



# ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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## INSIDE

**ANMF priorities 2022:**  
Targeting critical issues  
facing healthcare and  
the professions

**Medication custodians:**  
Why some nurses and  
midwives fall short  
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**An attitude of gratitude:**  
How giving thanks can  
help you through the day



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PRIORITIES  
2022**

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**Annie Butler**  
ANMF Federal Secretary

**A strong, resilient public health system properly funded to cope with surges in demand has never been more critical than now.**

**Yet as we have seen throughout the pandemic, Australia's healthcare system is under unmeasurable pressure with its workforce teetering on the edge of burnout from a lack of resources and support.**

**Why the government continues to fail to seriously address the issues crippling our healthcare system, which ultimately jeopardises the wellbeing of all Australians, defies belief.**

We know only too well that the health system was under significant stress before the pandemic. The impact of COVID-19 has simply exacerbated the situation.

With multiple demands on healthcare budgets, heightened by COVID-19, pressured states and territories have borne the brunt of public hospital costs.

But disappointingly, the federal government continues to ignore these increased pressures, bluntly refusing to commit to an equitable shared 50-50 Commonwealth-State split funding model proposed by state health ministers to assist with the financial burden state systems are enduring.

This refusal not only undermines our healthcare system but makes a mockery of the public platitudes Prime Minister Scott Morrison offers to nurses and frontline workers for the care they provide and the risk they have taken to their own health and safety during the pandemic.

If Mr Morrison genuinely valued nurses, midwives and care-workers, his government would have shown its support through enough funding for sufficient staffing levels, enough beds and adequate PPE.

Similarly, if the Morrison Government genuinely wished to improve older Australians' lives, it would have enacted the Aged Care Royal Commission into Quality and Safety's recommendations following its shocking revelation of the long-standing issues plaguing Australia's broken aged care sector.

Instead, despite the Commission stating there was no excuse for federal inaction, the federal government, which is responsible for private aged care, is still falling well short of enacting the most critical reforms, providing insult to older Australians and those who care for them.

These flawed responses have been further exacerbated by the Federal Government's bungled handling of the COVID vaccination roll out, especially in aged care.

In January last year, while declaring that the vaccination roll out was not a race, the Prime Minister announced aged care residents and workers as the top priority for COVID-19 vaccination and that his government would achieve their full vaccination by the end of April. But as we know, less than 10% of the aged care workforce actually received a vaccination by that time.

The ANMF demanded answers and action, as the Prime Minister, seeing the aged care workforce as an easy target and scapegoat, declared that COVID-19 vaccination would be mandated for aged care workers to mask his failure to secure enough vaccine supply, coordinate a proper public education campaign and to manage the logistics of the rollout in aged care.

While the federal government continued to flounder, the ANMF, other unions, aged care providers and, most importantly, the aged care workforce worked to make sure the aged care vaccination rollout succeeded – through these efforts, by the time the date for the mandate arrived, almost 99% of the aged care workforce had been vaccinated, with 55% accessing their vaccination through a state run hub.

In my view, it is no exaggeration to say that had the Prime Minister taken his responsibility to secure vaccine supply and protect Australians more seriously, we may have had a chance to get on top of last year's Delta outbreaks more quickly.

The damage caused by these failures is inexcusable.

We must have a robust health and aged care system so that all Australians get the care they expect and deserve.

Attention to these issues is critical. That's why the ANMF's targeted activity for 2022 includes highlighting the need for planning and ongoing management of COVID-19 and future pandemic preparedness; continuing our aged care national campaign for real change; lobbying for a sustainable and equitable health and maternal care system; guaranteeing justice and economic equality for women including eradicating the gender pay gap and ending gender-based violence, and calling for urgent action on climate change.

You can read more about these priorities in this issue of the journal.

I strongly urge you to consider whether you believe the current federal government has handled these significant issues responsibly and competently. It has never been more important than now for our political leaders to get it right. With a federal election looming, it is crucial all nurses, midwives, carers and Australians carefully consider who they are voting for and what policies they support to ensure we have a government that acts in the best interests of all.

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If you are a financial member of the ANMF, QNMU or NSWMA, 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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## Cancer survival rates continue to improve

**Cancer survival rates in Australia continue to improve, while death and incidence rates fall, according to a recent report by the Australian Institute of Health and Welfare (AIHW).**

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The report reveals a downward trend in the rate of new cancer diagnoses since 2008, yet an increasing rate for females.

“It is estimated that around 151,000 new cases of cancer will be diagnosed in Australia by the end of 2021, which is an increase from around 47,500 cases in 1982,” AIHW spokesperson Justin Harvey said.

“However, there has been a 5% decrease in the incidence rate over recent years from the peak of 508 cases per 100,000 people in 2008 to 486 cases per 100,000 people in 2021.”

The report, based on data up to the end of 2017 that doesn't take into account potential health service disruption due to COVID-19, shows that five-year survival rates from all cancers combined improved from 51% in 1988-1992 to 70% in 2013-2017.

“Changes in survival rates over time varied by cancer type, with the largest survival improvements seen in prostate cancer, kidney cancer, multiple myeloma, non-Hodgkin lymphoma and tongue cancer,” Mr Harvey said.

“While many cancers have high rates of survival, people diagnosed with cancers such as pancreatic cancer, lung cancer and mesothelioma have a less than 1 in 5 chance on average, of surviving at least five years after diagnosis.”

Cancer death rates have also continued to drop since the 1980s. By the end of 2021, the cancer mortality rate was expected to reach a new low of 149 deaths per 100,000 people.

## *New national awareness campaign on risks of drinking alcohol during pregnancy*

**Australia's first national awareness campaign on the risks of drinking alcohol during pregnancy and while breastfeeding has been launched.**

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More than one in four Australian women (29%) who are pregnant, planning a pregnancy, or would consider having a baby are unaware that drinking alcohol during pregnancy could cause Fetal Alcohol Spectrum Disorder (FASD), despite it being the leading non-genetic developmental disability in Australia.

A public survey of almost 1,500 Australian women aged 18-44 found almost half were not aware that alcohol use could cause harm even in the first few weeks after conception, while more than two-thirds, (69%) didn't know that alcohol freely crosses the placenta to the developing baby.

Developed by the Foundation for Alcohol Research and Education (FARE) and funded by the Australian Government Department of Health, the first instalment of the National Awareness Campaign for Pregnancy and Breastfeeding Women, titled *'Every Moment Matters'*, highlights that every moment matters in pregnancy when it comes to drinking alcohol. Alcohol consumed at any stage of pregnancy passes directly to the baby and can damage their developing brain and organs.

With the tagline 'The moment you start trying is the moment to stop drinking', the campaign will run until July 2024 and aims to help address the mixed messages people often receive about alcohol and pregnancy by providing accurate information and support.

For more information about drinking alcohol while pregnant, visit [everymomentmatters.org.au](http://everymomentmatters.org.au), call the NOFASD hotline on 1800 860 613, the Alcohol and Other Drugs hotline on 1800 250 015 or speak to a health professional.





## Online program helps people living with chronic pain to regulate emotions and flare-ups

**Australian researchers have developed a new online program to help people living with chronic pain better self-regulate and handle negative emotions as well as mitigate painful flare-ups.**

The Emotional Recovery Program, developed by researchers at Neuroscience Research Australia (NeuRA) and UNSW, has shown to lessen pain intensity by teaching people living with chronic pain to regulate and dial down difficult and intense emotions.

One in five Australians experiences chronic pain, with the condition limiting people's lives and often creating difficulties regulating emotions such as fear, worry, stress and low mood.

The program involves a blended treatment that includes six online emotion recovery skills training sessions delivered via Zoom and a web app via interactive modules and video tutorials.

Emotional Recovery Trainer Nell Norman-Nott said the trial showed there is now evidence that learning skills in emotional regulation helps people dial down difficult and intense emotions and lessen the intensity of pain.

"We commonly hear from people with chronic pain that emotional problems such as intense anger, excessive worry and stress can increase the intensity of pain. And the impact of COVID-19 has played a huge part in this, due to the contracted access to treatment due to clinic closures and the risk of infection."

To learn more about the program email the Emotional Recovery Team at [neurorecoveryresearch@unsw.edu.au](mailto:neurorecoveryresearch@unsw.edu.au)

## IRON DEFICIENCY – A HIDDEN PROBLEM?

**Iron deficiency is the world's most common mineral deficiency and an important public health problem in Australia.**

In a recent article in *Australian Prescriber*, Drs Shalini Balendran and Cecily Forsyth from Westmead Hospital and Central Coast Haematology explained that iron deficiency can cause more problems than just anaemia.

The World Health Organization (WHO) estimates that in Australia, just under one in 10 preschool children and more than one in 10 women of reproductive age have anaemia. However, up to three times as many people may have iron deficiency.

"Although iron deficiency can often cause anaemia, iron deficiency without anaemia can also cause a range of symptoms," Dr Cecil Forsyth said.

"You may feel tired, weak and irritable. Iron deficiency has also been associated with restless legs syndrome and fibromyalgia.

"It is important to diagnose and treat iron deficiency. This includes finding the cause of the iron deficiency and correcting it."

Diagnosis is usually made by measuring a protein (ferritin) that reflects the body's iron stores. Treating iron deficiency often involves changes to diet and taking iron supplements.

"Iron from meat is the most easily absorbed type of iron. While an adequate intake of iron can be achieved by eating a wide range of iron-rich vegetables like wholegrains, nuts and leafy greens, this is not usually enough to correct iron deficiency.

"If you are iron deficient, avoid tea, coffee, cocoa and red wine as these prevent the uptake of iron from the gut.

"Iron supplements are a safe way to treat iron deficiency. They should be taken one hour before or two hours after food," she says.





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

## Shortbread to be enjoyed any time of the year

**There has been no shortage of topics to write about during 2021 as nurses, midwives and carers have faced some of the most challenging and exhausting times in their careers responding to COVID-19.**

Unfortunately, there has also been an abundance of concerns to choose from in reporting the Morrison government's failings in implementing the much needed reform in private aged care, the vaccination 'stroll' out and the inability to establish national quarantine facilities. We have also witnessed inaction to genuinely address gender equality and sexual harassment in the workplace. Attention to these issues remain critical and will continue to be a key focus of our targeted activity in the New Year.

For now, at the end of another big year and as we start afresh in 2022, I have decided to follow on from my tradition set last year, where I make a small attempt to lighten the load. I wish to share another favourite holiday recipe that I hope you enjoy and have the time to share with friends and family.

This year it is my shortbread recipe that can be made any time of the year, really! Last year was taxing for so many on the back of a tough 2020. Cooking and

gardening are definitely my go-to for some relaxation and restoration.

Of course, so many ANMF members would have been on the frontline working this Christmas and festive season, but I do hope that many of you got some time out to rest, recoup and recharge. I can't think of another group of professionals who deserve it more.

A lot has changed in our lives in the last two years and the levels of exhaustion felt by many in our workforce is unparalleled. Enjoy what precious moments you can with family, friends and of course, our beloved pets, who in my home, have been afforded an exalted status in the house. Cooking and sharing food is certainly something I turn to de-stress and relax, and I hope you can enjoy this recipe at some stage too.

If you read this article before Christmas, wishing you and your loved ones (including the four-legged ones) a safe and peaceful festive season.

### *Festive season shortbread*

#### **INGREDIENTS**

200g plain flour sifted  
100g rice flour  
50g ground rice flour  
120g caster sugar  
250g butter  
(at room temperature)  
pinch of salt

#### **METHOD**

Preheat oven to 170°C.  
Grease baking trays with butter and flour.  
Combine sifted flours, salt and caster sugar in a large bowl.  
Rub in butter portions and combine. Knead lightly until a smooth dough forms.  
Transfer onto a floured surface and cut shapes to your preference.  
Place on the baking tray, space out to allow for some expansion.  
Bake in the oven until very light golden colour (do not allow to brown). Depending on your oven, this will usually take 20-25 minutes.  
Allow to cool and enjoy with a cuppa or beverage of choice!





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

**References:** 1. Ortiz R *et al. J Matern Fetal Neonatal Med* 2011;24:1-6. 2. Toblli JE & Brignoli R. *Arzneimittelforschung* 2007;57:431-38. 3. Jacobs P *et al. Hematology* 2000;5:77-83. Healthcare professionals should review the full product information before recommending, which is available from Vifor Pharma on request.

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Lisa Evans

## A day in the life of a Tasmanian secondary school health nurse

**School Health Nurses working for the Tasmanian School Health Nurse Program typically cover multiple schools, who instead of providing first aid or immunisations, aim is to support ‘schools to create a physical and social environment that promotes health and wellbeing and assists to improve the health and education outcomes for children and young people in Tasmania.’<sup>1</sup>**

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Our core business is health promotion and health education. The intention of the program is to provide short term intervention to assist students, referring on to an appropriate service if ongoing support is required and aiming to provide equity of access to healthcare for all students.

In high schools, nurses provide ‘drop in’ clinics for students to access support without the need for referrals, funds, transport or if applicable parental consent.

On any given day, a secondary school health nurse can expect to see students requiring follow up from previous meetings, new students attending the drop-in service, attending meetings to discuss new referrals from teachers or parents, and utilising any opportunity to plan for group work, classes, or health promotion initiatives.

Issues commonly seen in high schools include:

- Anxiety
- Mental health issues
- Students requiring hearing or vision tests
- Help with resilience
- Body esteem
- Nutrition
- Or any medical issues that may be impacting learning, including medication management within the school

Before the program commenced in June 2015, there were no school health nurses in Tasmanian schools.



Therefore, integrating and transitioning from a health department to an education department has been challenging with what may be considered a lack of shared goals and visions that usually assist with teamwork and cohesion in a workplace.

The Department of Education's (DoE) strategic plan states 'Learners first; every learner, every day'.<sup>2</sup>

While the goals of school health nurses may appear to differ to this statement, I believe, through dedication to their students, families and communities and a belief in the program, they have succeeded in merging the DoE's intention with the School Health Nurse purpose of 'better health for better learning'.<sup>3</sup>

This results in all students having access to healthcare in order to maximise educational attainment for long term future benefit.

The greatest highlight of working as a school health nurse is being there for students who don't have as much access to healthcare and support as would be ideal. Over the past five years, I have worked with multiple young people who have experienced considerable trauma in their young lives- some of their stories stay with you.

My favourite time of year is Term 4 when there are leavers' dinners and celebration assemblies. If students can successfully transition to college at the end of grade 10 with the capability and capacity to manage their health and wellbeing, I consider this a huge success.

Working on the North West coast of Tasmania also creates other challenges when referring students to external services when needed. Even living in urban areas on the coast, there is not always access to the available services in metropolitan areas.

The services that are available are often overstretched. Currently, many are not fully staffed because they cannot fill positions, resulting in most General Practitioners and external services being closed to new referrals.

Despite the challenges, some personal success stories include:

- Providing students without adequate means having a vision assessment in school and then being assisted in accessing the school spectacle scheme to receive reduced cost/free spectacles to complete their work along with their peers.
- Assisting families and students to improve class attendance by organising medication to be dispensed by the school resulting in students attending regularly.
- Supporting students who misbehaved because they couldn't hear to address their hearing issues.
- Aiding students who have anxiety about their exams with coping skills.
- Assisting students with intellectual disabilities to learn appropriate social behaviours that keep them safe and protect their vulnerability. This has included supporting students to live in safe homes.
- Helping students with eating disorders to eat without being prompted.

This is how I measure success.

Coming from the Emergency Department, I was used to the diversity and unpredictability of my working day. Schools are similar- one student might need a vision assessment, another may want to discuss nutrition another may be self-harming and require intervention and referrals. I love the diversity of the role and personally enjoy the autonomy and not knowing what your day will hold.

Equity of access to a health professional for all students is the greatest highlight and what I believe to be the jewel in the school nurse crown.

#### Author

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#### References

1. Department of Education. School health nurse program [Internet]. Hobart TAS: Tasmanian Government; No date [cited 2021/08/05]. Available from: [education.tas.gov.au/parents-carers/programs-and-initiatives/school-health-nurse-program/](http://education.tas.gov.au/parents-carers/programs-and-initiatives/school-health-nurse-program/)
2. Department of Education. Strategic plan [Internet]. Hobart TAS: Tasmanian Government; No date [cited 2021/08/05]. Available from: [education.tas.gov.au/about-us/our-department/strategic-plan/](http://education.tas.gov.au/about-us/our-department/strategic-plan/)
3. Department of Education. School health nurse program framework 2019-2022. Hobart TAS: Tasmanian Government; No date.



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**Over the past two years living with COVID-19, nurses, midwives and carers have been doing it particularly tough. With the pandemic far from over, the ANMF has determined a list of priorities the union plans to work on during 2022 to support the professions and the health systems they work in. Robert Fedele and Ben Rodin report.**

## Pandemic preparedness

**The ANMF will continue to highlight the need for improved planning in both the ongoing management of COVID-19 and future pandemic preparedness, even as the virus becomes normalised as part of everyday life in Australia.**

When NSW and Victoria were hit by the Delta variant of COVID-19 in the winter of 2021, it became clear that vaccination would be the best approach in both halting the rate of hospitalisation and the loss of life.

In preparedness to returning to “post COVID” normal life the Doherty Institute in August 2021 released modelling for Australia which signposted some of the steps forward for how Australia would manage COVID-19 in a post-suppression phase. However, questions still remained to how opening up the country would impact an overstretched healthcare system.

In August 2021, ANMF Federal Secretary, Annie Butler wrote a letter to Prime Minister Scott Morrison highlighting the fact that 300,000-plus nurses, midwives and care workers were set to be among those affected by the decisions made when the nation reopened.

“The impacts of re-opening and transitioning the country’s national COVID-19 response prematurely without adequate planning or sufficient resourcing will disproportionately affect nurses and midwives and their capacity for ongoing delivery of quality care,” Ms Butler wrote.

Already, prior to the ease of restrictions in places such as the Northern Regions of NSW, nurses and midwives were forced to manage the spread of COVID while more than 160 full-time equivalent nursing roles remained unfilled.

“Members at Lismore, Tweed, Grafton and the surrounding regions are all anxious about what lies ahead, given they have a very limited casual or agency pool to draw from. This is taking a toll on the remaining nursing staff, who often feel compelled to keep accepting overtime requests,” NSWNMA General Secretary Brett Holmes said in October last year.

“They’ve had very little reprieve since the pandemic hit our shores some 22 months ago, and it’s far from over.”

Moving forward, the ANMF’s aims for pandemic management are two-fold: To ensure that short-term planning guarantees the safety and workplace needs of nurses, midwives and care workers are met, while making sure long-term planning addresses all aspects of healthcare in relation to the ongoing impacts of the pandemic.

Despite a protracted and mismanaged vaccination roll out, and ongoing outbreaks of the COVID Delta strain, Australia has largely succeeded in reducing the spread of the Coronavirus and ultimately, saving lives.

However, many of the factors key to Australia’s success, including a robust economy, strong health system, geographical spread and relatively small population, sit removed from the nation’s pandemic plan, a document largely focused on the avian flu (H1N1), which has only received minor updates since 2014.

Ms Butler said, while COVID has shown the importance of pandemic planning, the system can only respond if it is built to do so.

“The COVID pandemic demonstrated just how important a strong, resilient public health system which is properly funded to cope with surges in demand, as we need to ensure that we don’t now neglect the system and cause unsustainable pressure on our healthcare professionals.”



## Aged care

**After progress towards meaningful aged care reform last year, in 2022 the ANMF will continue to expand its national campaign for real change, including legislated safe staffing ratios and skills mix, greater accountability and transparency for taxpayer provided funding, and valuing the work of nurses and care workers in delivering high quality and safe care that elderly nursing home residents deserve.**



The Aged Care Royal Commission's Final Report found inadequate staffing levels, skills mix and training were the principal causes of substandard care in Australia's current system.

Despite the Commission confirming there was no excuse for federal inaction, the Morrison Government fell well short of implementing the reforms recommended in its "once in a generation" \$17.7 billion aged care package in last May's Federal Budget.

Positively, the government did commit to mandating minimum care time staff must spend caring for aged care residents. From 2023, staff will be required to provide at least 200 minutes of care a day to each resident, including 40 minutes of care delivered by a registered nurse.



The ANMF said it was a good start but more needed to be done to ensure safe, quality care for Australia's vulnerable nursing home residents.

Most critically, the government's reforms didn't include any requirement for an RN to be on-site at all nursing homes 24/7, as recommended by the Royal Commission.

