursing and midwifery schools of education.

"Now is the time for Indigenous and non-Indigenous nurses and midwives to make a stand together, for justice and equity in our teaching, learning, and practice. Together we will dismantle systems, policy, and practices in health that oppress. The Black Lives Matter movement provides us with a 'now window' of accepted dialogue to build a better, culturally safe Australian nursing and midwifery workforce, ensuring that Black Lives Matter in all aspects of healthcare."

Strategies included recognising, confronting and challenging racism; authentically including Indigenous nurses and midwives in the dismantling and reform of structures in healthcare and education institutions that perpetuate racism; and cultivating curriculum that promotes the social and cultural determinants of Australia's First Peoples.

Leading nurse researcher Professor Debra Jackson believes the call to action provided an important impetus to consider racism in relation to nursing.

"I think it brought it home to us, that this [racism] isn't something that's happening in a faraway land in America, it's happening right here on our doorstep," she says.

Professor Jackson admits it was only as her nursing career progressed that she fully understood the glaring "whiteness" within the profession.

"Over time I realised that, actually, a lot of our discourses are grounded in whiteness. So much of our knowledge is based on white perspectives and white voices."

Her work with colleagues in pressure injury for several years is evidence of this, she says.

One of her doctoral students, Neesha Oozageer Gunowa's project, titled *Pressure injuries and skin tone diversity in undergraduate nurse education: Qualitative perspectives from a mixed methods study*, found pressure injury prevention overwhelmingly focuses on Caucasian people and identifying signs such as pinkness and redness, which, of course, only emerge in people with white skin.

It concluded classroom learning was predominantly framed through a white lens with white normativity being strongly reinforced through teaching and learning activities.

Reflecting on her nursing career, Professor Jackson says a pivotal moment occurred early on that made her realise racism was widespread.

When a First Nations patient had to have emergency surgery, Professor Jackson was shocked at the lack of empathy and respect shown to the patient.

The episode was so distressing that she resigned from her job.

It's why she maintains every nurse and midwife has a role to play in recognising and challenging racism.

"We have to start to call this out and we have to respond appropriately. People can't be racist to patients and neither can nurses be expected to tolerate racist abuse in the workplace," she says.

"We can all shrug our shoulders and say 'it's part of the job, it's just a patient saying it', but it's not acceptable. We have to, as a profession, draw a line in the sand and say racial abuse will not be tolerated to our patients or our staff. If any person is racially abusive towards a staff member, there must be consequences."

How can we support future rural generalist nurses to learn about working with paediatrics?

By Elise Ryan and Elyce Green

In Australia, nurses are the largest and most geographically widespread health discipline, representing 68% of the rural healthcare workforce.[1,2] Nurses working in small hospitals, multi-purpose facilities, and walk-in healthcare clinics are known as rural generalists/specialists.[3,4,5]

Rural generalist nurses have the capacity to care across the lifespan, health specialities and clinical acuity while maintaining a broad range of skills and can adapt knowledge and skills to emergent situations.[3,5,6]

Preparing rural generalist nurses to care for specialist clinical cases such as paediatrics is imperative for patient safety.[7] Anecdotally, nurses may be wary and hesitant of paediatric patients due to perceived complexity and fragility. Paediatric patients are not 'small adults'. They suffer from unique diseases, disabilities and mental health issues; have different physiological, emotional, psychological and social needs; and react to illness and injury in unpredictable ways.[7,8] Caring for paediatric patients with limited specialist knowledge or support can be challenging and high risk.[7]

Nursing education and clinical placement experiences during an undergraduate degree are the foundation for future clinical competency.[9] Rural clinical placements have been shown to promote rural generalist skills and improve work readiness of graduates.[10] A significant challenge lies in sourcing experience in paediatric settings in rural and remote areas as there are relatively few inpatient units spread across a large geographical area.[11] Undergraduate nursing students, therefore, may have minimal exposure to caring for paediatric patients in any clinical setting, and this is particularly the case in rural areas.[11]

One way to improve paediatric-specific clinical exposure within the current scarcity of paediatric clinical placements is through university-community partnerships to provide non-traditional placement experiences. Non-traditional placement locations include primary and secondary schools, early childhood education centres, camps (holiday camps, disability/health condition-specific camps), and health screening. Working with healthy children, children with stable chronic health conditions or those with a disability can provide unique insights into paediatric nursing that extends beyond acute care. Non-traditional placement models such as service-learning placements and interprofessional learning in these community settings are successful in nursing and other health disciplines such as physiotherapy and occupational therapy.[12,13,14]

Meaningful and impactful learning experiences such as those described above are known to broaden clinical skills, increase work readiness, and promote the development of a wide-ranging knowledge base.[14,15]

These experiences can be tailored to meet the Australian Nursing and Midwifery Accreditation Council's (ANMAC) Standards that govern nursing educational programs, such as the requirement for professional practice experiences to integrate knowledge of care across the lifespan and different contexts.[16] Non-traditional placement experiences working in the community promote interprofessional collaboration, autonomy, age-appropriate communication with children, clinical assessment and triage skills, community engagement, health promotion, cultural competence, and professional capacity building in an authentic context.[12,13,14,17,18]

Non-traditional placement experiences can also be tailored to meet learning objectives focused on several elements of Standard 2 in the registered nurse standards for practice – 'Engages in therapeutic and professional relationships'.[19]

Partnerships between industry and universities provide opportunities to achieve these learning experiences and promote the benefits of undergraduate professional practice experiences derived from working with paediatric populations. Such partnerships promote joint ownership of health outcomes and allow for resources to be shared. To create these partnerships, rural health professionals, community organisations and academics must be alert for opportunities, particularly across their networks. Partnership opportunities are also more likely to occur when individuals are aware of the benefits that may be achieved.

Education institutions have a precedent for providing undergraduate nursing students with high-quality learning experiences, but these opportunities can often be scarce, particularly when they must meet unique learning outcomes such as those focused on paediatric populations. Therefore, partnerships with industry organisations can assist education institutions in creating targeted learning experiences for students that meet the needs of the student and education provider. Industry organisations and health professionals are also able to benefit from these partnerships. Benefits that can be achieved by hosting students on placement include increased service delivery; growing workforce; promoting reputation; and creating a workplace culture where ideas and opinions are valued, new staff feel welcomed, and learning and rewards are valued.[20]

Innovation and proactivity are the future of nursing education and, as discussed above, can be fostered through industry-university partnerships. The authors encourage health professionals, community groups and academics to engage in discussions focused on local opportunities and build partnerships based on reciprocity to promote undergraduate learning opportunities.

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Emotional Intelligence in Nursing Leadership

By Jordyn Butler

The current Australian healthcare system is rapidly evolving, with increased demand and expectations on leaders. Consequently, leaders can no longer implement outmoded methods to lead healthcare organisations and staff.

Nursing leaders are expected to provide increasingly efficient, individualised quality care, whilst simultaneously managing issues affecting the nursing industry globally.[1] Key challenges faced by healthcare organisations include nursing shortages and increased turnover. There is increasing emphasis in current literature on the importance of emotionally intelligent leaders in healthcare and is a strong predictor of low nursing turnover.[2] Leadership is central to creating change within healthcare organisations.[3] Therefore, leaders must have requisite leadership skills, as they have a direct impact on patients, families, nurses and the multidisciplinary team.

To be an effective nursing leader, EI is critically important.[4,5] An emotionally intelligent leader can stimulate and foster innovative behaviours among their team. It is imperative leaders can motivate and inspire their staff to increase efficiency and productivity. However, a study by Prufeta[3] identified 31% of leaders require further emotional intelligence (EI) development training.

PROJECT OUTLINE

To inform this discussion, a comprehensive review of the literature was undertaken. Electronic databases were searched for relevant, peer-reviewed journal articles, with the following keywords: emotional intelligence, EI, Goleman's theory of EI, nursing leadership, interpersonal skills.

However, it should be acknowledged that only Goleman's Model of EI was explored. In this article, the term 'leader' refers to different clinicians at all levels within healthcare organisations, not just those that hold hierarchical leadership or managerial positions. The purpose of this article is to discuss the importance of having emotionally intelligent nursing leaders and present recommendations for continuing to develop EI based on current literature.

OVERVIEW OF THE ISSUE

EI is a self-development concept that is characterised as the ability to influence and motivate others by being attuned to their emotional needs, comprehending the reason for their emotions, ability to handle conflict effectively, and cultivating a supportive clinical environment.[6] Individuals with EI are critically aware of their emotions, strengths, weaknesses and their capabilities, enabling them to make informed decisions.[7]

EI is strongly associated with both transformational and authentic leadership theories. EI is considered the cornerstone of transformational leadership.[8,9] Transformational leadership encompasses change as a central concept and influencing colleagues to excel.[4,10] Transformational leaders are able to develop positive relationships with their team and be aware of their emotional needs.[11] Whereas authentic leaders are increasingly self-aware, promote positive mentoring, collaboration and a shared vision with their followers.[4]

GOLEMAN'S MODEL OF EMOTIONAL INTELLIGENCE

Goleman's model of EI can be applied to leadership; the model is comprised of five domains, self-awareness, self-regulation, motivation, empathy and social skills.[4,9,5] The model has three domains that relate to personal effectiveness (self-awareness, self-regulation and motivation) and two domains that relate to social competence (empathy and social skills), thus blending traits and abilities.[4] There are differing opinions regarding the importance of EI in leadership and predicting professional success. Goleman's EI model has been criticised for over-reliance on personality traits, which arguably cannot be altered and difficult to accurately measure.[4]

SELF-AWARENESS

Self-awareness is considered the most important attribute of EI, as individuals with a high degree of self-awareness can take personal responsibility for their actions and mistakes and acknowledge how their feelings affect themselves and others.[6] Emotionally intelligent leaders are reflective and contribute to cultivating a supportive work environment, subsequently increasing staff morale and coping with occupational stress.[12,13] Characteristics of a self-aware leader are transparency, resilience and accountability.[5] For leaders to increase their individual self-awareness, they need to be able to honestly and openly assess themselves and reflect on their strengths and weaknesses; seek regular constructive feedback, and be consciously aware of their emotional responses in stressful situations.[6] Nursing leaders are expected to build and sustain effective teams; thus, it is of paramount importance that they are honest with themselves and their limitations as they strive to develop or improve their self-awareness.[12]

SELF-REGULATION

Leaders who demonstrate self-regulation are passionate, thoughtful, motivated in seeking to make improvements, embracing change and in control of their emotions.[6] These behaviours help cultivate a therapeutic work environment, a culture of trust and integrity to ultimately improve patient outcomes.[9] A leader who exhibits self-regulation thinks before speaking, is measured in interactions, and is mindful of their emotional responses and, most importantly, other people.[14]

EMPATHY

Empathy is the ability to understand other people, their emotions, and thoughts and use that knowledge to influence their own actions.[6] Empathetic nursing leaders possess the ability to observe and interpret other's body language, are willing to learn from others through active listening and asking questions.[6]

SOCIAL SKILLS

Advanced social skills enable leaders to effectively communicate with colleagues in differing roles and departments and build professional relationships.[6] Strong communication skills are imperative to all leaders; effective communication can ensure that all team members feel valued, relevant and safe.[9]

Being emotionally intelligent can help remedy a conflict or dispute by appropriately addressing each individuals' emotions and being able to redirect those emotions into positive action.[9] Nursing leaders need to learn to ascertain the degree of required assertiveness when managing conflicts, as certain conflicts, require a passive response.[15] Assertiveness is considered a 'psychological muscle' that can grow as it is exercised and practiced.[15]

IMPORTANCE OF EMOTIONAL INTELLIGENCE IN NURSING LEADERS

EI is an important virtue for leaders as it enables them to successfully meet the growing demands placed on the healthcare system and expectations on nursing staff.[10] Leaders are required to attend to simultaneous clinical demands whilst attending to other managerial tasks and providing support to their team. EI is a vital skill for leaders to develop as it increases their effectiveness at managing themselves and others.[8,16]

It is highly beneficial for the nursing team if the leaders have EI as it influences critical thinking and decision-making about delivering high quality patient care whilst considering the patient's perspective.[7,17] Increased EI is correlated with decreased burnout, chronic stress, lower staff turnover, increased job performance, positive work-life balance and job satisfaction, ultimately enabling the provision of superior patient care.[18,12,19,17] Furthermore, leaders can use their enthusiasm to motivate nursing staff to provide high-quality patient care resulting in an increase in healthcare organisational performance.[6,12,10] To provide exceptional care to patients, nurses need to be emotionally intelligent to maintain physical and mental wellbeing. This is observed in a study by Fujino et al.[20] indicating a modestly strong positive correlation between nurses having increased EI and high clinical performance (r=0.45).

EI leaders can establish authentic relationships with colleagues, creating a positive work environment with high morale, thus increasing productivity.[6,10] Positive team culture is increasingly important amongst nurses due to growing demands in the healthcare industry.[2] A leader with high EI can act as a stimulus for creating and influencing a positive team culture and working environment. Culture can increase staff engagement and reduce intent to leave. Furthermore, EI leaders are able to create synergy between the team.[2] A research study conducted by Majeed and Jamshed[2] indicated a strong association between leader's EI and turnover intentions, supporting their hypothesis. Poor professional relationships can lead to misunderstandings, an increase in medication errors and poorer patient outcomes.[19] A study conducted by Celik[21] found a positive and statistically significant relationship between emotional regulation of nurses and patients' level of nursing care satisfaction (P=0.05).

Leaders with high EI are more likely to have advanced communication skills.[19] A cross-sectional analytical study conducted by Raeissi et al.[19] demonstrated a significant relationship between the level of EI and communication skills (r=0.775). Lastly, clinical ward environments with EI leaders have observed a reduction in horizontal violence amongst colleagues.[9]

INCREASING EMOTIONAL INTELLIGENCE

The need for emotionally intelligent leadership in nursing is widely acknowledged.[4] Current literature reflects that implementing a combination of strategies and approaches to increase EI will prove invaluable.[6] Developing EI competencies is a lifelong and cumulative process of reflecting on personal experiences.[7,22]

The implementation of EI programs and seminars enables managers, leaders, and nurses to acquire the knowledge, attitudes, and skills required to manage emotions, conflicts, and achieve professional goals.[10] Formal EI training may cover various aspects of the concept and may explore different models.[6] There are online tools that measure individual emotional quotients that may assist leaders in considering their personal EI in differing areas.[14] However, it should be acknowledged that there is no consistent or standardised tool to measure EI.[16] The measure for EI is emotional quotient (EQ).[14] After engaging in EI development training EQ should be re-assessed using the same tool, to accurately measure improvements.[14] A study by del Carmen Perez-Fuentes[18] found significant practice implications for implementing skills training programs for nurses, including managing emotions. However, the sample used in this study was very specific. This study also discusses the limitations of online questionnaires as they may be subject to desirability bias.

