ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL
VOLUME 27, NO.7
APR–JUN 2022

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Authorised by A. Butler, Australian Nursing and Midwifery Federation, Level 1, 365 Queen Street, Melbourne.

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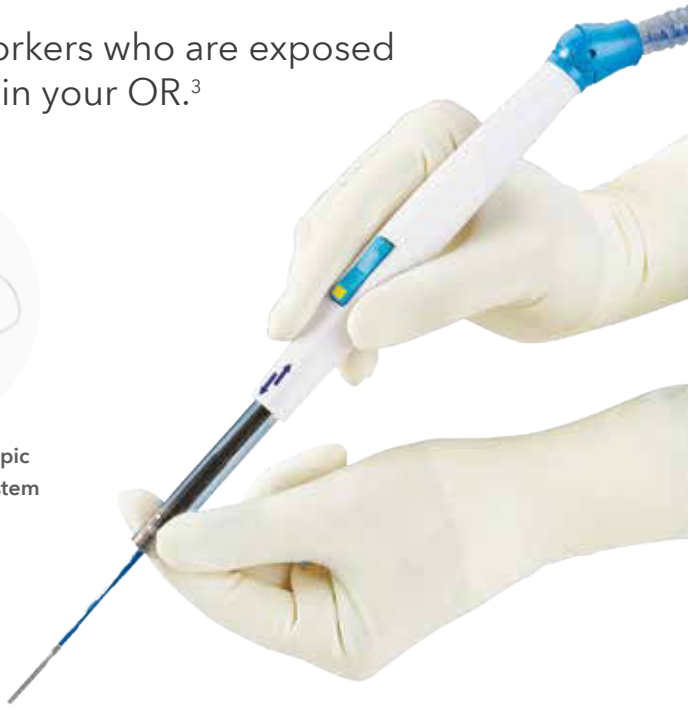

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Annie Butler

ANMF Federal Secretary

After a difficult two years navigating the pandemic, 2022 is turning out to be just as, if not more, challenging.

This is particularly the case for nurses, midwives and care-workers across the country and worldwide who are being forced to show their resilience and fortitude in the face of enormous, and in some cases, tragic adversity.

The recent catastrophic floods that devastated towns and communities in southeast Queensland and northern New South Wales have seen many, including our members, heart-wrenchingly lose their homes, belongings and livelihoods. With nurses and midwives additionally forced into crisis mode to manage the health impacts on their patients and their communities.

Further afield, we have been left horrified by Russia's deadly attack on Ukraine. The International Council of Nurses (ICN) has met with several Ukrainian nurse leaders who shared tragic accounts of the invasion.

At the meeting, one of the nurses explained that with the increased attacks, the hospitals were preparing for many wounded; however, they were worried about the lack of basic medical supplies.

Subsequently, the ICN has launched a global campaign, *#NursesForPeace*, which calls on the world's nurses to stand in solidarity with the nurses of Ukraine, and is calling for donations to the humanitarian fund.

The ICN and European nursing peaks have released a joint statement strongly condemning the actions of Russia and the disruptions and attacks to health services. The ANMF has become a signatory to the statement and the *#NursesForPeace* campaign to show our solidarity with our Ukrainian counterparts.

While these events have been occurring, the COVID pandemic has continued to affect our lives, placing tremendous strain on our health systems, nurses, midwives and care-workers.

Aged care has particularly felt the brunt of the pandemic on the back of the crisis the system has endured for many years.

Despite the Royal Commission recommending fundamental reform in the aged care sector over 12 months ago, the Morrison Government has failed to make any real change. Aged care nurses and care-workers are not only at breaking point but are furious that nothing has been done to fix the system, leaving vulnerable older Australians in nursing homes in continuing substandard conditions.

The ANMF is therefore ramping up our aged care campaign, "*It's Not Too Much to Ask*", demanding that politicians urgently make meaningful reform. Over the past few months, aged care members have rallied at Parliament House and across key electorates expressing disgust at the Morrison Government's inaction.

A new media campaign highlighting aged care nurses Irene and Samantha expressing their dismay is currently being broadcasted on television, radio, social media and billboards. To learn more about the campaign, turn to Federal Assistant Secretary Lori-Anne Sharp's column on page 16. To understand what it's like to work in aged care, read Irene's account on page eight.

Aged care is just one of the failures of this current government.

While Australia faces a future with increasingly extreme weather events featuring more floods, intense bushfires and droughts, the Federal Government has failed to plan for climate change's worsening impacts.

It's clear Morrison does not understand the urgency in addressing the issues and the consequences of failing to do so. The consequences of the recent floods will occur for some time, including significant health issues such as mosquito blood-borne viruses and water contamination.

Nurses however, are continuing their efforts to make a difference in sustainable practices within their workplaces, as demonstrated in this issue's Feature.

During May, we recognise nurses and midwives on International Day of the Midwife and International Nurses Day (IND).

The theme for IND, set by the ICN, is *Nurses: A voice to lead - Invest in nursing and respect rights to secure global health.*

It's abundantly clear that despite the tragedies worldwide, nurses and midwives are leading the way to make the world a better place for our patients and communities, which makes me proud to be part of this profession.

Nevertheless, the question remains, why our government continues to fail Australians by refusing to take action on what crucially matters.

I encourage you to continue to take a stand to actively make your voices heard for what is right and just.

To take a stand for aged care support "*It's Not Too Much to Ask*" campaign: **itsnottoomuch.com**

To support the *#NursesForPeace* campaign, visit **icn.ch/what-we-do/campaigns/nursesforpeace**

To donate to the ICN Humanitarian fund, visit **shop.icn.ch/collections/donations/products/icn-humanitarian-fund**

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REGULAR COLUMNS

FEATURE

CLINICAL UPDATE

EDUCATION

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Aged care workers fed up with government inaction ramp up the Campaign to fix the sector

The Australian Nursing and Midwifery Federation is calling out the Government's failure in addressing the aged care crisis by ramping up its aged care campaign *"It's Not Too Much to Ask"*, demanding that politicians fix the crippling issues plaguing the sector.

The Aged Care Royal Commission's two-year Inquiry, contained over 10,000 submissions involving distressing evidence from overwhelmed nurses, care workers, nursing home residents and their families. Since then, the sector has suffered worsening conditions exacerbated by the COVID pandemic.

Despite the Commission making 148 recommendations for the fundamental reform of aged care based on its findings, the Federal Government has failed to implement any meaningful change since the report was handed down 12 months ago.

ANMF Federal Secretary Annie Butler said nurses and carers were fed up and voicing their disgust that Mr Morrison and his Government have done nothing to reform the sector.

"A year since the Royal Commission delivered its Final Report, with one of the key recommendations for staffing ratios, nothing's changed. There's still not enough staff to give residents the basic care they need," Ms Butler said.

"We are fed up with this Government for abandoning aged care workers and residents and we're angry that Mr Morrison has let this all happen. Every day that Mr Morrison fails to act on safe, minimum staffing ratios, fails to deliver a decent, permanent pay rise for underpaid workers and fails to show our aged care workers and residents' dignity and respect is another day that elderly Australians in nursing homes continue to suffer."

Angry, frustrated and dismayed by the Government's lack of action, aged care nurses and carer-workers have also been speaking up in a series of national TV and radio commercials, billboards and a social media campaign that commenced 1 March on the first year anniversary of the Commission's findings.

In one TV ad, aged care nurse Samantha (on front cover) wipes away tears as she says: 'If you were to come into an aged care facility and see what I see every day you'd be heartbroken, you'd be disgusted and you'd want to make change too'.

Further action has included aged care workers and ANMF members rallying outside Parliament House in Canberra and front of targeted Federal MP offices in Victoria and Tasmania demanding action to reform aged care.

The Campaign, *"It's Not Too Much to Ask"* is demanding four key actions and commitments from federal politicians to help fix Aged Care:

- Fund and legislate minimum staff ratios, implementing minimum mandated care minutes and the right skill mix
- Fund and legislate the requirement for RN 24/7 in all nursing homes at all times
- Legislate clear transparency – funding tied to care
- Improve conditions and fund increased wages

To find out more and support the Campaign go to: **itsnottoomuch.com**

CATSINaM celebrates 25-year anniversary

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) has launched a campaign to celebrate its 25th anniversary, focusing on its powerful history of collective and individual activism.

From early March CATSINaM began paying tribute to its ancestors, Elders and members for 25 weeks, culminating in a national gala dinner on 20 August, through a series of profile stories, films, webinars, social media and special events to mark key dates such as Close the Gap, NAIDOC Week and National Reconciliation Week.

The forerunner of CATSINaM was the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), established in 1997 at a national forum attended by 35 Indigenous nurses. The aim of the national network of Indigenous nurses and midwives was to develop strategies to increase the number of Aboriginal and Torres Strait Islander people in nursing. Today, CATSINaM has almost 2,000 members and is a member of the National Aboriginal and Torres Strait Islander Coalition of Peaks.

CATSINaM CEO Professor Roianne West said Indigenous nurses and midwives draw on the strength of the organisation's founders to face current challenges.

"Strong Indigenous leadership has helped us navigate some of the profession's most challenging times – through COVID, bushfires, floods, and Black Lives Matter," she said.

"We are grateful for the leadership of Aboriginal and Torres Strait Islander nurses and midwives for putting Aboriginal and Torres Strait Islander nursing and midwifery on the national agenda and contributing to national debate and policy on the quality and safety of our health and education systems."

CATSINaM CEO Professor Roianne West

CATSINaM activists to be featured in the 25th anniversary campaign include founder Dr Sally Goold, inaugural patron Dr Lowitja O'Donoghue, Auntie Dulcie Flower, Auntie Jane Jones and Dr Lynore Geia.

COVID-19 death toll four times higher in lower-income countries than rich ones

Three million people have died since the Omicron variant emerged, shattering perceptions that the pandemic is over according to a report published by Oxfam on behalf of the People's Vaccine Alliance.

According to the report the COVID-19 death toll has been four times higher in lower-income countries than in rich ones.

While the pandemic has been devastating for rich countries like Australia, the world's poorest countries have been hardest hit, with women and children bearing a disproportionate burden. Lack of testing and reporting means that very large numbers of deaths due to COVID-19 go unreported, especially in the poorest countries.

Modelling using measures of excess deaths estimates that 19.6 million people have died because of COVID-19, over three times the official death toll. Based on this analysis, Oxfam calculated that for every death in a high-income country, an estimated four other people have died in a low or lower-middle income country. On a per capita basis, deaths in low and lower middle-income countries are 31% higher than high income countries.

Oxfam also calculated that three million COVID-19 deaths have occurred in the three months since the Omicron variant emerged. The figure shatters perceptions that Omicron's milder illness means the pandemic is coming to an end.

While most cases will be mild, the sheer number of cases means that numbers of deaths remain high.

"After two years, we all want this pandemic to be over, but politicians in rich countries are exploiting that fatigue to ignore the devastating impact of COVID-19 that continues to this day," Anna Marriott, Oxfam's Health Policy Manager said.

"While incredibly effective vaccines provided hope, rich countries derailed the global vaccine rollout with nationalism, greed, and self-interest. Suggestions that we are entering a 'post-COVID era' ignore the continuing deaths in primarily lower-income countries that could be prevented by vaccines."

Grattan: Reform Medicare to help sickest and poorest

Hundreds and thousands of the sickest and poorest Australians are missing out on healthcare because of gaps in Medicare coverage and high fees charged by medical specialists, according to a recent Grattan Institute report.