Encouragingly, last September, a private member's Bill, the *(Aged Care Amendment (Registered Nurses Ensuring Quality Care) Bill 2021*, introduced by Senator Rex Patrick, pushed for a national law requiring at least one RN on-site at nursing homes at all times by 2024.

"I'm concerned aged care residents are not getting the care they need, and the care is varied depending on where they are located across Australia," he said.

In 2021, the ANMF launched its new national aged care campaign: 'It's not too much to ask'.

The ANMF's recommendations for immediate action are:

1. RN 24/7 – at least one registered nurse on-site at all times
2. Mandated staffing ratios and the right skills mix
3. Greater transparency of funding tied to care
4. Improved wages and conditions

Last year, the ANMF also launched a work value application with the Fair Work Commission to lift the sector's nursing and care worker wages by 25% and improve working conditions and job security.

After years of declining quality in care and increasing neglect for elderly Australians, the Royal Commission clearly identified the scope of the problems and what federal government action is required.

As this year's federal election looms, the ANMF will ramp up its national aged care campaign. It is calling on every federal politician to make aged care an election priority to deliver a system that respects staff and residents and keeps them safe.

"Every politician must commit to implementing the recommendations from the Aged Care Royal Commission to support understaffed nurses and care workers and stop unnecessary suffering of residents," ANMF Federal Secretary Annie Butler says.

For too long, nurses and care workers have held the aged care system together. It's time they are adequately recognised and valued for their tireless efforts and commitment, she said.

"Each and every day there are forms of neglect simply because there is not enough staff," ANMF (Tasmanian Branch) aged care RN Irene McInerney says.

"There just isn't enough trained and skilled staff to help me provide for the ever-increasing needs in residential aged care facilities. When will the community finally get it? When will the government finally act? It's not too much to ask, is it?"

## Developing a sustainable and equitable health and maternal care system

**The ANMF has been increasingly concerned about the state of Australia's public healthcare across all sectors, including aged care and is demanding immediate action.**

The ANMF has argued that Australia's public health system is being eroded stemming from federal government under-resourcing. The COVID pandemic has exacerbated the situation, which has added extra pressure on an already overstretched public hospital and health system.

According to the AMA's recent Public Hospital Report Card, the system is declining because of the lack of hospital beds and 'ambulance ramping', delays in elective surgeries, decreases in ED performances and shortages of nurses and doctors.

ANMF Federal Secretary Annie Butler said that nurses and midwives have confirmed the AMA's findings and were at a breaking point trying to hold the system together.

"ANMF members have reported they are run off their feet day in and day out. Clearly, working under these conditions is just not sustainable or fair on healthcare workers or the community."

Ms Butler said what is urgently needed is a properly funded public health system.

To tackle the country's strained system, state health ministers called on the federal government last year to increase their share of health funding and develop a fairer national funding model.

Yet despite escalating costs intensified by the pandemic, the federal government has not acted on the request.

Consequently, the ANMF will continue to call on the federal government to urgently increase funding with a shared 50-50 Commonwealth-State funding model that grows in response to increasing demand and costs suffered by our public hospitals.

The ANMF will also lobby the government to urgently address the factors exacerbating the pressures on the public health system, including improving primary healthcare services.



ANMF Federal Secretary Annie Butler said integrating a strong primary healthcare system would improve the health of the community.

"This would lower overall healthcare expenditure over time and improve the performance of the healthcare system while ensuring the provision of improved equity and access for everyone."

To achieve a robust primary healthcare system, Ms Butler said the government must invest in primary and preventive care sectors, increasing health expenditure from 1.5 to 5%.

Further, she said the ANMF would press for models of care that allow nurses and midwives to work to their full scope of practice that would significantly improve the system.

"The evidence consistently shows that nurse-led models improve access to care, increase patient satisfaction and create positive and coordinated clinical outcomes," Ms Butler said.

Additionally, Ms Butler said nurse run clinics and nurse-led models of care could reduce care fragmentation for people with multimorbidity, keep people well and living in their homes, and manage their healthcare and chronic conditions for as long as possible.

"We will be calling on the expansion of evidence-based nursing and midwifery-led models of care such as nurse-led clinics in primary and acute healthcare, chronic disease and cancer care, rural/regional/remote health, maternity care and health and maternity care for Aboriginal and Torres Strait Islander people.

"We need to bring fairness back into the system and create access to healthcare for all, especially the most disadvantaged in our community."

## Gender inequity in the wake of COVID-19

**Female dominated industries, such as nursing, midwifery and care work, have been at the forefront of Australia’s COVID-19 pandemic response. Despite this reliance, essential workers holding hospitals and nursing homes together are among the most undervalued.**



As Australia continues to slide down the World Economic Forum’s Global Gender Gap Index- initially Australia ranked 15th when the index launched in 2006, and now ranks 44 out of 153 countries, it’s evident our government has failed to address existing and escalating gender inequalities adequately.

Women are often confronted by gender disparities, including lower wages and wage inequality, poverty, discrimination, and gender-based violence.

The gender pay gap is often the result of social and economic factors that reduce women’s earning capacity over their lifetime.

The historical and systemic undervaluing of women’s workplace contributions drives the gender pay gap. Factors include female-dominated industries, such as aged care, attracting lower wages, lack of workplace flexibility to accommodate caring responsibilities and higher rates of part-time work for women.

In recent years, women’s lower super balances, in particular, have given rise to growing levels of poverty and homelessness in retirement.

Evidence suggests women over the age of 55 are the fastest-growing group of financially insecure Australians, and this pandemic will set women further behind.

However, in a positive step last year, the federal government passed a Bill to amend the superannuation guarantee. From 1 July 2021 to 1 July 2025, the superannuation guarantee will increase from 9.5% to 12% in 0.5% increments, the first time it has increased since 2014.

Meanwhile, progress to abolish the \$450 threshold for superannuation contributions last year means many low-paid workers who work across multiple employers, particularly women and younger Australians, will finally be paid super on every dollar earned.

The ANMF was integral to these wins, which resulted from years of political and public campaigning by workers and unions.

Nevertheless, due to the gender pay gap and career breaks women take for caring responsibilities, they could still typically retire with up to 47% less retirement savings than men. One in three women retires with no super at all.

Acknowledging that women comprise 89% of Australia’s total nursing and midwifery workforce, ANMF Federal Assistant Secretary Lori-Anne Sharp said the union would continue to call on the federal government to eliminate the barriers that still exist for many Australian women in achieving equality.

“We need national plans and targets to end gender-based violence, achieve economic justice, eradicate the gender pay gap, reach equal parental leave for men and end the discrimination of First Nation’s women who are expected to work free under the Community Development Program,” she said.

Many ANMF branches across the country have already led the way in attaining paid family and domestic violence leave for their workforces. For example, the ANMF (Victorian Branch) secured its public sector nurses and midwives access to 20 days per year of paid special leave in the event of family violence.

Yet despite some inroads, the ANMF said more needed to be done and is calling for a national plan that targets gender equality.

“Women continue to carry the weight of unpaid care and domestic labour. Representing more than half the population, women should expect the same opportunities and advancement that are offered to men,” Ms Sharp said.



## Climate Crisis

**While the global COVID-19 pandemic has justifiably led the political and health agenda, the ongoing climate crisis remains the world's greatest emergency.**

The impact that the climate crisis has on our health systems and the health of our communities continually grows. For example, incidences of climate-related events like thunderstorm asthma and bushfires place considerable burden on our emergency departments and hospitals.

These events are becoming more frequent and disproportionately affect our most vulnerable, like the immune-compromised, the elderly and young children.

Therefore the ANMF believes everyone, including nurses, midwives and care workers, has a role in tackling the growing negative health impacts of climate change.

In recent years, the union has called on the Australian government to commit to developing a standalone policy on climate change with a key focus on health and wellbeing. The union has called for the implementation of an energy policy to transition to net zero emissions by 2030 and increase funding for climate-resilient health systems and climate change research.

The ANMF's position statement states that nurses, midwives and care workers are at the forefront of providing care to communities and individuals affected by climate change. They are also pivotal in leading the development of policy and influencing practices.

The ANMF's policy calls for urgent action by the government and all community sectors to reduce and limit carbon dioxide emissions from fossil fuels into the atmosphere and the need to prepare the health sector to deal with existing and future health effects of climate change.

Nurses, midwives and care workers should participate in the climate change debate, utilising their networks to lobby politicians, the media and the community on the importance of reducing carbon emissions and understanding that climate change is a public health issue.

Last November, the UK hosted COP26, the 2021 United Nations climate change conference, where global leaders met to reach an agreement on how to tackle climate change and accelerate action towards the

goals of the Paris Agreement, to limit global warming to 1.5 degrees and achieve net-zero by 2050, and the UN Framework Convention on Climate Change.

In Glasgow, many nations updated their plans and committed to continuing climate change across various areas.

In the lead-up, Australian Prime Minister Scott Morrison released the government's climate change roadmap, underpinned by reaching net zero emissions by 2050.

At COP26, Australia, the US and China did not sign up to a pledge made by dozens of countries to phase out coal-fired power.

Many health groups responded to Australia's net-zero 2050 announcement by calling for a stronger 2030 target.

In an open letter sent to the Prime Minister, 52 health and medical groups, including the Climate and Health Alliance, Australian Nursing and Midwifery Federation (ANMF SA Branch) and New South Wales Nurses and Midwives' Association (NSWNMA), called for climate action to protect Australians' health.

The health organisations want the government to legislate a 75% reduction in greenhouse gas emissions below 2005 levels by 2030 to reach net-zero by 2035, in line with the recommendations of climate scientists.

"The case for action is real, urgent and now," the letter reads. "The health community in Australia stands ready to support strong emissions reductions and the steps required to deliver them."

Climate change is undoubtedly the single biggest health threat facing humanity, and health professionals worldwide are responding to the health harms caused by this unfolding crisis.





James Lloyd

ANMF Federal Vice  
President

## An attitude of gratitude

**“I would maintain that thanks are the highest form of thought and that gratitude is happiness doubled by wonder” – GK CHESTERTON.**

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As I write this article in the last months of 2021, I can't help but reflect on the previous two years and how our lives have become dismantled. Prior to Covid-19, we had freedoms that we took for granted, such as hopping on a plane and flying to any earthly destination. But the pandemic demolished our innocence, and we had a new reality forced upon us. We've all had different challenges and perhaps found new ways to live, work, heal and learn. Perhaps we've become reacquainted with gratitude.

Gratitude involves the engagement of your senses. For example, after a long, dark winter, how blissful does it feel to turn your face to catch the rays of the emerging sun? Or relishing the warmth of being wrapped in a doona with a glass of your favourite beverage while the wind shakes the house and rain pelts the windows? The more you invoke your senses, the more your experience will be enhanced, and thankfulness follows.

My wife is a biologist and often lived in brutal, raw field conditions for extended periods. Yet she has this simple mantra she still repeats at the end of every day: “Warm... clean... dry... full belly... nothing hurts!” She knows that her basic needs are met and is therefore genuinely grateful. She remembers the deprivations of lacking basic luxuries that most of us in the developed world take for granted because she had spent so long shivering, stinky, soggy, starved, and sore. Nevertheless, even then, she was deeply thankful for the rare opportunities to travel to remote, inaccessible islands and to interact with magnificent wildlife, researching ways to protect them and make the world a better place. She had enough money for the basics, but little more. As a stereotypical nurse, I have been employed continuously for many years and don't worry about when my next paycheque (or shower) is. Despite this disparity, Heidi has been happier.

You can feel gratitude in simple moments where you experience something satisfying, like having coffee with a friend and creating an intellectual or creative connection that leaves you both energised from the interaction. A smile, hug or handshake can convey so much.

There is a direct link between happiness and gratitude. Research suggests that to be grateful for the simple things is extremely effective in improving your sense of subjective wellbeing. With gratitude, you acknowledge the positive aspects of your life, creating

more positive emotions, lessening anxiety, and feeling a greater sense of purpose. You then become more mindful and relish those simple moments. The more gratitude felt, the less room for negative thoughts. Research shows that people who can experience gratitude are able to push through adversities or traumas easier.

To gain the benefits from gratitude, practice it daily. Remember the turbulent times you toughed out and how far you've come - this sets up a contrast in your mind and gives perspective to the present moment. Watch your language - people who practice gratitude have a language style used by givers, the fortunate and those with abundant empathy. Smile - it's a simple act and smiling at someone at the end of a conversation or when they've granted a favour gives them a sense of gratitude, and you feel it too. Pick a time of day to actively reflect on these lovely aspects in your life and the contentment that results. Anchor yourself in the moment. Savour the abundance around you.

This article is not mandating how to be happy, as your life may be terribly taxing. But an attitude of gratitude may help you over that big obstacle that seems insurmountable. Your positivity is infectious and can affect people around you. Grateful people have more of the ingredients needed to thrive and flourish in life. Remember to say thank you; remember to acknowledge other people's efforts; remember to accept yourself; remember to volunteer and help others less fortunate.

So, pause now and reflect on what you cherish in this moment:

- That first cup of coffee or tea in the morning, revitalising you for the day.
- Having a job that gives you financial independence.
- The kindness of a friend or colleague who helps with your workload.
- A well-cooked meal, satisfying you in body and soul.
- Your favourite music giving you goosebumps.
- Sunshine, art, laughter, the ability to read, modern medicine, the right to vote, chocolate, indoor plumbing, new fuzzy socks, clean air, a friendly neighbour, spotting an aurora, holding hands – the list is endless!

“The little things? The little moments? They aren't little” – JON KABAT-ZINN

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†Savings figures are based on Smartleasing's negotiated buying power discount. Discount has been calculated with reference to the manufacturers recommended retail price current as at 1 October 2021 in NSW. Discount will differ depending on the State or Territory you purchase the vehicle in.



# Common COVID-19 related cultural concerns in nursing – A literature review

By Lesley-Anne Morgan

**The emergence of COVID-19 has created many challenges, including cultural related concerns and challenges, for nurses, health professionals, the health system and society more broadly. Whilst we may share elements of culture with others, culture differs from person to person, with each of us having different values, beliefs, and attitudes.**

These factors influence the way that nurses communicate with and provide care to patients and the way in which the nursing profession is perceived.

This report will focus on COVID-19 related cultural concerns in relation to nursing. This report will present facts as described in the literature and discuss the issues of COVID-19 related cultural concerns in nursing.

The report includes:

- a literature review;
- description of the methodology used to conduct that review;
- the findings of the review; and
- a discussion followed by a conclusion.

## LITERATURE REVIEW

### REVIEW QUESTION

What are the common COVID-19 related cultural concerns in relation to nursing?

### AIMS

The aim of the literature review is to assess the literature to understand the common COVID-19 related cultural concerns in relation to nursing.

### OBJECTIVES

1. To identify and evaluate COVID-19 cultural concerns in relation to nursing.
2. To discuss the COVID-19 cultural concerns related to nursing.
3. To formulate a conclusion in relation to the common COVID-19 cultural concerns in nursing.

### METHODOLOGY

A literature search to answer the question, "What are the common COVID-19 related

cultural concerns in relation to nursing?" was conducted using databases available through the Charles Darwin University library.

The search was limited to papers published between 2016 – 2021, papers published in English, peer-reviewed articles that were Full Text Online.

### SEARCH STRATEGY

The search strategy included using the Advanced Search option, inputting specific Boolean operators to combine terms and to conduct keyword searches within academic databases. The search was broad and included a variety of narrative inquiries and qualitative and quantitative papers.

Keyword searches using the following keywords and Boolean operators were as follows: COVID-19 AND Culture, COVID-19 AND Culture AND Nursing, COVID-19 AND Vaccine AND Nursing, Culture AND Nursing. The search filters used included ANY FIELD and CONTAINS.

The databases used to search for the evidence were: Wiley Online Library, SAGE Premier 2019, ScienceDirect, CINAHL Plus with Full Text.

### FINDINGS

The following findings arose from the literature search:

### SEARCH RESULTS

Initially there were 2,222 results returned. The results were then sorted by Title, with a Resource Type set to Article. The number of results was reduced to 1,553 relevant results once the filters COVID-19 and Nursing were selected in the Subject filter.

The five articles selected were:

### ARTICLE ONE

Bruns, D., Kraguljac, N., & Bruns, T. (2020). COVID-19: Facts, Cultural Considerations, and Risk of Stigmatization. *Journal of Transcultural Nursing*, 31(4), 326–332. doi.org/10.1177/1043659620917724

The above article was selected for this literature review because it was published in a nursing journal and cultural considerations relating to COVID-19 are discussed.

Whilst published in the United States in the *Journal of Transcultural Nursing*, the article relates to the broader health system rather than just the discipline of nursing. This article is a primary research article.

The main points covered in article one include the need to focus on appropriate methods of education, prevention, treatment, and follow-up to ensure a timely public health response to COVID-19 to reduce infections, serious illness, and deaths and how health professionals are key to this response.

### ARTICLE TWO

Connell, R. (2020). COVID-19/Sociology. *Journal of Sociology*, 56(4), 745–751. doi.org/10.1177/1440783320943262

The second article was selected because it was published in Australia, providing not only an Australian perspective but also a sociological perspective of the impact of COVID-19 on society. This article is secondary source and is related to the discipline of social sciences.

The main points covered in article two include COVID-19 being a social disaster as much as a medical one and that familiar sociological theory and methodologies does not necessarily apply to the COVID-19

## CLINICAL UPDATE

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pandemic. The need for different and new structures of power and organisation that consider social, practical, and humane responses are also discussed.

### ARTICLE THREE

El-Masri, M., & Roux, G. (2020). Can COVID-19 Mark the Rediscovery of Nursing? *Canadian Journal of Nursing Research*, 52(3), 174–175. doi.org/10.1177/0844562120921583

Article three was published in Canada and is related to the nursing profession. This article was selected as both COVID-19 and the nursing profession were key features, the fact that the article was published in Canada was also considered given the similarities between the Australian and Canadian nursing environments. The article is a secondary source.

The main points covered in article three include the important role that nurses and midwives have played throughout the COVID-19 pandemic, particularly during the Year of the Nurse and the Midwife in 2020 and how leaders and organisations have the opportunity to advocate for nurses and midwives now and after the COVID-19 pandemic ensuring that oppression and marginalisation in nursing is addressed.

### ARTICLE FOUR

Newham, R., & Hewison, A. (2021). Covid-19, ethical nursing management and codes of conduct: An analysis. *Nursing Ethics*, 28(1), 82–90. doi.org/10.1177/0969733020988316

Article four was published in the United States, in *Nursing Ethics* a journal aimed at the nursing profession. The article is primary research and is relevant to nurses, specifically nurse managers. This article was selected because it is relevant to nursing in the context of COVID-19 and discusses the relationship to codes of conduct and ethics, all of which are relevant to culture.

The main points covered in article four include the difficulties faced by the profession due to COVID-19 and the importance of codes of conduct, to help provide guidance to support nurse managers during this period. The article also discusses how the current pandemic has enabled the nursing profession and health institutions to be temporarily free from managerialism yet have continued to ensure professional practice along with ethical and practical decision making.

### ARTICLE FIVE

Hofmeyer, A., Taylor, R., & Kennedy, K. (2020). Fostering compassion and reducing burnout: How can health system leaders respond in the Covid-19 pandemic and



beyond? *Nurse Education Today*, 94, 104502–104502. doi.org/10.1016/j.nedt.2020.104502

Published in the United States, Article five was selected because culture, nursing and COVID-19 are discussed. One of the authors is from the University of South Australia and two authors are from the United Kingdom. Additionally, the Australian author played a part in this article being selected. The article is primary research related to the nursing discipline.

The main points covered in article five include the impact of COVID-19 on the health and safety of nurses, the rise of COVID-19 infections and deaths among nurses, the struggling health system in the United Kingdom and more broadly, and how this impacts on the ability of nurses to provide healthcare. Suggested actions to assist in addressing the key issues are also discussed.

### DISCUSSION

On 11 March 2020 the World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak a global pandemic.<sup>1</sup> Nurses have been always been the cornerstone of the health system, despite little recognition being given to the profession making up the largest proportion of the health workforce in Australia<sup>2</sup> and more than 50% of the global health workforce.<sup>3</sup>

In response to the early COVID-19 outbreak in Wuhan, China thousands of nurses were deployed from other provinces and cities to assist with management of the early crisis.<sup>4</sup> Nurses were on the front in Italy, when the pandemic began to unfold, responsible for choosing who would get treatment, and turning away mainly older people, due to an overwhelmed health system.<sup>5</sup>

Throughout the pandemic the heroism of nurses has dominated social media and they have been cheered on by royals, dignitaries, heads of state and supporters around the world.<sup>6</sup> It comes as no surprise that nurses have been held in high regard by the public and relied upon to lead and to significantly contribute to the COVID-19 response. Despite all of this, outdated and inaccurate views of nurses remain.<sup>3</sup> These views impact on the culture of nursing and give rise to COVID-19 related cultural concerns.