Implementing strategies to improve EI will prove invaluable to all nurses, not just nursing leaders and can increase career longevity.[20] Courses that provide for the continued professional development of both EI and critical thinking should be offered to all nursing staff, including graduate nurses, as these vital skills are often overlooked in undergraduate nursing curricula.[4] It has been identified that undergraduate nursing students receive minimal support and training to develop EI. EI education may lead to improved interpersonal communication and quality of management skills amongst graduate nurses and future nursing leaders.[11] Thus, emphasising the importance of developing EI for not just current leaders but for all nurses. Nursing managers and educators must consider EI training and development for graduate nurses to work towards creating a culture of being emotionally intelligent, self-reflective nurses.[17]

The workload and expectations of clinical leaders will inevitably remain fast-paced, multifaceted and unpredictable due to the nature of the healthcare system. Therefore, all nursing leaders, including those in formal leadership positions should be encouraged to partake in regular reflective practices to continue to improve their leadership skills and EI.[22]

Reflective practice and journaling is integral to increasing EI.[22,11] For leaders to develop EI, they first need to complete an honest self-assessment and reflect on their individual current performance.[6]

An additional strategy includes peer mentoring. It may prove beneficial for leaders with high EI to discuss and reflect confidentially with a mentor, as this exercise may promote wellbeing and increase self-awareness of their emotions and actions.[14]

NURSING INTERVENTIONS

Healthcare systems are an ever-changing climate of care; therefore, leaders must use a contemporary leadership approach.[7] Nonetheless, it is evident there is a lack of literature related EI to nursing leadership.[3] This is a component of nursing that requires further high-quality evidence to inform future practices and leadership-development programs.[4] It is of paramount importance that EI is assessed and considered when recruiting new leaders by asking specific questions that measure EI skills to ensure nursing leaders can cultivate a supportive work environment for all staff.[3] Literature identifies that Clinical Education should promote EI development to all staff.[19]

CONCLUSION

After undertaking an extensive literature review, the results illustrate that EI in nursing leaders is crucial. EI is not a new self-development concept, but it is a valuable skill that can be acquired and developed with persistence in conjunction with implementing strategies and adopting reflective practices. There must continue to be a focus and push to increase the emotional capabilities of nurses and clinical leaders. EI is invaluable for not only nursing managers and leaders but all nurses as it helps to provide the necessary insight and skills to manage conflict with patients, families and other staff, in addition to cultivating a supportive team environment. Thus, raising team morale and job satisfaction potentially increasing retention of nursing staff within ward environments, which is of paramount importance due to the current nursing shortage in Australia. The value of effective, emotionally intelligent nursing leadership on ensuring safe, quality patient care is unquestionable.

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James Lloyd

ANMF Federal Vice President

The subtle art of negotiation

"In any negotiations, put yourself in the other person's seat and see what their interest is" Diane von Furstenberg

Nurses, midwives and carers inherently have emotional intelligence. This gives us empathy, helps us practice ethically, enables us to stay emotionally stable, and allows us to adapt to unique cultural nuances. But there is one aspect of emotional intelligence that is perhaps underappreciated and underrated and feeds into all aspects of the care we give: skilful negotiation.

The subtle art of negotiation is one of the soft skills in our toolboxes. Simply, negotiation is the ability to vary points of view, interacting to reach a resolution or mutually agreed course of action or perspective. Effective communication with patients is the primary therapeutic foundation of quality healthcare.

Negotiation tactics are a part of conflict management. Two parties in conflict are brought together to find common ground and reach a mutually acceptable outcome. But in the realm of healthcare, I would argue that having negotiating skills is not about persuading an opponent. It is about understanding that both sides have the same goal (eg. optimal wellness), but the patient and caregiver may have different ideas on achieving that common goal.

Imagine how much easier our jobs would be if we consistently convinced our patients and colleagues to do what was beneficial for them? And wouldn't it be amazing if we were all born as expert negotiators? For example, a patient may be reluctant to mobilise after surgery, so we discuss and agree upon an outcome by giving them more extra time and analgesia to relieve pain.

Our professional lives would be so much simpler. But we deal with complex human beings, whether they are sick, disabled, vulnerable, or frightened. To provide care, we use a person-centred approach requiring high emotional intelligence and effective communication skills to understand their needs. Successful negotiators can manage their own emotions and learn to be calm, respectful, and responsive whilst remaining focused on the issue to be resolved.

TIPS ON EFFECTIVE NEGOTIATIONS

Several skills are required to be a good negotiator. Listen carefully and concentrate on what is being spoken. This provides beneficial information and importantly gives the patient the confidence that you are interested in their point of view. Ask questions, probe for more information, and understand their perspective. Allow for silences to reflect on what they have heard. Take breaks and allow the patient to revisit the issue later if they are not ready. Summarise what you both agree and disagree on, as this can provide clarity for both sides. Separate the person from the issue, and don't let bias affect how you deliberate.

But not all our work interactions involve a patient; no work environment or shift runs effortlessly. Our interactions also include negotiating with colleagues. Sometimes personalities clash, a co-worker may not pull their fair share of work, and sometimes the needs of the workplace and patients require staff to prioritise their workflow. In these scenarios, you can: 1) suffer in silence, 2) elevate the issue to your boss, or 3) negotiate with your co-worker to get the job done.

If you need to consult an issue with a co-worker, think of the following. Is this battle worth it? Will it achieve the required outcome? Be objective and don't negotiate with strong emotions. Pick the best time, as someone already very stressed may not respond well to any negotiated approach.

As an After-Hours NUM (AHNM), I needed to develop my emotional intelligence and negotiation skills. I work in an imperfect healthcare system. We have seemingly endless demands for our services and finite resources. Staff are often pushed to their limits.

I regularly use the following strategies to create outcomes that reflect the need of the workplace as an AHNM: asking questions and listening actively, not reacting to an angry person and having an open style of body language.

Negotiation, like the delivery of healthcare, is about understanding and engaging with people more successfully. Effective communication with patients, carers and colleagues is the foundation of any positive outcome. Having mature, mindful negotiation skills allow us to achieve results that benefit our clients, workplaces, and ourselves. Negotiation is a skill that can be learnt and refined over time, but I would argue it's a necessary skill for all nurses, midwives and carers.

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Continence care for pregnant and birthing women: An example of how midwives can make a difference

By Julie Tucker and Mary Steen

Best practice occurs when midwives continually reflect on how they provide daily clinical care and ask questions about current options and treatment available to women.[1]

Continually reflecting enables midwives to offer and provide optimal care but also identify any sub-optimal care. This continual process assists midwives in meeting the individual needs of women or a birth person and enacts a shared decision plan of care.

An individualised plan of care will consider and respect the cultural needs, values, gender orientation and preferences when providing care and thus promote a provision of high standard evidence-based practice.[1]

Yet, there is increasing evidence of third- and fourth-degree tears following vaginal births and variable reporting of this occurring across Australia, which has promoted an enquiry. Current evidence suggests that about 3% of Australian women following vaginal birth and 5% having their first vaginal birth will sustain a third- or fourth-degree tear.[2]

It is noteworthy that the Australian Commission on Safety and Quality in Health Care (ACSQHC, 2021) has recently released a new national clinical care standard for third- and fourth-degree tears.[2]

It is recognised that consistency in identification, reporting and care by health professionals optimises health outcomes for women with third- and fourth-degree tears.[3]

Therefore, the ACSQHC has provided an online fact sheet for women to access, which defines perineal tears and covers seven quality statements on care and information they should receive concerning third- and fourth-degree tears.[2]

The Information within the statements covers:

- shared decision making and informed consent;
- reducing risk during pregnancy, labour and birth;
- instrumental vaginal birth;
- identifying third- and fourth-degree perineal tears;
- repairing third- and fourth-degree perineal tears; and
- postoperative and follow up care.

The statements also briefly identify the need for discussion in follow up care for future child birthing and a range of health-related concerns, including incontinence. However, there is no guidance for how or when a woman would be screened for incontinence.

This is an identifiable gap in the information provided. Urinary and/or anal incontinence are potentially debilitating issues for some women. This can be particularly pertinent for those who sustain pelvic floor trauma where predominant symptoms such as flatus (gas) incontinence and rectal urgency (often variable reports), many of which report symptoms across the pregnancy continuum (3 to 65%).[4-6]

The Pregnancy handheld record is an important resource and records a pregnant woman's antenatal care and optimises shared decision involvement in her care. This shared care approach reduces the need to repeat concerns to each health professional that may result in less anxiety and stress.

This partnership approach also offers an opportunity to ask sensitive questions around bowel incontinence.[7] However, the lack of questioning and continuity between Australian states' pregnancy handheld records has been highlighted, identifying further barriers to disclosure and effective care.[8]

This disparity is concerning given the risk of urinary and bowel incontinence in women and compounding pelvic floor dysfunction for subsequent pregnancies and births.

A review of contemporary literature identifies pregnancy and childbirth as the greatest risk for pelvic floor dysfunction and bowel incontinence.[2] It has been reported that women with a history of incontinence prior to conception and birth are at risk of worsening bowel function five to 10 years

following their first birth.[6,9–11] Currently, there is little evidence of active screening being conducted, even though identifying a previous history of incontinence is beneficial and can reduce further demise of the pelvic floor. It can also assist in understanding factors that precipitate worsening incontinence such as, pre-pregnancy issues, pregnancy or birth-related trauma.

The first author's doctoral degree that investigated the gaps in clinical practice and explored factors that influenced the disclosure of bowel incontinence by women of reproductive age assisted in improving continence care in a large tertiary birthing centre. This scholarly work led to the development and validation of a specific bowel screening tool (BSQ).[6,12] This tool was informed by and included familiar words identified by women. The research findings of this study identified omissions and misunderstandings of terms used within current screening tools and, therefore, assisted in developing this new tool.

It was vitally important to consider women's use of language. This assisted in health literacy of the new screening tool and resulted in enhanced reporting of bowel incontinence symptoms, especially in the first trimester of pregnancy.

Interestingly, research findings established an overall high prevalence and variable reporting of bowel incontinence including, rectal urgency and flatus incontinence. The findings are comparable to other studies that included rectal urgency.[8–9] These findings are similar to those reported in studies that recognise the influence of additional pre-pregnancy and pregnancy factors, rather than just the consequences of labour and birth.[9–10]

The findings contribute to evidence-informed practice and thus promote improvements in clinical care. It is noteworthy that identifying variable and pre-existing symptoms through proactive screening, which may be overlooked in women who present with no current symptoms, can reduce the stigma and shame associated with bowel incontinence.

In summary, early identification improves continence care in the short term and also improves long-term health outcomes.

It is important to screen for incontinence and the new bowel screening tool has now been implemented in clinical practice at the study hospital. The translation of research evidence to inform clinical practice could not have been achieved without ongoing midwifery reflection and questioning of continence care for women. Involving women and using language they are familiar with has assisted in an effective tool being designed to detect bowel incontinence.

Author

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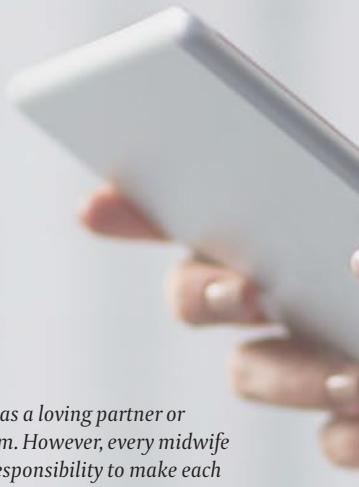
Being 'with woman': Midwifery students reflect

By Anna O'Connell, Nicole Phillips and Nicki Hartney

Towards the end of 2020, 65 students submitted a reflection on their own core philosophy of midwifery: what it means for them, as part of the assessment requirement for completion of the final midwifery unit of the combined Bachelor of Nursing/Bachelor of Midwifery degree.



They explored their experiences of walking alongside women they had cared for and considered how these experiences shaped their philosophy of care for the future. Within this unprecedented and turbulent year, the academics were struck by the eloquence and sincerity of student responses.

With university ethics approval and the consent from the students, we sought to share these reflections.

As health services struggled to prevent transmission of COVID-19, telehealth appointments replaced face-to-face assessment and support.

Despite the disruption, reading student reflections on their perception of the midwifery role, it was evident that the importance of being alongside each woman was understood.

"Tonight, a scrub nurse in theatre asked me why in the world I would choose midwifery over something as exciting as theatre. This question made me think for the rest of my shift. I may never single-handedly influence Australian statistics on caesarean sections and I may never discover the answer to solving perineal damage by myself. Tonight, though, I helped a woman hold her baby for the first time on the operating table because her husband was stuck in Cambodia due to COVID-19 travel restrictions and she didn't have a support person. I am thankful for the opportunity I get every day to participate in the smallest but most significant moments."

Students chose to persevere with their course during 2020, anticipating registration as midwives at the end of that year, prioritising woman-centred relationships in whatever way they could.

"Seeing … women in possibly their most vulnerable state, placing their full trust in you and your team, it all suddenly meant more than just helping a person bring their baby to the world: it was about fulfilling my role as a midwife and fellow woman, to advocate for them, empower them and protect their rights, body, dignity and choice."

The relevance and importance of midwifery care during pregnancy, birth, and into the postnatal period can impact a woman in a myriad of ways and for many years. An understanding of this was clearly and eloquently described in this student's reflection:

"During my aged care… [nursing] …. placement, I spoke with a 96 year-old woman who was in the end stages of life, she regaled me with memories of each of her children's births. Her memories were sharp, as though the experiences were yesterday, lingering feelings of how she was treated and how that made her feel after all this time. This encounter served as a reminder for me as a midwife that I can have a positive influence, one woman at a time, to advocate for her and provide her support in a way that she needs."

In their own words, students expressed their frustrations and also their determination to provide the care they saw as a right for all women.