The report, *Not so universal: How to reduce out-of-pocket healthcare payments*, found that in 2020-21, nearly half a million Australians did not see a specialist because they could not afford it, while even more deferred or did not fill a prescription because of cost.

Australians spend about $7 billion a year on out-of-pocket hospital medical services and on medications listed on the Pharmaceutical Benefits Scheme (PBS).

Grattan argues bulk-billing rates are too low and out-of-pocket payments too high for some services, meaning the poor and chronically ill often miss out on care the most.

The report's policy blueprint for a better Medicare includes:

- State governments expanding outpatient services to reduce wait times and the federal government funding bulk-billing specialist services in private clinics
- The federal government paying specialists for giving GPs over-the-phone advice about patients, without actually seeing the patient, to cut down referrals
- The government lowering the co-payment for people on multiple medications to slash pharmaceutical costs
- The government eliminating out-of-pocket payments for diagnostic services, such as scans and blood tests, and radiotherapy services, by funding them directly through a commercial tender

The report concludes that if state and federal governments invested an extra $710 billion per year on the reforms, Australians could save $1 billion in out-of-pocket payments each year, and more people would receive vital care.

ANMF National Aged Care COVID-19 Survey 2022

One in five aged care workers in Australia plan to leave their job within the next year due to chronic understaffing and a range of workplace challenges triggered by the COVID-19 pandemic, according to a national survey by the ANMF.

Conducted from January-February 2022, the survey asked aged care nurses and care workers about challenges during the pandemic, including access to vaccinations, RATs, and properly fitted PPE, as well as work hours and leave, and if they intend to quit.

Findings revealed they are overworked, stressed and feel 'unseen, unvalued and cast aside' by the Morrison Government.

One survey participant, a 64-year-old aged care worker from Victoria, cited understaffing as the main cause of the crisis.

"We are chronically short-staffed always. Some staff have resigned, and more are about to. Makes me very sad for the residents that rely on us so much but there is only so much we can take."

The results uncovered:

- 72% received three doses of COVID-19 vaccination, 27% received two doses
- 73% reported their employer provided RATs, 12% relied on mass testing sites, and 5% relied on buying them themselves
- 20% reported never, rarely, or only sometimes having enough PPE
- 48% reported working 8-hour shifts, 42% worked long periods without sufficient breaks, 40% worked double shifts, and 35% worked unpaid overtime
- 37% planned to leave their job within 1–5 years and 21% planned to leave within the next 12 months

"The survey shows us that the staff remaining in aged care only do so for the love and respect of the people they care for, but their wages and conditions do not justify the risks and pressure they experience every time they go to work. It's unsustainable," ANMF Federal Secretary Annie Butler said.

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International Day of the Midwife and International Nurses' Day: Celebrating our achievements and strengths in times like no other

Each year on 5 May, we celebrate International Day of the Midwife and on 12 May International Nurses' Day.

Over the past two years the landscape that nurses and midwives working worldwide has vastly changed from the impact of COVID-19.

On both these days and beyond, we recognise the courageousness of nurses and midwives and their dedication to their patients in the face of adversity.

We also recognise that governments can no longer continue to underinvest in health and must step up to protect, support and invest in nurses and midwives while strengthening health systems.

The International Council of Nurses IND have set 2022's theme as *Nurses: A Voice to Lead – Invest in nursing and respect rights to secure global health* and is encouraging the promotion of nursing work and the fight for nurses' rights to a safe working environment, decent wages and full participation in decision-making.

Likewise, the International Confederation of Midwives is calling for investment in quality midwifery care worldwide, improving sexual, reproductive, maternal, newborn, child and adolescent health in the process. The theme is *100 Years of Progress*.

This year *ANMJ* speaks with Denise Donaghey aged care nurse and Irene McInerney midwife about what the past two years have been like, and how they have maintained their resilience and supported each other.

INTERNATIONAL DAY OF THE MIDWIFE OFFERS OPPORTUNITY TO REFLECT

Denise Donaghey, Associate Midwifery Unit Manager at South Australia's Women's and Children's Hospital, says this year's International Day of the Midwife comes at a time during some of the most intense professional experiences of her life.

Yet despite the challenges as a result of the pandemic, Denise says it has allowed her and other midwives to demonstrate their very best in a demanding and unrelenting context.

"Everyone's stood up to the mark, I can honestly say," Denise says.

"We have put in a lot over the last two years".

Denise says the challenges have been significant, continuing with "business as usual" but also having to make changes as a result of the pandemic.

In particular, daily staffing across the hospital was exacerbated by factors such as staff redeploying for COVID response (testing clinics, vaccination, contact tracing, medi-hotels) and currently, an increase in staff furloughing.

The additional pressures of a pandemic have resulted in some staff retiring or changing hours of work. Denise says members of the team remain dedicated to the women and families they care for and would work overtime if other staffing contingency plans were still not able to ensure ward coverage.

Other challenges have been educating new staff, keeping a handle on COVID-19 protocols, donning and doffing PPE, and managing the concerns of women and other staff. Annual leave has also not felt the same, with "stay-cations" not yielding the same benefits as holidays – such as feeling free from work and returning refreshed.

Denise says, that of those challenges, following visitor restrictions for women who would normally bring multiple people with them into a maternity ward has required some difficult conversations.

"We are very patient and understanding, but we still have to be fairly firm because if there was an outbreak from us being lenient with one person, it could shut down a whole unit, and we can't take that risk," she explains.

"It's all about how you deliver the message by being firm... standing by what you've been told you have to do."

Denise admits that managing staff morale throughout the period was tough for her and colleagues with such a cumulative and extended burden. Still, things like Christmas celebrations, COVID-safe coffee and social drinks gatherings, and the ability to find humour in complex situations have helped.

"Midwives have a great ability to laugh about the silliest things sometimes," Denise explains.

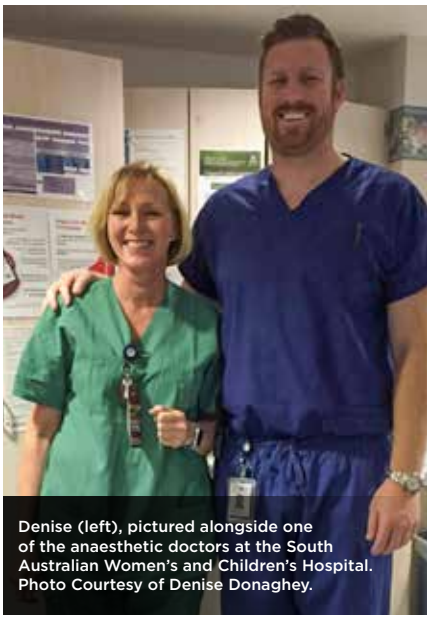
"We're not laughing at anything that shouldn't be laughed at, but you can find a funny side to most things and midwives tend to do that, so that brings the morale up a little bit."

Self-care routines have also helped Denise. Professional massages and regular walks of her three-year-old Golden Retriever have been vital in unwinding after demanding shifts. But Denise says with the pandemic now at a stage where some activities can resume, she has found herself utilising her new liberties.

"Just catching up with friends and family, those sort of things, now that we can, it's really important – it's really boosted most of our morale that we can see everyone again," she says, with staff looking forward to both a morning and afternoon tea to mark this year's International Day of the Midwife.

Nevertheless, the challenges of the last two years will remain in various forms for some time to come. Denise says, however, that the public should know that midwives will continue to have the interests of mothers and their babies at heart, despite the challenges of COVID-19.

Denise Donaghey (right), pictured alongside her daughter, a fifth year medical student whom she also mentored during her placement at the South Australian Women's and Children's Hospital. Photo Courtesy of Denise Donaghey.



Denise (left), pictured alongside one of the anaesthetic doctors at the South Australian Women's and Children's Hospital. Photo Courtesy of Denise Donaghey.

"No matter who you are, whatever walk of life you come from when you walk into our department, we strive to get the best outcome: We are there as the advocate and the caregiver," Denise says.

NURSES STEPPING UP TO THE CHALLENGE DURING THE COVID-19 PANDEMIC.

Tasmanian aged care RN Irene McInerney knew it was coming. After watching nursing homes in New South Wales and Victoria battle COVID-19 outbreaks during various waves of the pandemic, she feared the deadly virus would inevitably penetrate her facility once interstate borders opened up late last year.

It became reality in early February, with 26 residents and more than a dozen staff contracting COVID-19 following outbreaks at the aged care home.

"That's pretty full on when you're the only registered nurse on night shift with three carers," Irene says. "You feel like you're running a mini-hospital."

Aged care workers, already plagued by years of chronic understaffing, have faced numerous challenges during the pandemic, including navigating new infection control procedures and supporting residents amid rolling social restrictions and limited visitation rights.


Tasmanian aged care RN Irene McInerney

When COVID-hit, Irene says the facility was left playing catch up. For example, nurses weren't given Rapid Antigen Tests (RATs) soon enough and promised extra staff arrived 10 days later, after the worst had passed.

"Survival mode is what I called it. You just did your best and tried to support the residents," she says.

During outbreaks, residents isolated in their rooms.

"A subtle type of depression crept into some of the residents," Irene reveals.

"You're trying to support them and give them hope that it's not going to be like this forever."

Irene tried to adapt as best she could, spending an extra minute or two with residents or making phone calls to their loved ones to maintain connection. She also brought in carnations, which she grows herself, for residents returning from hospital.

Nevertheless, delivering care remains problematic in the new COVID normal, where gowns and masks are mandatory.

"The residents have trouble understanding us because they can't see our faces and lips, so communication is key," Irene says.

While resident care is paramount, staff too have struggled during the pandemic, making self-care more important than ever.

To support colleagues, Irene makes a point of acknowledging their efforts and offers assistance with residents whenever possible. Her self-care philosophy, 'do what makes you happy', steered her towards camping or gardening on her days off.

"We've probably got to do ourselves a favour and try not to overthink things too much and just know we did the best job we could."

Irene, the face of the ANMF's latest campaign for legislated aged care ratios, has worked in the sector for decades.

"Each shift I do I feel like I make a difference to the older people," she says.

"I just feel like I've got that acumen or the kind of caring and patience which that side of nursing takes. I think it is underestimated how well you have to get aged care, because these people are vulnerable."

Sadly, though, Irene has witnessed the sector deteriorate year after year, with the erosion of trained staff, excessive workloads and poor pay crippling the ability of aged care workers to deliver quality patient-centred care.

"Some staff are literally crying during shifts and I can admit to being one of them."

Understaffing compelled Irene to work night shifts to carry out "the nursing she signed up for" and do her job properly. Yet, as the only RN on afternoons and nights charged with caring for 65 residents, many with complex needs, delivering care often means choosing who receives assistance and who must wait.

"It makes me really angry. You go home not wanting to take things from work away with you, but you almost feel like you have to debrief on a daily basis because you're so frustrated and angry because you're rushing around all the time apologising to residents for being late to so many things.

"We need the staff and we need more pay to attract more people into the industry.

"What are you waiting for? Get on and improve things because we're all drowning. How many really good nurses are going to leave the industry before they finally hear us."

Irene, who celebrates International Nurses' Day each year, believes the entire profession, especially aged care nurses, deserves enormous recognition for working through the pandemic.