As stated by Grehan<sup>7</sup> history, heritage, tradition, and the past are concepts commonly associated with culture, with these concepts also giving rise to culture in the nursing profession. The nursing profession, having evolved over hundreds and thousands of years, and having a history of being an unskilled workforce of low status, until the rise of the Nightingale nurses in the eighteen and early nineteen hundreds, has helped to shape the culture of nursing and also the perception of nurses in society more broadly.

As members of the wider society, and having come from varied backgrounds, nurses bring their own culture to the profession. Connell<sup>5</sup> indicates that COVID-19 has had a significant impact on households, where lockdowns increased the domestic obligations of women, and in the workplace, where feminised occupations such as nursing were 'on the front line'. The nursing profession has been under momentous pressure to perform, continue to deliver compassionate care and fulfil their domestic duties, all while responding to COVID-19. Some have even reported discrimination on the basis of having to manage family responsibilities<sup>8</sup> during the COVID-19 pandemic.

A culture of fear of the virus has evolved, in not only nursing but society as a whole. As stated by Bruns et al.,<sup>4</sup> avoidance behaviours such as minimising direct contact with patients and missing shifts had been common during the COVID-19 pandemic as health professionals were concerned about contracting COVID-19. This view is supported by Bradfield et al.,<sup>9</sup> who reported that health staff providing maternity care during the COVID-19 pandemic were more likely to be concerned about occupational exposure to COVID-19 through working in a health setting than those receiving care in these environments. They were also concerned about how, if they did contract the virus this would impact their family, particularly when facing personal protective equipment (PPE) supply and access issues.<sup>8</sup>

There is no dispute that the COVID-19 pandemic has drastically changed the way healthcare is delivered.<sup>9</sup> Newham & Hewison<sup>10</sup> indicated that it was the culture of some nurses not to speak out about poor standards of care because of the attitude and behaviour of their managers, with this becoming a significant concern whilst nursing staff try to balance the service response to the COVID-19 pandemic. Shortages of PPE and unpredictable work conditions have been linked to burnout and impact on the mental health and wellbeing in the nursing profession.<sup>8</sup> This impacts nurses' ability to continue to meet societies expectations.

Hofmeyer, Taylor & Kennedy<sup>11</sup> discuss the relevance of constructs such as empathy, emotion regulation, compassion, and self-care to sustain wellbeing, resilience, and effectiveness in relation to nursing during the COVID-19 pandemic. This is important from the perspective that the COVID-19 pandemic has created an opportunity for the general public to observe directly the vital role that nurses play and the sacrifices they make to care for others.<sup>6</sup> However, this puts the nurses under sustained pressure to continue to meet societies heightened expectations of the profession. At some point there will be an unprecedented amount of burnout, particularly where there is inadequate staffing and long working hours and isolation from family and friends,<sup>8</sup> within the profession, if strategies are not implemented to reduce burnout in nurses.

Rates of work-related stress and mental health issues have continued to increase throughout

the pandemic.<sup>11</sup> High workload, violence in the workplace, burnout, and exposure to potentially psychologically traumatic events<sup>8</sup> are all factors that impact on the mental health and wellbeing of nurses. These factors have increased throughout the COVID-19 pandemic.

It has been reported that nurses have experienced increased discrimination and negative treatment from the community due to concerns about nurses spreading the virus.<sup>8</sup> The COVID-19 pandemic offers the opportunity for peak bodies to better engage with society and to better educate communities about the pivotal role that nurses play, beyond providing direct patient care.<sup>6</sup>

The above discussion provides an overview of some of the key COVID-19 related cultural concerns in relation to nursing. As COVID-19 is an evolving space, the impact on the nursing profession will continue to evolve as will the COVID-19 related cultural concerns impacting nurses.

## CONCLUSION AND RECOMMENDATIONS

To understand, evaluate, identify, and manage COVID-19 cultural concerns in nursing, it is important to have knowledge about the evolution of the nursing profession, given this has contributed to the culture in the nursing profession. Understanding more broadly how culture in society is shaped through our similarities and differences, how culture influences how we perceive ourselves, one another and our place in the world<sup>12</sup> is also important.

This report provides only a sample of the COVID-19 related cultural concerns related to the nursing profession. Common COVID-19 related cultural concerns identified include:

- The way in which the public perceive the nursing profession, particularly in response to the COVID-19 pandemic.
- The historic view of the nursing profession, including the perception that the role was generally unskilled and low paid.
- That a large proportion of the nursing workforce is female and the impact this has on home and family duties.
- The culture of fear, including fear of speaking up to managers and fear of contracting the virus.
- The impact that the COVID-19 pandemic has had and continues to have on the mental health and wellbeing of nurses, including the issue of burnout.

It is recommended that further research related to the impacts of COVID-19 on the nursing profession and the associated cultural concerns is required to better answer the question: *What are the common COVID-19 related cultural concerns in relation to nursing?*

## Author

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## References

1. Cucinotta, D., & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. *Acta bio-medica*, 91(1), 157–160. doi.org/10.23750/abm.v91i1.9397
2. McMillan, M. (2020). Nation's nurses on the COVID-19 frontline: An opinion piece by the Australian Government's Chief Nursing and Midwifery Officer, Alison McMillan. [health.gov.au/news/nations-nurses-on-the-covid-19-frontline](https://health.gov.au/news/nations-nurses-on-the-covid-19-frontline)
3. Godsey, J.A., Houghton, D.M., & Hayes, T. (2020). Registered nurse perceptions of factors contributing to the inconsistent brand image of the nursing profession. *Nursing Outlook*, 68(6), 808–821. doi.org/10.1016/j.outlook.2020.06.005
4. Bruns, D., Kraguljac, N., & Bruns, T. (2020). COVID-19: Facts, Cultural Considerations, and Risk of Stigmatization. *Journal of Transcultural Nursing*, 31(4), 326–332. doi.org/10.1177/1043659620917724
5. Connell, R. (2020). COVID-19/ Sociology. *Journal of Sociology*, 56(4), 745–751. doi.org/10.1177/1440783320943262
6. El-Masri, M., & Roux, G. (2020). Can COVID-19 Mark the Rediscovery of Nursing? *Canadian Journal of Nursing Research*, 52(3), 174–175. doi.org/10.1177/0844562120921583
7. Grehan, M. (2013). Visioning the future by knowing the past. In Daly, J., et al. (Eds.), *Contexts of Nursing* (pp. 16). Elsevier Australia. ProQuest Ebook Central, [ebookcentral.proquest.com/lib/cdu/detail.action?docID=1723947](https://ebookcentral.proquest.com/lib/cdu/detail.action?docID=1723947)
8. Stelnicki, A. M., Carleton, R. N., & Reichert, C. (2020). Nurses' Mental Health and Well-Being: COVID-19 Impacts. *Canadian Journal of Nursing Research*, 52(3), 237–239. doi.org/10.1177/0844562120931623
9. Bradfield, Z., Wynter, K., Hauck, V.V., Kuliukas, L., Wilson, A. N., Szabo, R.A., Homer, C., & Sweet, L. (2020). Experiences of receiving and providing maternity care during the COVID-19 Pandemic in Australia: a five-cohort cross-sectional comparison. *PLOS ONE*. doi.org/10.1101/2020.09.22.20199331
10. Newham, R., & Hewison, A. (2021). Covid-19, ethical nursing management and codes of conduct: An analysis. *Nursing Ethics*, 28(1), 82–90. doi.org/10.1177/0969733020988316
11. Hofmeyer, A., Taylor, R., & Kennedy, K. (2020). Fostering compassion and reducing burnout: How can health system leaders respond in the Covid-19 pandemic and beyond? *Nurse Education Today*, 94, 104502–104502. doi.org/10.1016/j.nedt.2020.10.4502
12. World Health Organization. (2017). Culture matters: using a cultural contexts of health approach to enhance policymaking. Retrieved from [euro.who.int/\\_data/assets/pdf\\_file/0009/334269/14780\\_World-Health-Organisation\\_Context-of-Health\\_TEXT-AW-WEB.pdf](https://euro.who.int/_data/assets/pdf_file/0009/334269/14780_World-Health-Organisation_Context-of-Health_TEXT-AW-WEB.pdf)



**Kristen Wischer**  
Senior Federal Industrial  
Officer

## It's time for paid family and domestic violence leave – we won't wait

**In March 2018, the Fair Work Commission determined to include five days unpaid family and domestic violence (FDV) leave in all modern awards.**

**In December 2018, the right to five days unpaid leave was expanded to cover all national system employees under the National Employment Standards.**

While many ANMF members benefit from access to paid leave under enterprise agreements – the entitlement is far from universal. This means many people, predominately women, who are seeking support while in a violent relationship, making plans to leave, or re-establishing their lives after leaving must do so with no dedicated paid leave.

The FWC decision incorporated a review process to take place three years after the right to unpaid leave came into operation.

The FWC review is now underway and is considering the following questions:

1. whether employees should be able to access paid personal/carer's leave for the purpose of taking family and domestic violence leave;
2. the adequacy of the unpaid paid family and domestic violence leave entitlement; and
3. whether provisions should be made for paid family and domestic violence leave.

The ACTU is now seeking to vary awards to include an entitlement to 10 days paid family and domestic violence leave. Witness statements and submissions have been filed at FWC in support of the application. Statements have been obtained from a range of front-line workers who provide services to people experiencing the effects of family and domestic violence, including one from an ANMF member, an RN working at St Vincent's Hospital Melbourne in a program to support both staff and patients experiencing FDV.

The evidence aims to show the steps that need to be taken in the process of leaving a situation of FDV, such as seeking medical and therapeutic support, setting up financial independence, often in a situation of financial control, seeking police intervention, finding alternative accommodation, arranging new child care and schools and sometimes changing work arrangements. Nearly all of these preparations need to occur in work time. It is estimated it can take more than 140 hours to escape and recover from an abusive relationship.

The evidence also draws attention to the economic cost of FDV; for the individual it is estimated the cost of leaving FDV is more than \$18,000 per person. Research shows that in 2014-15, the cost to the Australian economy of women experiencing physical

violence, sexual violence or emotional abuse by a partner was \$12.6 billion and by 2015-16 the cost had increased to \$22 billion. It can only be assumed that the impact of COVID-19 on households will have an even greater financial and personal cost.

The data referred to in the evidence shows that not only is it predominantly women who experience the effects of FDV, but that women who have experienced FDV earn relatively lower incomes both in the short and long term. Given the ongoing prevalence of FDV, which affects one in four women, it is clear that FDV is a barrier to achieving gender equality both in the workplace and more generally.

A report prepared on behalf of the FWC notes that FDV leave is an important means for maintaining the economic security necessary to potentially leave and recover from a violent relationship. This is echoed in the member witness statements from nurses, doctors, paramedics, lawyers and social workers, who explain that in their experience, a key barrier to people accessing critical support is not being permitted to take leave and being unable to afford to take time off without pay.

The ACTU application will be listed for hearing in 2022. At the same time, the ACTU is running the campaign *We Won't Wait - Australian Unions* to raise awareness about the importance of paid FDV leave in all workplaces. The campaign material includes a toolkit to help workplace delegates promote workplaces that offer paid leave and information about how to achieve paid FDV leave where the entitlement is not available. The material includes a link to a national petition calling for 10 days paid FDV leave as a minimum entitlement, which we urge you to sign.

It is critical that paid FDV leave be incorporated into awards as a minimum entitlement as it not only supports the individual to take the necessary steps to leave an abusive relationship, but also helps women stay in employment that is vital to their future economic security. Paid FDV leave is key to individuals surviving and rebuilding their lives and this benefits all our community.



# RECOGNISING AND RESPONDING TO SEXUAL VIOLENCE IN ADULTS

## A Three-unit Program

## ARE YOU A NURSE WHO CARES FOR VICTIMS OF SEXUAL VIOLENCE?

### COURSE DESCRIPTION

Monash University's Department of Forensic Medicine and the Victorian Institute of Forensic Medicine (VIFM) have developed a three-unit course in recognising and responding to sexual violence in adults.

This training program is funded by the Commonwealth Department of Social Services (DSS) as an initiative under the Fourth Action Plan of the National Plan to Reduce Violence Against Women and their Children 2010-2022. The training will help nurses recognise and respond appropriately to adult disclosures of sexual violence.

### DURATION AND FORMAT

Each six-hour Unit will be delivered online over a six-week period and will include live sessions with clinicians with expertise in responding to sexual violence. The course has been designed to be interactive. You can register interest in a single unit or seek to enrol in all three units.

### PROFESSIONAL RECOGNITION

Each Unit will be endorsed by the Australian College of Nursing as a 6-hour CPD activity.

### UNIT 1: SEXUAL VIOLENCE DRIVERS AND IMPACTS

This Unit covers the contexts and drivers of sexual violence, risk factors, prevalence, indicators, societal attitudes, perpetrator behaviours; consequences; the role of police, the justice system and psycho-social support services.

### UNIT 2: RESPONDING TO SEXUAL VIOLENCE

This Unit focuses on the sexual assault consultation. It covers trauma-informed communication, patient and practitioner safety, ethics, history taking, medical care, consent for a physical examination, forensic principles, documentation and referrals.

### UNIT 3: RESPONDING TO SEXUAL VIOLENCE IN AT-RISK COHORTS

Some groups and individuals are more vulnerable to sexual violence. This Unit covers at-risk patient characteristics and life stages; intersectionality; barriers to disclosure; community-specific prevalence; indicators; responses and referrals.

### COURSE DIRECTORS

**Associate Professor  
David Wells OAM**

Senior Education Coordinator,  
Department of Forensic Medicine

**Dr Maaïke Moller**

Adjunct Senior Lecturer,  
Department of Forensic Medicine  
Forensic Physician,  
Victorian Institute of Forensic Medicine

### DATES

Delivered from February 2022

### COST

**Free**

### CONTACT

E: [svtraining@monash.edu](mailto:svtraining@monash.edu)

### REGISTER INTEREST

Scan QR to visit website  
and register interest.



# Understanding Foundational Pharmacodynamics

By ANMF Federal Education Team

**Before discussing pharmacodynamics in depth, it is important to define the term and distinguish this branch of pharmacology from the branch called pharmacokinetics.**

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**Pharmacokinetics** is the branch of pharmacology that studies the relationship between time and the concentration of a drug at various sites in the body, by measuring the absorption, distribution, metabolism, and excretion of the drug.

**Pharmacodynamics** studies the effects of a drug on the body by measuring drug binding to receptors and dose-response curves.

Knowledge of how drugs act on receptors will help you understand why and how drugs have particular effects on the body.

*\* Drugs usually act through binding specific cell receptors within the body.*

## RECEPTORS

Receptors are molecular complexes within or on the surface of a cell that selectively bind specific substances, also referred to as ligands, and elicit a response on the cell or organism.

Upon administration, a single drug molecule can bind to a wide variety of biological molecules as it circulates throughout the body. In most cases, this binding does not produce any biological effect. However, if the binding of a drug to a biological molecule leads to an effect, the molecule is classified as a drug receptor. The majority of drug receptors are regulatory molecules, which also act as receptors for endogenous ligands such as hormones or neurotransmitters. Though several types of molecules may function as drug targets, most drug receptors are proteins.

There are four major types of receptors in the body:

- G protein-coupled receptors
- Enzyme-linked receptors
- Ion channels
- Nuclear Hormone receptors

## LIGANDS

Endogenous molecules and drugs can serve as receptor ligands. Ligands can be classified as agonists or antagonists, based on the biological effect they have on their corresponding receptor. Ligands can also be categorised based on their binding site on a target receptor, which can be the primary active site or a different region on the receptor called allosteric site.

## AGONISTS

Drugs may be agonists, which activate receptors.

Agonists are ligands that, upon binding to a receptor, evoke its activation.

Agonists can be divided into two classes, depending on the ability to activate the receptor.

- Full agonist
- Partial agonist

## ANTAGONISTS

Drugs may be antagonists, which prevent receptors from being activated.

Antagonists are ligands that, upon binding to a receptor, inhibit its activation. Once bound to the receptor, antagonists block the potential binding of endogenous agonists that would otherwise activate the receptor.

Antagonists can be divided into reversible and irreversible antagonists, depending on the way they interact with receptors.

Antagonists can also be classified as either those that compete with the agonist at the same binding site on the receptor (the active site) or those that bind to a distinct binding site to that of the agonist (the allosteric site) on the same receptor. Agonists of the latter are referred to as allosteric antagonists.





# EDUCATION

## QUANTITATIVE PHARMACODYNAMICS

Scientists and clinicians use mathematical models to describe a fundamental pharmacodynamics relationship when studying a drug – the relationship between the dose of the drug given to the patient and its effects in the body.

Methods used to quantify the relationships between dose, response, and receptor binding include:

- Dose-response curves: The logarithm of the drug concentration is plotted versus the response
- The efficacy of the drug: It is determined by the maximum effect of the drug,  $E_{MAX}$
- The potency of a drug: It is determined by the concentration necessary to achieve 50% effect – the  $EC_{50}$
- The affinity of a drug for a receptor: It is determined by the binding strength of a drug to a receptor – the inverse of  $K_D$

Understanding quantification methods will help you better describe the pharmacodynamics properties of drugs.

## DOSE-RESPONSE CURVES

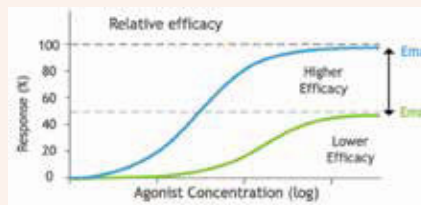
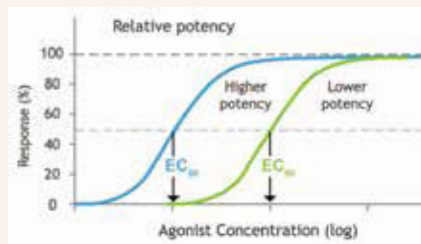
The fundamental tool for analysing the relationship between the administered dose of a drug and the physiological response to the drug is known as the dose-response curve. The dose-response curve is a graph that plots the logarithm of the drug concentration on the x-axis and the percentage of the maximum response to the drug on the y-axis.

Several abbreviations are commonly used when describing a dose-response curve:

- $E$  = the drug effect at a given concentration
- $C$  = the drug concentration
- $E_{MAX}$  = the maximum effect that can be produced by a drug.

A drug with a high  $E_{MAX}$  is said to have high efficacy

- $EC_{50}$  (or half-maximal effective concentration) = the concentration of a drug that produces 50% of the maximum effect. A drug that has a low  $EC_{50}$  – that requires a small concentration to produce 50% of maximum effect – is said to have a high potency



## AFFINITY

Drugs that are potent agonists can achieve a full effect before all available receptors have been occupied, whereas other drugs, like partial agonists, may never reach a full effect even if all available receptors are bound. In other words, drug binding and drug effect are not always directly proportional.

The property that quantifies binding strength is known as affinity. It is often measured using the equilibrium dissociation constant ( $K_D$ ).

## CLINICAL PHARMACODYNAMICS

Although quantitative methods are key tools for understanding the fundamental relationships in pharmacodynamics, they can be difficult to apply in the clinical setting. Many factors beyond the dose-

response curve of a drug will affect the way that a drug functions in the context of patient therapy.

## MEASURES OF THERAPEUTIC RESPONSE

All drugs cause more than one (1) single and specific effect. Besides the desired therapeutic effects, drugs may also cause unwanted toxic or adverse effects.

Two (2) clinically relevant measures that compare the therapeutic effects and the toxic effects of a drug are:

- The therapeutic window; and
- The therapeutic index.

To understand these measures, it is also necessary to comprehend the concepts of:

- Median effective dose ( $ED_{50}$ )
- Median toxic dose ( $TD_{50}$ )

## FACTORS AFFECTING THERAPEUTIC RESPONSE

There is usually a large amount of variation in the response to a drug, both between patients and within an individual patient over the course of treatment.