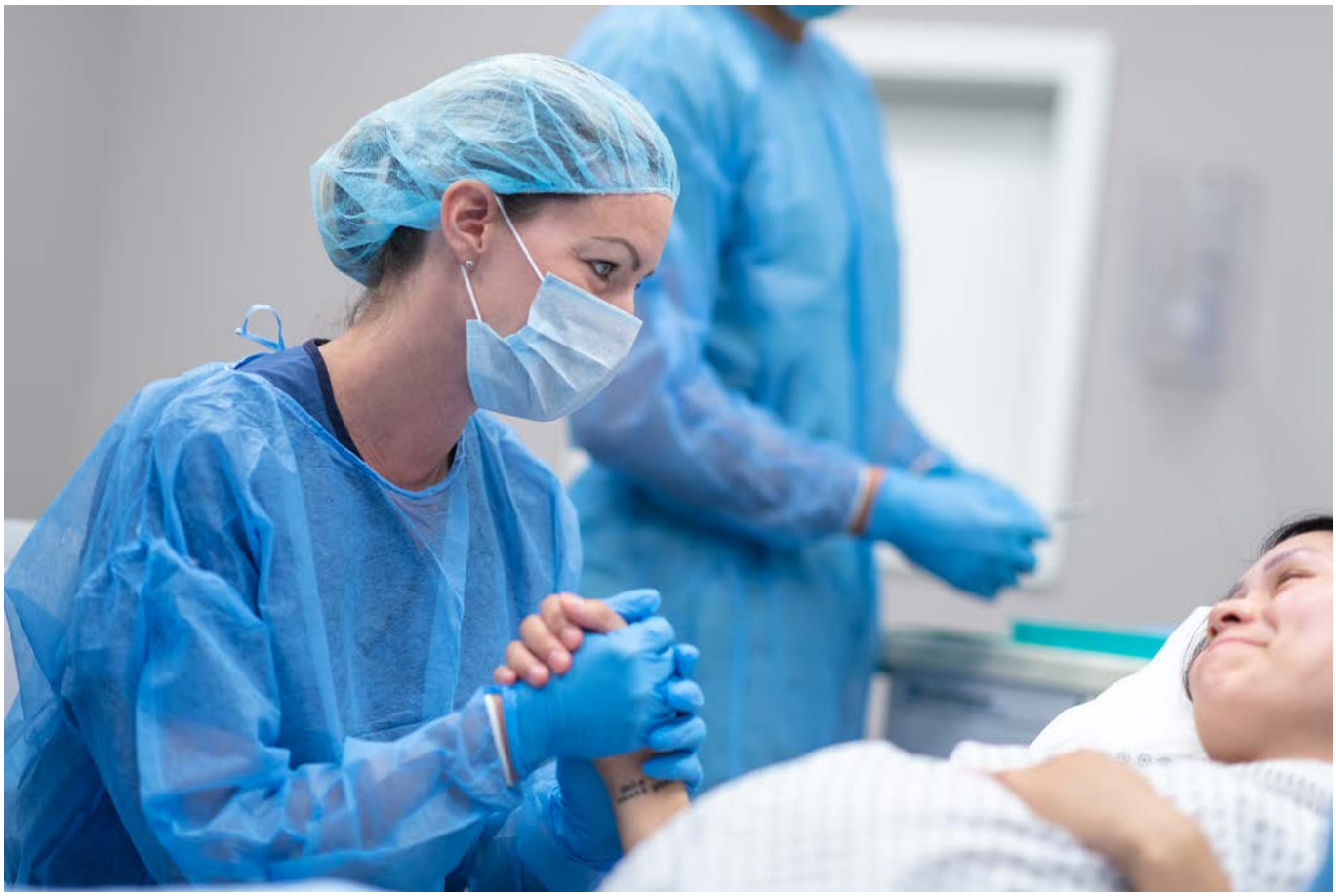
"Not every woman has a loving partner or strong support system. However, every midwife has the power and responsibility to make each interaction and each episode of care as woman centred as possible. The medicalisation of care may feel as though birth has been hijacked from women. The midwife, being the common denominator between clinical care and holistic care, can help to break down attitudes of fear and restore faith and empowerment to birth."

"While COVID-19 is an exaggerated example due to its influence on the physical and emotional maternity care provided, it has acted as a reminder of the agility and knowledge required for care surrounding women with cultural, socio-economic and geographical health determinants."

Students embraced a broad view incorporating a commitment to the rights of women. The importance of childbirth to empowerment and respect for women is evident in the following reflections:

"I learned that being a midwife involves entering into an incredibly personal relationship with the woman and being with her as she is pushed to her limit and at her most vulnerable. It means both giving and receiving trust, offering compassion and walking alongside the woman to the other side of that experience. By doing this, the midwife can support the woman not only to survive but to realise her own power and strength."

"I have found my voice. I have a role to protect women's dignity, freedom of choice and innate capacity to birth. Midwifery is an art that uses your hands, your mind, and your heart to guide, support, and cherish women and new life."



"What began as a burning desire to share in one of the most memorable experiences of a woman's life, has flourished into an obligatory yearning to advocate for a woman's rights in optimising her child birthing experience. In nearing the end of this journey, despite the tribulations, I can confidently declare that nothing in my life is yet to bring me more joy, satisfaction and purpose."

Renfrew et al.[1] assert that students of midwifery who have lived, worked, and learned through the pandemic will retain the impact of this experience throughout their working lives. It would be reasonable to assume that student's care for women, babies and families will be indelibly marked by their experiences throughout the pandemic:

"From a philosophical standpoint, I believe that midwifery is the practice of empowerment, education, advocating, understanding and multidisciplinary input.

I value respect, compassion and teamwork, which I believe are vital to ensuring that the care we provide to women not only meets their expectations but exceeds them to make sure that women feel as though they are decision makers in their care, and listened to and understood throughout their pregnancy, birth and postnatal period. I hope to be the midwife that women remember, with a lasting impression for the dedicated care provided to them during the time I have cared for them."

"My philosophy is based around meeting women where they are in life and being the facilitator to support them through a life-altering experience. I have discovered that as a midwife I am not an expert. I am simply the one to appreciate where this woman has been, what she is going through now and guide her in a way that is culturally, emotionally and physically supportive. I am here for her, her baby, her family and her birth experience. A woman does not come into my life seeking help, I come into hers offering support, compassion and skill."

As academics and facilitators of student learning we walked alongside our students during a turbulent, confronting, unprecedented final year of their studies, glad to have been able to encourage and support their wellbeing where we could. We are reassured that the future of midwifery is in caring, compassionate and skilled hands, uplifted by the words of these novice practitioners who first and foremost, understood how to truly be 'with woman'.

Authors

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Anna O'Connell

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Daniel Crute
Federal Industrial Officer

The new Nurses Award 2020

Over seven years ago, in 2014, the Fair Work Commission (FWC) commenced a review of the Nurses Award. The process is now complete, with the Nurses Award 2020 commencing on 9 September 2021.

While the Nurses Award 2020 looks largely the same as the previous Nurses Award 2010, some significant changes have been made due to the award review, together with a plain language tidy up and clause re-ordering to make the Award easier to read and understand. In January 2019, some substantial changes were made.[1]

INCREASE TO REST BREAKS BETWEEN SHIFTS

The FWC agreed with the ANMF that rest breaks between rostered shifts should be increased from eight to 10 hours. This change was strongly opposed by employer representatives.

The FWC agreed with the ANMF's arguments around safety:

> … It will often be impractical for an employee to leave the workplace, travel home, eat and sleep for a healthy duration and travel back to work with an eight hour break between shifts. For this reason, the employee's agreement should be obtained to reduce from 10 hours as the employee will be in the best position to manage their own fatigue.[2]

MORE DETAIL AND ENFORCEABLE RIGHTS IN MEAL BREAKS CLAUSE

Previously the meal breaks clause did not specify a time when breaks should occur, giving total discretion to employers. The new clauses from 2018 clarify that meal breaks will be taken between the fourth and the sixth hour after beginning work, where reasonably practicable.

FREE FROM DUTY AND ON-CALL

Previously the Award had allowed employers to roster a worker five days per week and then have them on-call on their days off, meaning the employee never had a day where they were truly given a chance to rest and pursue personal and family activities. Changes made in late 2018 mandated that days free from work include being placed on-call.[3]

TELEPHONE AND OTHER REMOTE ON-CALL WORK

The ANMF had sought that the Award clearly state that doing remote work, such as telephone advice or emails, out of hours should be compensated like all other recall work with a minimum of three hours per engagement. Employers were generally opposed to this and instead sought to insert a small allowance.

Ultimately the FWC took a different view to all parties and inserted clauses that provide if an employee is recalled to work and required to perform that work via electronic communication away from the workplace, they will be paid a minimum of one hour's work at overtime rates. For work longer than one hour, they will be paid for the time worked rounded to the nearest 15 minutes at the appropriate overtime rate.

RATE OF PAY FOR CASUALS WORKING OVERTIME, WEEKENDS AND PUBLIC HOLIDAYS

Another issue raised during the award review process was the result of excellent work by the ANMF's QNMU Branch in April 2019. The QNMU successfully demonstrated that the rate of pay for casual employees working overtime, weekends and public holidays were calculated on a compounding basis in the Domain Aged Care[4] decision.

As the "exposure draft" of the proposed new Award did not contain the correct higher rates spelled out in Domain Aged Care, this needed to be addressed. The Australian Industry Group made an application to amend the Nurses Award 2010 that would have effectively reduced casual rates for overtime, weekends and public holidays. The application was unsuccessful, and the decision in Domain Aged Care was affirmed.

A substantially rewritten exposure draft was published in May. It clearly recognised that casuals covered by the Award are entitled to casual rates for overtime, weekends and public holidays calculated on a compounding basis. The Award includes a clear definition of the "casual hourly rate", which is used to calculate casual pay on overtime, weekends and public holidays. Schedule B of the new Nurses Award 2020 also has wages tables for the casual hourly rates for weekends and public holidays.

The changes to the Award also form the basis of assessing whether an enterprise agreement will pass the 'better off overall test', so it's important to be aware of what the Award contains when it comes to bargaining.

The Nurses Award 2020 is a contemporaneous, easy-to-read document, which has brought improvements to the minimum safety net and greater clarity of entitlements.

Footnotes

1. [2019] FWCFB 121
2. [2018] FWCFB 7347 at [114]
3. Ibid., at [97]
4. Australian Nursing and Midwifery Federation v Domain Aged Care (QLD) Pty Ltd T/A Opal Aged Care [2019] FWCFB 1716

Naomi Riley
Federal Professional Officer

Have you taken a moment?

The COVID crisis permeates so many elements of who we are and what we do. Many people are struggling with the emotional toll of life being out of their control, and it is no wonder when you consider all that has happened in the past 18 months.

For nurses and midwives, even with smaller numbers of infections compared to the international experience and periods of zero transmission, there continues to be reports of the healthcare system being under increasing pressure. This in turn creates a growing toll on the emotional health of those working on the frontline.

Flashback to the beginning of 2020, with our health system already overburdened by providing care for all manner of health concerns considered part of day to day life. We collectively watched with growing concern the start of the pandemic and the overwhelmed health services in Wuhan. That was the start of it.

From there, the reports worsened, COVID was detected in Australia, the rules and restrictions were progressively announced. Freedom to work, travel, exercise, visit friends and family, all came under the remit of governments.

It was, and still is, a bit surreal that a pandemic has and is really happening.

Everyone has their personal "COVID" stories. Here is a tiny snapshot of one of mine.

At the beginning of the pandemic, I was halfway through pregnancy with our family's third baby. Visits at the hospital became a lonely affair with no partners or children allowed. The beautiful midwifery group practice rooms were relocated in the hospital to make way for a COVID maternity ward, and my hopes for a non-medicalised birth felt threatened. I was petrified I would get COVID and be without my support people when my baby was born or, my absolute worst nightmare, be separated from my newborn baby. Thankfully, I did not get COVID, but the arrival of our son was not without complications. With hospital visitors limited, including my partner, the time around his birth was another relatively lonely experience. More complications in the weeks that followed with my bub's health and mine meant more medical appointments and hospital visits alone with him. What would have been stressful experiences pre-COVID were dialled up amid stage 4 restrictions and still so many unknowns about the virus.

Being on the other side of healthcare delivery, I could feel the underlying level of anxiety and stress of workers, including nurses and midwives on the front line. I was cognisant of the added pressure the health system was experiencing of needing to be THE support for those requiring healthcare who were attending to their health needs alone amidst stay at home orders.

And here we are, over 18 months on, continuing to experience lockdowns, the threat of COVID overrunning our health system, and restrictions on attendance to healthcare services.

HOW DOES THIS RELATE TO PROFESSIONAL PRACTICE?