On 12 May, she says she feels like walking up the street, wearing a big badge, to let people know that there are nurses and carers like herself that genuinely care about the elderly.

"It's much tougher times, and more than ever, we've just got to be proud of our efforts. The community says we are one of the most trusted professions there are. We want the government to say, 'hey those nurses are struggling, they need more support and staff, what can we do for you?"

Of course there are many more stories of nurses and midwives doing it tough, trying to navigate their environment through times of adversity.

If you are having difficulties you do not have to suffer the challenges alone.

Contact you state or territory Branch for support and information.

Or contact Nurse and Midwife Support that provides a 24/7 national support service for nurses and midwives providing access to confidential advice and referral. *nmsupport.org.au* or call *1800 667 877*

James Lloyd

ANMF Federal Vice President

PPE, plastics, and the environment: A cautionary note

The effects of discarded plastics on the environment have been well documented in recent years.

We've all seen images of vast rafts of rubbish in our oceans, marine debris in our waterways and litter on our shorelines and streets. Plastic items, made from fossil fuels, has been found in the deepest ocean trenches, within Antarctic ice cores and on our highest mountains. They are found in the agricultural land where our food is grown, in the water we drink and even in the air we breathe.

Before the pandemic, we were learning about this issue and even initiating changes, such as banning single-use plastic bags in supermarkets. But towards the end of 2019, the focus on reducing plastic use was disrupted due to COVID-19.

Single-use plastics and items that contain them, such as PPE, are now in massive demand within the healthcare sector. Production ramped up to enormous levels. Overnight, disposable masks, gowns and gloves become one of our main defences against COVID-19. Soon afterwards, our excessive use of disposable PPE became apparent: it is trashing our planet.

PPE use is one of the most reliable and affordable defences against infection and transmission of the COVID-19 virus. Plastic materials are durable, water-resistant, flexible, and cheap, making them the material of choice for most disposable medical tools, equipment, and packaging. The ability to dispose of medical equipment after just one use reduces infection. Contamination of practical items in health was once common; however, life-saving plastics have revolutionised the medical industry.

Overall, as a tool in our kit bag of pandemic defences, plastics in PPE have allowed us to protect countless millions of people from COVID-19 infection. Plastics have protected nurses, midwives and carers from catching coronaviruses and subsequently has allowed us to continue giving care and assistance to the sick, dependant and vulnerable members of our community.

However, despite the obvious benefits of plastics in PPE during this pandemic, plastic use is a double-edged sword. And the problem is rapidly getting worse.

Prior to the pandemic, plastic pollution was already a global issue. Yet as of August 2021, an estimated EXTRA 8.4 million tonnes of plastic waste have been dumped into the environment rather than being disposed of correctly. Discarded masks are entering waterways, oceans, and other environments. How many discarded masks have you seen on the streets, parks, or sidewalks lately?

There is no place on Earth that plastic debris has not been documented. Those used in PPE can take 400+ years to break down - into smaller bits of plastics. These synthetic polymers do not disappear but break up into smaller and smaller pieces (microplastics and then nanoplastics), making them more available to microscopic animals at the base of the food web. In fact, almost all the plastics ever produced over the decades still exist now: globally, only 9% of all plastic is recycled and just 12% is incinerated.

One significant issue with plastics is that they contain nasty chemicals which can cause a myriad of health effects at minute concentrations. For example, certain plasticisers (which make plastic products less brittle and more user-friendly) are estrogen mimics. One of these, called bisphenol A (BPA), is known to feminise when leached from plastic products. Research has documented the feminisation of some wild animals in contaminated areas to the point that they can no longer reproduce.

We've already learned how to reduce our plastic use outside work, including using paper straws and carrying our own bags to the supermarket.

But there are no easy or immediate solutions to how we can reduce our dependence on plastics in healthcare. No current technology or solution exists that can quickly reduce our reliance. Bioplastics, for example, are currently not a long-term solution, as they do not decompose in a landfill, contaminate plastic recycling streams, and still contribute to marine debris. Recycling can help reduce waste overall but is complicated by lack of investment and is often not profitable. Not all plastics are easily recyclable and those that are often require chemical processes that are inherently problematic. And while certain bacteria have been discovered that "eat" plastics, these are currently a scientific curiosity and may even encourage people to litter more.

Plastic materials are obviously indispensable in healthcare and in public health safety. But the pandemic has greatly exacerbated the global environmental threat of plastic pollution through irresponsible disposal. There are no easy solutions. But let's heed this clarion call and invest the time, research, money, and political will to end this throwaway culture of plastics on our planet.

We are fouling our own nest – let's clean up our act!

CLIMATE CHANGE AND HEALTH: CODE RED FOR HUMANITY

Tackling climate change is a key priority for the ANMF and its members. With a Federal election looming nurses and midwives want to see meaningful action from the government to reduce emissions and give support for those trying to make an environmental difference in healthcare. *Natalie Dragon* reports.

"It's about making a choice to be part of something bigger, collectively making a difference. It's better than sitting and worrying about what's happening to the planet – it's empowering," says NSW mental health RN Sarah Ellyard of her climate change advocacy.

Sarah is a member of the NSW Nurses and Midwives' Association (NSWNMA, ANMF NSW Branch) Climate Reference Group, committed to promoting climate action within the workplace and the healthcare system.

"Nurses are constantly voted the most trusted profession. Now, more than ever, people are listening to nurses. We are a powerful voice. The more of us that can contribute, the more impact we can have," she says.

Former coordinator for her local Stop Adani group, Sarah spoke for the NSWNMA at a rally organised by Workers for Climate and Action and the Australian Student Environment Network in February 2021.

"For me, it was making the decision to turn up at that first [Stop Adani] meeting. Through the Stop Adani campaign, I met other people in healthcare concerned about climate change and what was happening in the healthcare space. It's taken me a while to connect my work as a nurse and my interest in climate and put them together."

The World Health Organization (WHO) has declared climate change 'the greatest threat to global health in the 21st century'. Australians are set to witness increasing severe health challenges from climate-related hazards and disasters, including bushfires, drought, floods, and heatwaves. Addressing the health impacts of climate change through mitigation and adaptation strategies is one of WHO's top priorities.

THE CALL TO ACTION

Action is needed across all levels of government, industry, the community, and the health sector to reverse the global warming trend and protect the health of communities.

In 2021, at the 26th UNFCCC Climate Change Conference (COP26) in Glasgow, 50 countries committed to developing climate-resilient and low-carbon health systems. Australia, the US, and China did not sign up to a pledge to phase out coal firepower. Ahead of COP26, Prime Minister Scott Morrison released the federal Coalition's climate change roadmap, which commits to reaching net zero emissions by 2050.

Executive Director of the Climate and Health Alliance (CAHA), the peak body on climate change and health in Australia, Fiona Armstrong, said Australia was increasingly out of step with the rest of the world.

"We acknowledge the Australian government's commitment to a net-zero emissions target by 2050. However, there is much more that needs to be done to ensure a low carbon and resilient health system in Australia and for our Pacific Island neighbours. Not just on climate policy in general, but in how it responds to the growing evidence of the impact of climate change on people's health."

In recent years, the ANMF has called on the Australian government to commit to developing a standalone policy on climate change with a key focus on health and wellbeing. Many countries now also include health in their national climate plans to the Paris Agreement, says Ms Armstrong.

"Australia must prioritise health protection from climate change just as it has done from COVID – this starts with putting health at the centre of the national adaptation plan.

"We urge the Australian government to develop an ambitious national strategy that both mitigates Australia's emissions, secures the health of the community and builds resilient health systems."

Health and medical groups have called for 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 recommendations of climate scientists. The latest evidence shows that even if countries fulfil all their commitments under COP26, global land surface temperature will exceed 2.4 C by the end of the century.

GLOBAL GREEN AND HEALTHY HOSPITALS

Healthcare is responsible for 4.4% of global emissions, making it one of the most significant contributors to climate change through the procurement of goods and services, energy use, waste, and transport. In Australia, healthcare generates almost a 10th of the nation's overall carbon emissions.

The Global Green and Healthy Hospital (GGHH) network is an international community of hospitals and health organisations committed to reducing their ecological footprint. As of June 2021, there are 111 GGHH members representing over 2,000 hospitals and health services across Australia and New Zealand.

Clinical nurse at Sunshine Coast University Hospital (a GGHH), Rachael Jackson, set up the Emergency Department Environment Team two years ago. The team of about 39 members has implemented several waste reduction strategies and procurement changes to contribute to more sustainable practices within the ED.

Ros Morgan, Environmental Health Officer pictured with the food composter at the ANMF (Vic Branch) Melbourne office

Sustainability tree in the Qld Sunshine Coast University Hospital health service's corridor with recycling bins underneath

"We were trying to get like-minded people together who are passionate about the environment and making a difference in healthcare. A lot of people can make a difference. It's how we can tap into that in a viable way,' says Rachael.

The health service recycles metals such as suture pack scissors, IV fluid bags/outer bags, copper wire from saturation probes, cardboard and paper, batteries, coffee cups and water bottles. Mobile recycling stands with various waste streams are visible in the department. There are plans to recycle the metal from single-use aluminium crutches.

Rachael says quick wins inspire. "Start with something small. For us, it was the injection trays which are made of plastic, we use thousands of them. It was visible to everyone – what most people saw was that we were using plastic one day and the next day, we had moved to biodegradable. It was a lightbulb moment for some people. Small wins make a difference. You can tackle harder things down the track."

Rachael is the ED representative on the hospital's Sustainability Committee.

"We have a sustainability lead and a sustainability plan for the health service. We are a GGHH hospital and have buy-in from our Executive Director – this means something to us; we are going to implement this into how we operate. People drive the change collectively and make it sustainable.


Ros Morgan, ANMF (Vic Branch) Environmental Health Officer (centre) teaching (pre COVID).

It's a collective mentality. How can we embed this as part of our culture?"

CODE RED FOR HUMANITY

University of Southern Queensland nursing and public health researcher and lecturer Dr Aletha Ward argues that action on climate change is not something we can deal with in a decade.

"It must be dealt with now. We are not only dealing with the pandemic, but what the IPCC states is a 'code red for humanity'. We do not have the luxury to back away on reducing emissions and building resilience in our systems and communities to adapt to climate change impacts.

"We should be building resilience into our healthcare plans. There's a lot of work being done on resilience in New Zealand following earthquakes – how people will get food, water, access to healthcare after an earthquake. We haven't done that – not in healthcare nor at an individual level – and we are really exposed."

Dr Ward and colleagues are leading a systematic review on nurses' role within healthcare in reducing carbon emissions.

"If the global healthcare sector were a country, we would be the fifth-largest emitting country in the world. The paradox is that we care for the most vulnerable to climate change, yet we are one of the largest emitters," says Dr Ward.

Nurses must lead the way if the sector is to achieve carbon neutral in less than 30 years, say the researchers.

"We need to shift our perception from 'it is not our role' to 'it is our role' and we can be powerful in this space. COVID has demonstrated our role as a nurse in the public health sphere. It is our scope of practice," says Dr Ward.

"From strategies to reduce waste and recycle at the bedside, to influencing federal and state policy agendas, we must be prepared as a profession to address the health consequences of climate change and provide leadership to reduce emissions within the healthcare sector.

"This is more than just waste reduction and recycling. It's about advocating for change, leading by example to reduce emissions, understanding the impact of climate change, advocating for those most vulnerable to the poor health impacts of climate change, helping communities at risk to build resilience and have healthcare plans, researching and leading the way in implementing change and coming up with innovative solutions."