Some of this variation is due to pharmacokinetic factors such as absorption, distribution, metabolism, and excretion of the drug from the body. However, there are pharmacodynamic factors that can affect the variation response:

- Incomplete diagnosis
- Co-administration of other agents
- Receptor number and function
- Concentration of endogenous ligands

1 HOUR  
CPD

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

The complete tutorial will give you one hour of CPD.

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

NSWNMA, QNMU and ANMF NT members have access to the course for free.

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

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





**Dr Micah D J Peters**

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## References

- Osingada CP, Porta CM. Nursing and Sustainable Development Goals (SDGs) in a COVID-19 world: The state of the science and a call for nursing to lead. *Public Health Nurs.* 2020;37(5):799-805.
- Roy Morgan. Roy Morgan Image of Professions surveys of Australians 14+ between 1976 – 2021 [Online]. Roy Morgan. 2021. Available: roymorgan.com/findings/8691-image-of-professions-2021-april-2021-202104260655.
- IPSON MORI. IPSOS MORI Veracity Index 2021 [Online]. 2021. Available: ipsos.com/en-ie/ipsos-mrbi-veracity-index-2021-who-do-we-trust.
- Brent R. Politics as a driving force in nursing and health care. *Nursing Economics.* 2020; 38(6):282.
- Dayant A. Forecasting vaccination in the Pacific [Online]. The Interpreter. 2021. Available: lowyinstitute.org/the-interpreter/forecasting-vaccination-pacific
- King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. *The Lancet.* 2009;374(9683):76-85.
- World Health Organization (WHO). Climate Change and Health [Online]. WHO: Geneva. 2021. Available: who.int/news-room/fact-sheets/detail/climate-change-and-health (Accessed 8 Nov 2021).
- Tukuitonga C, Vivili. Climate effects on health in Small Islands Developing States. *Lancet Planetary Health.* 2021;5(2):E69-70.
- Butterfield P, Leffers J, VÅsquez M D. Nursing's pivotal role in global climate action *BMJ* 2021; 373:n1049 doi:10.1136/bmj.n1049

# Supporting nursing and health in the South Pacific: A regional responsibility

**Nurses are a powerful, influential group who are critical to achieving the United Nations' 2030 Agenda and 17 Goals for Sustainable Development. This is especially important for Australia's Pacific Island neighbours.**

As the largest, most trusted workforce group, nurses drive significant change at every political level to improve the world for everyone, especially the most vulnerable members of society. As Australia nears almost complete COVID-19 vaccine coverage, the most disadvantaged, marginalised communities represent many of those yet to receive a dose. This can also be said for some of the less fortunate Pacific Island nations which are now facing a COVID-19-driven humanitarian crisis due to remoteness, workforce shortages, misinformation, and low levels of trust in health workers.

COVID-19 is one of many dire threats to health and wellbeing in the South Pacific where less favourable social determinants of health (nutrition, housing, sanitation, education, poverty) can predispose indigenous populations to both infectious and non-communicable diseases. Climate change represents the largest threat to global health and wellbeing, and already most negatively impacts disadvantaged South Pacific island communities despite their minimal contribution to global emissions. Increasing droughts, coastal flooding, temperatures, and extreme weather all combine to detrimentally impact vulnerable South Pacific communities and the health professions and workers there are already facing challenges especially among young children, women, older people and people with disabilities.

Without immediate action from larger nations, especially Australia, it will be too late. Between 2030 and 2050, malnutrition, malaria, diarrhoea, and heat stress are anticipated to lead to an additional 250,000 deaths every year – all results of climate change.<sup>5</sup> Most of these deaths will occur in poorer nations including the South Pacific.

In 2018, I had the honour of attending the South Pacific Nurses Forum (SPNF) in the Cook Islands. At this event, over 300 nurses and nursing organisation representatives from 17 countries around the South Pacific came together to discuss their work on a range of issues from nursing education and training, clinical practice, and health research to political advocacy and humanitarian aid. It was clear that while nurses are major contributors to health and occupy many health and political leadership positions in the South Pacific, there are still many ways that nurses and nursing organisations in Australia and New Zealand can help to support our colleagues. Some of this important work is already underway via the WHO Collaborating

Centre for Nursing, Midwifery, and Health at the University of Technology, Sydney led by registered nurse, Professor Michele Rumsey. Nurses and nursing organisations can respond to the threat of climate change by ensuring nurses – particularly women – take on executive leadership roles, enhancing nursing students' skills, and rekindling activism and advocacy. Here is where nurses at all levels – from student to senior leader – can take immediate action.

Other ways we can support our South Pacific nursing colleagues is through mentoring, collaborating, and enabling them to access and succeed in initiatives that help build valuable skills and experience in evidence-based healthcare. This might be through enabling better awareness and uptake of recent developments, techniques, and technologies in evidence-based clinical practice that can improve care and outcomes. Enabling nurses to work to full scope of practice in all settings and also to embed nurse-led models of care especially in areas with low numbers of other healthcare professionals is another. Further, Pacific Island nurses can be supervised and funded to undertake advanced research training and education through opportunities to study towards Masters by Research or PhD degrees at Australian institutions either in person or as remote-access students. This is important because many island nations have limited access to university education. Here, it is vital that efforts to empower South Pacific nurses does not lead to skills-drain where instead of remaining in country and building their community's health and wellbeing, nurses may opt to move away to larger economic powers. This risk is particularly relevant as many of these countries require strong nursing workforces to deal with the ongoing pandemic.

Australian nurses are the keystone to our universal healthcare system and carry the responsibility of the health and wellbeing of our country's population. As our world becomes increasingly connected through the progression of globalisation, it is vital that we also consider our responsibilities to travel across borders to supporting and improving the health, wellbeing and lives of our neighbours. At the beginning of 2022, Australia is emerging from a traumatic couple of years, but the impacts of the pandemic and climate change will continue for many communities in the South Pacific. I and my colleagues in the ANMF and UniSA's Rosemary Bryant AO Research Centre are committed to doing what we can to aide our colleagues there, and I urge you to consider how you can help too.



**Julianne Bryce**  
Senior Federal  
Professional Officer

## Nurses and midwives key to quality use of medicines

**Nurses and midwives know that while medicines make a significant contribution to the treatment of ill health, the prevention of disease, increasing life expectancy and improving health outcomes, they also have the potential to cause harm.**

The quality use of medicines requires that the appropriate medicine is prescribed; that it is available at a price the person can afford; and that it is prescribed, dispensed and administered correctly. The goal for the use of any medicines is to promote quality of life.

Quality use of medicines strives to reduce avoidable harm and improve health outcomes.

This year has afforded the ANMF a number of opportunities to provide input to national work to improve the quality use of medicines.

Originally published in 2000, the National Medicines Policy is currently under review. Well due for an update, this high level document has four central objectives – timely access to affordable medicines; appropriate standards of medicines safety, quality and efficacy; quality use of medicines; and a responsible and viable medicines industry.

On behalf of members, the ANMF has participated in consultation for this review through a written submission and focus groups. Our aim is to ensure the critical role of nurses and midwives in the quality use of medicines, particularly medicines administration and increasingly prescribing, is considered and addressed.

Earlier this year, the Australian Commission on Safety and Quality in Health Care (the Commission) was engaged by the Australian Government Department of Health to review and update the Guiding principles for medication management in the community (2006) and the Guiding principles for medication management in residential aged care facilities (2012). In October and November, the ANMF, in consultation with our state and territory Branches, prepared responses to the Commission for these reviews. Members also participated in focus groups established to gather feedback from nurses managing medicines in a variety of contexts of practice.

ANMF responses highlighted the two main areas in need of review. These being the role of nurses in medicines management and administration and the importance of a mandated staffing and skills mix to deliver safe care. We urged the Commission to address these issues in the updated guiding principles. Copies of our responses are available at: [anmf.org.au/pages/professional-submissions](https://anmf.org.au/pages/professional-submissions)

This year the Commission has also developed resources to support residential care providers and software vendors to implement and optimise their electronic National Residential Medication Chart (eNRMC) medication management systems. These

eNRMC systems will be used to streamline processes for medication management and enable electronic prescribing, removing the need for paper prescriptions. The government engaged the Commission to develop these resources. The ANMF participated on the Expert Advisory Group convened by the Commission to provide oversight of this work. The guide, workbook and information resource are available under new publications at: [safetyandquality.gov.au](https://safetyandquality.gov.au)

Work has commenced in recent months on the review of the ANMF *Nursing Guidelines for the Management of Medicines in Aged Care*, developed to promote the safe delivery of medicines to older people. The aim of these guidelines is to provide support and direction for registered and enrolled nurses for the management and administration of medicines in aged care, as well as clarifying the role of assistants in nursing.

Given the current reviews of the government's national quality use of medicines publications, this timely review of our guidelines is being undertaken to ensure currency and relevance to best practice aged care, legislative and regulatory requirements, and evidence-based nursing practice.

The ANMF guidelines will be cross-referenced in the revised Australian Government Department of Health national medicines guiding principles publications for residential aged care and community care, detailed above.

Finally, once again, the ANMF was invited by the Society of Hospital Pharmacists to participate on the Editorial Committee for the 4th Edition of the *Don't Rush to Crush* (DRTC) publication. The main audience for this resource are nurses, midwives, pharmacists and prescribers, who may, of course, be nurse practitioners or midwives with an endorsement for scheduled medicines.

Before giving an oral medicine, nurses and midwives need these fundamental questions answered quickly, accurately and safely: can I crush it?; can I disperse it?; can I open the capsule?; is there a suitable liquid formulation? can I give the injection orally?

The new edition includes 590 oral medicines, with 50 additions. It also contains the results of extensive testing of over 100 oral liquid medicines against the International Dysphagia Diet Standardisation Initiative (IDDSI) standards for thickness of foods and fluids – vital safety information for people with swallowing difficulties.

Work on this review will be completed shortly and copies of the new DRTC will be available in the new year.



**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*

## Medication custodians: Falling short of expectations

**Whilst the majority of health professionals who have the lawful right to prescribe, supply or administer medications do so as lawful custodians of these drugs, there are some whose conduct falls short of professional expectations.**

This not only increases the risk to the public but also has the potential to damage the reputation of the professions and undermine the trust the community has in health professionals' practice. For the practitioner there are serious personal and professional consequences as they face potential regulatory action and criminal liability.

In *Pharmacy Board of Australia v Tran (Review and Regulation)* [2021] VCAT 1249 (25 October 2021) the tribunal highlighted the importance of the role pharmacists have in the provision of healthcare in the community and in protecting public health. In their view the pharmacist does much more than merely following a script and dispense medications. Rather than take the script at face value the pharmacist is required to exercise independent judgement as to whether there is something about the script that could cause harm to the patient or the community. This is also a layer of protection from harm should the prescribing officer make a mistake or incorrectly prescribe medications.

As such they have a gate keeper role that also requires them to be vigilant in identifying drug seeking behaviour through scrutinising scripts to determine if they have been forged or altered and consider if the types and quantities of drugs sought raise cause for suspicion. Pharmacists also have an obligation to report such suspicions to the relevant health department for follow up and investigation.

In this case Tran admitted that rather than practice with such vigilance she 'blindly followed' the scripts presented by a manipulative patient over a period of three years and five months. During this time she provided this person a total of 52,368 tablets of codeine-containing analgesics over the course of 167 prescriptions which averaged out to 39 tablets a day. Tran acknowledged that it was apparent from the scripts in evidence that whilst they had been genuinely written by a doctor, they had been fraudulently altered with handwriting that attempted to mimic the original prescribing officers writing adding in Panadiene Forte and/or Valium. On multiple occasions she also supplied repeats that had not been authorised by the prescribing doctor. Tran was found guilty of professional misconduct, received a reprimand, a six month suspension and had conditions placed on her registration for when she returns to practice.

This finding came after her criminal trial in the Magistrates Court where she pled guilty to 10 charges in relation to 457 breaches of drugs, poisons and controlled substances laws and was fined \$10,000 and ordered to pay \$10,708 costs.

In another case the Health Complaints Commission in NSW found Dr Mohammadi guilty of unsatisfactory professional conduct and professional misconduct for prescribing excessive amounts of opioids, failing to properly assess patients, not identifying signs of drug addictive behaviour and failing to refer patients on who were in need of specialist care. Mohammadi claimed that he was able to determine if someone was drug addicted by looking into their eyes rather than looking at their behaviour although conceded that sometimes he did miss picking up the cues.

In one case he oversupplied fentanyl to a patient for 64 days, in addition to prescribing fentanyl to three patients for non-therapeutic reasons. He admitted having no experience in treating drug addicted patients acknowledging that he was too soft with them.

The tribunal noted that Mohammadi was remorseful and intended no harm, however, considered his conduct reckless with respect to the doses and quantities of drugs he supplied to the identified patients. They were satisfied that he knew some of the patients were drug seeking or drug dependent and wrongly thought he was treating their addiction. The tribunal is yet to deliver its orders (Vella J, 2021).

There have also been several recent cases where health practitioners have misappropriated drugs for their own use. One drug addicted pharmacist who was found guilty of altering prescriptions and possessing a trafficable quantity of Xanax was given a two year community correction order after he falsified patient supply records obtaining 33,250 Xanax pills. He was also found guilty of professional misconduct in the tribunal (Shapiro P). These cases serve as a reminder to all those custodians of medications of the need to ensure that professional standards of practice are maintained in this area and how we should all be vigilant in ensuring that proper prescribing, dispensing and administration of drugs is practiced across the professions.

### References

Pharmacy Board of Australia v Tran (Review and Regulation) [2021] VCAT 1249 (25 October 2021)

Shapiro P, 2021. Methhead former Melbourne pharmacist William Trieu swindled 33,250 Xanax Alprazolam tablets. *Herald Sun* 15 November 2021.

Vella J, 2021. Auburn doctor Masoud Mohammadi guilty of professional misconduct. *NT News* 15 November 2021.



Tess Cooper

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Simon Cooper (PhD)

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## Pain management for patients with dementia: Identification and management

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By Tess Cooper and Simon Cooper

**The Australian Bureau of Statistics<sup>1</sup> reports that in 2018 there were 219,000 Australians with dementia – of which 43% experienced chronic pain that may have been difficult to recognise and treat.**

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The incidence is high in this population due to comorbidities and age, whilst cognitive impairment may result in a reduced ability to report pain.<sup>2</sup> When in pain, those with dementia may become aggressive or agitated, which are frequently misunderstood and inappropriately treated.<sup>2</sup> Additionally, there is a lack of evidence and insufficient management guidelines.<sup>3</sup>

In this brief review, we aimed to investigate how pain is identified and managed. Methods included searching the contemporary peer-reviewed literature (2014-21) for original research published in English, including participants  $\geq 65$  years. An initial 532 papers were identified and reduced to 10 (quantitative and qualitative studies) when the full inclusion criteria were applied.

## RESULTS

### IDENTIFYING PAIN

Identifying pain in those with dementia is challenging<sup>4,5</sup> and predominantly linked to patients' inability to self-report.<sup>6</sup>

Family and carers are recognised as a key resource in identifying pain but may disengage when the patient is institutionalised.<sup>6</sup> Nursing staff can identify some possible pain-related behaviours, eg. confusion and aggression, but admit that such behaviours need to be repeated before they are linked directly to pain.<sup>7</sup>

Staff experience and skill are therefore pivotal with a requirement to understand their patients, recognise behavioural cues, and develop trust.<sup>8</sup>

### PAIN MANAGEMENT

Management of pain for those with dementia is challenging which includes refusal and administration difficulties - possibly due to an inability to recognise medication needs.<sup>9</sup>

This may lead to untreated pain and further agitation. Dysphagia is also common in late-stage dementia, restricting the use of oral analgesia, whilst advanced dementia leads to muscle wasting resulting in intramuscular injection challenges.<sup>9</sup> Opioid use is also restricted due to physicians' reluctance to prescribe them,<sup>10</sup> whilst Nowak et al.<sup>2</sup> identified that pain undertreatment is likely.

Further, others have identified that physicians avoid prescribing adequate analgesia due to the possibility of adverse events.<sup>7</sup> The presence of disruptive behaviours can also lead to mistreatment of possible pain<sup>2</sup> and where restraints are used leads to increased anxiety and

pain.<sup>7</sup> Nursing home residents with dementia and disruptive behaviours are treated with more sedatives than analgesics<sup>2</sup> and mistreatment of pain with antipsychotics can increase the chance of delirium in persons with dementia, adding complexity to pain management.<sup>7,11</sup>

### EDUCATION AND PATIENT ASSESSMENT

There is a call for consistent international guidelines for managing pain for those with dementia, including updated training regimes to enable staff to implement guidelines.<sup>2,7</sup>

A lack of education in this field is reported throughout (eg. ref 4,9,12) and may be dependent on the clinical speciality.<sup>8</sup> For example, hospice nurses receive adequate education, but acute and aged care nurses receive little or none.<sup>9</sup>

Pain assessment questionnaires for those with dementia are available, eg. the Abbey Pain Scale<sup>13</sup>, but their validity and reliability are questionable. For example, the ability to distinguish between pain and distress<sup>8</sup>, whilst assessment outcomes may be consistent with symptoms of depression.<sup>12</sup> Peisah et al.<sup>8</sup> therefore, recommends individualised pain assessments developed through the identification of unique pain-related behaviours. Nakashima et al.<sup>11</sup> elaborate on this, suggesting that familiar carers should be recruited to determine each resident's appropriate pain assessment and intervention.

### CONCLUSION

Dementia patients are very likely to suffer untreated pain caused by communication issues involving patients, carers and clinicians. Undertreatment and mistreatment of pain are apparent, with improvements required in education and pain assessment methods. Pain management approaches must take into account the degree of cognitive decline and include multi-factorial approaches to enhance management. Consideration should be given to:

- Multi-professional education;
- Staffing adequacy;
- Family and carer involvement;
- Cross-disciplinary communication and collective staff interpretation of pain<sup>5</sup> empowering staff and carers as "needs interpreters";<sup>8</sup>
- Individualised pain assessment methods; and
- future research focussing on effective assessment and treatment procedures.<sup>12</sup>

### References

1. Australian Bureau of Statistics (2020). *Dementia in Australia*. <https://www.abs.gov.au/articles/dementia-australia>
2. Nowak T, Neumann-Podczaska A, Deskir-Smielecka E, Styszynski A & Wiczerowska-Tobis K. Pain as a challenge in nursing home residents with behavioural and psychological symptoms of dementia. *Clinical Interventions in Aging*, 2018(13), 1045-1051. <http://dx.doi.org/10.2147/CIA.S157246>
3. Pain management in dementia. International Association for the Study of Pain (2019). [https://www.apsoc.org.au/PDF/GYAP/2019\\_GYAP/Fact\\_Sheet\\_4\\_Pain\\_Management\\_in\\_Dementia\\_English\\_edited.pdf](https://www.apsoc.org.au/PDF/GYAP/2019_GYAP/Fact_Sheet_4_Pain_Management_in_Dementia_English_edited.pdf)
4. De Witt Jansen B, Brazil K, Passmore P, Buchanan H, Maxwell D, McIlpatrick SJ, Morgan SM, Watson M & Parsons C. 'There's a Catch-22': The complexities of pain management for people with advanced dementia nearing the end of life: A qualitative exploration of physicians' perspectives. *Palliative Medicine*, 2017, 31(8), 734-742. <https://doi.org/10.1177/0269216316673549>
5. Lichtner V, Dowding D, Allcock N, Keady J, Sampson EL, Briggs M, Corbett A, James K, Lasrado R, Swarbrick C & Closs SJ. The assessment and management on pain in patients with dementia in hospital settings: A multi-case exploratory study from a decision making perspective. *BMC Health Services Research*, 2017, 16(427). DOI 10.1186/s12933-016-1690-1
6. Minaya-Freire A, Ramon-Aribau A, Pou-Pujol G, Fajula-Bonet M & Subirana-Casacuberta M. Facilitators, barriers, and solutions in pain management for older adults with dementia. *Pain Management Nursing*, 21(2020), 495-501. <https://doi.org/10.1016/j.pmn.2020.03.003>
7. Rantala M, Kankkunen P, Kvist T & Hartikainen S. Barriers to postoperative pain management in hip fracture patients with dementia as evaluated by nursing staff. *Pain Management Nursing*, 2014, 15(1), 208-219. <http://dx.doi.org/10.1016/j.pmn.2012.08.007>
8. Peisah C, Weaver J, Wong L & Strukovski A. Silent and suffering: a pilot study exploring gaps between theory and practice in pain management for people with severe dementia in residential aged care facilities. *Clinical Interventions in Aging*, 2014(9), 1767-1774. <http://dx.doi.org/10.2147/CIA.S64598>
9. De Witt Jansen B, Brazil K, Passmore P, Buchanan H, Maxwell, McIlpatrick SJ, Morgan SM, Watson M & Parsons C. Nurses' experiences of pain management for people with advanced dementia approaching the end of life: A qualitative study. *Journal of Clinical Nursing*, 2017, 26(9-10), 1234-1244. <https://doi.org/10.1111/jocn.13442>
10. Barry HE, Parsons C, Passmore AP & Hughes CM. Pain in care home residents with dementia: An exploration of frequency, prescribing and relatives' perspectives. *International Journal of Geriatric Psychiatry*, 2015(30), 55-63. DOI: 10.1002/gps.4111
11. Nakashima T, Young Y & Hsu WH. Do nursing home residents with dementia receive pain interventions? *American Journal of Alzheimer's Disease & Other Dementias*, 2019, 34(3), 193-198. DOI: 10.1177/1533317519840506
12. Thakur ER, Amspoker AB, Sangsiry S, Snow AL, Stanley M, Wilson N, Freshour J & Kunik ME. Pain among community-dwelling older adults with dementia: factors associated with undertreatment. *Pain Medicine*, 2017(18), 1476-1484. DOI: 10.1093/pm/pnw225
13. Australian Pain Society, Pain in residential aged care facilities: management strategies, 2nd Edition (2019) [https://www.apsoc.org.au/PDF/Publications/APS\\_Pain-in-RACF-2\\_Abbey\\_Pain\\_Scale.pdf](https://www.apsoc.org.au/PDF/Publications/APS_Pain-in-RACF-2_Abbey_Pain_Scale.pdf)

# Making our voices heard is key to improving global health outcomes

**Public health needs nurses to stand up and make their voices heard in policy, according to registered nurse and US Congresswoman Lauren Underwood and the Health Minister of Seychelles, registered nurse and midwife Peggy Vidot.**

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The nurse-politicians, who spoke at the 2021 International Council of Nurses (ICN) Congress held virtually late last year, explained why nurses need to participate in health change and what barriers hindered these changes.