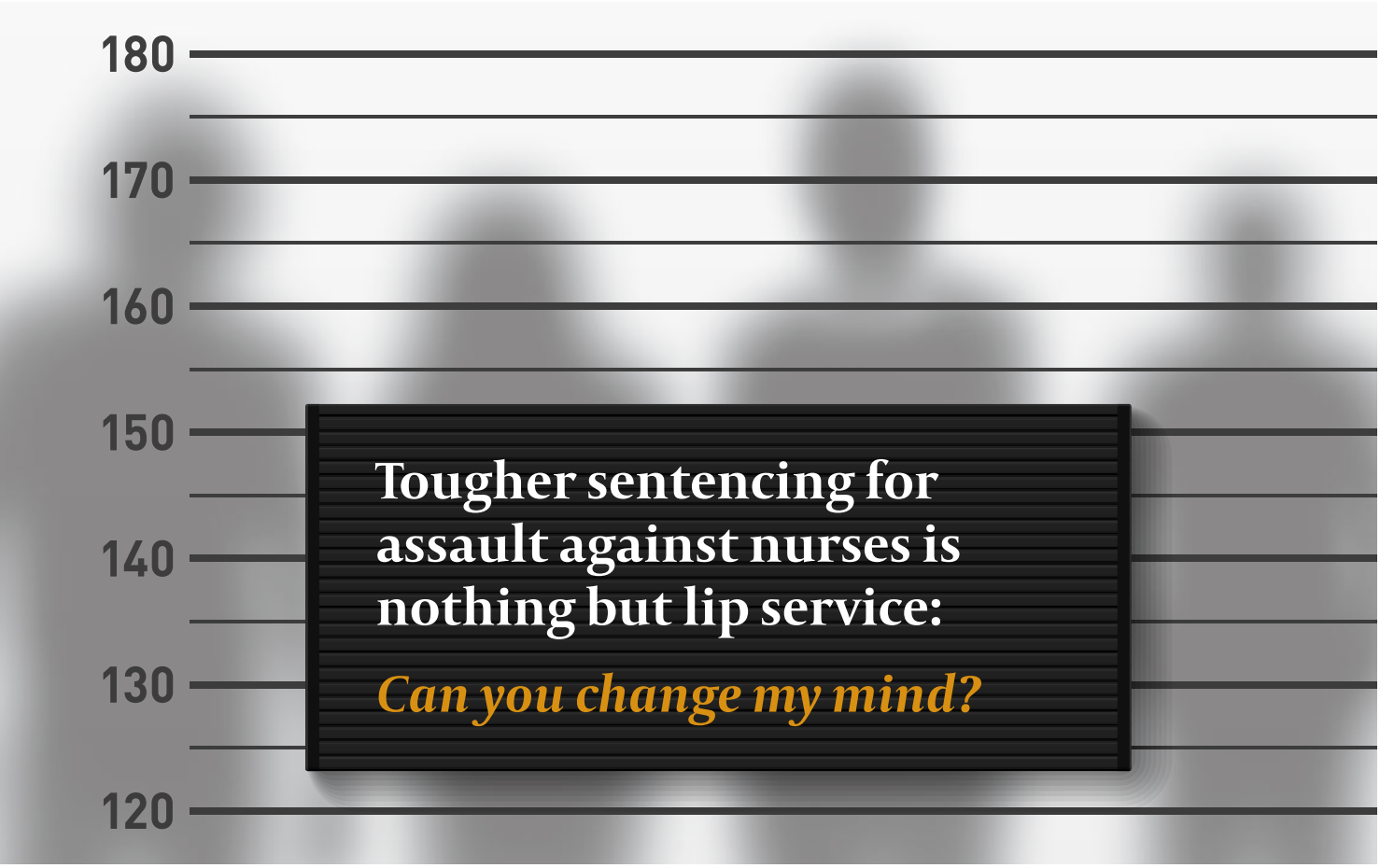
As nurses and midwives, we put so much of ourselves into looking after others. The pandemic has asked nurses and midwives to step up a notch when they were already pushed. To continue to turn up to work. To care for our community and be the support in the absence of others. Nurses and midwives have been hailed for the compassion and kindness they have shown during this time.

Unfortunately, as nurses and midwives, we don't always have the same amount of compassion and kindness for ourselves or our colleagues. We also often have so much compassion for others that we downplay our own experiences and tell ourselves, 'it could be worse', seldom acknowledging that whilst it could be worse, it still isn't easy.

How does this play out for self-care, personal and professional relationships and the mental health of our caring professions?

As the pandemic goes on, as you continue to work caring for others, take a moment, or more, to think about how you are going. What are your COVID stories? What are your wins, even the small ones? Have you been showing yourself compassion and kindness?

Your ANMF Branch staff are there for you if you need it. You can also contact Nurse and Midwife Support, a 24/7 national support service for nurses and midwives providing access to confidential advice and referral. It's okay to ask for help: **nmsupport.org.au**



Tougher sentencing for assault against nurses is nothing but lip service:

Can you change my mind?

By C.J. Cabilan

Occupational violence (OV) is much more pervasive than is acknowledged in the nursing discipline. Occupational violence is verbal and/or physical attack that occurs in the workplace and could potentially lead to harm. Verbal violence can include (but not limited to) yelling, insults, intimidation, threats, bullying, harassment, use of derogatory gestures and swearing. Physical violence can include (but not limited to) striking, slapping, punching, spitting, kicking, choking, biting, pushing, sexual assault and use of weapons against staff.[1]

It is an irony that one (myself included) is passionately raising awareness of an underreported problem.[2,3]

Looking beyond formal reporting systems, it is known that around 60-70% of nurses in Australia have reported experiencing verbal or physical forms of OV.[4,5] While both forms of violence can be impactful, this article focuses on physical violence against nurses.

Physical violence represents about 20% of OV that is reported to occur in healthcare.[6] Nurses are commonly grabbed, hit, spat at, kicked, pushed, or punched by patients.[5]

These incidents result in physical injuries, permanent disability, post-traumatic stress disorder, anxiety, and depression among the staff involved.[7]

There are financial losses from sick leave and compensation claims,[8,9] and possibly from recruitment of new staff to replace sick or injured staff for health services.

Recognising the magnitude and burden of physical violence, nurses have been calling for changes based on law reform, including tougher sentencing as deterrents.[10] Physical violence is punishable by law as assault, and each state or territory in Australia has its own legislation on its criminalisation. In recent years, certain jurisdictions have taken a decisive stance by imposing lengthier maximum imprisonment on those found guilty of assaulting nurses (see Table 1). The importance of this legislation is highlighted repeatedly and loudly when extreme cases of physical violence-hit (excuse the pun) mainstream media. It seems that the importance fades as time passes; and resurrects when another nurse suffers.[11-14]

While 'tougher sentencing' is a welcome progress towards prevention, its application is concerning. Around 12-30% of physical violence is reported in hospital registers;[2,3,15] and <1% is reported to law enforcement.[16] Putting this into context, at best, three in 10 nurses file a hospital incident report and practically barely anyone files a police report. If hardly any nurses report to law enforcement, who is being brought to justice for assaulting nurses? What then is the deterrent value of the legislation?

Based on incidental narratives from the existing literature, there are disincentives to reporting to legal authorities and subsequently pursuing legal action:

- Employers discourage reporting due to perceived reputational harm[17]

If hardly any nurses are reporting to law enforcement, who is being brought to justice for assaulting nurses? What then is the deterrent value of the legislation?

- Employers may not be forthcoming with information about legal processes[18]
- Employers apparently do not advocate for their nurses[19]
- Employers and legal authorities show unwillingness to support and pursue legal action against perpetrators[15,17]

Central to these narratives is the lack of empowerment and support for nurses to report provided by their employers.

The consequence being, if assaults are not reported to the police, there can be no legal process. Without legal process, the legislation can be rendered ineffective. Collectively, if the legislation is in effect to deter violence against nurses, nurses must have the support systems to enable them to report assaults formally and to understand and navigate the legal system.

Employers are key to instigating this support system. Only then

can we improve the reporting culture, see perpetrators penalised accordingly, influence community views that assaults on nurses are serious and warrant significant penalties, and so deter occupational violence.

Author

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She received a Queensland Advancing Clinical Research Fellowship to complete her PhD to develop, implement, and evaluate an occupational violence risk assessment tool.

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TABLE 1. State legislation governing penalties on assaults against nurses

STATE	LEGISLATION	PREVIOUS MAXIMUM IMPRISONMENT	CURRENT MAXIMUM IMPRISONMENT
WA	Criminal Code 1913	7 years (Section 317A)	10 years (Section 318, from 27 April 2008)
QLD	Criminal Code Act 1899 (Section 340)	7 years	14 years (from 5 Sep 2014)
SA	Criminal Law Consolidation Act 1935 (20AA)	–	15 years (3 Oct 2019)
	Criminal Law Consolidation Act 1935 (5AA)	5 years	7 years (from 3 Oct 2019)
NT	Criminal Code Act 1983	7 years (Section 188A)	16 years (Section 189A, from 7 Nov 2019)
TAS	Criminal Code Act 1924	–	1 year
ACT	Crimes Act 1900 (Section 26)	–	2 years
NSW	Crimes Act 1900 (Section 59)	–	5 years
VIC	Crimes Act 1958 (Section 31)	–	5 years

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

Voluntary assisted dying (VAD)

There have been a number of attempts to legalise euthanasia in Australia over the years. In 1995 controversial legislation was passed in the Northern Territory – The Rights of the Terminally Ill Act 1995 (NT), which had both widespread support from those supporting death with dignity and right to die groups and condemnation from those who opposed euthanasia supporting a right to life.

This Act was abolished in 1997 by the Commonwealth Government using their power in the Australian Constitution, and from that time, euthanasia was again unlawful in Australia.

However, in recent times the right to a dignified death has gathered momentum and support and is now lawful in Victoria (from 2019) and Western Australia from July 2021.

Both Tasmania and South Australia have passed laws to enable VAD in their jurisdictions. However, when this becomes lawful has yet to be proclaimed, it is anticipated that it will be in 2022.

Whilst each Act has variations within the provision, the general intent is similar as is the eligibility criteria.

For example, eligibility criteria includes the need for the person to be 18 years of age or over with capacity, an Australian citizen ordinarily resident in the jurisdiction with a defined illness that will cause death within the prescribed time or where suffering cannot be relieved in a tolerable manner.

A fundamental principle is that the decision is voluntary and free from coercion and that information regarding VAD is provided appropriately at the person's request. Indeed, provisions, for example, in the Victorian (S 8) and SA legislation (S 12) clearly prohibit registered health professionals from initiating a discussion or suggesting VAD to anyone in the course of providing a health service to that person.

To do so would be regarded as unprofessional conduct. This is in contrast to the position in WA (S 10) and Tasmania (s 17), where in WA, a registered medical practitioner or a registered nurse practitioner may initiate a discussion or suggest VAD to a person they are providing a health service for IF at the same time they also provide information on treatment and palliative care options and the likely outcome of those options.

In Tasmania, any registered health professional may do this as long as at the same time, they advise the person that a registered medical officer would be the most appropriate person to discuss VAD with. Otherwise, there is prohibition on registered healthcare workers initiating the discussion or suggesting VAD to a person they are providing a health service to.

Each piece of legislation has provision for conscientious objection that enables practitioners not to participate in VAD in any way, including providing information regarding VAD.

There are also provisions in the legislation that make it clear that dying by VAD is not suicide, nor would it be seen that the person providing the substance for a VAD would be aiding and abetting a suicide.

This is important as in all jurisdictions, aiding and abetting someone to commit suicide is still unlawful in all jurisdictions in Australia – even if the person requests this.

Where a person does participate in another's suicide – even at their request, they are open to charges of aiding and abetting a suicide, manslaughter or murder.

Motive for doing so whilst maybe compelling would not change the culpability here. There have been a number of cases where family, friends and health practitioners who have assisted in a person's suicide have been prosecuted for this.

For example, in R v Susan Dowdle [2018] NSWSC 240, a mother was convicted of manslaughter after the mercy killing of her son she received a two year non-parole sentence however, as she had been held on remand for two years – it was considered that her term had been served and she was immediately released.

As each piece of legislation has complex provisions regarding the application, assessment, implementation process and mandatory education requirements for those eligible to be involved, it is important that health practitioners become familiar with the legislation of their own jurisdiction.

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End-of-Life Choices (Voluntary Assisted Dying) Act 2021

Voluntary Assisted Dying Act 2021 (SA)

Voluntary Assisted Dying Act 2019 (WA)

Voluntary Assisted Dying Act 2017 (Vic)

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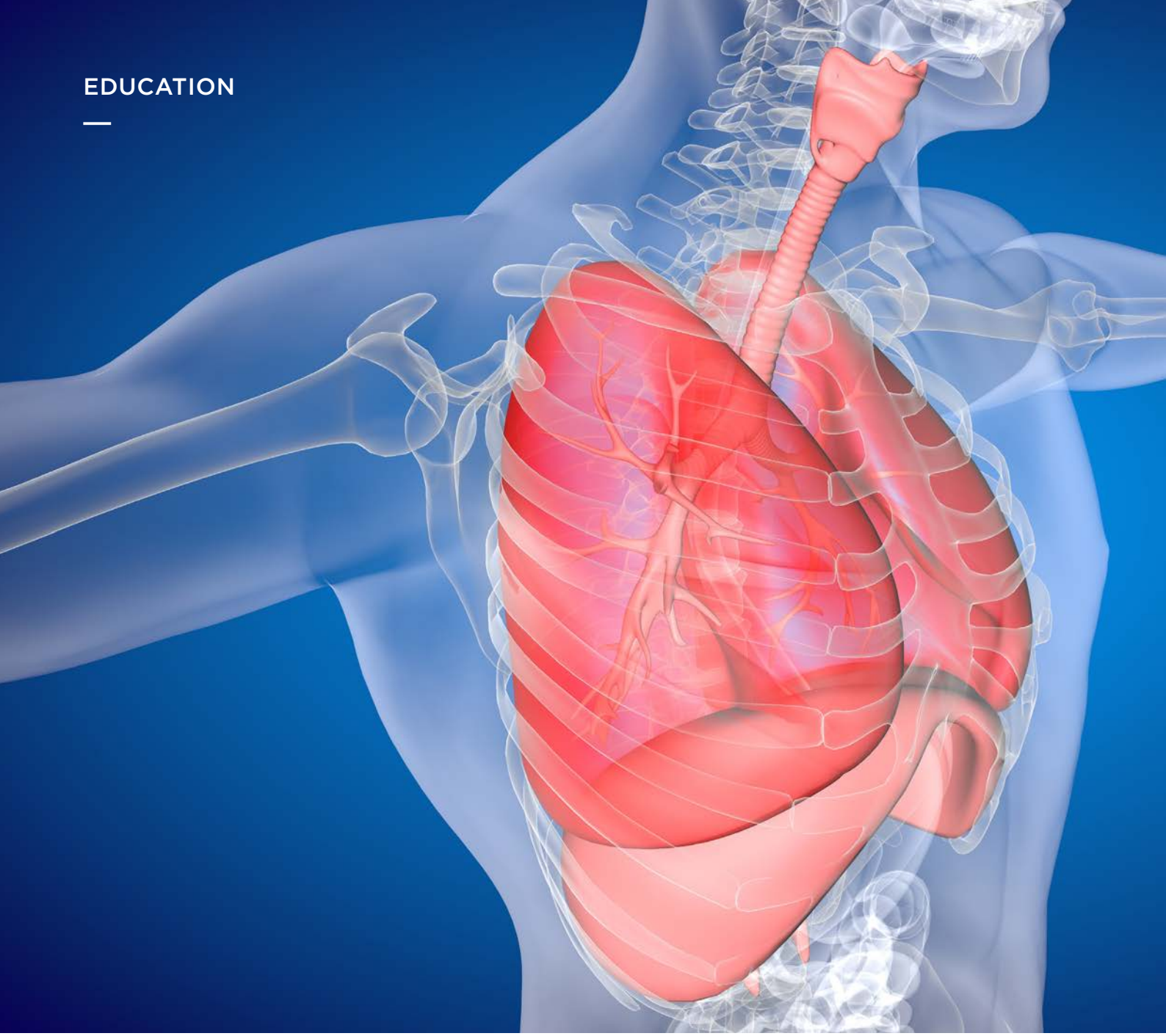

The following excerpt is from the ANMF's respiratory failure tutorial on the Continuing Professional Education (CPE) website.