One of the study's key recommendations was that climate change, emissions reduction, sustainability, and resilience are embedded in undergraduate and postgraduate degrees.

"Change is going to be difficult without this. We are currently scoping what is occurring in our nursing degrees in Australia. We currently do have sustainable development goals included in undergraduate curricular and while Goal 13 (take urgent action to combat climate change and its impact) is intrinsically linked to all 16 of the other goals, it does not seem to feature strongly in curricular,' says Dr Ward.

A WASTE CRISIS

The scale of waste the healthcare system produces has reached unprecedented levels during COVID. Disturbingly, our members report that recycling and other sustainability initiatives have been hindered due to safety concerns over COVID spread and contamination.

Flinders Medical Centre recycling COVID masks

"It has been disheartening," observes Ros Morgan, Environmental Health Officer with ANMF (Vic Branch). Both the EPA and the Department of Health have provided guidelines for managing recycling during COVID. Even though there is community transmission, recycling continues – there are protocols and safety procedures in place to manage it.

However, with the increased awareness is an opportunity for people to be part of the solution, says Roslyn.

"We need to keep our eye on the big picture – this is about transforming healthcare, this is continuing irrespective of COVID, we are changing cultural expectations and demand in Australian healthcare.

"There are so many ways we can be part of the solution – from gas free hospitals to Victoria's single-use plastic ban, to a move away from petroleum products, to how we reduce and manage waste."

"There are resources ready to assist people through the Victorian Waste Education project. We have the tools ready for people to use. Determine the tools you can use in your clinical setting and download the resources."

"A lot of nurses, midwives and carers want to be involved but are unsure how to introduce sustainability into their workplace. Every year hundreds of nurses and midwives share their stories at the Health and Environmental Conference, showing us in practical ways how to reduce emissions, stop waste, and preserve resources."

NURSES LEADING THE WAY

Flinders Medical Centre was the first hospital in South Australia to introduce PVC recycling in 2017. Anaesthetic ANUM Darren Bradbrook was awarded a Local Heroes award last year for his campaign to introduce several recycling streams in the operating room (OR), which resulted in a 60-70% reduction of OR waste to landfill.

"COVID has curtailed what we were doing, but we didn't stop, we've continued

to go on. We have solid infrastructure to continue our current streams of waste reduction and recycling and renewables. We want to reduce our carbon footprint and we have an agreed model for buy in and common pathways to implement change," Darren says.

FMC has started recycling single-use N95 face masks. "They're used for four hours on average and then discarded. We have specific bins in strategic places where there's major traffic rather than them going into the general waste bin," says Darren. "We need to be carrying out best practice for safety and maintaining a healthy working environment, but we also need to continue our work in waste reduction and other sustainability initiatives.

"People need to keep talking no matter what the situation with COVID. Certainly, people are talking; they're having those crucial conversations. People are talking about how to provide best healthcare and health promotion but not causing ill-health to the environment."

ANMF Tasmanian Branch members Jane Usher, Emma and Brenton Lovering, launched 'GreenMed' with Jane's husband Mat two years ago. Mat was an outdoor education and sustainability teacher who became a medical device representative in theatre.

"Mat was shocked to see the bags of waste that were going to landfill. He was used to encouraging 70 kids to reduce their combined lunch waste to fit into his hand," says Jane.

GreenMed teamed up with Envorinex, an Australian-owned company, to recycle single-use hospital plastics, starting with the polypropylene wrap used for wrapping surgical instruments for sterilisation.

"Polypropylene is a resource that at times is hard to get, especially during a pandemic, as it's used in PPE. It's a voluminous cloth that takes up a huge amount of space and is buried deep in the ground as landfill at the end of its short life," says Jane.

The 'Keep me in the loop' program is a closed-loop circular program that takes single-use plastics and preserves them through redesign and remanufacturing into new products for clinical use. These products are then re-collected in bins at stations around the healthcare facility and re-recycled over and over. GreenMed has developed single-use medicine cups and injectable trays for use in healthcare, providing an option that never goes to landfill.

ANMF Victorian Branch member and regional RN Natalie Loogman says one of the main barriers is finding companies that will recycle the waste.

"It's difficult for us in West Gippsland being in a regional area. We don't have the same options in terms of access and expense. We have no universal soft plastic recycling stream. Because of these challenges, we are trying to prevent waste in the first place.

"So much time and money are spent converting to disposable equipment, and it's mostly for the convenience of not cleaning," she says.

"We have an onsite linen service which has benefited us during COVID. Most health services use disposable surgical drapes and instrument wrap, which has been difficult to source during the pandemic as the raw materials have been redirected into the manufacture of PPE."

Natalie, who has six recycling streams/waste streams at home, was inspired to transfer sustainability to the workplace after attending the ANMF Victorian Branch Sustainability Conference about five years ago.

Natalie's tip is to find something that saves the health service money. She cost assessed the economics of reusable trays instead of disposable trays used to draw up injectable anaesthetic drugs in the OR, which do not have to be sterile.

"I wanted to find a solution that didn't involve recycling. We've saved approximately $15,000 since we started the use of reusable trays in 2018. It was our first major win."

POLITICAL WILL

The UK's National Health Service (NHS) announced in October 2020 its aim to be the world's first net-zero emissions health system - to reach net-zero by 2040 and reduce emissions by 80% by 2028-2032. 'We make no apologies for pushing progress in this area while still continuing to confront coronavirus,' Sir Simon Stevens said.

ANMF Tasmanian Branch member Jane Usher who has launched Green Med with blue wrap recycling

The NHS met its first 12-month targets, with an emissions reduction the equivalent of 1.7 million flights from London to New York.

The ANMF has called for similar political will in Australia, including the implementation of an energy policy to transition to net zero emissions by 2030 and increased funding for climate-resilient health systems and climate change research.

"We need an immediate national just transition plan with funding and support for workers and communities impacted by both the climate crisis and a shift to clean, non-fossil fuel technologies," says Roslyn Morgan.

"There is a need for systemic change to support individuals. Clinicians have been driving this change and carrying this burden for too long. It's time for government to step up and implement the support and resources they need."

FURTHER RESOURCES

ANMF position statement on climate change: anmf.org.au

GreenMed: greenmedical.com.au

Resources for the clinical setting can be found at: anmfvic.asn.au/healthenvironmentalsustainability

ANMF Victorian Branch has just released an online CPD on how to start a Green Team in your workplace visit: cpd.anmfvic.asn.au

Save the date: anmfvic.asn.au/events-and-conferences/2022/05/13/health-and-environmental-sustainability-conference [13 May]

ANMF Victorian Branch member and West Gippsland RN Natalie Loogman

Lori-Anne Sharp

ANMF Federal Assistant Secretary

Private aged care crisis … still waiting Mr Morrison

Aged care nurses and care workers across the country are fed up and taking action to demand meaningful reform in private aged care.

On 8 February, ANMF aged care members rallied at Parliament House, Canberra and again on 1 March to mark the one year anniversary of the Aged Care Quality and Safety Royal Commission report, targeting key electorates in Victoria and Tasmania. Determined to witness change, aged care nurses and care workers expressed their disgust that the much-anticipated reform so desperately needed in private aged care continues to be largely ignored by the Morrison Government.

Members shared their harrowing stories of missed care due to dangerously low staffing levels the emotional and physical toll experienced when you just can't get to those residents in need because there is simply not enough staff on the ground. Members explain that the situation has worsened one year from the Royal Commission report.

Exhausted nurses and care workers are the single element holding the system together, many working double and triple shifts during the Omicron wave.

Susan Walton, NSWNMA member, job delegate and aged care worker, has worked in the same private aged care facility for 18 years. She told the crowd that she often works night shift on the floor by herself, looking after 40 residents.

"Our residents are getting sub-standard care. You cannot physically look after 40 people by yourself," she said. "Mr Morrison, do I go to Mr Smith who is in pain, or Mrs Jones who is on the floor, or John who has got behaviour problems and is intruding into other people's rooms? I have floor alarms going and buzzers going. What would you like me to do?"

The private aged care crisis must be a key election issue in the upcoming Federal election, which is scheduled for May 2022. Urgent reform is well overdue, and we need a government that will take action and implement mandated staffing ratios in private aged care as a priority and deliver a system that respects staff and residents and keeps them safe.

Aged care has suffered from chronic and widespread understaffing for over a decade. This is because there is no 24 hr RN presence in every nursing home or adequate staff ratios or transparency over how tax payers funds are spent. This is not acceptable. The ANMF will continue to pressure politicians and urge all members to support the ANMF's campaign **itsnottoomuch.com**.

Stand with aged care nurses, residents and their families to demand your federal politician make aged care a priority this upcoming federal election. You can help by going to **itsnottoomuch.com** to show your support, sign up and send a letter to your local federal MP.

ANMF asks include:

1	2	3	4
Fund and legislate at least one RN in nursing homes 24/7 at all times.	Fund and legislate minimum staffing ratios- implement minimum mandated care minutes and the right skill mix.	Legislate clear transparency measures that require funding to be tied up to care.	Improve conditions and fund increased wages.

Omalizumab improves asthma control in children and young people during Australia's bushfire season: Two case reports

By Sarah Gnanaseharam

ABSTRACT

Paediatric nurses have a crucial role in health promotion. During Australia's devastating bushfire season, nurses and physicians had heightened concern for children with chronic poorly controlled asthma due to long months of smoky haze. The introduction of the subcutaneous drug, Omalizumab, usually administered two to four weekly, was life-saving to a small cohort of paediatric patients.

Omalizumab is a recombinant deoxyribonucleic acid (DNA) derived from a humanised monoclonal antibody that selectively binds to human immunoglobulin E (IgE).

IgE is the immune mediator involved in the clinical presentation of asthma in children with wheezing, coughing and shortness of breath, caused by the inflammatory responses and narrowing of the airways.

Previously, this has resulted in children with severe allergic asthma having acute deterioration, prolonged hospital admissions, and increased risk of mortality, affecting childhood experiences and reducing the quality of life. Furthermore, this burdens healthcare systems with extended bed stays and healthcare costs.

This paper is a report of two paediatric patients who have battled chronic asthma from early childhood, but since the trial of Omalizumab, they have significantly improved their asthma control.

It is essential to acknowledge the drug's effectiveness and promote its use among health professionals. Nurses are at the frontline and are vital in providing knowledge and education. Alongside physicians, nurses are essential promoters of treatment. The multifaceted role of paediatric nurses as carers, advocates and health promoters places them in a crucial position to improve the quality of care for children, young people and their families.

Keywords: Chronic asthma, Omalizumab, quality of life, reduced hospital admissions, health promotion, case report

INTRODUCTION

In late 2019 and early 2020, Australia was consumed with bushfires that flounced across more than 11 million hectares, with record-breaking temperatures and smoke haze that filled the skies for months. Amongst the millions of people who lost property and houses were those who were silently struggling with their worsening health problems.

According to the National Asthma Council Australia[1] bushfire smoke, debris and ash particles distributed by the wind can trigger asthma symptoms, causing wheezing, breathlessness, coughing and chest tightness.

During this season, it was predicted that increased presentations for asthma would be expected in emergency departments and healthcare settings, especially for those around fire zones and those affected by smoke haze.[2]

More so in the paediatric population, due to children being more susceptible to becoming unwell with more rapid deterioration.