During the plenary, Rep. Underwood spoke about how nurses play an intrinsic role in every area of the pandemic response.

“We’re all united in this effort, and I think that as we look to the future, that there is going to be more willingness for public investment in all aspects of nursing,” Rep. Underwood said, specifically alluding to elements of the American COVID experience.

“During the pandemic, we’ve seen two things happen, kind of in parallel: The consequences of a systemic underinvestment in public health... [and] the other is [that] we’ve seen the consequences of allowing communities to have shortages of physicians, of nurses, of other really important healthcare providers.”

To address the issues, Rep. Underwood said greater investment in nursing education and ensuring that the nursing workforce cohort was included in the public health policy discussions the same way as other professions.

“We [the nursing workforce] don’t have the luxury anymore of claiming to be apolitical; we can’t say, ‘Someone else will handle that,’” she said.

Ms Vidot’s presentation historically contextualised the need for nursing leadership, going beyond policymaking to look at other campaigns, roles and initiatives that have politically promoted nursing practice as part of public health.

Ms Vidot historically referred to nurse leaders and the evolution of nurse roles within government health bureaucracies, such as creating the Chief Nursing Officer. However, despite 28 million nurses forming the most significant part of the global health workforce, their policy role remained limited, she said.

“Nurses remain, in large part, mainly policy implementers, rather than policy drivers,” Ms Vidot said. “These are known facts, and nurses have lived with this knowledge for decades.”

Yet Ms Vidot said evidence showed that the role of nursing was shifting, but other factors, such as professional status, gender and class, also limited the ability of nurses to influence public health policy more greatly.

Nevertheless, Ms Vidot said these barriers were not insurmountable.

“I believe that nursing can overcome many of these constraints and position itself to transform public health,” Ms Vidot said.

“Nurses need to venture in areas not traditionally associated with nursing; they need to become engaged in politics to drive change... We need to have nurses sitting at the tables that matter.”

The Biennial International Council of Nurses Congress, representing 130 national nursing bodies worldwide, attracted more than 5,500 nurses from 132 countries to the event.

The Congress gave nurses and nurse academics the opportunity to share their experiences and present their research to disseminate best practices worldwide.

The *ANMJ*, along with the UK’s *Nursing Times* and the US’ *American Journal of Nursing*, were proud media sponsors of the event.



Health Minister of Seychelles, registered nurse/midwife Peggy Vidot



US Congresswoman Lauren Underwood



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# COVID-19 Quarantine Queen: A lived experience

By Cate Mabey

Thanks to the pandemic, having to travel and quarantine can be a difficult and frustrating while also frightening at times. Mental health nurse Cate Mabey gives insight into her experiences when quarantining numerous times after international travel.



Quarantine/isolation is the separation and restriction of movement of people who have potentially been exposed to a contagious disease to ascertain if they become unwell, to reduce the risk of them infecting others, according to the definition provided by the Centers for Disease Control and Prevention, Quarantine, and isolation, 2017.

Yet, I was soon to learn the real meaning of quarantine and isolation during the COVID-19 pandemic.

I had taken two years leave from working in community mental health to accompany my husband on a posting in Malaysia. No sooner had we arrived in Malaysia and settled into a new rhythm of life, COVID-19 struck.

## **MARCH 2020**

### ***Home quarantine one – 14 days in my oldest son’s garden flat***

I experienced my first quarantine/confinement when returning to Australia. The time in confinement dragged. I love exercise, so it was hard for my mental health to be confined to a small space. Fortunately, I was able to enjoy the garden

during the day, for which I was very grateful. I was well looked after by my family and friends, regular yoga, puzzling, knitting, and reading. As Malaysia had closed its borders, there was no indication that I would return any time soon, so post-quarantine I returned to my role working in community mental health.

## **SEPTEMBER 2020**

### ***Quarantine two – 14 days Kuala Lumpur (KL)***

I returned to Malaysia and in order to do so, there was much paperwork required, both from the Australian and Malaysian governments. The airport’s processes at KL were confusing, and after six hours of being “processed” we arrived at an unspecified hotel in the centre of KL. We were escorted to a very small room which was very claustrophobic. This experience of quarantine was vastly different from my first. Not only was I in unfamiliar territory, but I was also unsure of the exact quarantine process mostly due to the language and cultural barriers. I felt vulnerable and

isolated, especially once the door was closed. I was grateful to have met a fellow Australian while travelling back to Malaysia and she was in a room down the corridor from me. We did daily exercise challenges using water bottles as hand weights. We also did daily ‘welfare checks’ on each other. I was concerned about her as she was a diabetic with an insulin pump. She had unwittingly been placed on a high carbohydrate diet in the hotel, and consequently, she was experiencing nightly drops in her blood sugar. I suggested she contact her endocrinologist in Malaysia for advice and she was able to recalibrate her pump over the phone with his guidance.

The next nine months living in Malaysia were spent in several different phases of lockdown. This experience left my husband and I COVID-19 fatigued.

We were lucky to be provided an opportunity to return home to Australia in June 2021 for the birth of our second grandchild. We both felt really grateful as we understood how difficult it has been for many people living overseas with no ability to return home at all.

**JUNE 2021****Quarantine three –  
Australian hotel “with hubby”**

My third 14-day quarantine experience was completely different to my previous two. Not only was I able to share it with my husband, but we also had time to prepare both mentally and physically for what was to come. We hired fitness equipment, attended classes run and paid for by the hotel, practised daily yoga, and my husband worked while I studied and crafted. We were also lucky enough to have a large living area, a balcony for fresh air and sunshine, and familiar food. I know very well that my third quarantine experience was not what many others experienced. Very few hotels have balconies, the quality of food among the various hotels used for quarantine differed tremendously, and depending on when and where you quarantined, access to training equipment was limited. The most important aspect for me was a daily welfare check.

We considered ourselves very fortunate during this period. That said, we were naturally grateful when released to feel the cold winter air and sunshine on our faces. This was one day prior to the Delta virus spread in NSW that started in Bondi and was still going at the time of writing this article (mid-September 2021). We left Sydney as quickly as possible, Canberra and family bound.

By the time I left Australia in late August 2021, the virus had taken a firm hold in many communities of NSW. Canberra was also in its first week of lockdown. I was travelling solo this time as my husband had returned to work the month prior. I felt very anxious about the journey to Malaysia, the impending fourth quarantine; and leaving my family.

**AUGUST/SEPTEMBER 2021****Quarantine four – Kuala Lumpur**

My fourth quarantine experience was different again as this time my husband and I were able to identify our preferred quarantine hotel from a list provided by the Malaysian government. I used the same hotel my husband had stayed at on his return as he had reported a generally positive experience.

On arrival in the airport, it only took about four hours to be processed, however, due to the number of people being processed, and the heightened sense of concern relating to the Delta variant, it proved to be a very stressful experience. When I finally reached my quarantine hotel room, I was pleased to find I had a big window overlooking a pond and lush greenery. My cleaning process began; bagging of travelling clothes (to be washed later), showering, wiping switches and surfaces with antibacterial wipes, and unpacking.

Having done this a few times, I was well prepared: coffee bags, healthy snacks, muesli, a teapot; and loose-leaf tea (it's the small things that count), yoga mat, skipping rope, yarn, books, puzzle, watercolor paint, and paper. My luggage was nearly entirely full of quarantine entertainment. From my previous experiences I had learnt that a daily balanced routine of exercise, communication, relaxation, brain stimulation and creative pursuits is essential for sustaining a positive mental outlook during long periods of isolation. What I hadn't planned or prepared for was being tested positive for COVID-19 the day before I was due to be released!

**SEPTEMBER 2021****Quarantine five (Extension of fourth)**

Testing positive to COVID-19 was a shock. I was swabbed on Monday morning, and I received a text on Wednesday morning stating I had tested positive to COVID-19. At first, I thought it was spam, but after a phone call to the hotel front desk and the subsequent transfer to the medical team, it was confirmed. I was directed to pack up as I would be transferred to another hotel the next day for a further 10 days of quarantine.

I cried a lot that day. I reached out to family and friends who provided the positive support I needed to get through the next 24 hours. Thankfully I received my second vaccine shot in early August so my symptoms, whilst mostly gastrointestinal-related, were minimal. And thankfully due to being a mental health nurse and reading widely, I supported my own mental health through staying connected, focusing on positives, and maintaining my daily routine.

This was a very challenging life experience as I confronted my own feelings of shame around the stigma of contracting the virus, a different health system, a language barrier, along with fear and isolation. I am safely home now (in Malaysia) and have been researching the impacts of quarantine and isolation on mental health which are many and varied and should not be taken lightly. So, it should go without saying that I am not keen for another quarantine, nor to be the quarantine queen.

**Author**

*Cate Mabey is a registered nurse who has worked in a variety of public health nursing roles. She has worked as a policy officer in Federal Health and has completed post-graduate studies in mental health where she took on a mental health nursing role in ACT Health. Currently, she is undertaking a 'sabbatical' while accompanying her husband on an overseas posting to Malaysia.*





EDUCATION

PART 2

## Intensive clinical skills Bootcamps for final year nursing students

By Monica Peddle and Jen Austerberry

Traditionally undergraduate nursing students receive education regarding the theoretical and practical aspects of nursing before attending clinical placement. However, COVID-19 caused interruptions to clinical preparation for nursing students with physical restrictions necessitating that only essential clinical skill sessions were facilitated face to face.

All other learning related to clinical care was directed to be facilitated online using synchronous and asynchronous approaches. Additionally, many students had interrupted clinical placements during 2020. Consequently, second-year nursing students entered third-year with a less than ideal preparation resulting in a potential deficit in clinical confidence, clinical reasoning, fundamental health assessments and technical and non-technical skills.

The clinical settings that undergraduate nursing students enter are characterised by high acuity patients with short stays, high workloads and complex systems and processes.<sup>1</sup> To support students to develop the clinical competence required, intensive clinical skills training programs are suggested to be effective in senior students.<sup>2</sup> Additionally, these programs can provide evidence to clinical partners of student's ability to provide safe care.<sup>3</sup> However, there are dissenting views on the value of intensive clinical skills training programs. Some authors indicate no statistical difference with untrained peers,<sup>4</sup> and others proposing that intensive clinical skills training is required to ensure satisfactory learning experiences.<sup>5</sup> Therefore, to address the deficits in student preparation for practice and investigate the influence of intensive clinical skills training on the ability of senior nursing students to provide acute care, an intensive clinical skills Bootcamp was implemented before the commencement of year three subjects.



The Bootcamp program was determined by input from academic staff and clinical partners to support theory and technical and non-technical skills revision and development. The teaching and learning activities were designed to be interactive, experiential, and informative. Small groups of up to eight students rotated through a series of clinical skills stations and simulation experiences, with each group supported by an academic facilitator. An ethically approved mixed methods study is underway to explore the impact of this intensive clinical skills Bootcamp on the self-reported perception of nursing students of their ability to provide care in acute situations.

Preliminary data suggest that the intensive clinical skills Bootcamp enabled students to review, consolidate and reinforce technical skills. "It reinforced our learning and helped consolidate all the theory parts which we got last year" with the practical (FG1P1). Other students reported that the opportunity to be 'put on the spot' in immersive simulation and 'to think about that one patient' was effective. "I feel more confident than when I came in here this morning" (FG1P2). Feedback from industry partners indicated the Bootcamp had a discernible impact on the student preparation for practice for those students who attended.

Investigations of educational innovations that promote competence in clinical practice and maintains patient safety in clinical practice will provide tangible benefits. These benefits not only impact study participants but also to curriculum designers, program accreditation bodies and potentially the wider society from improved healthcare outcomes.

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### References

1. Sterner A, Säfström E, Palmér L, Ramstrand N, Hagiwara MA. Development and initial validation of an instrument to measure novice nurses' perceived ability to provide care in acute situations-PCAS. *BMC nursing*. 2020 Dec;19(1):1-9.
2. Park S. Effects of an intensive clinical skills course on senior nursing students' self-confidence and clinical competence: A quasi-experimental post-test study. *Nurse Education Today*. 2018 Feb 1;61:182-6.
3. Hinton A, Chirgwin S. Nursing education: reducing reality shock for graduate Indigenous nurses - It's all about time. *Australian Journal of Advanced Nursing, The*. 2010 Sep;28(1):60-6.
4. Chan ZC, Cheng WY, Fong MK, Fung YS, Ki YM, Li YL, Wong HT, Wong TL, Tsoi WF. Curriculum design and attrition among undergraduate nursing students: A systematic review. *Nurse Education Today*. 2019 Mar 1;74:41-53.
5. Barnard A, Owen C, Tyson A, Martin S. Maximising student preparation for clinical teaching placements. *The Clinical Teacher*. 2011 Jun;8(2):88-92.



## Riding the wave to reduce the theoretical and practical divide

By Suzy Bowdler, Tracey Moroney, Shahla Meedya and Wendy Nielsen

Nursing graduates have identified a divide between their education's theoretical and clinical components, making them feel unprepared for their transition into clinical practice.<sup>1,2</sup>

Nursing students are unique because, demographically, they range from school leavers to mature-age students with varied life experiences. Personal experiences ground learning and thus, from which undergraduate nursing education is built. It is important nurse educators recognise this when creating curriculum to develop nursing students' learning.

Legitimation Code Theory (LCT) is a practical framework that recognises knowledge as its own entity and a relatively new framework. It can analyse educational practices<sup>3</sup> but only rarely in nursing.<sup>4</sup> Importantly, LCT recognises the learner's previous knowledge and experiences.<sup>3-5</sup> Among the dimensions of LCT,<sup>3</sup> semantics can guide curriculum design for nursing education.<sup>4,5</sup>

Semantics focuses on meanings specified in the language used.<sup>3-5</sup> There are two components of the semantics dimension: semantic gravity is the context-dependence of the language, whilst semantic density refers to the complexity of the language used.<sup>3-5</sup>

Cumulative knowledge development occurs when existing knowledge is recognised. Learners are moved through learning activities that become increasingly abstract to build contextualised meanings and use increasingly technical language such as medical terminology compared to 'everyday' language.<sup>3-5</sup> These knowledge-building moves can be profiled on a Cartesian plane in a semantic profile.

Increasing or decreasing the waving pattern of the semantic profile moves the learner up or down levels of complexity. Ideally, both semantic density and semantic gravity 'wave' on the Cartesian axes.<sup>3-5</sup> Achieving this 'semantic wave' pattern is the aim of a content module for nursing students in the current curriculum project.

The waving semantic profile deliberately moves students between their prior conceptions and experience to connect to explicit technical knowledge to reduce the gap between personal and field-based knowledge. So, the new knowledge is contextualised as the learner creates new understandings that build on practical application of the knowledge.

Nursing education has traditionally taught theoretical and practical knowledge

separately,<sup>1</sup> and we hypothesise this contributes to the gap students currently identify. In other fields, such as engineering, curriculum design that builds semantic waves has helped students move productively from the laboratory setting into practical work.<sup>4</sup>

Our work aims to develop similar transferable knowledge between theory and clinical practice for nursing students.

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### References

1. Scully N. The theory-practice gap and skill acquisition: An issue for nursing education. *Collegian*. 2011; 18(2):93-98.
2. Monaghan T. A critical analysis of the literature and theoretical perspectives on theory-practice gap amongst newly qualified nurses within the United Kingdom. *Nurse Education Today*. 2015; 35(8):e1-e7.
3. Maton K. *Knowledge & Knowers*. Routledge: Taylor and Francis; 2013.
4. Maton K. Semantic waves: Context, complexity and academic discourse. In: Martin J, Maton K, Doran Y, ed. *Accessing academic discourse: Systemic functional linguistics and legitimation code theory*. Routledge: Taylor and Francis; 2020. p. 59-82.
5. Maton K. Cumulative and segmented learning: exploring the role of curriculum structures in knowledge-building. *British Journal of Sociology of Education*. 2009; 30(1):43-57.



## A collaborative care project during COVID-19 sets a new standard of care for children with medical complexity, tracheostomies and mechanical ventilation

By Beckie Petulla, Dominique Spork, Jessica Gleeson, Aoife Hyland and Emma Sov

Children living in regional NSW with medical complexity face challenges in access to healthcare.

Due to the COVID-19 pandemic, these challenges were compounded for children requiring tracheostomies and mechanical ventilation because of the potential for increased risk of aerosolisation and SARS-CoV2 transmission.

This challenged healthcare providers to review current models of care and redefine how healthcare is delivered. Improving equitable access to appropriate care for children with medical complexity requiring tracheostomies and mechanical ventilation supports care closer to home, improves outcomes for patients, their families and the healthcare services supporting them.

The objective of this paper is to share the experiences associated with the delivery of a Collaborative Care Project between Sydney Children's Hospital (SCH)–Randwick – a part of the Sydney Children's Hospitals Network and rural health services within Western New South Wales Local Health District (WNSWLHD) during the COVID-19 pandemic.

The key outcomes of this project include:

- effective utilisation of a multi-disciplinary team at a local and tertiary level;
- halving the length of stay in a tertiary hospital for tracheostomy and ventilator-dependent patients; and
- upskilling local teams to allow children living in regional NSW to receive appropriate and well-supported care closer to home.



The Collaborative Care Project began with a series of virtual case conferences between SCH, WNSWLHD, Primary Healthcare Networks and non-government organisations to identify needs and priorities for the patient, gaps in service resources and abilities, shared care planning to lead, support, and increase communication, decision-making and integrated care.

To facilitate a smooth transition from SCH to WNSWLHD, a core clinical team comprised of Clinical Nurse Consultants/Specialists from both Local Health Districts (LHD) and a Senior Respiratory Physiotherapist developed a series of education workshops combined with simulation labs and practical training.

Complex airway and ventilation education and training were provided for 118 clinical and support staff from WNSWLHD, Primary Healthcare Networks, NSW Ambulance and non-government organisations.

The education aimed to support and increase local capacity to provide safe, accessible and timely care in regional NSW. The Collaborative Care Project promoted empowerment and confidence among attendees, providing an opportunity for skills acquisition, improved clinical knowledge, and gained experience to manage this cohort of patients better.

This Collaborative Care Project has set a new standard of care for children with medical complexity that is modifiable and not limited to children with medical complexities and tracheostomies.

The Collaborative Care Project has changed how service delivery for children requiring tracheostomies and/or mechanical ventilation is approached. For patients living in regional NSW with medical complexity, appropriate care cannot be determined by one site or LHD. By partnering together, improved access to appropriate care can be achieved. This project supported care closer to home for a complex patient resulting in improved outcomes and an overall decreased length of stay during the COVID-19 pandemic and with sustainable resources can be replicated in the future for other children.