This course reviews the physiologic components of respiration, differentiates the main types of respiratory failure, and discusses medical treatment and nursing care for patients with respiratory failure.

Because respiratory failure is a common respiratory condition, you are likely to come across patients in various stages of respiratory failure, either due to infections or chronic respiratory conditions.

To have a good understanding of the pathophysiology of respiratory failure, you must have a sound understanding of the respiratory system, respiration and ventilation, including gas exchange.

The human respiratory system is a series of organs responsible for taking in oxygen and expelling carbon dioxide. The respiratory system works with the cardiovascular system to deliver gases between lungs, blood and cells.

It also plays a role in acid-base balance.

OXYGEN

Oxygen is an essential requirement for cellular metabolism. Adequate blood flow and normal haemoglobin levels are necessary for the transport of oxygen to the cellular level.

Cells cannot store oxygen and require a continuing supply diffusing across cell membranes from the capillary blood.

The human body needs oxygen to sustain itself.

A decrease in oxygen is known as hypoxia, and a complete lack of oxygen is known as anoxia.

These conditions can be fatal; after about four minutes without oxygen, brain cells begin dying, leading to brain damage and ultimately death.

VENTILATION AND RESPIRATION

The lung is highly elastic. Lung inflation results from the partial pressure of inhaled gases and the diffusion-pressure gradient of these gases across the alveolar-capillary membrane.[1]

The lungs play a passive role in breathing, but ventilation requires muscular effort.

Respiratory failure

By ANMF Federal Education Team

Respiratory failure is one of the most common reasons for admission to the intensive care unit (ICU) and a common comorbidity in patients admitted for acute care. It is the leading cause of death from pneumonia and Chronic Obstructive Pulmonary Disease (COPD).[1]

RESPIRATORY FAILURE

Respiratory failure occurs when one of the gas-exchange functions, oxygenation or CO2 elimination fails.

A wide range of conditions can lead to acute respiratory failure, including drug overdose, respiratory infection, and chronic respiratory or cardiac disease exacerbation.

Respiratory failure may be acute or chronic. It may also be classified as hypoxemic or hypercapnic.

Hypoxemic: There is not enough oxygen in the blood. However, the levels of carbon dioxide are close to normal.

Hypercapnic: There is too much carbon dioxide in the blood and near normal or not enough oxygen in the blood.[2]

ACUTE RESPIRATORY FAILURE

In acute respiratory failure, life-threatening derangements in arterial blood gases (ABGs) and acid-base status occur, and patients may need immediate intubation.

Clinical indicators of acute respiratory failure include:

Partial pressure of arterial oxygen (PaO_2) below 60 mm Hg, or arterial oxygen saturation as measured by pulse oximetry (SpO_2) below 91% on room air;

- $PaCO_2$ above 50 mm Hg and pH below 7.35; and
- PaO_2 decrease or $PaCO_2$ increase of 10 mm Hg from baseline in patients with chronic lung disease (who tend to have higher $PaCO_2$ and lower PaO_2 baseline values than other patients).

CHRONIC RESPIRATORY FAILURE

In contrast, chronic respiratory failure is a long-term condition that develops over time, such as with Chronic Obstructive Pulmonary Disease (COPD).

Manifestations of chronic respiratory failure are less dramatic and less apparent than those of acute failure.[3]

Causes of hypoxia or respiratory failure:

- CNS injury or depression: Drugs, head injury, cerebral bleed/clot.
- Altered nerve pathways: Spinal injury with cord damage, high spinal anaesthetic.
- Muscle weakness/paralysis, muscle spasms: Neuromuscular disorders, seizures, tetanus, spinal injury.

- Loss of chest wall integrity: Fractured ribs or sternum.
- Lung damage: Lung contusion, pneumothorax, chest infection.[4]

SIGNS AND SYMPTOMS

Patients with impending respiratory failure typically develop shortness of breath and mental status changes, which may present as anxiety, tachypnoea, and decreased SaO2 despite increasing amounts of supplemental oxygen.[1]

Acute respiratory failure may cause tachycardia and tachypnoea.

Other signs and symptoms include periorbital or circumoral cyanosis, diaphoresis, accessory muscle use, diminished lung sounds, inability to speak in complete sentences, an impending sense of doom, and an altered mental status.

The patient may assume the tripod position to further expand the chest during the inspiratory phase of respiration.

In chronic respiratory failure, the only consistent clinical indicator is protracted shortness of breath.[1]

NURSING CARE

To detect changes in respiratory status early, assess the patient's tissue oxygenation status regularly. Evaluate ABG results and indices of end-organ perfusion.

Keep in mind that the brain is extremely sensitive to O2 supply; decreased O2 can alter mental status. Also, know that angina signals inadequate coronary artery perfusion.[1]

In addition, stay alert for conditions that can impair O2 delivery, such as elevated temperature, anaemia, impaired cardiac output, acidosis, and sepsis.

As indicated, take steps to improve V/Q matching, which is crucial for improving respiratory efficiency.

To enhance V/Q matching, turn the patient regularly and timely to rotate and maximise lung zones. Because blood flow and ventilation are distributed preferentially to dependent lung zones, V/Q is maximised on the side on which the patient is lying.[1]

Regular, effective use of incentive spirometry helps maximise diffusion and alveolar surface area and can help prevent atelectasis.

Regular rotation of V/Q lung zones by patient turning and repositioning enhances diffusion by promoting a healthy, well-perfused alveolar surface.

These actions, as well as suctioning, help mobilise sputum or secretions.[1]

ASSOCIATED MALNUTRITION

Malnutrition is associated with impaired mechanical function of the lungs in both chronic and acute respiratory insufficiency. It can impair the function of respiratory muscles, reduce ventilatory drive, and decrease lung defence mechanisms and higher susceptibility to infections and pressure sores.

Clinicians should consider nutritional support and individualise such support to ensure adequate caloric and protein intake to meet the patient's respiratory needs.

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COVID-19 vaccines protect us against harm and death from other causes

The SARS-CoV-2/COVID-19 pandemic has revealed that healthcare systems operate with strictly limited resources, workforce constraints, and variable accessibility.[1,2]

Throughout the pandemic, we have witnessed health sectors of entire countries, both developing and advanced, brought to the brink of collapse.[3]

We now face this situation in Australia with New South Wales struggling to cope with growing case numbers and even South Australia grappling with a continuous crisis of hospital 'ramping' as paramedics struggle to cope even without COVID-19.

While an overwhelmed health system is not an unavoidable outcome of the pandemic, and could certainly have been foreseen based on past experience, the likelihood of it occurring appears to increase where timely, decisive policy decisions, effective and adequately funded public health and social measures, and citizen trust and adherence are poorer.[4]

As well as saving lives and reducing illness, a principal aim of the COVID-19 vaccination program and range of public health measures and social restrictions is to prevent or minimise the risk of overwhelming health systems.

Here, as we have seen abroad, would be where otherwise readily treatable conditions or injuries,[5] even childbirth,[6] may become harder to safely and effectively manage due to staff, space, and resource shortages. Here is where doctors, nurses, and midwives must make heart-wrenching choices regarding who can be saved and who cannot.

It is distressing to see that with these obvious and significant impacts, opponents to vaccines and social restrictions mobilise campaigns presumably to undermine public confidence and willingness to participate in attempts to combat the pandemic.[7]

One argument that often appears to be put forward against vaccination is that COVID-19 vaccines do not *completely* prevent illness and death.

Here, vaccination opponents focus on reports of hospitalisations, intensive care unit admissions, and deaths of vaccinated individuals with little regard to the fact that most reports contain neither information about why patients were admitted in the first place nor the causes of death.[8] Further, with rising vaccination rates and the fact that COVID-19 vaccinations reduce risk but do not completely prevent infection, it is understandable that an increasing proportion of vaccinated individuals would present with a range of issues while also positive for COVID-19.

Reports of COVID-19 and all-cause mortality reveals that all-cause related deaths appear to climb, corresponding to COVID-19 related deaths.[9,10] These findings are unsurprising. Strained health systems struggling to cope with unmanageable numbers of presentations and admissions while attempting to implement effective respiratory protection programs for all patients and visitors in a context of:

i. limited resources;
ii. lower staffing levels due to ill-health and absence; and
iii. high levels of stress and burnout simply cannot provide the necessary care and treatment that patients need.

Vaccination, public health measures, and social restrictions cannot and will not completely protect every person from the risks of infection, illness, hospital admission, or death.

What these interventions do, however, is quite significantly and practically reduce the risk and frequency of these events occurring. This gives health systems and the staff working within them the breathing room they need to care for people who present with COVID-19-related illnesses and those presenting with a range of other completely unrelated illnesses and injuries.

Unless our health and aged care systems are significantly and comprehensively improved, then vaccination and social restrictions will be necessary to protect our community not just from COVID-19 itself, but from the risks of harm and death from all other causes.

Article with references available on *ANMJ* website

Preceptoring the preceptors: Empowering and sustaining our profession

By Erin Wakefield

A preceptor is 'an experienced, resourceful nurse or midwife who facilitates and evaluates learning and assists in critical thinking and development of nursing skills while fostering independence and socialisation' of novices.[1, P.107]

The Code of Conduct for both nurses and midwives outlines the requirement of teaching, supervising, and assessing to develop our workforce.[2] But how are busy nurses and midwives supported to do this?

Due to workforce demographics (particularly in speciality areas), preceptorship may occur with little or no preparation.[3,4,5] Staff may be offered a mandatory single short course;[1] soon outdated and not followed up in a practical manner by the provider. Many feel unprepared for this role.[6]

There are numerous reasons a nurse or midwife will volunteer for or be requested to take on a preceptorship role. It is an acknowledgement by management and peers of professional skills standard, ability, positivity and other interpersonal attributes conducive to education.[7]

Teaching is satisfying and rewarding and provides the opportunity to develop a new generation of nurses.[3] Reciprocal learning is enabled - particularly when the preceptee has a high level of inquiry.[8]

It also aides the preceptor to be conversant with best practice and evolving policy standards.[4] There is pleasure in sharing the enthusiasm of a novice and in witnessing confidence and ability grow in the clinical environment.[4]

On the flip side, there are challenges associated with preceptorship. It can lead to burnout, adds to the clinical workload,[9] and novices need consistent attention and supervision.[4]

Providing best-practice patient care must be balanced with optimising learning opportunities.[6] Tension can occur in a mismatch between the actual and desired time available for components such as reflection and documentation. Complaints and personality mismatch can also cause stress,[4,10] as can the administrative requirements.[6]

In the author's tenure as a clinical nurse educator (CNE), she worked in a busy, semi-rural operating suite, which provided primarily obstetric and general surgical services. A large part of the role was caring for pre-registration students and graduate nurses undertaking a perioperative rotation. It was always understood that novice success fundamentally depended on the experienced, passionate team of preceptors who were by their side in theatre or recovery room each day; a logistical condition that could, of course, not be met by a CNE.[11]

When new to the role, the author set out to support and empower preceptors. They were all clinical practice experts but had undertaken very little training for teaching in the clinical environment. For successful preceptorship, the preceptor must be self-efficient and confident in their clinical role. They further need the ongoing support of management and colleagues,[4] and long term provision of education.[12] Together with rostering assistance from the nurse unit manager, the CNE commenced monthly education sessions for the wonderful group of perioperative preceptors.

Initially, topics were based around the principles of adult learning, such as the Bondy scale and assessment requirements,

Bloom's taxonomy learning styles and new methods of providing 'on the spot' feedback.

As time went on, this was developed further into more theoretical concepts such as developing critical thinking skills in the clinical context, bridging the theory knowledge gap, guiding the novice through transition, the challenge vs support model of teaching, leadership skills and active reflection within debrief.

Participants' opportunity to debrief about the challenges of preceptorship in a busy operating suite (where protected time for learning is not always easy to squeeze in) was considered a positive aspect of the preceptorship education program.

The chance to ensure all were on the same page with learner objectives and performance was also valued. Given the nature of the clinical environment, it was not always possible to have all members present, so meeting handouts were provided, as was individual conversational debrief.

The author believes this informal, monthly program was successful in empowering preceptors to be more effective in their clinical teaching, supervising and assessing role.

Debrief had the dual outcome of providing a space for problem-solving and the opportunity to come together as a team, enabling colleagues to support each other.[4] This program helped to sustain preceptors. It provided goodwill within the department and assisted in improving not only the attraction to what is sometimes a thankless and stressful role but contributed to the positive learning culture of the operating suite.

Author

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EDUCATION

PART 1

Response to Occupational Violence in Emergency (ROVE)

By Karen Taurima

Occupational violence is verbal and/or physical attack that occurs in the workplace and could potentially lead to harm. Verbal violence can include (but not limited to) yelling, insults, intimidation, threats, bullying, harassment, use of derogatory gestures and swearing. Physical violence can include (but not limited to) striking, slapping, punching, spitting, kicking, choking, biting, pushing, sexual assault and use of weapons against staff.[7]

Occupational violence (OV) impacts almost every nurse who works with patients. It negatively impacts the provision of patient care, patient experience, staff capacity and satisfaction, and healthcare organisations.[1–4] It is particularly problematic in emergency departments (EDs).

Facility location, staff pool size, and independent hospital quality measures, such as Magnet status and professional awards, do not appear to protect facilities from OV and its impacts on staff morale and retention.[4,5]

Independent staff surveys in Australian EDs reveal that often nurses' primary concern is OV and that OV can have the biggest appreciable effect on staff workplace satisfaction.[6] Despite this, very few ED-based interventions to detect and then manage OV have been developed, implemented and evaluated.[6,7,8]

Many factors contribute to this lack, including unreliable data due to poor reporting of OV incidences (often linked to frequency, administrative burden and inaction), the complexity of initiation of OV in EDs (varied patient history, ED contexts, time of day, relative level of ED crowding) and the challenges of aligning a multidisciplinary team, including clinical, administrative and security staff to create a coherent and cohesive response.[1,2,5,9,10]

Cost of surveillance and provision of 24-7 skilled staff has also contributed to a lack of OV prevention and management.[1,7,11] The interventions trialled are often physically (security) and/or pharmacologically based and may not meet the needs, expectations or desires of ED staff or patients.