However, in a small cohort of paediatric patients with chronic asthma, exacerbations and hospital admissions were prevented. The two cases reported in this paper were on a trial of the drug, Omalizumab during the bushfire season. To date, there are limited studies of this drug trial on children in the northern and southern hemispheres, and no case reports of this drug in paediatric patients residing in Australia.

Omalizumab is indicated for children over six years of age with moderate to severe allergic asthma that is uncontrolled and where standard therapy is proven ineffective. Omalizumab is a monoclonal antibody therapy that 'targets inflammatory pathways that activate immune responses leading to airway inflammation.'[3]

Children must meet the specified criteria to commence the trial of this drug and it can be prescribed within the Pharmaceutical Benefits Scheme (PBS) by approved specialists.[4]

This requires patients to complete an asthma control questionnaire that is interviewer-administered.[5] Clinical information on diagnosis and severity, tests results of total IgE levels or blood eosinophil counts and arrangement of ongoing follow up assessments must be provided by the primary health practitioner.[3]

The toxicity and severity descriptors for the listing of Omalizumab include exhaustion of inhaled corticosteroids, inhaled beta-2 agonists and oral corticosteroids.[6]

In this case report, Omalizumab has proven significant improvement in asthma control, despite Australia's most substantial climate change challenges that fuelled extreme weather of ravaging bushfires. Consequently, highlighting the need for nurses and clinicians to promote the use of this drug for the paediatric population to improve the health of children and young people with chronic asthma.

PATIENT A

PATIENT INFORMATION

Patient A, a 10-year-old female residing in New South Wales, Australia, with chronic asthma. At six months of age, Patient A and family were on holiday at Sea-world in Queensland, Australia, and were forced to rush into hospital due to severe illness.

Patient A presented with wheezing and shortness of breath. The episode resulted in a four-day stay in the hospital.

Nurses administered oxygen to Patient A to maintain adequate oxygen saturation levels above 90%. In addition, blood tests were performed on Patient A, including venous blood gases and C-reactive proteins, which detected no abnormalities. Patient A was discharged with no clear explanation about the diagnosis. Moreover, Patient A was deemed too unsafe to return home on an air flight due to potential respiratory complications, therefore the family drove home across state borders to New South Wales.

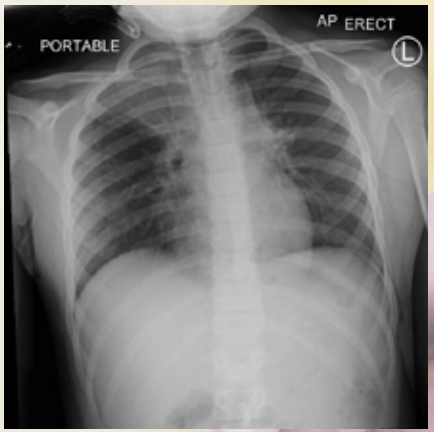
Patient A was admitted with subsequent acute hospital admissions three to five times a year with lengths of stay up to seven days until a diagnosis of asthma at the age of three. The following five years included more blood tests, chest X-rays, lung function tests with repeated hospital emergency presentations, and inpatient admissions for Patient A. In addition, Patient A was representing Australia in regional swimming and athletics sports at the time but thought the rise to state competitions would be relinquished due to the devastating effects of asthma exacerbation and extended periods of hospital admissions that were experienced in early childhood.

At eight years of age, Patient A was taken to the resuscitation bay in the emergency department at a metropolitan hospital. Patient A presented with severe hypoxia, with oxygen saturations of 86% in room air. Patient A acutely deteriorated and required a non-rebreather mask to administer oxygen. Nurses delivered 20 minutely bursts of Salbutamol nebulisers and Prednisolone. Due to further deterioration, Patient A required intravenous Hydrocortisone and intravenous Magnesium Sulphate, following the paediatric state-wide asthma guidelines.[7] Nursing staff had significant clinical concerns for the health of Patient A due to the rapid deterioration.

CLINICAL FINDINGS

Nurses provided one-on-one care for Patient A, who was acutely deteriorating. It was noted that Patient A had a penicillin allergy but was of no significant concern to this acute episode. Chest auscultation revealed widespread wheeze and crepes in the left upper zone. Radiographs revealed collapse and consolidation in the right upper lobe and mild perihilar bronchial wall thickening. According to reports, this remained persistent for several days (Figure 1).

Figure 1 Chest X-ray of Patient A



The medical team carried out blood tests that revealed no inflammatory markers elevation. The patient had no fever to suspect infection or progressing pneumonia. A normal total IgE range is 0 to 4 kU/L in newborns and 0 to 148 kU/L in older children.[8] Patient A, IgE level was taken two days after the acute episode and revealed elevated levels of IgE 1734 kU/L. The elevation in IgE levels indicated a likely exposure to specific allergens causing the acute deterioration.

TIMELINE

The drug, Omalizumab was recommended for Patient A by a paediatrician, specialising in respiratory medicine, following the repeated acute episodes of deterioration to hospital and elevated IgE levels. IgE mediated conditions, like asthma, have historically been treated with corticosteroids, antihistamines, and anti-inflammatory medications. However, Patient A failed to respond to these treatments.[9] Patient A met toxicity and severity descriptors for approval, with uncontrolled severe allergic asthma and high IgE levels. The use of inhaled corticosteroids, inhaled beta-2 agonists and oral corticosteroids was exhausted. Patient A already had nine emergency admissions, 21 inpatient admissions, and over 31 outpatient visits since the age of one.

In April 2019, Patient A started on the trial of Omalizumab. At the time of drug commencement, her weight and height were appropriate for age, with a BMI of 19.7kg/m2. At age 10, Patient A's treatment included inhaled Breo Ellipta and oral prednisolone. Salbutamol inhalers were only required once or twice a week during activities or sport and Singulair was discontinued.

Since commencement of Omalizumab therapy, there has been a significant reduction in hospital admissions for Patient A.

Patient A records only one inpatient admission with wheeze requiring salbutamol inhalers, attributed to the seasonal weather change. Patient A now has bimonthly subcutaneous Omalizumab injections and reports no side effects to the drug. Although it requires outpatient visits to the hospital every two weeks, it is only a 30-minute consultation compared to hospital admissions for several days.

Since the commencement of Omalizumab, Patient A has been able to participate in state athletic competitions and is due to extend the trial of the drug for a further six months.

PATIENT B

PATIENT INFORMATION

Patient B is a 17 old female, trained dancer, aspiring to be a paramedic. Patient B reported a very shadowed childhood due to repeated hospital admissions. On Christmas Eve, Patient B was taken to hospital at age two, presenting with wheezing and shortness of breath, triggered by coryzal, flu-like symptoms.

Paternal and maternal history of chronic asthma provided this family with insight into asthma management, alongside a sibling who was also being treated for asthma. Therefore, the family was familiar with asthma medications, including salbutamol and prednisolone.

At age five, sensitisation to animals and food allergens like peanuts was discovered. Patient B had frequent admissions to hospital lasting one to three days, while requiring regular salbutamol and Atrovent inhalers at home. The effect of severe allergic asthma progressed into the teenage years, with more hospital admissions. Patient B reported several episodes of wheeze and chest tightness which required oxygen in hospital for extended periods of time. Furthermore, increasing length of stays in the hospital for up to six days.

At age 11, following cross-contamination of nuts in a birthday cake, Patient B was rushed to hospital where, in a resuscitation bay, nurses administered intramuscular Adrenaline, nebulised Salbutamol and Atrovent, saving this young girl's life.

Further episodes were experienced on a family holiday to the United States when Patient B ate chips at a baseball game and had a suspected anaphylactic reaction. Patient B had signs and symptoms of an acute reaction, in response to a food allergen, with facial swelling, eye swelling, redness and itchiness. Patient B describes her childhood years as always being sick and in hospital. The family stress levels were increased during family outings and at dance auditions, with the potential for Patient B to have asthma exacerbations and likely hospital admissions.

CLINICAL FINDINGS

At age 14, with a confirmed diagnosis of asthma, eczema and allergies, Patient B needed further intervention. Patient B had been exposed to several chest X-rays due to acute hospital admissions, alongside blood tests and lung function tests which highlighted the need for further treatment. Skin prick test results showed moderate responses to house dust mite and pollen from shorter grasses, reactivity to hooved animals, insects and mould. Food allergen tests showed a response to peanuts and a small response to prawns.

Following four acute emergency admissions, chest X-rays with moderate to severe asthma exacerbation revealed no abnormalities. Although anaphylaxis to peanut was excluded, consultation with an allergy and immunology physician, recommended an EpiPen be prescribed due to accidental exposures in food, providing high risk of acute deterioration, if antihistamines were not readily available. IgE levels were significantly elevated in Patient B, IgE 1729 kU/L.

TIMELINE

Omalizumab was commenced in March 2019 with good adherence to treatment while continuing Symbicort nocte and salbutamol as required. Weight and height were appropriate for age with a BMI 24.4kg/m2. Patient B had reported 20 emergency admissions, 23 inpatient admissions and 24 outpatient visits throughout childhood. The commencement of Omalizumab has improved quality of life for Patient B and the family. Patient B has had no further admissions to hospital, no further need for steroid use (prednisolone) and limited need for salbutamol inhalers. Patient B had previously missed several days of school, and since the commencement of Omalizumab treatment, Patient B has had no missed school days due to chronic asthma.

DIAGNOSTIC ASSESSMENT & THERAPEUTIC INTERVENTION

Patient A and B both expressed the challenges of dealing with chronic asthma in childhood and teenage years. The exposure to chest X-rays at every admission was counter-effective at times, not indicating a change in the clinical management of the acute asthma episodes.

Clinical findings from spirometry for Patient A are expressed in Figure 2. Spirometry enables the measurement of changing lung volumes during forced breathing manoeuvres, used to monitor children with chronic asthma and determine the degree of airway obstruction.[10] The FeNO measurements for Patient A, pre- and post-Omalizumab revealed a significant reduction from 102ppb to 20ppb. Nine months after starting Omalizumab treatment, the spirometry was abnormal, consistent with a mild obstructive pattern with an only bronchodilator response. Therefore, Patient A has required continuation of regular Brio ellipta and salbutamol when required.

Both patients identified that frequent hospital admissions did not allow them to experience a normal childhood. Patients A and B reported subcutaneous injections every two weeks preferable over frequent hospital stays due to asthma exacerbation. Although, momentary pain would be endured during the administration of the subcutaneous drug.

Furthermore, Patient B's parents reported frustrations of no subsidised funding for asthma medications compared to the recognition found with conditions like diabetes. It was recognised through Patient B's family that the burden of a chronic condition like asthma not only affects the child but the whole family.

FOLLOW-UP AND OUTCOMES

Since commencing Omalizumab, Patient A has had no hospital admissions for over 10 months, with significant improvement in asthma control, with no side effects. Patient B reported no admissions to the hospital since commencing Omalizumab and no days off school, even during the bushfire season.

Patient A and B both have good adherence to fortnightly subcutaneous Omalizumab injections and six-month follow up with their treating paediatrician. This drug has contributed to significant improvement in the quality of life for both Patient A and B and also for their families. Nursing staff have observed significant advances in the patients' tolerability of the medication and administration is less time consuming, with consultations only lasting 30 minutes. Furthermore, Patient A reported having less fear of coming into the hospital, knowing that inpatient stays were no longer required, and clinic visits were less confronting than acute emergency admissions.