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## Professional Portfolios

By Lisa-Kim Wright

**I am a nurse educator in a tertiary healthcare facility with Magnet® designation.<sup>1</sup> This status is acknowledged as the gold standard for nursing excellence, translating to quality patient care.<sup>2</sup>**

The organisation has established a professional development program for nurses/midwives supporting Magnet accreditation and lifelong learning. The program assists nurses and midwives in developing professional portfolios. There are also similar programs in America and New Zealand.<sup>3,4</sup>

Professional portfolios are organised proof that clinicians align with professional standards and indicate the professional's vision of future growth and capacity building.<sup>5(p3)</sup> Successful completion of a program supported portfolio showcases nursing/midwifery expertise and evidenced professional competence to practice.

The basic level portfolio includes curriculum vitae; Australian Health Practitioner Regulation Agency (AHPRA) registration<sup>6</sup>; role description; continuing professional development (CPD) activities; personal professional philosophy; annual performance review and demonstrating how the Nursing and Midwifery Board of Australia (NMBA) professional standards<sup>7</sup> are met.

For those who have completed postgraduate study and/or are involved in research, quality initiatives, and teaching, there are advanced levels of 'proficient' and 'expert' and where writing to the NMBA standards requires an organisational and leadership viewpoint.

Initial attendance at a workshop provides an overview of the program and revises professional registration evidential and legislative responsibilities. The program allows access to an electronic log to record CPD activities that meet AHPRA audit standard.

My role includes helping attendees update, develop and curate their documents, with guidance for writing to the NMBA standards. A key aspect of the portfolio is specific examples to demonstrate how the standards are met. They can be identified by discussing their day-to-day professional work and then reflecting on the experience. My involvement with the nurses/midwives as they debate their practice has highlighted that this evokes explicit recognition of how their skill, knowledge and attitude substantially influence patient outcomes and, importantly, how they affect the interactions with colleagues and the patient/family experience of healthcare.

Nurses/midwives represent more than half of the Australian healthcare workforce<sup>8</sup> and are thus pivotal in the standard of care. This human service industry relies on nurses/midwives to maintain competency, be proactive with learning opportunities, positive with change initiatives, provide contemporary patient/family centred care, work effectively with colleagues, and manage their own wellbeing to optimise sustainable healthcare.

Program completion confirms that nurses/midwives meet their practice requirements, but the true merit lies in the reflection process. Deliberate thinking about practice offers a strategy to limit unconscious task focussed actions and encourages a more mindful discerning approach, promoting job satisfaction, intentional planning of professional development, and encourages collaborative care as appreciation of alternative perspectives, both of colleagues and clients is forefront.<sup>9,10</sup>

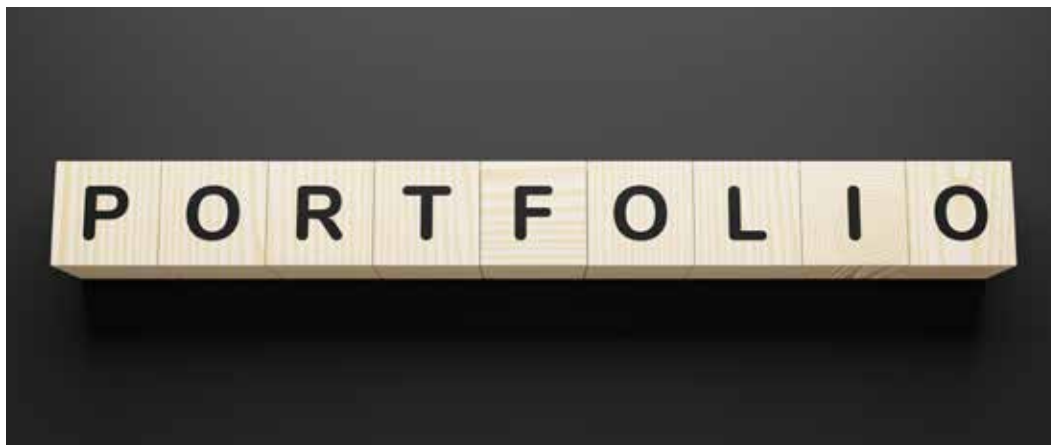
As the role of nurses/midwives continues to evolve with the increasing scope of practice, developing a portfolio offers a structure for ongoing education and training with the ability to reflect, an educational imperative.<sup>10</sup> The stories they share and their insightful comments are humbling and make one proud to be a member of these trusted professions.

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### References

1. American Nurses Credentialing Center [Internet]. [place unknown]: ANCC; [date unknown]. Magnet Recognition Program®; [cited 2021 Jun 26]. Available from: [nursingworld.org/organizational-programs/magnet](http://nursingworld.org/organizational-programs/magnet).
2. Rodríguez-García MC, Márquez-Hernández VV, Belmonte-García T, Gutiérrez-Puertas L, Granados-Gómez G. Original Research: How Magnet hospital status affects nurses, patients, and organizations: A systematic review. *Am J Nurs*. [Internet]. 2020 Jul [cited 2021 Jun 27]; 120(7):28-38. Available from [pubmed.ncbi.nlm.nih.gov/32541337](http://pubmed.ncbi.nlm.nih.gov/32541337) DOI:10.1097/01.NA.0000681648.48249.16
3. Burket TL, Felmler M, Greider PJ, Hippensteel DM, Rohrer EA, Shay ML. Clinical ladder program evolution: journey from novice to expert to enhancing outcomes. *J Contin Educ Nurs* [Internet]. 2010 Aug [cited 2021 Jun 27]; 41(8):369-374. Available from: [pubmed.ncbi.nlm.nih.gov/20506926/](http://pubmed.ncbi.nlm.nih.gov/20506926/) DOI:10.3928/00220124-20100503-07
4. Nursing Council of New Zealand [Internet]. Wellington. NCNZ [date unknown] Nursing PDRPs [cited 2021 Jul 4]. Available from: [nursingcouncil.org.nz/Public/Nursing/PDRPs/NCNZ/nursing-section/PDRPs.aspx?hkey=3d8d3ab7-5ff4-46c6-a0ef-aea67738249](http://nursingcouncil.org.nz/Public/Nursing/PDRPs/NCNZ/nursing-section/PDRPs.aspx?hkey=3d8d3ab7-5ff4-46c6-a0ef-aea67738249)
5. Cusack L, Smith M. Portfolios for nursing, midwifery and other health professions. 4<sup>th</sup> ed. Australia: Elsevier; 2020. 23 p.
6. Australian Health Practitioner Regulation Agency [Internet]. Melbourne VIC: AHPRA [date unknown]. Registration; updated 2020 Nov 27 [cited 2021 Jun 26]. Available from: [ahpra.gov.au/Registration.aspx](http://ahpra.gov.au/Registration.aspx)
7. Nursing and Midwifery Board of Australia [Internet]. Melbourne VIC: NMBA [date unknown]. *Professional Standards*; 2016 Jun 1 [cited 2021 Jun 27]. Available from: [nursingmidwiferyboard.gov.au/Codes-Guide/lines-Statements/professional-standards.aspx](http://nursingmidwiferyboard.gov.au/Codes-Guide/lines-Statements/professional-standards.aspx)
8. Australian Institute of Health and Welfare. [Internet]. Canberra: AIHW; 1987. Nursing and midwifery workforce 2015; 2017 Aug 17 [cited 2021 Jun 26]. Available from: [aihw.gov.au/workforce/nursing-and-midwifery-workforce-2015/contents/who-are-nurses-and-midwives](http://aihw.gov.au/workforce/nursing-and-midwifery-workforce-2015/contents/who-are-nurses-and-midwives)
9. Cioffi JM. Insight and discovery in clinical nursing practice. *Collegian* [Internet]. 2017 Apr [cited 2021 Jun 27]; 24(2):191-6. Available from: [doi.org/10.1016/j.collegn.2015.10.004](http://doi.org/10.1016/j.collegn.2015.10.004)
10. Miraglia R, Asselin ME. Reflection as an educational strategy in nursing professional development. *J Nurses Prof Dev* [Internet]. 2015 Mar-Apr [cited Jun 27]; 31(2):62-72. Available from: [pubmed.ncbi.nlm.nih.gov/25790356](http://pubmed.ncbi.nlm.nih.gov/25790356) DOI:10.1097/NND.0000000000000151



## Professional portfolio development: Personally and professionally rewarding and satisfying

By Narelle Biedermann, Tracey Ahern and Helena Harrison

In Australia, registration and professional practice standards require nurses to maintain capability for practice and demonstrate continuing professional development (CPD).<sup>1-2</sup>

Engaging in CPD assists nurses to maintain standards for practice and fosters a lifelong approach to learning.<sup>3</sup> Relevant CPD can increase confidence, capabilities and reduce work-related anxiety, resulting in higher standards of practice, continuous quality improvement and improved patient care.<sup>3</sup> When focused on career aspirations, CPD boosts career progression.<sup>4</sup> While nurses are motivated to engage in CPD, a key challenge is having a structured process to document outcomes to demonstrate competence that reflect standards for practice and recognition for CPD activities.<sup>3</sup>

In 2017, JCU Nursing and Midwifery created an online Master of Nursing course with three majors: Leadership and Management, Education, and Advanced Practice. A core subject in the courses focuses on developing a professional portfolio. Built on Cusack and Smith's approach to portfolio development,<sup>3</sup> this unique subject encourages students to apply knowledge and practical techniques to create a reflective portfolio they can adapt to meet their professional needs. Using a purposefully designed portfolio framework and customised templates, students are encouraged to reflect on their professional practice and document how they meet their standards for practice. Students are guided to identify and record CPD activities to demonstrate learning and development and produce evidence to validate learning and practice outcomes. Through this process, students understand the type and quality of evidence needed to effectively demonstrate their learning and performance. As a result, students compile quality evidence of both the process and products of their learning and practice – how they learn and develop and their outcomes.<sup>3-4</sup>

While the subject is challenging, students describe the outcome as personally and professionally rewarding. Students



Image design: Helena Harrison

recognise a well-structured portfolio supported with reflective practice facilitates regular engagement in learning and development and provides a means to document professional competence. Students frequently express the value of structured reflection and CPD to their professional practice and pride in their career achievements. Students report how they used their portfolio as part of registration audits, successful job applications and promotions, and annual performance development plans. Graduates shared their motivation to continue to set personal and professional career goals. One graduate explained that they would never have dreamed of achieving a higher leadership position without learning the value of habitually undertaking, reflecting on, and documenting CPD in their professional portfolio.

A well-structured professional portfolio fosters a commitment to lifelong learning and supports nurses and midwives in maintaining standards for practice, meeting CPD obligations, and achieving career aspirations. The benefits of offering a subject that cultivates an understanding of the value of a professional portfolio to practice and the methods to develop and maintain an effective professional portfolio are limitless.

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**Conflict of interest:** All authors are employees of the university offering the

subject within a suite of nursing and midwifery degree programs. The authors report no other conflict of interest.

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### References

1. Nursing and Midwifery Board of Australia. Professional standards. NMBA. 2021. Accessed July 04, 2021. [nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx](https://nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx)
2. Nursing and Midwifery Board of Australia. Registration standard: Continuing professional development. 2016. NMBA. Accessed July 04, 2021. [nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx](https://nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx)
3. Cusack L, Smith M. *Portfolios for nursing, midwifery and other health professions*. 4th ed. Elsevier; 2020.
4. Mlambo M, Silén C, McGrath C. Lifelong learning and nurses' continuing professional development, a metasynthesis of the literature. *BMC nursing*, 2021; 20(1) Article 62: 1-13. doi. org/10.1186/s12912-021-00579-2

**Message Stick: Safe sleep education with Aboriginal families in SA – sharing knowledge in the community**

**By Nina Sivertsen, Tahlia Johnson, Wilhelmine Lieberwirth, Anna Dowling, Sharon Watts and Julian Grant**

**Healthcare professionals are continually challenged by the need to provide health information that successfully changes health practices<sup>1</sup>.**

University nursing and midwifery tertiary education include preparing graduates to undertake patient and family education within their nursing role, and healthcare professionals provide safe sleep education to numerous families in their daily clinical practice.

This is an important part of person and family centred care.<sup>2</sup> Yet how mainstream health personnel connect with Aboriginal families in their care around this important issue is unclear. Nurses often provide

this support, but how nurses facilitate each patient’s and their family’s learning seems invisible in the nursing literature<sup>2</sup>. Important to note is that the health system currently provides no safe sleep space alternative for Aboriginal families that recognise cultural practices of co-sleeping and closeness to baby<sup>3</sup>.

This is a story about safe sleep education and how to translate safe sleep messages into the community. The story is part of the *Safely Sleeping Aboriginal Babies in SA – Doing it Together*, where families enrolled in a safe sleep program that provides Aboriginal families with safe sleep education and a Pepi-Pod®. This plastic box acts as a separate sleep space and surface and enables co-sleeping. The families who found the Pepi-Pod® and sleep education useful expressed that they want more families to know about safe sleep education. Families said they want to share the safe sleep education message with other families to keep Aboriginal babies safe while sleeping.

Overall the project includes an education blitz around safe sleep messaging, counting 235 healthcare professionals. Of the 70 families enrolled who were eligible to participate, 44 families fully completed the program, as 26 families were unable to be contacted for follow up.

Aboriginal community researchers have been driving the Pepi-Pods® into the community. This included delivering the Pepi-Pod® and, importantly, the safe sleep education. Many of the 44 families mentioned the impact of the individual and personal safe sleep education session with the Aboriginal community researchers. Families found the education to be personalised and easy to understand and put into practice.

As part of the safe sleep education, visual tools were used to help our research team communicate the importance of safely sleeping their babies. Within these tools includes a small plastic tube to signify an airway. A significant number of families who provided feedback on the education program all spoke about the tube and how it gave them a visual image of why a flat, safe space for babies to sleep is so important. Results from the education blitz for health professionals also identified that health professional knowledge was relatively low relating to what makes a baby’s head and airway at risk of SUDI. Focussing on the air tube may offer a way forward for safe sleep messaging.

Many participants commented in follow-up interviews that they felt confident passing their pods on to other family and friends having a baby and making sure to



Community researchers working with the Pepi-Pod® program Sharon Watts and Anna Dowling (pictured), Wilhelmine Lieberwirth and Tahlia Johnson (not in picture). Photo by Nina Sivertsen

forward the safe sleep education they received from our Aboriginal community researchers. Reciprocity is an important aspect of Aboriginal cultures, and in this instance, safe sleep education was passed on like a message stick.

This project has contributed to increased knowledge of safe sleep practices amongst Aboriginal families in SA and highlighted the role Aboriginal families play in translating safe sleep education in the community. The research team hopes the findings contribute to the Pepi-Pod® program and that safe sleep education will become standard practice within SA Health following the translation period. What is clear is that as a health system, we need to think about alternative designs for safe sleep education settings/sessions for Aboriginal families.

The project has now concluded data collection and sharing, and translating the findings of the overall project is in progress, with results being written up for publication.

**Acknowledgements:** This project is funded by a Medical Research Future Fund and consist of a diverse research team including research partners: SA Health, Women’s and Children’s Health Network, Child and Family Health Services and Aboriginal Health Council SA, and industry partners: Country Health SA (Port Augusta and Whyalla), Northern Adelaide Local Health Network (Lyell McEwin Hospital), Women’s and Children’s Hospital specifically the Aboriginal Family Birthing Program, and Nunkuwarrin Yunti.

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**References**

- Middlemiss W, Brownstein NC, Nelson SP, Manchiraju S, Leddy M, Steliotes N, Grzywacz JG. Crafting effective messages to enhance safe infant sleep. *Journal of the American Association of Nurse Practitioners*. 2021 Jun 1;33(6):441-50.
- Thompson DL, May EJ, Leach M, Smith CP, Fereday J. The invisible nature of learning: Patient education in nursing. *Collegian*. 2021 Jun 1;28(3):341-5.
- Grant J, Sivertsen N, Deverix J, Steeb A. 'It looks like a breadbox': a pilot study investigating implementation of the Pepi-Pod® program with Aboriginal families in metropolitan South Australia. *Primary Health Care Research & Development*. 2021;22.



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**Think Globally, Act Locally: The SDGs as a framework to futureproof nursing**

By Lorraine Fields, Bonnie Amelia Dean, Stephanie Perkiss and Tracey Moroney

Recent global and local concerns have had a significant impact on society. COVID-19 has shown the global reality of widespread inequality and the importance of ensuring that universal health coverage leaves no one behind.

Closer to home, the devastating Australian bushfires revealed climate change’s impact on the environment and society. Furthermore, the Australian media revealed allegations of sexual misconduct against women at the country’s highest leadership levels, demonstrating that we are far from achieving gender equality.

While it may not be immediately apparent, these issues impact health and pose complex challenges for the nursing profession. The Sustainable Development Goals (SDGs) adopted by the United Nations

(UN) General Assembly in 2015 offer a blueprint for education and action<sup>1</sup> that addresses each of these challenges.

Nurse educators have a responsibility to ensure that future generations of nurses are aware of the complexities that lie ahead and are equipped for the future of healthcare.<sup>2(p264)</sup>

Using the SDGs as a framework for education and to help understand present and emergent challenges provides an opportunity of ensuring a prepared workforce of nurses as “change agents”,<sup>3(p650)</sup> that can take action toward the SDGs. The UN acknowledges that the achievement of the SDGs requires significant societal transformation,<sup>1</sup> and nursing curriculum needs to reflect this change.

Traditional teaching methods, such as didactic lectures, will not create the transformation students require to recognise themselves as leaders of change in issues such as universal health coverage, inequality, climate change and gender equality.<sup>4(p3)</sup>

Instead, the nursing curriculum should be constructively aligned to the SDGs, whereby learning outcomes, content, and assessments reflect sustainability. The SDGs offer a vehicle for education and creating transformational change through raising awareness on a range of local and global challenges. This may empower future nurses to take sustainable action to make

a difference within their workplace and in their local communities. In turn, these small actions may lead to a culture of change across the nursing profession and, when compounded, can contribute to larger systemic issues creating significant global impact.

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**References**

1. United Nations (2015) The sustainable development agenda [un.org/sustainabledevelopment/development-agenda/](http://un.org/sustainabledevelopment/development-agenda/) Accessed: June 2021
2. Collins, E., Ross, J., Crawley, J. and Thompson, R. 2018. An undergraduate educational model for developing sustainable nursing practice: A New Zealand perspective. *Nurse Education Today*, 61: 264-268.
3. Upvall, M. J. and Luzincourt, G. 2019. Global citizens, healthy communities: Integrating the sustainable development goals into the nursing curriculum. *Nursing Outlook*, 67(6): 649-657.
4. Melling, A. and Pilkington, R. 2018. *Paulo Freire and transformative education: Changing lives and transforming communities*. UK: Palgrave Macmillan.



## Bring in the 'RUSOM'

By Linda Sweet, Susan Sweeney, Vidanka Vasilevski, Wendy Watson and Shane Crowe

What is a RUSOM, you ask? Well, RUSOM stands for a Registered Undergraduate Student of Midwifery and is a new employment role at Western Health, Melbourne; the first health service in Victoria to trial this new role.

Fourteen RUSOMs from three different universities, currently completing either a four-year dual nursing and midwifery degree or a three-year midwifery only degree, have been employed to provide care in the postnatal wards.

The RUSOMs are in their final year of study and are provided leave and flexible rostering to attend their university commitments.

A RUSOM supports the work of registered midwives by providing basic care to women and their newborns and conducting associated tasks.

Each RUSOM is supervised by a registered midwife responsible and accountable for the tasks delegated to them.<sup>1</sup> The RUSOM role has clear guidelines for activities. These include providing direct care such as assisting hygiene including baby baths, providing nutrition assistance including breastfeeding support, mobility assistance, safe environment maintenance and restocking, answering call bells, some basic documentation and offering general support and education to women and their families.