PAH-ED has developed the **Q**ueensland **O**ccupational **V**iolence **P**atient **R**isk **A**ssessment t**o**ol (QOVPRAO), the first step in clinical staff management of OV. This evidence-based, validated and fit for purpose violence risk assessment tool will be integrated into triage and ongoing assessment processes for all patients via ieMR, enabling and empowering nurses to consider and be alert to risks of OV.[10-11]

The second step, ROVE, or **R**esponse to **O**ccupational **V**iolence in **E**mergencies, also developed in the ED at PAH, is a unique OV management program. ROVE was developed and run by nurses to respond to potential or actual instances of OV appropriately to mitigate the impact of OV in the ED.

The 24/7 ROVE team capitalises on OV management strengths already developed by experienced ED personnel and their capacity to combine clinical and patient care-focused criteria with the need to protect staff. ROVE Team deployment is modelled on the hospital Rapid Response Team, which responds to medical emergencies throughout the hospital. ROVE also offers opportunities to combine education of less experienced/confident clinical staff with effective management of real-world instances of aggressive or violent patients.

As with all evidence-based processes, the impacts of the OV response on both arms (QOVPRAO and ROVE) are regularly evaluated. Data thus far suggests that ROVE, potentially triggered by QOVPRAO, enables a comprehensive, rapid, targeted, nurse-led response to OV with extremely positive outcomes. OV is a complex, multifaceted problem. This project, led by senior ED management and capitalising on combined workforce and research strengths, is helping to address the risks and incidences of OV in this ED, supporting staff, patients and ultimately the organisation.

The ROVE team in training

Author

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What nurse graduates need to know

By Karen Missen

An engaging chapter in a new book for nursing students, 'Becoming Practice Ready', provides practical advice for nursing students about preparing for and making the most of clinical placements.

The chapter, by Federation University Associate Dean of Teaching Quality and Student Retention and Senior Lecturer in Nursing, Dr Karen Missen, arms students with knowledge of **key challenges** and how to address them.

Nursing students are expected to take on a range of shifts, including evening, overnight and weekends. Managing this **time pressure** can be challenging for mature students with family responsibilities. They face **financial pressures** because it's not advisable and often impossible to continue with other paid work while on placement.

Dr Missen frankly addresses **ethical and emotional challenges** students can face in clinical settings.

On the ward nursing students, may witness poor nursing practice, including physical or emotional abuse of patients, breaches of patient safety, privacy and dignity, the provision of substandard or outdated care, and clinical errors.

When they try to raise concerns about their observations, they may encounter hostility or resistance. In worst-case scenarios, students experience bullying and incivility.

"A study by Budden et al. (2017) revealed that 50% of nursing student respondents experienced bullying and harassment behaviours while undertaking clinical placements and that the main perpetrators were registered nurses."

EXCITING OPPORTUNITIES

Despite all the possible challenges, Dr Missen writes that clinical placements can be incredibly rewarding and pivotal for final year students: "One of the most exciting things about the final stages of nursing study is that you will get the opportunity to be more actively and independently involved in patients' care."

Another bonus is the opportunity to develop professional relationships and networks with potential postgraduation employers and co-workers: "The clinical placement environment provides students with the opportunity to foster relationships with nurses who may be potential referees for graduate year applications."

Dr Missen's key points of advice for graduating student nurses:

- **Be professional and maintain safety:** Dress according to the specified uniform. Be punctual – arrive at least 15 minutes before shifts.
- **Maintain standards and scope of practice**: Follow appropriate clinical procedures and protocols under the supervision of a registered nurse and work only to the level of practice commensurate with your nursing program.
- **Be self-directed**: Meet with your preceptor on your first day of placement and go through your learning objectives. Identify your strengths and limitations and set goals each week.
- **Acknowledge limitations:** Intellectual honesty is critical to safe practice. Acknowledge when you do not know something. Ask questions, seek help and support.

Left to right Karen Missen, Eleanor Shannon, Lauren Campbell, Adam Wight and Georgia Ridgway – International Clinical Placement in Nepal

- **Seek regular feedback:** Actively request feedback from staff you are working with. Be aware that feedback can be formal or informal, so be sure to monitor verbal and nonverbal communications.
- **Access resources:** Read local policies, procedures and guidelines. These might include infection prevention and control, dress code, manual handling, equality and diversity, electronic devices, and social media use. Organise resources specifically designed for quick access to medication information, calculation formulas and other essential reference material pertinent to your learning.
- **Engage proactively in learning and developing**: Seek and engage in diverse experiences to meet your learning goals and develop your capability as a registered nurse.
- **Learn about diagnoses and procedures** pertinent to your patients.
- **Practice procedures** even if you have done them before.
- **Reflect on what you have learnt** at the end of each shift to reinforce learning. Keep a de-identified record of these reflections for your portfolio.

From the chapter 'Becoming Practice Ready' by Dr Karen Missen in *Transition to Nursing Practice from student to professional* published by Oxford University Press

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Workplace-based education for specialist neonatal nursing in Australia: Time for a rethink perhaps

Research undertaken by the Education Special Interest Group from the Australian College of Neonatal Nurses (ACNN) identified existing workplace-based (WPB) education strategies may not be suitable for 21st-century neonatal nurses, and innovative WPB education may be required.

The study also found that 27% of participant neonatal nurses will be retiring in the next decade, and there are fewer neonatal nurses replacing this loss of expertise. This has been recognised in England also wherein 2016-17, 33% of neonatal nurses were approaching retirement age. However, the managers were hiring above establishment requirements to provide staff time to gain knowledge and experience.[1] To fill this impending gap in Australia, steps must be made to prevent the attrition of younger nurses and provide quality WPB education for neonatal nurses.

This research identified most (80%) of neonatal nurses had postgraduate neonatal qualifications. One-third of the participants were currently enrolled in further postgraduate studies. However, tertiary education is challenging for both managers and nurses where busy clinical areas and inadequate staffing contribute to nurses reluctance to obligate to further professional education.[2] The participants in this study identified professional and personal demands as barriers to further education, emphasising the value of WPB education.

The participants identified that most WPB education was delivered in group sessions delivered on the crossover between the early and late shifts; however, these sessions were not convenient to attend for many. Furthermore, many identified this model did not suit their learning needs. Like other research[2], this study found learning needs were related to age and experience; the experienced older nurses favoured individualised education, while the younger novice nurse preferred education in groups.

The Clinical Nurse Educator (CNE) requires organisational support for professional development in the education role. Although the CNE may be expert clinicians, many often lack confidence and expertise as an educator.[3] This study identified few CNEs with education degree qualifications, and nearly half of them identified high work demands that prevented them from further studies in this area.

Contemporary literature recognises a direct link to an educated workforce and patient outcomes. However, part-time and casual workers often miss out on WPB educational opportunities.[4] In this study, 71% of respondents were employed either part-time or casually, primarily working weekends and night shifts; few CNEs worked these hours. It has been recognised that working long shifts affords less opportunity for WPB education.[5] In this study, most respondents worked either 12-hour or 4-6-hour shifts. They also identified these shift patterns prohibited attending WPB education. Many respondents (60%) felt the compulsory organisational education was prioritised over specialist neonatal WPB education. Mandatory education must incorporate, not replace, specialised clinical workplace learning.

The small participant numbers and the fact that only one survey was undertaken is a limiting factor of this research. Findings may not be easily generalised to the broader population. However, as the findings reflect contemporary WPB education literature, the conclusions drawn may be transferable more broadly. Furthermore, purposive recruitment confined the study to Australian neonatal nurses, which may imply findings are culturally bound by the social context in English speaking Australia.[6]

In conclusion, WPB education presents many challenges for neonatal nurses in Australia. The casualisation of the workforce is not compatible with a Monday-to-Friday office-hours WPB education delivery. Additionally, group education sessions do not satisfy all learning needs. WPB education for the 21st-century neonatal nurse requires inventive approaches that accommodate different learning needs and is easy to access in the clinical context.

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Developing digital capability: Transforming the nursing and midwifery workforce one byte at a time

By Carey Mather and Helen Almond

To remain central in providing person-centred care in healthcare environments, nurses and midwives must engage in continuing professional development. Life-long learning includes developing digital health capability embedded in nursing and midwifery education and professional experience.

The convergence of digital technologies with healthcare is enhancing efficiency, making healthcare delivery more personalised and precise.

Digital health transformation, knowledge management and skill development of the nursing and midwifery workforce require a systematic approach towards sustained change. Globally, digital health strategies, standards and frameworks are now readily available and can enable all nurses and midwives to become change champions.[1-3]

In Australia, the release of the National Nursing and Midwifery Digital Health Capability Framework[4] (the Framework) provides clear direction for higher education and healthcare environments to assess, support and guide their students, nurses, and midwives toward becoming proficient in using digital health technologies. Developing digital health professionalism in nursing and midwifery can lead to meaningful digital healthcare transformation.

Individuals and organisations can use the Framework[4] to assess digital health capability. It promotes opportunity for the development of digital healthcare literacy, now fundamental in all healthcare organisations. Using the Framework,[4] educators can appreciate, adapt and embed the fundamentals of digital health capabilities into courses. By using the Framework,[4] students can assess their capacity and focus on gaps identified in their capability.

When nursing profession bodies overtly encourage educators to acquire the knowledge and skills to embed digital health technologies into the curriculum, students will become better prepared to model digital professionalism and advocate for the digital future that has now arrived. Students can learn about using health information systems, including understanding safety, quality, security, and privacy issues in the 'real world' rather than being unprepared through being 'locked' out of organisation intranets where much of the learning students' needs are hosted or misunderstanding their responsibilities when using digital health technologies.[6]

On-campus, the Framework[4] can be used during lectures, tutorials, and simulation activities, as educators must have the capability to engage and assess their students in the value of collecting and transforming data whilst considering their patients or clients. Utilising pause and reflect techniques in the safe environment of simulation enables educators to empower students to learn appropriate data collection methods and knowledge transformation, which is essential for best practice.

The transformation of digital health technology into practice will change the nursing and midwifery workforce into a digitally enabled health profession. The Australian Digital Health Agency National Digital Health Strategy[5], Nursing Informatics Position Statement[7] and the Framework[4] can guide and support nurses and midwives in leading the digital transformation and confidently use digital health technologies to deliver healthcare one byte at a time.

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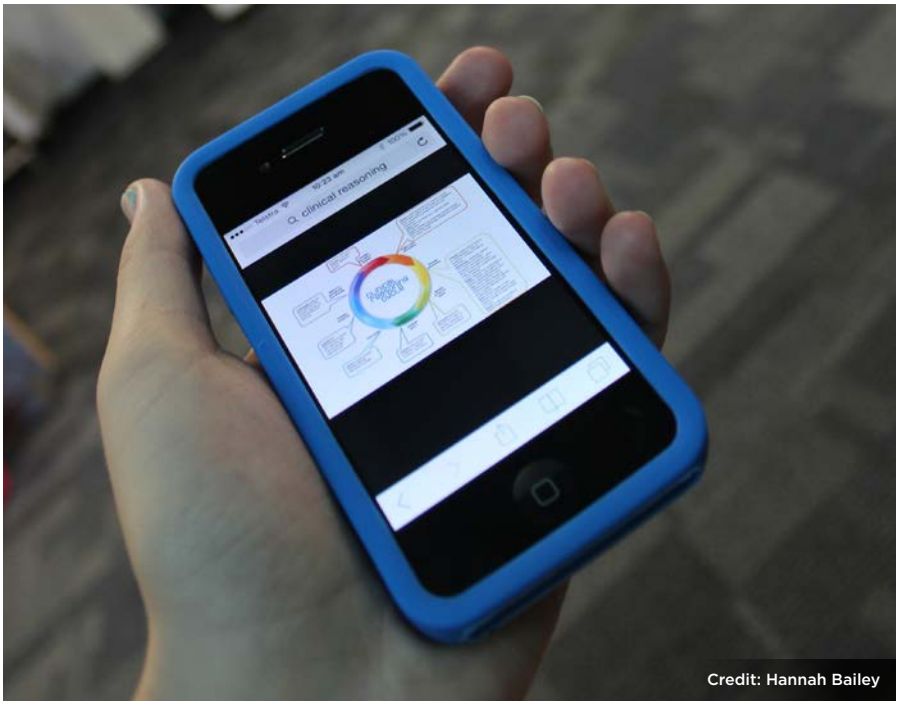
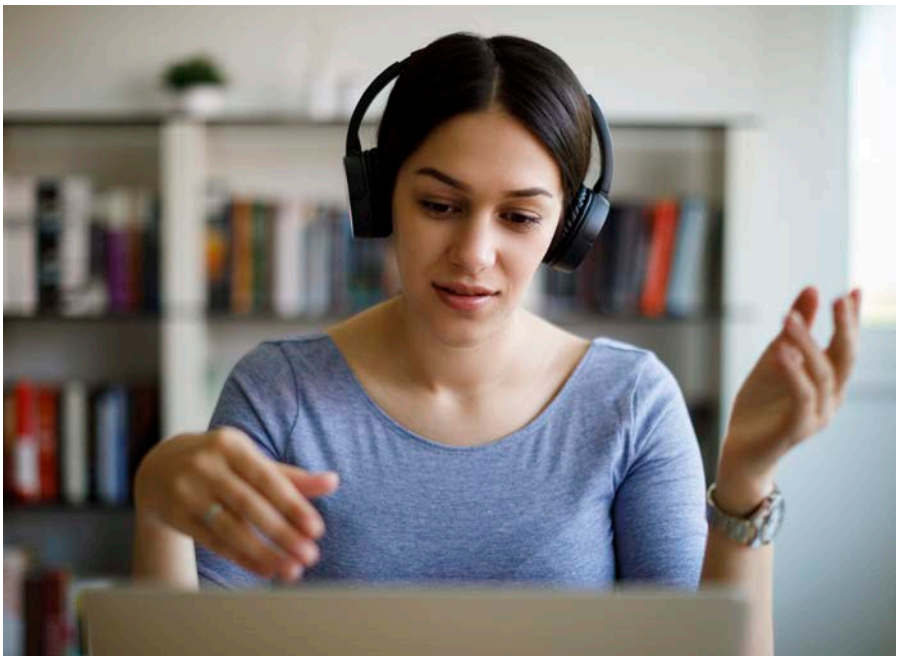


Credit: Hannah Bailey

Fast and furious shift to online education requires pedagogy transformation

By Omar Smadi, Diane Chamberlain, Fathimath Shifaza and Mohammad Hamiduzzaman



COVID-19 has accelerated the shift to online/blended courses without a suitable educational theoretical framework for nursing educators in Australian universities.