Patient A did not report any adverse side effects to Omalizumab. However, Patient B reported mild musculoskeletal pain to the limb of the injection site and feeling tired on the day of injection, but reports return to baseline after 24 hours.

DISCUSSION

Omalizumab is the first targeted biological treatment approved for children with chronic asthma.[11] Omalizumab remains an underutilised drug for children with moderate to severe allergic asthma, in Australasian society. The mechanism of its action is shown in Figure 3, and patients' response to this drug is significant.

See figure 3.

The Australian eligibility criteria for IgE requires patients to have a total serum IgE concentration ≥ 30-75IU/mL.[13] In both cases, IgE levels were significantly higher before starting Omalizumab therapy. However, IgE levels were significantly reduced following treatment with Omalizumab. In effect, haltering the impact of asthma symptoms. Patient A and B's usual response with chronic asthma included airway oedema, smooth muscle contraction, wheezing and chest tightness, and was effectively disengaged through the use of this drug.[14]

Alongside the burden to patients and families with extended hospital stays, specific events can have a psychological effect on children. At age nine, Patient A described feeling afraid of hospitals and not having a normal childhood. Patient A recollects the several blood tests endured during hospital admissions, which was a painful procedure. Poorly managed pain from blood testing can have short term and long-term psychological impacts on children and young people, as described by Patient A, 'as fear' affecting quality of life.[15]

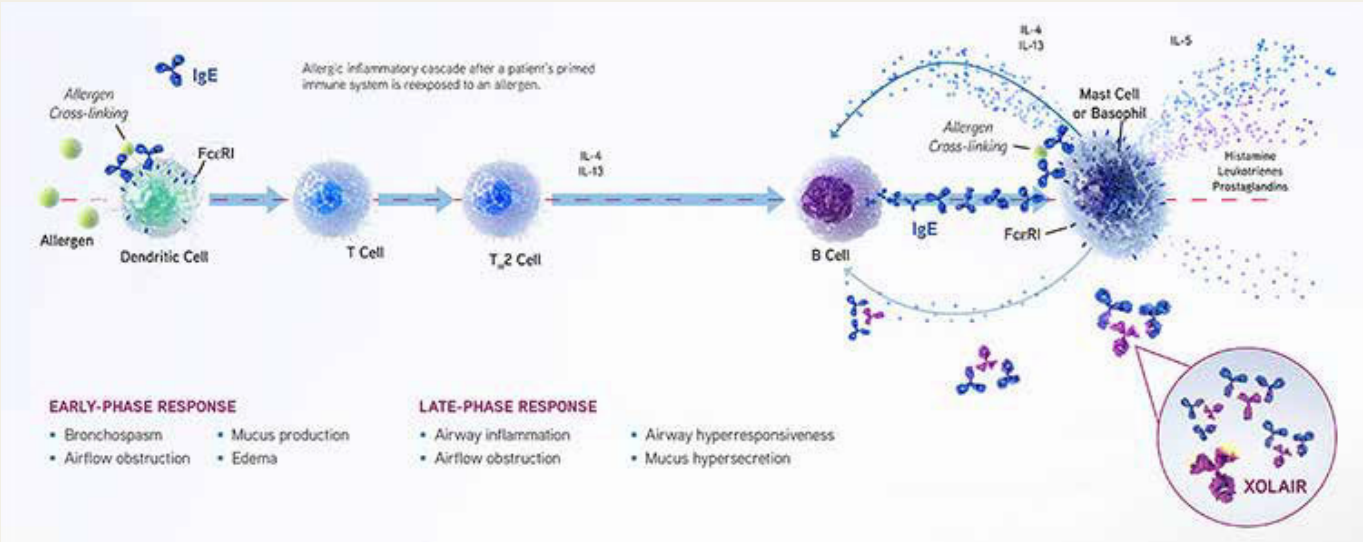
A European study reported three children receiving treatment and referred to Omalizumab as providing a 'renewed optimism' for managing children with severe asthma.[11]

Omalizumab has been shown to reduce asthma exacerbation rates while also

Figure 2 Spirometry results for Patient A

Patient A		
	Baseline (Year 2019)	**After 9 months + Omalizumab**
FEV1 (% pred)	98	77
FVC	105	94
FEF25-75%	76	44
FEF	122	88
FeNO	102	20
Current treatment	Salbutamol + Singulair + oral steroids (prednisolone)	Brio Ellipta 200/25 + PRN Salbutamol

Figure 3 Omalizumab mechanism of action designed to target IgE[12]



reducing the use of inhaled corticosteroids in children. The toxicities and side effects of standard treatments, while associated with poor asthma control, do not promote children's health in Australian society.[16] Health promotion is described as the process of enabling people to increase control and improve their health. As defined by the World Health Organization,[17] it can only be achieved by building healthy public policies, creating supportive environments and strengthening communication action and personal skills. Nursing staff are vital in bringing health initiatives to the forefront. Consequently, there is a need to promote the use of Omalizumab for the treatment of moderate to severe asthma, in more paediatric facilities in Australia to alert clinicians of its existence and capabilities to improve quality of life for children and young people.

According to the Australian Medicines Handbook,[18] the most common adverse effects from Omalizumab include injection site reactions, rash, bleeding (nosebleeds, heavy menstrual bleeding, haematoma), headache and musculoskeletal pain. However, experiences from Patient A and B significantly differ from the evidence cited. Patient A had no adverse reactions, while Patient B reported mild musculoskeletal pain.

CONCLUSION

The case reports suggest that Omalizumab has shown a considerable reduction in hospitalisation and significant improvement in the quality of life for children with moderate to severe allergic asthma. It constitutes a health promotion response from the leaders of paediatric care in Australia, with nurses at the forefront. However, initiation and prescribing of Omalizumab should be in collaboration with a paediatrician, respiratory physician or immunologist.[13] The patients in this case report they did not experience the severe adverse effects reported in the literature, and the benefits of Omalizumab far outweighed the potential side effects. There is a renewed hope for children and young people facing the challenges and burden of uncontrolled chronic asthma.

The use of Omalizumab is still vastly limited within Australia, and literature on the paediatric population is scarce. Additional research is needed to identify patients' long-term outcomes on Omalizumab. However, the two cases reported support the use of Omalizumab by informing health clinicians of a significant reduction in hospital inpatient admissions, a vast improvement in asthma control and acknowledgment of the improvement in patient experiences with a chronic condition. Nurses are vital in supporting patients and families on this journey to improve healthcare outcomes through new and innovative treatments, like Omalizumab and in addition, being a source of education and health promotion for Australia and the world globally.

PATIENT PERSPECTIVE

Patient A reported Omalizumab as "life-changing." Patient A's mother stated that Patient A is "a different child since treatment and she is now at ease having this treatment, making family life so much better."

Patient B reported that Omalizumab provided "vast improvement in managing asthma, heightening my personal confidence and capabilities."

INFORMED CONSENT

The patients and their parents/legal guardians provided informed written consent for the case report to be published.

ABBREVIATIONS

PBS	Pharmaceutical Benefits Scheme
IgE	Immunoglobulin E level
DNA	Deoxyribonucleic acid
BMI	Body Mass Index
PRN	Pro re nata (as needed)
FeNO	Fractional exhaled Nitric Oxide
PPB	Parts Per Billion

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Empowering multicultural women through health education

By Bindu Joseph, Ligi Anish, Annie Churchill and Elianna Johnson

The School of Health (SOH) at Federation University is deeply committed to community engagement, especially with health promotion activities directed towards multicultural women.

Academics from the School of Health commenced a health promotion program: 'Empowering multicultural women through health education'.

An individual's ethnicity and culture significantly influence perceptions of health and wellbeing, health behaviour and health literacy. Victoria is a culturally diverse state in Australia, with 28.4% of individuals born overseas.[1]

Evidence suggests that Culturally and Linguistically Diverse (CALD) backgrounds populations have a higher risk of chronic conditions and below-average access to health services attributed to low levels of health literacy, language barriers, discrimination and lack of awareness.[2]

CALD populations have high rates of preventable diseases (such as diabetes, cardiovascular disease and cancers) and low rates of physical activity, preventative screening attendance and dietary understanding.[3]

CALD populations are also attributed to higher rates of mental health conditions impacting health and wellbeing and an overall lower life expectancy than other populations.[3]

Social and economic factors also influence CALD women's health. Women from CALD communities account for 47% of workforce participation compared to 59.2% of women from other populations within Australia.[4]

CALD women primarily are attributed to caring responsibilities of children and families, resulting in limited exposure to external services to support their health and wellbeing. Migrants may have low education and literacy rates, resulting in a lack of understanding of health information and participation in society, resulting in a lack of social connection.[3] It is therefore essential for healthcare professionals to participate in community collaboration and conduct health education and promotional activities among multicultural community members.

The conceptualisation of this health promotion program by SOH, Federation University, started with the celebration of International Women's Week. The collaboration has continued following positive feedback and requests expressed by the CALD community women's group. The program aims to improve health awareness and understanding of physical and mental health wellbeing across the lifespan and promote help-seeking behaviours. The sessions are conducted fortnightly through virtual platforms in collaboration with the South East Multicultural Women's Network in Victoria and combine various multicultural not for profit organisations.

The fortnightly topics for health education activities were based on participant requests and coordinated by the group leader. Selected topics were carefully presented in a simple, uncomplicated language without medical jargon to suit the participants' level of understanding. The academics were proficient in practising culturally safe behaviour. The topics' physical and mental health aspects were discussed, with the opportunity for participants to ask questions directly to the presenters.

Each session concluded with the distribution of local and national resources and local healthcare services information for the participants.

The health promotion principles of this fortnightly activity included introducing a broad health concept selected by the participants (collated by the group leader). This active decision making ensured the participants were interested in the topics under discussion and the process would empower them to engage in the discussions to gain greater control of knowledge and actions required for their health.

A lively discussion and question time also helped participants to action queries in a comfortable and safe online environment.

CONCLUSION

The culturally and linguistically diverse women who participated in our fortnightly health promotion program agreed the activities were relevant, informative and supportive of their healthcare queries. Community collaboration and productive, innovative, and mutually beneficial

partnerships can improve health outcomes and improve patient satisfaction. However, there is an evident gap in providing these services for CALD populations with poor access to health information.

The success of this small collaboration heightens the need to address a gap in health promotion and education for multicultural communities with limited or no access to key ESL resources and health information. Therefore, it is suggested that health promotion in these female CALD communities who currently "miss out" on health information activities may reduce their healthcare footprint costs if targeted for participation in the future.

POST SCRIPT

As a result of this initiative, significant thought has also been given to multicultural women with little ESL skills and how health literacy can be addressed with this "overlooked" cohort. Free-to-air media services can reach 99% of the Australian population and commercial television broadcasters offer up to 15 digital TV channels.[5]

Of note, there is little free to air television and radio advertising for CALD communities to be clinically informed, eg. multilingual spoken options on Covid-19 literacy and family health. While limited print resources eg. brochures, are found in some health domains, it appears there is little access to appropriate and supportive information via free to air television and radio for this cohort of women and their families.