Evidence from pilots in Victorian hospital settings suggested that Registered Undergraduate Students of Nursing (RUSON) were well received by staff and patients, and the implementation of their roles was associated with reduced overtime and agency costs.<sup>2</sup>

Furthermore, they worked effectively within their scope of practice, promoted satisfaction of their nursing colleagues, improved the quality of patient care, and their presence on wards were associated with reduced incidences of patient falls.<sup>3</sup>

The benefits of the role for the RUSON themselves have also been outlined,<sup>4</sup> finding that having such a role allowed them to feel part of the hospital team, have direct involvement in patient care, and make a real impact with their work. They also reported a greater sense of autonomy, opportunities to develop critical thinking skills, and enhanced confidence and mastery in basic nursing skills. We anticipate similar outcomes from the RUSOM trial. The RUSOM role may also benefit the student as they promote the development of clinical skills by immersion in the clinical environment and direct exposure to the workforce builds skills for work readiness upon graduation.<sup>5</sup> The RUSOM role can also provide a means for financial support while studying<sup>1</sup>.



RUSOM Claire Youren says: "Being a RUSOM has allowed me to gain a deeper understanding of the role midwives have in providing woman-centred care."

The RUSOM health assistant role was developed to support the healthcare system and alleviate midwifery workforce shortages.<sup>6</sup> Our objectives were to:

- increase quality of care to women and babies;
- improve the working lives of our midwives;
- increase midwife satisfaction;
- staff our wards to proactively meet changing demands, and attract the best midwifery students to Western Health; and
- complement the students' undergraduate experience and ideally retain them as graduates.

An extensive mixed-methods evaluation is currently underway with positive preliminary results. For example, all the RUSOMs that responded to a recent survey (n=12) said they found the role stimulating, enjoyable, and felt respected as a valuable team member. One RUSOM commented, "I just love the RUSOM role. It is actually a midwifery student's dream come true". Midwives that responded to a recent survey (n=74) were overwhelmingly positive about the RUSOM role, and 95% said they had increased satisfaction with their work because of the RUSOM introduction, and 97% felt RUSOMs be valued members of the team. One midwife explained, "RUSOM are a great support to our midwives and the team. Their help is so valuable to our women, midwives, and for their own development."

The RUSOM role is a valuable adjunct in the provision of midwifery care and education at Western Health. With forecasted midwifery workforce shortages and increased maternity service demands, is it time to 'bring in the RUSOM?'

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### References

1. Australian Nursing and Midwifery Federation. RUSON employment model. [anmfvc.asn.au/ruson](http://anmfvc.asn.au/ruson) (2020, accessed 14 May 2020).
2. Department of Health. *Evaluation of three Better Skills Best Care pilot projects*. 2011. Victoria: Department of Health Victoria.
3. Department of Health and Human Services. *Health Assistants in Nursing*. 2015. Victoria: Department of Health and Human Services.
4. Algoos M and Peters K. The experiences of undergraduate Assistants in Nursing (AIN). *Nurse Education Today* 2012; 32: 197-202.
5. Hasson F, McKenna HP and Keeney S. A qualitative study exploring the impact of student nurses working part-time as a health care assistant. *Nurse Education Today* 2013; 33: 873-879. Research Support, Non-U.S. Gov't.
6. Department of Health and Human Services. *Registered undergraduate student of nursing (RUSON): Employment and implementation guide*. 2020. Victoria: Health and Human Services.

## Using appreciative inquiry approaches to support newly qualified midwives during early transition-to-practice

By Samantha Nolan

In this article, 'NQM' will be used to describe a newly qualified midwife in their first year of practice, rather than the commonly used Australian term 'new grad'.

The described approaches have relevance regardless of initial employment within a hospital-based 'graduate program' or autonomous primary healthcare context.

International recognition that early-career midwives often leave due to role dissatisfaction,<sup>1,2</sup> highlights the importance of exploring supportive strategies during their transition to professional practice.

NQMs are known to be vulnerable to high levels of workplace stress and anxiety,<sup>3,4</sup> possibly exacerbated by unrealistic role expectations, a perceived theory-practice divide, excessive

workload demands or the need to adapt to new social identities and institutional norms.<sup>5-7</sup>

Monthly Forums (accessed online or face-to-face) incorporating appreciative inquiry (AI) approaches, recently introduced into a QLD tertiary-hospital transition program to enhance support for NQMs, are being positively evaluated.

AI approaches demonstrate the capacity to strengthen midwifery students' mentorship experiences,<sup>8</sup> leadership attributes and facilitate transformative reflection.<sup>9</sup> At Forums, imagery cards are used to facilitate practitioner reflexivity (examples provided). 'Caring Conversations' and 'The Senses Framework'; strategies developed,<sup>10</sup> refined<sup>11</sup> and used by AI-advocates in varied contexts<sup>9,12-14</sup> are used to demonstrate the benefits of strengths-based approaches, enhance workplace culture and strengthen midwifery identity, communication and collegiality.

Similar approaches are used in 'SERAPHIM – Strengthening Leadership and Preceptorship in Midwifery through education' workshops, part of an industry-university-partner\* collaboration within the same HHS. Evaluations suggest midwives highly value them with varying levels of experience and length of service.

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### References

1. Harvie K, Sidebotham M, Jennifer F. Australian midwives' intentions to leave the profession and the reasons why. *Women and Birth*. 2019;32.
2. Bacchus A, Firth A. What factors affect the emotional well-being of newly qualified midwives in their first year of practice? *MIDIRS Midwifery Digest*. 2017;27(4):444-50.
3. Avis M, Mallik M, Fraser DM. 'Practising under your own Pin'- a description of the transition experiences of newly qualified midwives. *Journal of Nursing Management*. 2013;21(8):1061-71.
4. Fenwick J, Hammond A, Raymond J, Smith R, Gray J, Fourreur M, et al. Surviving, not thriving: A qualitative study of newly qualified midwives' experience of their transition to practice. *Journal of Clinical Nursing*. 2012;21(13-14):2054-63.
5. Kitson-Reynolds E, Cluett E, Le May A. Fairy tale midwifery – fact or fiction: the lived experiences of newly qualified midwives. *British Journal of Midwifery*. 2014;22(9):660-8.
6. Griffiths M, Fenwick J, Carter AG, Sidebotham M, Gamble J. Midwives transition to practice: Expectations and experiences. *Nurse Education in Practice*. 2019;41.
7. Holland P, Tham T, Gill F. What Nurses & Midwives Want: Findings From the National Survey on Workplace Climate and Well-being. Monash Business School, Monash University: Australian Consortium for Research on Employment and Work (ACREW); 2016.
8. Stulz V, Francis L, Pathrose S, Sheehan A, Drayton N. Appreciative inquiry as an intervention to improve nursing and midwifery students transitioning into becoming new graduates: An integrative review. *Nurse Education Today*. 2021;98:104727.
9. Jefford E, Nolan S, Jomeen J, Maier B. Giving midwives a voice – Qualitative perspectives of an 'empowering decision-making workshop'. *Journal of Clinical Nursing*. 2021.
10. Cooperrider D, Whitney D. A Positive Revolution in Change: Appreciative inquiry. in: Cooperrider D, Sorensen P, Whitney J, Yaeger T, editors. *Appreciative inquiry: rethinking human organization towards a positive theory of change*. Champaign, IL: Stipes Publishing LLC; 2000.
11. Dewar B. Appreciative inquiry: The appreciative inquiry process Scotland: My home life Scotland; 2014 [Available from: myhomelife.uws.ac.uk/scotland/what-is-appreciative-inquiry/]
12. Dewar B, MacBride T. Developing caring conversations in care homes: an appreciative inquiry. *Health and Social Care in the Community*. 2017;25(4):1375-86.
13. Taylor C, Mills A, Schmied V, Dahlen H, Shuiringa W, Hudson M. What works to engage young parents into services? Findings from an appreciative inquiry workshop. *Contemporary Nurse*. 2012;42(2):258-71.
14. Jefford E, Nolan S, Munn J, Ebert L. What matters, what is valued and what is important in mentorship through the appreciative inquiry process of co-created knowledge. *Nurse Education Today*. 2021;99(104791).

### PHOTOS REPRESENT IMAGES CHOSEN DURING THE FORUM



"Feeling as though feedback comes from a place of warmth is important, whatever you need encouragement to reflect on comes easier when you feel as though the person truly values and your contribution to the team."



"I felt as though I was sinking, I thought everyone understood that I needed urgent assistance, but they didn't seem to respond as I would have expected which made me doubt myself. It taught me to ensure everyone is absolutely clear about what I need from them."



## It's all in a name: Re-envisioning mandatory training to essential learning - enhancing compliance, engagement, and change

By Elisabeth Black, Hazel Maxwell and Steven Campbell

The National Safety and Quality Health Care Standards (NSQHS) reflect the expectations of the public in ensuring that frontline healthcare workers such as nurses are accountable for their professional practice.<sup>1-2</sup> Despite an overt commitment to their patients, nurses often report that due to competing workplace demands, completing all of their mandatory training obligations within expected timeframes is challenging.<sup>3-10</sup>

The rapidly evolving and complex nature of healthcare services, clinical practices and models of care require an agile approach to learning.<sup>11-12</sup> Nursing workforce design requires that there be a close alignment between the skill, knowledge and expertise of nurses, and the services they deliver.<sup>12-14</sup> By requiring nurses to continue their professional development over time, regulatory bodies ensure nurses are aware of the established link between lifelong learning, continuous improvement, and patient safety.<sup>11,15-17</sup>

Clinical governance systems and standards are put in place to ensure organisations and individuals comply with 'mandatory' learning requirements to maintain public confidence in the healthcare system and its services, and mitigate risks to patients.<sup>1-2,17-20</sup>

This study presents a unique understanding of the factors that influence the ability of nurses and interdisciplinary colleagues to complete their mandatory training obligations in the context of a large teaching hospital in Sydney, Australia.

The participants in this study are from a variety of professions and are representative of the makeup of a contemporary healthcare workforce in Australia. The study explored factors that enable or impede healthcare workers to meet their professional obligations

to complete their mandatory training. A mixed-methods approach was used.

The quantitative component involved training compliance data collected by the organisation. The qualitative component consisted of 22 semi-structured interviews with nurses and other members of the interdisciplinary team, and two focus groups with key informants such as clinical nurse educators, nurse educators and senior nurse managers and executives.

The data from interviews and focus groups reveal the true complexity of the nature of learning, and the requirement for mandatory training that have remained mostly unexplored in this context to date. Motivation to undertake mandatory training is undermined by significant organisational and operational pressures, frustrations, variability in workplace cultures, the participants own personal values, and beliefs about the relevance of their required learning, and their understanding of their professional practice responsibilities and accountability to their patients.

What emerged from the data was a layering of perceptions, beliefs- both professional and personal, values, workplace cultures, and expectations that enhanced or decreased motivation with clear differences emerging between two purposively selected cohorts of learners - 'early' and 'late' adopters. Comparison between the two cohorts revealed that a dominant workplace culture that values 'essential learning' and allows for some flexibility of approach and acknowledges multiple perspectives, will enhance alignment to the values and beliefs that underpin worker motivation and transform the mindset the word 'mandatory' can evoke. A small paradigm shift that has potential to transform existing cultures and enable those that acknowledge difficulty meeting requirements, to complete the requisite professional and clinical governance requirements that our community expects.

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### References

1. Australian Commission on Safety and Quality in Health Care. Clinical Governance for Nurses and Midwives. Sydney: ACSQHC; 2017.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Version 2. Sydney: ACSQHC; 2021.
3. Beckett, H. Effect of e-learning on nurses continuing professional development. *Nursing Management*. April 2020;27(2):16-22.
4. Viljoen, M., Coetzee, I., Heyns, T. Critical Care Nurses reasons for poor attendance at a continuous professional development program. *American Journal of Critical Care*. 2017; 26 (1)70-76.
5. Pool, I.A., Poell, R.F., Berings, M.G.M.C., tenCate, O. Motives and activities for continuing professional development: An exploration of their relationships by integrating literature and interview data. *Nurse Education Today*. 2016; 38: 22-28.
6. Casey, M., Cooney, A., O'Connell, R., Hegarty, J.-M., Brady, A.-M., O'Reilly, P., Kennedy, C., Heffernan, E., Fealy, G., McNamara, M. and O'Connor, L. 'Nurses', midwives' and key stakeholders' experiences and perceptions on requirements to demonstrate the maintenance of professional competence'. *Journal of Advanced Nursing*. 2016; 73(3): 653-664.
7. Churchouse, W., Brooker, M., Barnes, J., Fabb, L., Burns, C. Improving nurse education and mandatory training within a cardiac centre. *British Journal of Cardiac Nursing*. 2016; 11 (12): 607-612.
8. Summers, A. Continuing Professional Development in Australia: Barriers and Support. *The Journal of Continuing Education in Nursing*. 2015; 46 (8): 337-339.
9. Brand, D. Attendance at NHS mandatory training sessions. *Nursing Times*. 2015;29(24): 42-48.
10. Grovranos, M., Newton, J.M. Exploring ward nurses' perceptions of continuing education in clinical settings. *Nurse Education Today*. 2014; 34: 655-600.
11. Henderson, A. Prescott, C. Re-envisioning continuing professional development to improve patient outcomes. *Nurse Education Today*. 2020; 89 (104402):1-4.
12. Hayes, C. Approaches to continuing professional development: putting theory into practice. *British Journal of Nursing*. 2016; 25 (15): 860-864.
13. Murphy, G.T., Gilbert, J.H.V., Rigby, J. Integrating interprofessional education with needs-based health workforce planning to strengthen health systems. *Journal of Interprofessional Care*. 2019; 33 (4):343-346.
14. Kent, F., Nankervis, K., Johnson, C., Hodgkinson, M., Baulch, J., Haines, T. 'More effort and more time'. Considerations in the establishment of interprofessional education programs in the workplace. *Journal of Interprofessional Care*. 2018; 32 (1):89-94.
15. Shinnars, J. Individual and Collective Competence. *Journal of Continuing Education Nursing*. 2017; 48(4): 148-150.
16. Shinnars, J. Nursing Professional Development and Continuing Education in 2019: Organization, Assessment and Evaluation. 2019; 50(1):6-8.
17. Nursing and Midwifery Board of Australia. Factsheet. Continuing Professional Development. 2019.
18. Nursing and Midwifery Board of Australia. Code of Conduct for Nurses. 2018.
19. Nursing and Midwifery Board of Australia. Enrolled Nurses Standards for Practice. 2016.
20. Nursing and Midwifery Board of Australia. Registered Nurses Standards for Practice. 2016.

**“Sorry, you’re on mute”:  
Hepatitis B nursing  
education in the age  
of COVID-19**

By Rachel Woodcroft, Adi Hoare,  
Sami Stewart and Melinda Hassall

Australia’s Third National Hepatitis B Strategy (2018–2022) targets include 80% of people living with chronic hepatitis B (CHB) diagnosed by the end of 2022.<sup>1</sup>

The 2018/19 *Viral Hepatitis Mapping Project National Report* outlines that of the 226,566 people in Australia living with hepatitis B (HBV), 72,274 (31.9%) are undiagnosed.<sup>2</sup>

Nurses and midwives play a crucial role in the cascade of care, especially in finding those undiagnosed. In 2020, the impacts of COVID-19 on the screening and monitoring of HBV became apparent. There was a decrease in hepatitis screening and monitoring: -19.1% and -8.7% respectively, compared to previous increases of +3.4% and +4.1% respectively in April-December 2018 and 2019.<sup>3</sup>

A decrease in screening impacted diagnosis and was observed as a 14.8% decline in HBV diagnoses from April-December 2020, compared to the same period in 2019.<sup>3</sup> If this trend continues, Australia will be unable to achieve the goal of 80% of people living with CHB diagnosed.

COVID-19 posed unprecedented challenges to delivering workforce education in 2020 and 2021. Recognising the importance of HBV education for nurses and striving towards national strategy targets, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) undertook a process to review and adapt the HBV nursing education program to be delivered online.

It is critical to embed principles of adult learning when developing nurse education. For example, to keep adult learners engaged, it is important to incorporate various learning methods.<sup>4</sup> As such, through consultation with expert clinical advisors, ASHM delivered this course with a combination of live sessions, including interactive case studies, polling, and self-directed activities to be completed online.

ASHM’s monitoring and evaluation framework, including a post-course survey, provided the opportunity to compare the



effectiveness of the online course delivery and subsequently make evidence-based changes to ensure that nurses learning needs related to HBV were met. A key learning from feedback related to the length of training. Twenty seven percent of survey respondents strongly agreed that ‘the length of the courses was about right for content covered’. This data initiated a further review of content and the development of a self-guided online learning activity to complete the learner’s experience.

By continuing education online throughout 2020/2021, ASHM has contributed to nurses feeling more confident in explaining HBV transmission, interpreting HBV serology, and discussing HBV vaccination schedules, with 87% of survey respondents reporting confidence in these areas. Delivering this education online has challenged ASHM to consider the principles of adult learning whilst balancing the quality of materials with the need to reduce content to suit an online learning experience. This is considered through an understanding of ‘Zoom-Fatigue’ as nurses face abundant online learning opportunities. ASHM hopes that nurses and midwives will be provided with quality education to solidify their role in achieving the national targets by delivering this online HBV education and continuing evaluation and review.

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**References**

1. The Australian Government Department of Health. Third National Hepatitis B Strategy 2018 – 2022. Canberra ACT (AU): Australian Government Department of Health. 2018. 40 p. [health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/\\$File/Hep-B-Third-Nat-Strategy-2018-22.pdf](http://health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1/$File/Hep-B-Third-Nat-Strategy-2018-22.pdf)
2. MacLachlan JH, Smith C, Towell V, Cowie BC. Viral hepatitis mapping project: National report 2018–19. Darlinghurst, NSW, (AU): Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM); 2020. 128 p. [ashm.org.au/programs/Viral-Hepatitis-Mapping-Project/](http://ashm.org.au/programs/Viral-Hepatitis-Mapping-Project/)
3. MacLachlan, JH. Impacts of COVID-19 on BBVSTI testing, care and treatment: Medicare data analysis. Melbourne VIC (AU): WHO Collaborating Centre for Viral Hepatitis, Doherty Institute for infection and Immunity; 2021.19 p. [doherty.edu.au/uploads/content\\_doc/COVID-19\\_impacts\\_-\\_BBVSTI\\_treatment\\_and\\_care\\_\(data\\_to\\_January2021\)\\_FINAL.pdf](https://doherty.edu.au/uploads/content_doc/COVID-19_impacts_-_BBVSTI_treatment_and_care_(data_to_January2021)_FINAL.pdf)
4. Collins, Jannette. Education Techniques for Lifelong Learning. Radio Graphics [Internet]. 2004 September [cited 2021 July 8]; Vol 24 (no.5). Available from: [pubs.rsna.org/doi/full/10.1148/rg.245045020](https://pubs.rsna.org/doi/full/10.1148/rg.245045020)

## Student mentorship: Supporting pre-registration nurses in foundational skill development

By Carolyn Hays, Sonia Matiuk and Lisa Townsend

The way pre-registration nursing students' link what they learn in the tertiary setting to the realities of clinical practice has long been the subject of nursing discourse.<sup>1,2</sup>

The 'theory-practice gap', describes the gaps between the completion of pre-registration study and the transition to graduated practice,<sup>3</sup> and bears similarities to those pre-registration nursing students face each time they undertake clinical practicum.

Transitioning from the safety of the tertiary institution to clinical practice presents inherent challenges, stresses, and vulnerabilities for novice nurses.<sup>1,4-7</sup>

Bridging gaps in knowledge and skill and addressing student vulnerability requires multiple strategies and resources. Teaching clinical skills in a clinical laboratory context before attending clinical practicum is one such strategy.<sup>8</sup> However, varying curricula requirements, together with time and space constraints and increasing academic to student ratios, often mean that pre-registration nurses have limited opportunity to practice and master newly acquired skills.<sup>9,10</sup> This can leave students feeling under-prepared to face clinical practicum.<sup>11</sup>

Many pre-registration nursing programs offer students opportunities for unsupervised independent skills to supplement supervised clinical laboratory practice. Unsupervised clinical practice laboratories pose inherent risks and challenges for novice nurses, including the risk of injury when practising inherently hazardous skills. These include manual handling or sharps related

skills and the possibility of reinforcing incorrect technique placing both the student and the patients they will care for at risk.

To minimise these risks, a university in Australia sought to embed a pilot support program for first-year pre-registration Bachelor of Nursing students to practice and enhance foundational clinical skills, mentored by specially trained second-and third-year pre-registration nursing students.

The mentoring process allows students to collaboratively practice skills and communicative elements of practice they have learned to facilitate knowledge and skill consolidation and encourage attendance.<sup>10</sup> The opportunity to ask the mentors who had 'been there before them' about what to expect and how to prepare for clinical practicum also proved valuable, increasing mentee self-confidence and self-efficacy and facilitating socialisation to the nursing profession.