The quality of online/blended courses is about the content and a need for suitable pedagogical design, clear instructions, and a collaborative environment based on a valid and reliable theoretical framework.[1] Nursing education needs transformation of its pedagogy and learning frameworks to provide meaningful online or blended learning experiences to the students during the pandemic. Adopting online/blended teaching skills becomes integral to the nurse educators' role in supporting the profession's collaborative nature. The Community of Inquiry (CoI) framework, described by Garrison, Anderson, and Archer,[2] offers the potential for designing deep, meaningful, and interactive online educational experiences in higher education. The CoI framework is a social constructivism-informed framework comprising cognitive, social, and teaching presence, which may reduce the gap between pedagogy, technology, and learners' needs in nursing education.[1] We, therefore, investigated the applicability of the CoI framework to online/blended nursing education in Australia.

A sequential explanatory mixed-methods study was conducted in three Australian universities. The quantitative study phase reported that the CoI framework is applicable to online/blended nursing courses[3]. In contrast, the qualitative phase identified that the CoI framework was implicitly embedded in the educators' practises in course design and delivery.[4]

Semi-structured interviews with the nurse educators also generated knowledge about the challenges and facilitators in adopting the CoI framework. The challenges were a lack of use and understanding of the educational theoretical framework, an insufficient evaluation process, feeling of isolation and low motivation, inadequate e-learning support, large student cohort, complex learning management system, and heavy workload. In contrast, current practices will facilitate the adoption of CoI, such as the use of a case/problem-based learning, use of blended learning, formative assessment, group work and content co-creation of the materials. Integrating the two study phases produced meta inferences of the transformative role that CoI could play in nursing education.

The study findings indicated the potential of the CoI framework to transform nursing education and generate a transitional model to help novice educators during their role changing to become better online educators. The key in this transformation is the **explicit** use of the CoI framework in course design, delivery, and evaluation. The CoI framework can transform nursing education by providing a comprehensive framework focusing on teaching, social, and cognitive aspects. For example, teaching presence can be promoted by using videocasts, podcasts, webinars, discussion forum interactions, live chat, or a range of other approaches. The social presence can be facilitated through various blended learning methods involving social media and inter-professional education. Finally, the development of cognitive presence includes constructing authentic assessment items that require critical thinking and collaborative problem-solving through simulation technology.

Given the government and university emphasis on improving nursing students' satisfaction and reducing attrition, it is essential to acknowledge how CoI has contributed positively to the outcomes in non-health disciplines. However, for the CoI framework to be utilised to the maximum, universities should invest in staff development programs to become competent in using the framework.

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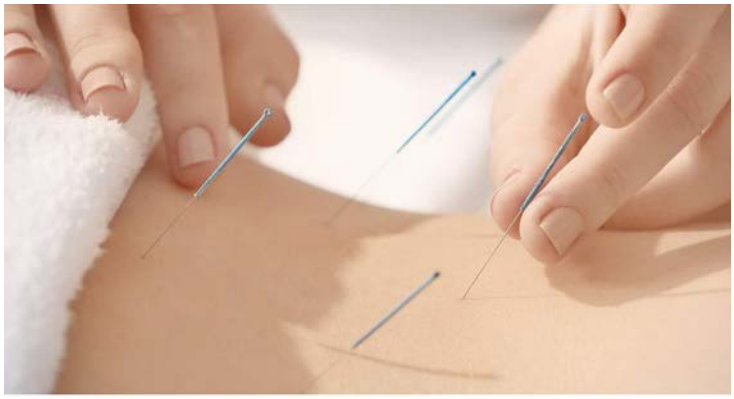
Acupuncture, its place in nursing: Why do nurses need to know about such modalities?

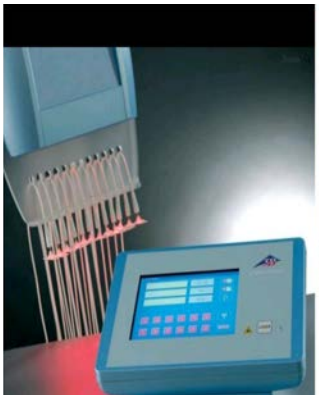
By Carol Chunfeng Wang

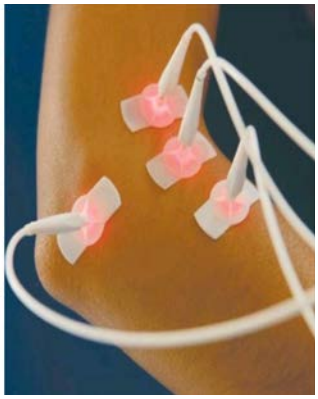
As health professionals committed to integrating safe and effective treatments for better patient outcomes, acupuncture remains a valuable tool. This article attempts to demystify the technique for our Western nursing colleagues.

Traditional Chinese Medicine (TCM) modalities such as acupuncture and moxibustion, also known as complementary and integrative health, have been well embraced by many communities worldwide to support optimal health and quality of life.[1,2]

The philosophy of TCM is central to the way of living (Massey & Kirk, 2015), yet many health professionals know little of the techniques due to insufficient knowledge of such therapies.[3,4] The conceptions of holistic nursing practice[5] fully embrace and are compatible with TCM philosophy and theoretical underpinning[3,6] and yet have not been well integrated into nursing curricula and practice.[3] Why do nurses need to know about such modalities? Because your patients are using them.







Photos: ECU Acupuncture Research Clinic

Acupuncture has become widely recognised as the most popular complementary and alternative therapy in Australia over the last 20 years.[3]

The framework underlying acupuncture is fundamentally holistic and provides an interesting model for nurses and other health professionals who seek different ways to approach healthcare and improve patient outcomes. Despite the tremendous popularity of acupuncture as an alternative treatment in our country, Australian nursing students still receive no formal training in it as part of their required studies. Most Australian health professionals probably know little or nothing about its theoretical structure or explain how it differs from Western medicine.

Acupuncture has been practised for more than 4,000 years in China and is widely used in pain management. Subsequent studies have further demonstrated that acupuncture treatment can serve as a promising treatment modality for many health conditions in neurological, endocrine and metabolic, circulatory, and respiratory diseases.[7]

Nurses in Australia should embrace the philosophy and practices of holistic modalities and include acupuncture as an additional skill. This would expand their already remarkable healing capacity. Students enrolled in nursing programs, especially programs offered for nurse practitioners and advanced nursing specialists, could adopt this philosophy by incorporating Eastern healing and Western medicine elements. This would expand their understanding of the fascinating world of Eastern medicine. Through this learning experience, they will discover the value of well-rounded treatment approaches that address the mental and spiritual elements that often give way to physical suffering.

Incorporating integrating holistic health concepts, Dr Carol Wang is building a research program around the effectiveness of acupuncture, acupressure, Moxibustion and Cupping therapy. Her focus is on chronic pain, women's health, or mental health. There is also an opportunity for nurses to research these areas.

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Editor's note

All health practitioners and/or nurses undertaking these practices of holistic modalities which include acupuncture must ensure they are providing care consistent with their registration requirements and the National Law.

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Preparing nurses to work in remote health practice: Evaluation of a post-graduate program

By Sue Lenthall, Chris Rissel, Heather Jensen, Deborah Russell and Supriya Mathew

Remote area nurses (RANs) work in an advanced and extended practice role that undergraduate education does not prepare them for.[1] They work in generally low resource areas, with less professional and personal supports, often in a cross-cultural situation.[2]

The remote health workforce is unstable, with difficulties with recruitment and retention and very high turnover rates with a reported turnover for RANs for NT government very remote clinics in 2013-2015 of 148% for RANs.[3]

The Remote Health Program (RHP) was a joint development between Flinders University and the Council of Remote Area Nurses of Australia (CRANA), and in collaboration with the Australian College of Rural and Remote Medicine (ACRRM) and the Services for Australian Rural and Remote Allied Health (SARRAH) to prepare and educate nurses and health professionals for working in remote areas of Australia. The program comprises the Graduate Certificate and the Graduate Diploma in Remote Health Practice and Master of Remote and Indigenous Health.

METHODS

The research objectives were to evaluate satisfaction with and impact of the RHP. All students who had enrolled in any of the Remote Health Program courses from 1999 to 2019 (n=1,251), including non-completers and for whom an email address was available (n=1,021), were sent an online questionnaire asking about satisfaction and experiences with the course/s. Students were also asked about their confidence level regarding the necessary skills to practice in a remote community.

RESULTS

One hundred and fifty-six eligible former students (15.3%) responded, most of whom had a nursing background (78.3%), with the rest a range of medical practitioners and 15 different allied health professions.

Respondents' overall rating of the courses was very high, with 84%, 89% and 80% of those completing the Graduate Certificate, Graduate Diploma and Masters course, respectively, rating the course as good or excellent. Similar proportions would strongly or very strongly recommend the course to others (87%, 95%, and 76%, respectively), and agreed or strongly agreed that they were confident that they had the skills to practice in a remote community (65%, 84%, and 84%, respectively). Topics with higher levels of self-reported improvement in confidence were remote health, Aboriginal and Torres Strait Islander health, social determinants of health and primary healthcare.

Three quarters (73%) of students had worked in a remote or very remote location since completing their RHP course, compared to 58% when they started the course. Almost half (47%) of the respondents reported RHP course facilitated employment in a remote setting. One-third (35%) reported that the course had contributed to them staying longer in a remote setting. One-third (33%) reported that the course had facilitated a workplace promotion.

DISCUSSION

The results indicate a high level of satisfaction with the RHP among participants. The RHP appears to help prepare nurses and health professionals to work in remote Australia and increase self-confidence with skills needed for remote practice. Considering the difficulties in recruitment and retention, facilitation of employment in remote communities and contributing to longer stays in remote communities are important remote health professional workforce outcomes of the RHP.

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The surgical rotation program – "Surgical swapsies"

By Monique Dixon, Hayley Bergin, Stephanie A'Court, Kayla Shea and Eun Ju (Jenny) Kim

At the Sydney Children's Hospitals Network (SCHN) Westmead Campus, graduate nurses are allocated a 12-month placement in one department. It was proposed that they would be given opportunity to rotate between the four surgical wards – burns, cardiac, surgical and orthopaedic – upon completion of their graduate program through the *Surgical Rotation Program*.

The *Surgical Rotation Program* offers exposure to a broader range of patients, illnesses, treatments and multidisciplinary teams. The program aims to enhance nursing knowledge, skills, and experience from each clinical specialty area, transfer knowledge to and from the home ward; and promote interaction with diverse teams that enable networking.

METHOD

Eligible staff are notified of the *Surgical Rotation Program,* and interested nurses respond to an expression of interest to their Nurse Unit Manager. A total of four participants are selected through an interview process. Successful participants commence on their home ward and rotate third monthly through the surgical wards.

At the beginning of each rotation, participants are allocated supernumerary shifts. A workbook is given to participants at the commencement of the program, which contains a set of competencies specific to each ward. Participants attend four study days, one related to each specialty.

At the end of each rotation, participants are required to provide feedback using a standardised feedback form. Upon completion of the program, participants are required to give feedback on the overall program. The Clinical Nurse Educators (CNEs) from each specialty review the feedback and implement adjustments to the program accordingly.

RESULTS

From 2016 to 2019, participants completed an evaluation form for the overall program. All participants *strongly agreed* that the surgical rotation program met their expectations and learning needs. All participants *strongly agreed* that the assessable components increased their level of knowledge and their practice within the clinical specialty area and that the educational opportunities provided by the specialty clinical area met their learning needs. Overall, all participants rated the surgical rotation program as *excellent*.

A participant expressed that: *"I loved it! Very valuable and would strongly recommend to other nurses."* Another participant stated that: *"It was an incredible opportunity that helped to enhance my confidence in providing nursing care to patients and their families. I thoroughly enjoyed learning about the different specialties through study days, workshops, in-services, worksheets and completing competencies. I felt it was very organised, and everyone from each of the clinical specialty areas were extremely supportive and friendly."*

A significant majority of participants have progressed in their career development and have taken on leadership roles from the program. From the 20 participants, five have become CNEs, with one currently working in clinical governance, one has become a Clinical Nurse Consultant, and three have become Clinical Nurse Specialists. Furthermore, five out of the 20 participants moved from their home ward to a different clinical specialty area.

CONCLUSION

The *Surgical Rotation Program* has been determined as highly successful due to a number of reasons. Firstly, the program has run for the last five years with ongoing interest and high demand from staff, resulting in an increase from one to two intakes per year with all permanent staff able to apply for the opportunity. Additionally, all participants have successfully met the objectives of the program, as demonstrated through their feedback. All participants have also been able to transfer the knowledge obtained from the program back to their home wards. Moreover, the program has enabled participants to progress both professionally and personally.

Left to right: Rawaan James, Jordan Mace, Sophie Buckland, Eun Ju (Jenny) Kim and Kayla Shea

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Enhancing nursing and midwifery students' clinical placements: Development of the National Placement Evaluation Centre

By Simon Cooper, Robyn Cant, Colleen Ryan and the NPEC project

This paper raises issues about the quality of nursing and midwifery students' clinical placements in Australia.

Clinical training hours have dropped noticeably across the years, with Australian nursing students undertaking a bachelor's degree required to complete 800 hours of clinical placement. This is compared to 2,800 hours in South Africa and 2,300 in the UK. COVID-19 has had an additional impact with some jurisdictions, such as the UK, enabling changes to the structure of programs.[1]

In Australia, the availability and allocation of placements are highly competitive, with significant and often unregulated charges levied on universities.