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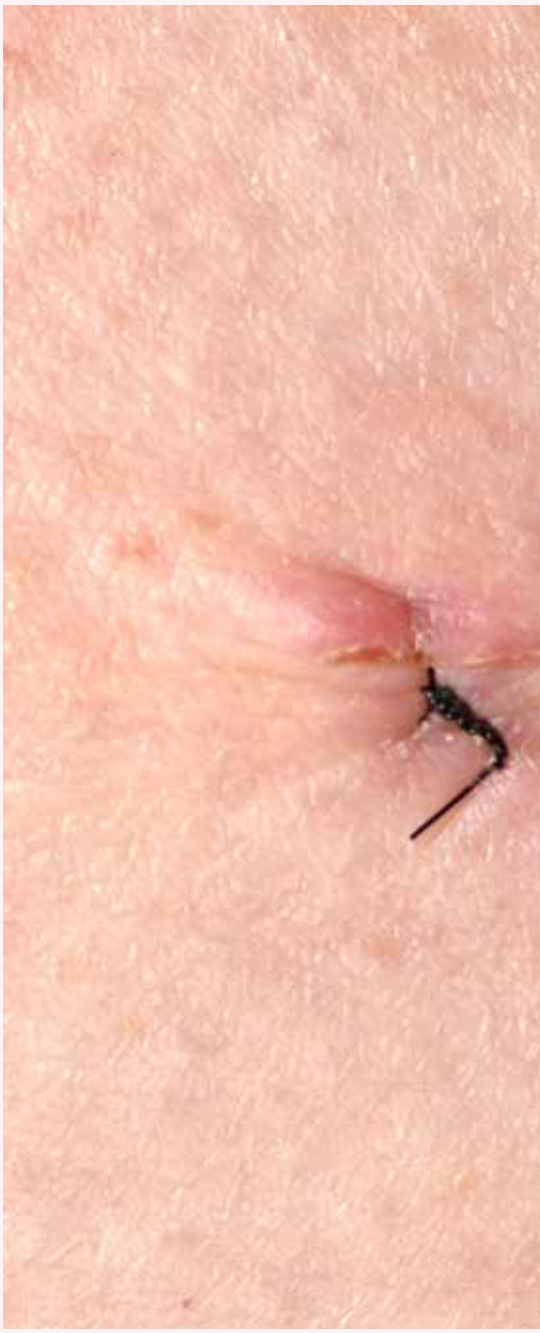
Wound management

By ANMF Federal Education Team

Wound management is an ongoing treatment of a wound by providing an appropriate environment for healing, by both direct and indirect methods, together with the prevention of skin breakdown.



Proper management is determined by the wound's size, depth, severity and location over the care period. This management is changing rapidly due to the advancement in technologies which is shedding more light on the aetiology of the wound and its healing process.

Nurses play a crucial role in the management of wounds. They need to have good current knowledge and be more aware of their own wound care practices to bring about more effective wound management.

To provide quality wound care, you must have a sound understanding of skin structure, the wound healing process and the type of wound you are caring for.

It is also important to understand barriers to effective wound healing.

Applying evidence-based wound management knowledge and skills is paramount for achieving the best possible patient outcomes.

A wound is any damage or break in the surface of the skin

They can be:

- Accidental, eg. burns, abrasions, paper cuts, skin tears
- Surgical, ie. incision
- Due to underlying disease, eg. diabetic ulcers
- Due to some skin conditions such as eczema or psoriasis[1]

WOUND HEALING

Healing is a response to the injury that sets a sequence of events in motion. Except for bone, all tissues heal with some scarring.

The object of proper care is to minimise the possibility of infection and scarring, minimise pain, and promote client comfort.

New insights into wound healing and wound care management have led to a proliferation of wound dressings and care products and it is important to know which is the correct product for the type of wound being cared for.

Wound healing is a complex sequence of events. It requires nurses to have good assessment skills and currency of knowledge about the best treatment options available for managing varying types of wounds.

STATISTICS

The care of wounds is an important and costly aspect of healthcare in Australia due to the frequency and complexity of clinical presentations involving wounds.

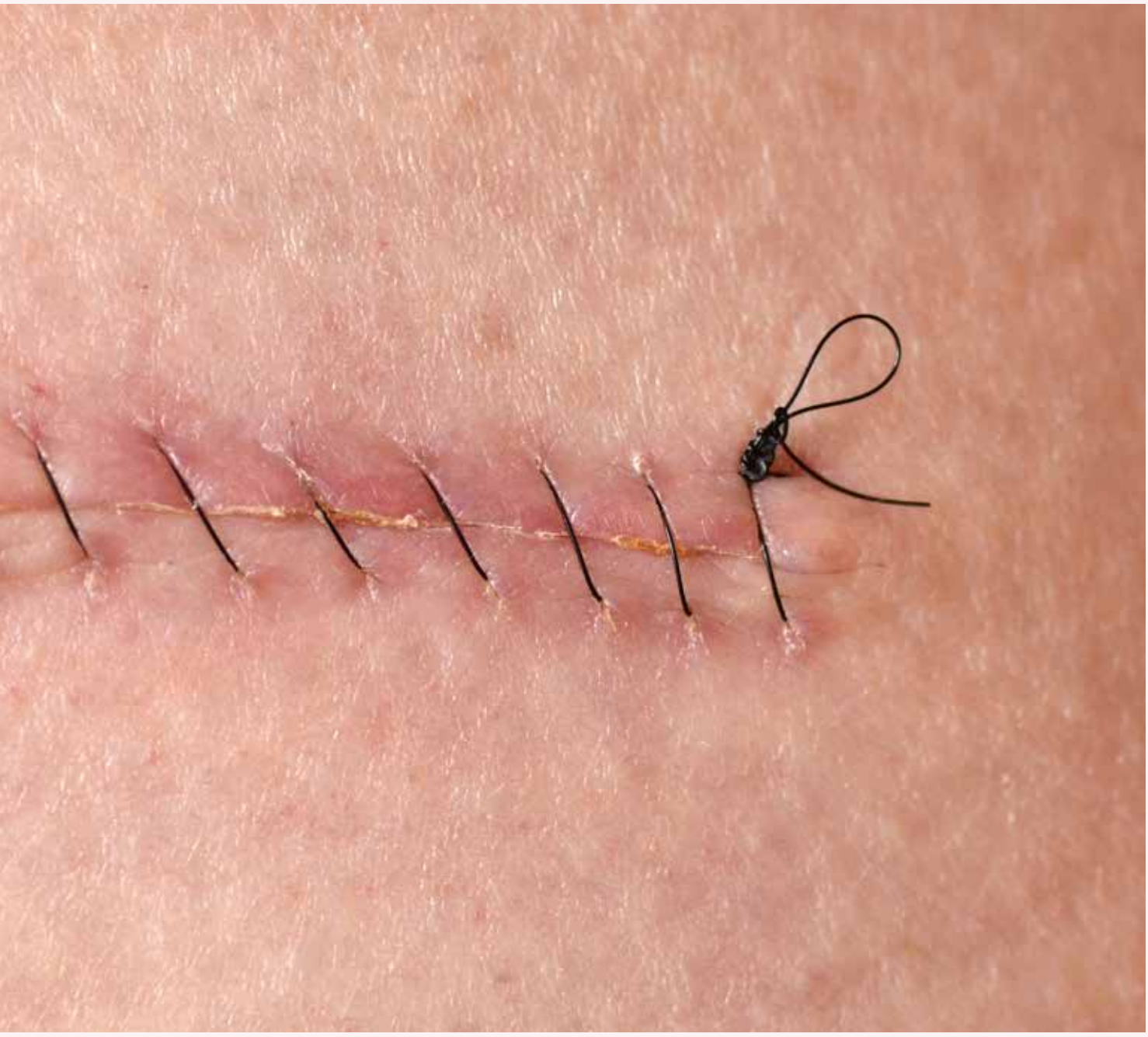
However, Australian data is limited on the incidence and prevalence of chronic wounds within all healthcare settings, particularly within the primary care setting.

The majority of chronic wounds in Australian hospitals and residential aged care facilities (RACF) consist of pressure injuries (84%), venous leg ulcers (12%), diabetic foot ulcers (3%) and arterial insufficiency ulcers (1%).

Approximately 450,000 Australians currently live with a chronic wound, directly costing the Australian healthcare system around AUD$3 billion per year.[2]

Chronic wounds are most prevalent among people aged over 60 years and those with chronic health problems such as diabetes, obesity and cardiovascular disease, all of which are increasing in prevalence.

Most chronic wounds are linked to at least one of these chronic diseases, particularly diabetes and peripheral vascular disease. Chronic wounds present a significant health and economic burden to the Australian



healthcare system, providers of healthcare services and patients themselves.

This burden is often underestimated as available data is largely limited to hospital and residential care facilities. Chronic wounds may also be considered merely as complications of other comorbid conditions or a normal part of ageing and, therefore, not accurately reflected in the data regarding the overall burden of disease. However, chronic wounds have been shown to severely impact quality of life, reduce an individual's capacity to work, and increase social isolation.[2]

Evidence shows that most chronic wounds are not properly diagnosed or treated and most healthcare providers receive little or no formal wound care training.

Inconsistencies in wound management practice and the use of outdated methods contribute to high costs and poor patient outcomes. With this in mind, key obstacles in providing evidence-based practice in wound management include limited education and training among health professionals, lack of awareness and support to invest in optimal clinical care, and the inadequate reimbursement and high costs associated with providing the best available wound care services.

Appropriate funding and enhanced education in primary care may improve the uptake of evidence-based practice, which would result in faster wound healing and better outcomes for patients.

Therefore, the expertise and skill associated with wound management must be highly emphasised, as care must be adapted to each patient with careful consideration given to underlying disease.[2]

WOUND PREVENTION AND MANAGEMENT

Wounds Australia promote seven core standards for wound prevention and management (the Standards).

The Standards include the scope under which healthcare professionals' practice in collaboration, clinical decision making, documentation, education and corporate governance.

The Standards provide a framework that governs clinical practice, improves safety of care and contributes to care delivery at a consistently high level, promoting positive outcomes.

Standard 1 **Scope of practice**

Standard 2 **Collaborative practice**

Standard 3 **Clinical decision making: assessment**

Standard 4 **Clinical decision making: planning and practice**

Standard 5 **Documentation**

Standard 6 **Education**

Standard 7 **Corporate governance**[3]

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2 HOURS CPD

This is an excerpt from the Wound Management course on ANMF's Continuing Professional Education (CPE) website.

The complete tutorial offers two hours of CPD.

Topics covered in the course include: Statistics, wound management and prevention, skin structure, the healing process, factors that influence healing, types of wounds, wound assessment, wound management, wound cleansing, wound pain, wound dressings and general wound dressing procedure.

To access the complete course, please go to: 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**

anmf.org.au/cpe

Julie Reeves

ANMF Federal Professional Officer

Supporting early career nurses and midwives

The national Early Career Nurse and Midwife working group have been working together for many years now with the common goal of supporting early career nurses and midwives to find meaningful employment and transition support. The group has recently achieved a number of important outcomes.

As the Chair, I feel honoured to support this dedicated group of more than 20 nurses and midwives who work in various settings, including health policy, academia, regulation, professional organisations and the union, to progress our common objectives.

The group has a number of key objectives, which include: monitoring and recommending changes to the collection of workforce data relating to employment; monitoring and addressing current issues that arise for early career nurses and midwives; and communicating and collaborating with governments and other key stakeholders regarding employment and transition requirements.