Making a positive impact on the transition from the university clinical learning and teaching environment to the real world of clinical practicum throughout the nurses' journey to graduation requires well developed and appropriate preparatory opportunities. The provision of discretionary clinical practice laboratories supported by student mentors is an important addition to the suite of educational opportunities available to students.

We acknowledge other faculty, academic, and professional staff members who have helped facilitate this project.

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### References

- Greenway K, Butt G, Walthall H. What is the theory-practice gap? An exploration of the concept. *Nurs Educ Pract*. [Internet]. 2019 Jan [cited 2021 June 15];34:1-6. Available from: doi.org/10.1016/j.nepr.2018.10.005
- Saifan A, Eid AbuRuz M, Rami M. Theory practice gap in nursing education: a qualitative perspective. *J Soc Sci*. [Internet]. 2015 May [cited 2021 June 28]; 11(1):20-29. Available from: dx.doi.org/10.3844/jssp.2015.20.29
- Monaghan T. A critical analysis of the literature and theoretical perspectives on theory-practice gap amongst newly qualified nurses within the United Kingdom. *Nurs Educ Today*. [Internet]. 2015 Aug [cited 2021 July 5];35(8):e1-e7. Available from: doi.org/10.1016/j.nedt.2015.03.006
- Benner P. From novice to expert: Excellence and power in clinical nursing practice. Menlo Park: Addison-Wesley; 1984. pp. 13-34.
- Hayes C, Power T, Davidson PM, Daly J, Jackson D. Simulation: smoothing the journey from undergraduate to new graduate. *J Nurs Manag* [Internet]. 2018 Jul [cited 2021 July 2];26(5): 495-497. Available from: doi.org/10.1111/jonm.12676
- McCloughen A, Levy D, Johnson A, Nguyen H, McKenzie H. Nursing students' socialisation to emotion management during early clinical placement experiences: A qualitative study. *J Clin Nurs*. [Internet]. 2020 Jul [cited 2021 June 28];29(13-14):2508-2520. Available from: DOI: 10.1111/jocn.15270.
- McPherson S, Wendler MC. Safe clinical practice in pre-licensure nursing students: A concept analysis. *Nurs Forum*. [Internet] 2020 Jul [cited 2021 June 28];35(3):513-522. Available from: doi-org.ezproxy.lib.uts.edu.au/10.1111/nuf.12457
- Francis G, O'Brien M. Teaching clinical skills in pre-registration nurse education: value and methods. *Br J Nurs*. [Internet] 2019 Apr [cited 2021 July 2];28(7):452-456. Available from: DOI: 10.12968/bjon.2019.28.7.452.
- Irvine S, Williams B, McKenna L. How are we assessing near-peer teaching in undergraduate health professional education? A systematic review. *Nurs Educ Today*. [Internet]. 2017 Mar [cited 2021 July 2];50(42):42-50. Available from: doi.org/10.1016/j.nedt.2016.12.004
- Stenberg M, Carlson E. Swedish student nurses' perception of peer learning as an educational model during clinical practice in a hospital setting – an evaluation study. *BMC Nurs*. [Internet]. 2015 Mar [cited 2021 July 2];14(1):1-7. Available from: DOI: 10.1186/s12912-015-0098-2.
- Solvik E, Solveig S. Training nursing skills: A quantitative study of nursing student's experiences before and after clinical practice. *Nurs Res Pract*. [Internet]. 2018 Nov [cited 2021 July 2]; 1-9. Available from: DOI: 10.1155/2018/8984028.



**An infection control link nurse network in Residential Aged Care: Innovation in collaboration**

By Scott Lang and Joanna Harris

The COVID-19 pandemic was declared in Australia in early 2020. Concerns related not only to the impact on the acute care sector but also the residential aged care sector (RACF).

Early in the pandemic, COVID-19 outbreaks in RACF had devastating outcomes. Infection prevention and control (IPC) expertise was suboptimal in some of these RACF outbreaks.<sup>1</sup>

This report describes the work undertaken by the IPC team within a NSW Local Health District (LHD), to support and strengthen IPC capacity within the 44 RACF within the local geographical area.

The first stage of this project was to visit each of the 44 RACF to undertake an IPC and COVID-19 preparedness audit. The baseline audit consisted of 97 individual audit points sitting within 10 major headings.

This audit revealed no onsite IPC-qualified staff and inconsistencies in IPC education and product availability within local RACFs. Several recommendations for improvement, and offers of practical support, were made to each RACF.

Coincidentally, the Australian government established the requirement to employ IPC nurse leads in all RACFs.<sup>2</sup> It was apparent from the initial audit that these newly appointed IPC nurses would require ongoing support. This was achieved by establishing a RACF IPC Link Network,<sup>3</sup> initiated to provide monthly educational updates for 12 months.

Preparation for the Link Network involved an electronic survey seeking suggestions from aged care staff, IPC leads and their managers of educational requirements. Education topics were selected from the



results of this survey. Meetings are hosted on a web-based platform, and afterwards presentations are distributed to the RACF IPC leads to replicate the education to staff within their RACF.

This initiative enhanced linking and collaboration between the LHD IPC team and the newly appointed RACF IPC leads. Additionally, using a virtual platform enabled all 44 RACFs to join, gain education, discuss unique issues specific to their site and network with other RACF leads.

Several IPC link nurse programs have been established in acute care settings,<sup>3</sup> but there are no other reports of their establishment in RACF. Their objective is to reduce the impact of communicable diseases on individuals and organisations by improved IPC practice. This initiative will not be evaluated until the IPC Link Network education program is completed in December 2021. However, it is already known that the RACF staff, including frontline clinicians, site managers, general managers and chief executives have welcomed the

support provided by the LHD and that this has enhanced preparedness for COVID-19 risk within their facilities.

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**References**

1. Cousins, S. (2020). Experts criticise Australia's aged care failings over COVID-19. *The Lancet*, 396(10259), 1322-1323.
2. Commonwealth of Australia 2020. Royal Commission into Aged Care Quality and Safety aged care and COVID-19: a special report. [agedcare.royalcommission.gov.au/sites/default/files/2020-10/aged-care-and-covid-19-aspecial-report.pdf](https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/aged-care-and-covid-19-aspecial-report.pdf) accessed 07/07/2021
3. Cooper, T. (2004). Delivering an infection control link nurse programme: improving practice. *British Journal of Infection Control*, 5(6), 24-27.

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**PPE training and auditing: A quality improvement activity to raise staff awareness, measure compliance and improve staff and patient safety**

By Anne Kimberley

Personal Protective Equipment (PPE) education, embedded in an Infection Prevention and Control e-learning package, has been an annual mandated requirement for staff in direct patient care roles at the Sir Charles Gairdner Osborne Park Health Care Group, which includes a tertiary and secondary hospital.

Since February 2020, in response to the COVID-19 pandemic, a specific 'COVID-19 PPE Awareness' 30-min face-to-face training session was developed to support staff and patient safety. This was rolled out across the healthcare group by nurse educators from the Centre for Nursing Education (CNE) for all staff cohorts, including medical, nursing, allied health, pharmacy, cleaners, catering, health service assistants, patient transport, administrative staff, engineering, ICT and facilities management. This training also included the COVID-19 swabbing techniques. Due to the high demand for PPE supplies in the clinical settings and the need for physical distancing, this training was a face-to-face presentation with no practical component. During 2020 over 2,500 staff attended this training session from across the healthcare group.

Towards the end of 2020, an evaluation of this training, via email, was distributed to all staff who attended the 'COVID-19 PPE Awareness' session. In addition, an observational audit of staff donning and doffing PPE was undertaken over eight weeks in the clinical areas identified in a COVID-19 surge plan. In the secondary setting, the audit was conducted on all staff donning and doffing for any patients across the hospital.

The COVID-19 PPE Awareness session evaluation identified several key improvements for the face-to-face session. The most common theme was the need for a practical component. An evaluation of



Credit: North Metropolitan Health Service

the translation of theory to donning and doffing practice occurred by observational auditing and indicated that compliance of PPE use in practice required significant improvements.

Recommendations from the session evaluation and workplace auditing were tabled at the executive Pandemic Response Group (PRG), and a project role was endorsed and commenced in early 2021.

**THE PROJECT ROLE**

**Aim:** To implement the recommendations endorsed by the PRG, including:

- review the COVID-19 PPE training into an interactive 2021 session;
- roll out a Train the Trainer model to ensure widespread implementation of the 2021 COVID-19 PPE training session;
- develop a moderation schedule to ensure consistent delivery of the 2021 session;
- develop a comprehensive PPE Auditor Training Program, including workplace validation for new auditors; and
- re-audit PPE practices for an improvement in staff knowledge and compliance.

**CHANGES WE HAVE MADE**

Recommendations have been implemented. The next audit schedule commenced August 2021.

Evaluation of participants attending the '2021 COVID-19 PPE Update' sessions has been positive. The majority have indicated the most valuable aspect is the interactive donning and doffing component.

The Auditor Training Program is well received and continues to build competence and confidence in clinical auditors.

A PPE Spotter Model is being developed to enhance our readiness for a potential widespread surge in COVID-19 presentations and support staff and patient safety.

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**Searching for family-centred quality improvement projects: Using the empowerment of parents in intensive care**

By Claire. Collins, Thomas Morgan, Ivan Chen, Graham Waldock, Pia Woods, Emma Firth and Karen Gajic

Our children’s intensive care unit is participating in a nationwide study called Empowerment of Parents in the Intensive Care (EMPATHIC 30-AUS) Survey,<sup>1,2</sup> accredited translated version of the internationally utilised EMPATHIC 30 questionnaire.

As part of the Essentials of Care (EOC) program, we evaluated the data received from the surveys to develop small quality improvement (QI) projects within our unit.

The survey questions allowed a numerical scoring from 1-6 in five different domains (information, care and treatment, parental participation, organisation and professional attitudes). Space for free written feedback was also available. The EOC team reviewed the rating and written feedback regularly since the start of the study in three-month blocks. After collating the comments into themes, we designed QI projects to address and resolve any issues identified.



Initially, a common theme was identifying the staff caring for their child each shift. We responded with the initiation of a staff photograph board located inside the unit’s entrance and a whiteboard at each bed space. The whiteboards identified: child’s name, doctor for the shift, nurse for the shift and parents’ names – this is completed by the nurse each shift. Since the staff photograph board and whiteboards have been used feedback has improved, parents can refer to the photo board if they forget their staff members names. This has been useful for other staff and health professionals who also utilise the photo board for reference.



During the data review, a ‘you said/we did’ poster was developed and is displayed next to the staff photograph board. This is to highlight to families that we hear them, acknowledge their comments and respond to them<sup>3</sup>. The poster is updated with each data review.



Positive comments reflected gratitude, confidence in staff and satisfaction in doctors and nurses professional attitudes, care and treatment and organisation of the unit. This is shared with the staff, and any names mentioned, including individual comments, are entered into a ward ‘Above and Beyond’ award ballot box.

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**References**

1. Latour, J.M., Duivenvoorden, H.J., Tibboel, D., Hazelzet, J.A. and EMPATHIC Study Group. The shortened EMpowerment of PArents in The Intensive Care 30 questionnaire adequately measured parent satisfaction in pediatric intensive care units. *Journal of Clinical Epidemiology*, 2013; 66(9), pp.1045-1050.
2. Gill, F.J., Wilson, S., Aydon, L., Leslie, G.D. and Latour, J.M. Empowering parents of Australian infants and children in hospital: Translation, cultural adaptation, and validation of the EMpowerment of PArents in the Intensive Care-30-AUS Questionnaire. *Pediatric Critical Care Medicine*, 2017; 18(11), pp.e506-e513.
3. Abuqamar, M., Arabiat, D. and Holmes, S. Parents’ perceived satisfaction of care, communication and environment of the pediatric intensive care units at a tertiary children’s hospital. *Journal of Pediatric Nursing*, 2016; 31(3), pp.e177-e184.



## You matter: Finding your self-compassion

By Mary Steen

**A scoping review recently conducted by Steen et al.<sup>1</sup> reported that self-compassion could help reduce work-based stressors, ie. anxiety, stress, compassion fatigue, and burnout in nurses and midwives.**

The review, *The influence of self-compassion upon midwives and nurses*, highlights evidence to suggest that self-compassion can enhance nurses' and midwives' ability to be compassionate to others.

An educational workshop has been developed from evidence identified from undertaking this scoping review.<sup>1</sup>

You matter: Finding your self-compassion education and training workshop has

been piloted with clinical educators. Two workshops were held at the Chief Nurse's education rooms in Adelaide on 3 November 2020. Twenty-two nurse/midwife clinical educators who are members of South Australia Practice Development Network (SAPDN) and employed by SA Health attended the workshops.

The workshop aimed to increase awareness and ability for self-compassion. Clinical educators completed a (12-item) self-compassion scale,<sup>2</sup> before attending the workshop.

Data analysis demonstrated a self-compassion mean of 38.38 out of 60, which indicates that clinical educators had a moderate to low level of self-compassion. On completion of the workshop, an evaluation confirmed that all clinical educators acknowledged the importance and value of compassion to self and others. Almost all of the educators strongly agreed that the workshop provided them with a clear understanding of self-compassion and strategies that can be used. The interactive workshop content assisted

them in understanding the underpinning philosophy and awareness of health and wellbeing benefits of self-compassion. All educators reported that they would practice self-compassion in the future. Ten confirmed that they would like to attend a 'train the trainer' session to teach self-compassion care and strategies to other nurses and midwives.

This preparatory work has now led to a research study being planned, and ethical approval has been granted.

Around 400 nurses and midwives will be given an opportunity to participate in the study. They will be asked to complete a pre-educational self-compassion questionnaire (online) before registering to attend a workshop at metropolitan and rural clinical sites. Two post-compassion questionnaires will be completed immediately after attending a workshop and at 6-8 weeks. Some nurses and midwives will be given an opportunity to be interviewed at three months.

The topic of self-compassion and emerging evidence of the influence this has upon



## The evolution of an Infection Control Mentorship Program

By Julie Riek and Joanna Mary Harris

This article describes a nurse education initiative within a NSW public health organisation.

The infection management and control service (IMACS) comprises a team of clinical nurse consultants (CNCs)<sup>1</sup> and a nurse manager. The IMACS service covers eight inpatient facilities (1,100 beds) and associated community-based services. In 2009 an Infection Control Link program was established to support improved education opportunities and communication between the IMACS team and clinicians working in direct contact with patients.<sup>2</sup>

The program involved attendance at bi-monthly IPC Link meetings and an annual IPC seminar day. Meetings involved provision of IPC updates, audit feedback, opportunities for members to provide feedback, ask questions and network with colleagues. The annual seminar included presentations and workshops from various speakers including public health, microbiology, and infectious diseases experts.

While attendance at the seminar day was consistent, the bi-monthly meetings proved challenging for members to attend regularly. In response to feedback the IMACS team redesigned and renamed the program. The Infection Control Mentorship Program commenced in 2019. This initiative aims to provide one on one mentorship to participants. There are four objectives:

- To improve participants knowledge and awareness of IPC principles and practice.
- To improve participants' confidence in their communication with patients and colleagues on IPC matters.
- To support succession preparedness for aspiring IPC nurses.
- To strengthen clinical leadership and education skills of the IMACS CNCs.

Each participant meets monthly with their nominated IMACS CNC to support them through the program.

The Mentorship Program is an 18 month program with four phases. Each phase brings new learnings and objectives:

- Back to basics including completion of online IPC modules;<sup>3</sup>
- Identifying issues and planning a project;
- Implementation and evaluation of a project; and
- Dissemination of a project at the annual IMACS seminar day.

Outcomes from the 2019 program include improved equipment cleaning following a project exploring barriers to the cleaning of reusable equipment, and increased awareness of Aseptic Non Touch Technique (ANTT) through a project to develop educational resource posters.

The program was suspended in 2020 due to the COVID-19 pandemic and recommenced in 2021 with nine participants. The current cohort are nurses from various services including emergency, surgical, medical, geriatrics and rehabilitation.

The following words from a participant in the 2019 cohort express her reflections and experience of the program: *"The Infection Control program allowed me to have a greater insight to infection control and how I am part of the process. It gave me confidence to recognise areas that needed improvement in infection control processes in my area."*

### Authors

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### References

1. New South Wales Government, Ministry of Health. Clinical nurse/midwife consultant- List of domains and functions. 2017 (cited 7 July 2021). Available from: [www.health.nsw.gov.au/pds/ActivePDS/Documents/IB2017\\_002.pdf](http://www.health.nsw.gov.au/pds/ActivePDS/Documents/IB2017_002.pdf)
2. Teare EL, Peacock A. The development of an infection control link-nurse programme in a district general hospital. *J Hosp Infect* (Internet). 1996 (cited 7 July 2021);34(4):267-78. Available from: [sciencedirect.com/journal/journal-of-hospital-infection](https://doi.org/10.1016/S0195-6701(96)90107-3) doi: 10.1016/S0195-6701(96)90107-3.
3. ACSQHC. Infection prevention and control eLearning modules. 2019 (cited 23 June 2021). Available from: [safetyandquality.gov.au/our-work/infection-prevention-and-control/infection-prevention-and-control-elearning-modules](https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/infection-prevention-and-control-elearning-modules)

health and wellbeing is relevant not only to nurses and midwives but all health professionals, patients, their families, communities, and society at large. Therefore, a series of studies are being planned for future research.

Nurses and midwives in South Australia will be able to learn more about the study via a designated website: [compassionateselfcare.org](http://compassionateselfcare.org)

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### References

1. Steen M, Javanmard M & Vernon, R. 2021. The influence of self-compassion upon midwives and nurses: A scoping review. *Evidence-Based Midwifery*, vol.7, no. 3, 16-30
2. Raes, F, Pommier, E, Neff, KD & Van Gucht, D. 2011. Construction and factorial validation of a short form of the self-compassion scale *Clin. Psychol. Psychother*, vol. 18, no. 3, pp. 250-255. doi:10.1002/cpp.702



### Welcome to our new recipe page

Each issue we will be featuring a recipe from Maggie Beer's Foundation, which ensures research, education and training will lead to better outcomes and the delivery of nutritious and flavoursome meals to our ageing population in nursing homes.

However, Maggie's vision is not only to improve nutrition and wellbeing for the aged, but also for all who enjoy good wholesome food.

We invite you to try Maggie's recipes. Send in a photo of you and your creation from this issue, and in a sentence, let us know what you liked about it. If we pick your entry, we'll publish it in the next ANMJ and reward you with a \$50 Maggie Beer voucher.

To find out more about Maggie Beer's Foundation go to: [maggiebeerfoundation.org.au](http://maggiebeerfoundation.org.au)



## Spiced parsnip & carrot cake with ginger cream cheese icing

*It seems that everyone has a go-to carrot cake recipe, though have you ever tried incorporating parsnips into the mix? The earthiness of parsnip works so beautifully with the warm, familiar spice palate in this cake.*

PREP TIME 20 minutes | COOK TIME 30-40 minutes | PORTIONS 32

### INGREDIENTS

3 cups self raising flour  
1.5 cups dark brown sugar  
2 tbsp ground ginger  
1 tbsp cinnamon  
2 tsp all spice  
6 eggs  
1 cup coconut oil melted  
1 cup milk  
230g grated parsnip (2 packed cups)  
230g grated carrot (2 packed cups)  
1 cup walnuts chopped  
Good pinch of salt

### Ginger cream cheese icing

225g block cream cheese  
2 tbsp butter  
1.5 tsp fresh grated ginger  
500g icing sugar

### METHOD

1. Preheat the oven to 170 degrees and line a shallow half size gastronome tray with baking paper.
2. In a large bowl combine the flour, dark brown sugar, ground ginger, cinnamon, allspice and mix well, then also set aside.
3. Place 1 cup of coconut oil in the microwave to melt, about 45 seconds.
4. In another bowl place the eggs, milk and oil then whisk to combine. Pour the wet ingredients over the dry ingredients and stir until just combined. Fold in the parsnip, carrot and walnuts.
5. Transfer batter into the prepared gastronome tray and place in the oven.
6. Bake for 30 to 40 minutes or until a skewer comes out clean from the centre. Set aside to cool completely before frosting.

### Ginger Cream Cheese Icing

7. Place room temperature cream cheese, ginger and butter into a mixing bowl or stand mixer with a whisk attachment and beat until extremely smooth.
8. Slowly add in the icing sugar until all incorporated. Spread over the top of the cooled parsnip & carrot cake and serve.

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