Internationally the quality of placements has been questioned with varied reports from Australia, indicating exemplary ward leadership versus patient safety concerns[2] and negative experiences in Iran and the UK, including discrimination, neglect and lack of support.[3,4] Positive reports emerge where the workplace is welcoming with applicable supervision and support.[5]

CONTEMPORARY DEVELOPMENTS

In line with these concerns, the Council of Deans of Nursing and Midwifery (Australia and New Zealand) [CDNM] is leading a project to improve the quality of clinical placements across Australia. The advisory and working groups include 19 Deans of Nursing and Midwifery and their representatives. The work commenced with a review of available student placement evaluation tools, of which 10 were identified. However, these often included cultural and international differences, outdated contexts, and were too long from a feasibility perspective. This led to the development of the Placement Evaluation Tool (PET) (Nursing Student) after a trial with 1,263 students across Australia.[6] The PET was found to be valid and reliable, and easy for students to complete with 20 questions rating the clinical environment and the level of learning support.

The PET survey also revealed the positive nature of placements across Australia.[7] Completed pre COVID-19 (July 2019–Feb 2020) the majority of respondents had a positive placement experience (a PET mean score of 78%), and 30% being highly satisfied overall. However, 11% were dissatisfied and raised significant concerns concerning staff attitudes, the working environment, and the unpaid student's lifestyle challenges.

OUTCOMES

These findings were in line with the findings of the 2019 Australian review of nurse education (Schwartz[8]) with a call for a national review of the quality of clinical placements. As such, the National Placement Evaluation Centre (NPEC) has been developed **npec.org.au/** with the aim of rating nursing and midwifery placements across Australia in a benchmarking exercise that will lead to quality improvements and applicable education enhancements for clinical supervisors. Currently available on the website are placement assessment tools for nursing and midwifery students and their supervisors. In the future, the website will offer functionality enabling universities, their students and industry supervisors (educators) to upload completed PET reports for local evaluation and national anonymised benchmarking. Additionally, the NPEC will develop and house a range of interactive educative materials that will enable educators and supervisors to improve the quality of clinical placements.

Bearing in mind the availability and variability of clinical placements, the current clinical challenges during a pandemic, and healthcare education's changing face to distance and blended learning approaches, a national quality improvement program is essential. It will be increasingly important over the coming years.

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And The NPEC project team – see npec.org.au/project-team/

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Learning in a virtual world: The emergence of screen-based clinical simulation

By Simon Cooper, Robyn Cant and Colleen Ryan

This paper considers the changing face of clinical education and the emergence of screen-based virtual simulation (VS).

Virtual forms of education have emerged with advancing technology, advantages of blended and distance learning, increasing challenges of workplace learning and the restrictions on face-to-face learning in the current COVID-19 pandemic.

Clinical simulation, using manikins and patient actors, enables learners to practice skills without risk to patients. Significant evidence is now available indicating the efficacy of simulation-based learning - including an umbrella systematic review (a review of reviews).[1] However, such approaches are resource-intensive and costly, requiring purpose-built facilities, specialist equipment and technical education skills benefiting a limited number of learners.

With improvements to technology/internet, screen-based simulation has emerged. These virtual simulation forms can be accessed at any time or place and repeated at will with emerging evidence of their effectiveness and benefits.[2]

MODALITIES AND FORMS

The focus of virtual simulation programs is broad, covering technical skills such as wound care, medication and patient deterioration management and non-technical skills such as clinical judgement, interprofessional working and critical thinking.

Fully immersive programs include a range of educational materials and assessments within which interactive simulated scenarios are embedded. In most programs, patients tend to be depicted as avatars eg. Laerdal's vSim for nursing[3], but patient actors are recorded in others.[4] Users take a clinicians' role requiring them to select options with performance scored and feedback provided.

Alternatively, virtual reality simulation is a three-dimensional world often generated through a user headset depicting changing images dependant on the user's gaze.

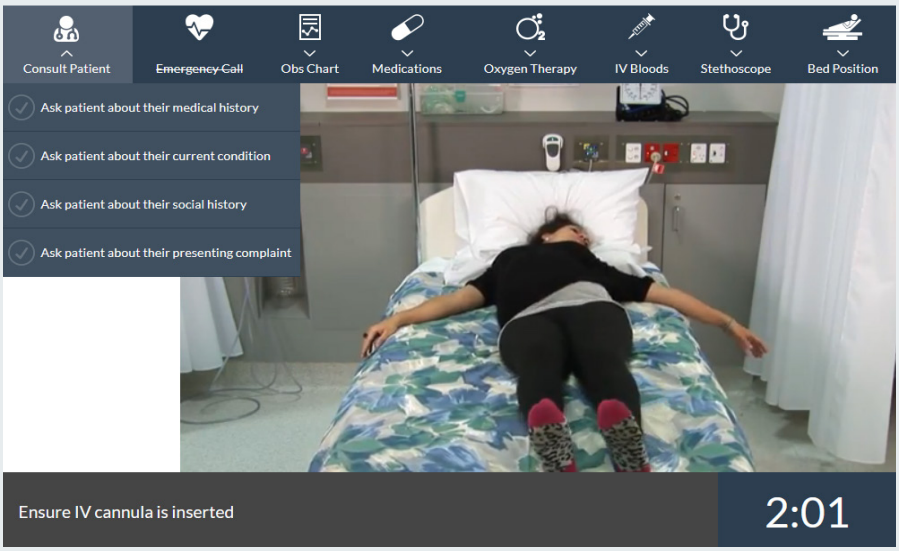

FIGURE 1: First2Act screen capture demonstrating an eclamptic woman undergoing a seizure and a range of 'drop down' options.

Such programs are highly interactive with high levels of fidelity (believability)[5] and have been developed for a broad range of subject matter, including cultural empathy[6] medication and preeclampsia management.[5]

AVAILABILITY

Subscription-based programs include 'Body Interact', which features a range of clinical cases for nursing (**bodyinteract.com/the-simulator/**). A 'Second Life' virtual learning program in public health nursing7 with a number of further options available in the same field **youtube.com/watch?v=x355wCwTTZs** Elsevier's 'Shadow Health' program that includes a range of clinical scenarios which aim to enhance critical thinking **evolve.elsevier.com/education/simulations/** and Laerdal Medical's suite of avatar-based simulations for medical/surgical nursing and health assessment.[3]

A forerunner in the field is the Australian based 1.5-hour patient deterioration program First2Act[4] **first2act.com/** which includes a range of interactive learning materials and high fidelity simulations using patient actors covering adult and obstetric emergencies (Figure 1). In addition, Bethards et al.[8] have produced a list of other commercial and free programs.

CLINICAL LEARNING OUTCOMES AND COST BENEFITS

Studies report the positive impact of virtual simulation on knowledge, skills development, confidence and satisfaction etc. For example, Padilha et al.[9] compared virtual simulation with face to face simulation, identifying significant improvements in knowledge with the virtual group. Further, in extensive evaluations of the First2Act patient deterioration program, a range of studies have identified improvements in knowledge, skills and impacts on patient safety.[4] Cost benefits of virtual simulation over face-to-face approaches are also significant with minimal ongoing costs for virtual simulation once developed[10] and savings of up to two thirds over face-to-face costs.[11]

CONCLUSION

Virtual simulation approaches are emerging as an alternative and adjunct approaches in education and are likely to reduce the time it takes to reach competency. Programs are easy to access at any time and from any place, enabling learners to repeat scenarios as often as they wish. There are notable cost benefits over face to face learning, and the high-fidelity programs mirror reality, closely enabling safe and realistic practice for time-bound emergency situations. However, programs tend to limit actions to singular tasks (ie. no multi-tasking) and teamwork, and non-technical skills are less likely to be incorporated.

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New model of academic support aimed at improving pharmacology knowledge

By Michelle Freeling, Kung-Keat Teoh and Ying Yu

Pharmacology knowledge is essential for all nurses to ensure safe patient care. It is required that nurses have fundamental pharmacology knowledge before administering medication to patients to ensure patient safety.[1]

Medication administration skills involve critical thinking and knowledge application, which are underpinned by pharmacological theory.[2] These skills are essential for new graduate nurses.[3] However, nursing students often report difficulty understanding the scientific concepts relating to the mechanism of interactions between medications and their targets.[4] Lack of pharmacokinetics and pharmacodynamics knowledge is a significant contributing factor to medication administration errors which affects patient safety.[5]

There is a lack of literature relating to pharmacology knowledge acquisition and curriculum design. In Australia, Bullock and Manias[6] found nursing programs pharmacology content varied widely. Further, nursing graduates were not satisfied with pharmacology education. This, coupled with the challenges of studying at a tertiary level, means that nursing students often feel frustrated and overwhelmed.

A new model of academic support for pharmacology learning was trialled in the Bachelor of Nursing (BN) program at Flinders University to address this issue. Students were provided with focused video lectures on pre-identified academic skills required to complete the pharmacology topic successfully. These resources were prepared by Student Learning Support specialists, the Topic Coordinator, who is a nursing expert, and a clinical pharmacist.

The information specifically addressed study techniques, pharmacology assessment preparation, and further face-to-face or individual support options. This was also supported by academic and student learning support lead question-and-answer sessions throughout the semester.

Student feedback suggests that the resources have been useful to alleviate learning anxiety and understanding of academic skills.

Overall, the method of pharmacology delivery to BN programs needs further evaluation to ensure graduate nurses are prepared to administer medication safely and confidently. Further research relating to the integration of pharmacology delivery methods, stakeholders expectations and students feedback in the nursing curriculum is needed.[7]

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Virtual reality trial put nurses and midwives' skills to the test

By Catherine Betcher and Luke Wainwright

Townsville Hospital and Health Service (THHS) and The Clinical Skills Development Service are interested in investigating virtual reality, a novel and highly immersive technology, as it promises to address potential infection risks associated with close proximity that have come about during the Covid-19 pandemic.

Recently THHS participated in The Oxford Medical Simulation Virtual reality trial, the first trial of its kind in Queensland. The project was delivered over three months to February 2021. Approximately 150 nurses, midwives and medical staff participated in the various scenarios chosen for the trial. Both Townsville Hospital and Health Service and The Clinical Simulation Development Service are interested in evaluating technology that provides a scalable solution to rural and remote education.

The Oxford Medical Simulation software delivers clinical scenarios that give the learners the benefits of traditional simulation in virtual reality. This allows learners to practice more, learn from their mistakes, and improve patient care.

Using Oculus headsets, learners were immersed in a high-fidelity simulated virtual reality environment with acutely unwell patients in true-to-life clinical scenarios. The environment, patient and other team members are fully interactive, with conversation and physiology adapting to actions and treatment. Learners manage the patient as in real life: assessing, instigating treatment and interacting with their interdisciplinary team against the clock. The environment, patient and other team members are fully interactive, with artificial intelligence-driven patient behaviour, adaptive conversation, and dynamic physiology.

The learner makes a diagnosis, performs, and interprets investigations, treats the patient and manages their team under pressure scenarios. Users then receive personalised feedback guided reflection and performance metrics.

The scenarios include pharmaceutical modelling and dynamic physiology that is clinically accurate and provides a realistic, authentic experience.

Immediate constructive feedback consolidates knowledge, while gamification encourages repetition to improve performance.

We are looking forward to providing opportunistic learnings for staff finding it difficult to leave ward areas to attend training.

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Catherine Betcher and Sandra Roberts
Nurse Educators Clinical Education and Simulation Services
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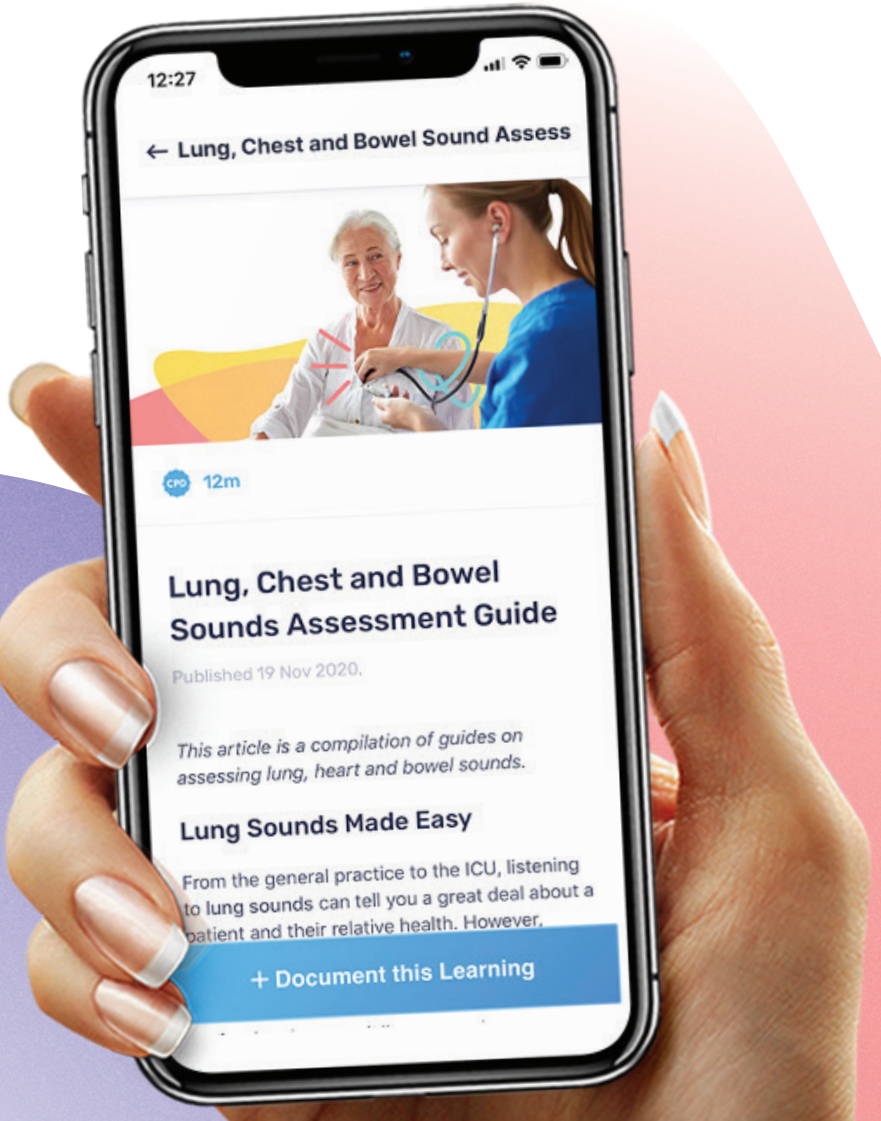

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