WORKFORCE DATA

The working group has been monitoring and analysing available data relating to the employment of these nurses and midwives for many years. The ANMF produces a yearly data set report. Despite this, the data on underemployment of nursing and midwifery graduates remains unclear. At the beginning of each year, we are unable to clearly identify how many newly graduating nurses and midwives in Australia gain meaningful employment following graduation. Jurisdictional health departments are able to identify how many positions are available in public health services and how many gain employment, however, the data on those who gain employment in private hospitals, aged care or in primary health settings is not collected and therefore, the whole picture is not understood. Without this data, it is difficult to develop effective policy to address issues leading to both under and unemployment.

The working group has been and continues to work closely with anyone willing to listen to address these data issues. We have formally met with the Commonwealth Chief Nursing and Midwifery Officer, the Commonwealth Department of Health, Ahpra and the NMBA, outlining the issues and suggested solutions. Everyone we meet with is dedicated to working together and through our collective work, a number of possible solutions have been progressed. These include enhancing graduate specific data collected in the workforce survey at registration renewal, enhancing the accuracy of the available student register data, and developing a survey for graduates to complete when they finalise their NMBA initial registration. If these actions were implemented, the professions would have at our fingertips the data we need to support employment of early career nurses and midwives.

UNEMPLOYMENT FOR EARLY CAREER NURSES AND MIDWIVES

Although we struggle to accurately identify how many graduating nurses and midwives haven't found meaningful employment, we use an annual ANMF survey which shows that many have been unsuccessful to date. The working group is dedicated to supporting these colleagues to remain connected to the professions and we continue to work with all stakeholders to improve employment opportunities for these nurses and midwives. The group also recently developed a *Fact Sheet – Support for Early Career Nurses and Midwives in Securing Employment* to assist these nurses and midwives in gaining employment and to outline supports they can easily access.

AHPRA/NMBA NOTIFICATIONS

Of concern to the working group is an increase in notifications being made against newly graduated nurses and midwives. Like other professions, nurses and midwives in their first year of practice need support to transition from student to a nurse or midwife. They need time and a safety support net to consolidate theory into practice. Unfortunately for some early career nurses and midwives, the lack of effective support has led to a notification. These nurses and midwives are new to the professions and often don't know who to turn to. The working group has developed a *Fact Sheet- Early Career Nurses and Midwives and Notifications*. This fact sheet provides an overview of the notification process, links to further information and where they can access support in a difficult time.

Early career nurses and midwives are a key part of our professions now and into the future. They need to be employed and supported during transition. The working group will continue to advocate for our early career nurse and midwife colleagues and I hope you will do the same.

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Kristen Wischer

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Aged care Work Value case – The aged care sector stakeholder consensus statement

The Royal Commission into Aged Care Quality and Safety found that wages and conditions in the aged care sector need to improve to ensure attraction and retention of a suitably skilled and qualified workforce.

In addition to recommending that unions bring work value applications in the Fair Work Commission, the Royal Commission also recommended the Aged Care Workforce Industry Council (ACWIC) lead the Australian government and the aged care sector to a consensus to support those applications.

The ANMF and other aged care sector unions have upheld their end of the bargain. Three applications are now on foot to increase wages by 25% for aged care workers, covered by the three aged care related awards, including the Nurses Award. In conjunction with making the applications, we requested ACWIC to act on the recommendation to help parties reach any consensus positions that would support the Work Value case.

As a result, ACWIC engaged former Fair Work Deputy President Anna Booth to convene stakeholder meetings to try and reach agreement on key evidence that would support the case that the work of aged care workers is undervalued. The first meeting, held in September 2021, was attended by representatives of the major employer groups, many providers, consumer groups and the applicant unions. The Commonwealth government advised that they would not be participating in these meetings.

In the following months, over a number of meetings, the parties worked hard to draft a document that reflected a range of significant consensus positions. At the conclusion of discussions, the Consensus Statement was circulated to all stakeholders who attended meetings, seeking endorsement of the Statement. In addition to the ANMF, HSU and UWU supporting the Statement, key employer representatives and consumer organisations have endorsed the Statement. We were very pleased to file the Consensus Statement with the Fair Work Commission in December 2021.

Here are some of the key points agreed:

- Stakeholders agree wages in the aged care sector need to be significantly increased because the work of aged care workers has been historically undervalued
- Minimum wages in awards need to be set according to the value of the work done, recognising increases in complexity of the work, skills and responsibility involved in the work and the changes to the conditions under which work is done
- Aged care consumers are entering aged care with more frailty, co-morbidities and acute care needs
- Expectations of RNs have increased markedly along with a shift of residents' needs from low to high clinical care needs. At the same time, the number of ENs has decreased
- AINs and PCWs in residential and home care are performing increasingly complex work
- Wages in aged care need to be competitive to attract and retain the number of skilled workers needed to deliver safe and quality care
- Any increase in wages must be fully funded by the Federal government

Since filing the Consensus Statement, the aged care sector has again experienced the devastating effects of COVID-19 and pressure on the Federal government to address the crisis in aged care has continued to grow. There is no doubt that low wages, particularly compared to what a nurse can earn in the acute sector or at a vaccination hub, are contributing to the problems faced in attracting and retaining staff in aged care. Similarly, a care worker can earn more in the disability sector than in aged care.

The Federal government has continued to take a 'hands off' approach to the Work Value case and has made what appears to be only a begrudging statement that it will absorb any outcome of the case. What is needed is leadership and active participation in the case.

The Work Value case is listed for hearing in late April to early May. Over 100 witness statements from union members, officials and experts have been filed on behalf of the ANMF, HSU and UWU. They tell a compelling story of why and how the work is undervalued and of the dedication, care and skill that is brought every day to the care of older people. It is time for the Federal government to listen to the evidence. The Consensus Statement is a valuable starting point.

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AND PREVENTIVE
MEDICINE

RECOGNISING AND RESPONDING TO SEXUAL VIOLENCE IN ADULTS

A **Free** Three-unit Program

ARE YOU A MIDWIFE OR 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 is a Department of Social Services (DSS)-funded initiative under the *National Plan to Reduce Violence against Women and their Children 2010-2022*.

Monash University is seeking expressions of interest from midwives and nurses who provide primary health care services to undertake this training at no cost. You can enrol in single or multiple Units.

DURATION AND FORMAT

Each six-week Unit includes two one-hour Zoom workshops and four hours of online interactive learning.

PROFESSIONAL RECOGNITION

Each unit has been accredited or endorsed for professional development by the Australian College of Nursing; the Royal College of General Practitioners; the Australasian College for Emergency Medicine and the Australian College of Rural and Remote Medicine. Each unit equates to six professional development hours.

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.

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Dr Micah D J Peters

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

24/7 registered nurse staffing in nursing homes is feasible and essential

The pandemic has exposed the urgency of 24/7 registered nurse staffing in Australian nursing homes.

Despite the need for 24/7 RN presence in nursing homes, the government has argued that this would be neither necessary nor feasible.

The Royal Commission modelling suggests that nursing homes will need an additional 6,325 full-time equivalent (FTE) RNs, 2,439 ENs, and 38,623 carers to achieve at least 'three-star' staffing in every home.[1]

Three-star staffing was recommended by the Royal Commission as a starting point to support dignified, high-quality care.[2]

Three-star staffing means the average resident could receive 200 minutes of care per day from RNs, ENs, and carers, including 40 minutes from RNs.[3] Nursing homes would also need to ensure at least one RN is onsite for morning and afternoon shifts from 1 July 2022. Implementation of these reforms was delayed by the government until October 2023.

The government has not agreed to implement the Commission's recommendation of 24/7 RN presence from 1 July 2024, nor increases to a total of 215 minutes of care per resident per day including at least 44 minutes from RNs ('four-star' staffing).

Neither the Commission nor the Government agreed to implement ANMF's recommended best-practice 'five-star' staffing.[4]

The ANMF recommends a staged approach for staffing reform; between now and mid-2026, staffing levels and skills mix would be required to increase to best-practice standards.

Fundamental to this, nursing homes would also need to ensure 24/7 RN presence from now.

This is both feasible and necessary to protect vulnerable residents during the pandemic and impending influenza season.

A Senate Committee suggested that there is insufficient evidence to support the feasibility or relevance of 24/7 RN presence in nursing homes.[5] This seems incompatible with the growing body of evidence that RN care is associated with better outcomes.[6]

It could be argued that the burden of proof should fall on the government to demonstrate that 24/7 RN presence would not support safe, high-quality, dignified care.

Weighted to estimate results for Australia's 2,716 nursing homes, the 2020 Aged Care Workforce Census reported that 80% of 1,329 participating nursing homes had at least one RN rostered on duty overnight every day.[7]

This indicates that most nursing homes already ensure that at least one RN is present overnight when staffing is usually lowest.

It would be reasonable to assume that if 80% of nursing homes already have at least one RN overnight, then it is likely that this is also true for other shifts.

The Commission heard that 35.5% of Australian nursing homes currently staff below a 'three-star' standard where residents receive less than 30 minutes of RN care per day.[2]

Plausibly, the same nursing homes that don't have at least one RN on night shift are those that provide less than three-star RN staffing.

To return to the modelling, if 6,325 RN FTE were added to Australian nursing homes, then every home would be staffed to a three-star minimum standard and would have enough RNs to ensure 24/7 RN presence.

As the government has already agreed to raise the minimum RN staff time standard to 'three stars', there is no reason to suggest that every nursing home could not feasibly ensure at least one RN is present on every shift.

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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

Honest appraisals – essential for safe delivery of clinical care

The Wallace review into the safety of maternity services at the Bacchus Marsh Hospital (BMH) concluded that there were catastrophic and unprecedented systemic governance failings within the obstetric services there.

The investigations into the cluster of potentially preventable stillbirths and neonatal deaths between 2008-2015 that followed continue to provide lessons for all practitioners to consider.

In all, 101 reported matters have been investigated by Ahpra and the National Boards concerning the conduct of 43 registered health professionals. Following the investigations, 21 practitioners were deemed not to be a risk to the public due to the practitioners either having surrendered their registration or demonstrating they had taken remedial action with respect to their performance and no regulatory action was taken. For the remaining practitioners, six were cautioned, six had conditions imposed on their registration and 10 were referred to either a panel hearing or tribunal (Ahpra News, 2022).

The most recent tribunal finding provides insight into the need for good governance structures, particularly in relation to staff performance appraisals and the need for individual staff members to undertake self-reflection in response to adverse events to identify limitations/deficits in practice in order to take remedial action to improve levels of competency.

In this case, the tribunal found that 16 allegations against Benedicto (a junior doctor at the time) in relation to the obstetric care of eight patients in her care to be proven, determining that the doctor's conduct amounted to both professional misconduct and unprofessional conduct. The conduct of concern included deficiencies in cardiotocography interpretation and record-keeping, failing to arrange an emergency caesarean section, failing to work within her limits of competence and failing to develop suitable management and treatment plans.

Although the tribunal acknowledged the systemic issues at the hospital where services were stretched due to population growth, staff shortages and unaddressed deficiencies in clinical skills needed for the safe delivery of babies, it concluded that poor working conditions did not absolve practitioners – even junior ones, from taking responsibility for their own incompetence or dangerous practice.

A part of Benedicto's submission was that she was often left to work alone and not supervised as required. Indeed her supervisor - Parhar's conduct had already been subject to review by a tribunal where it found serious failures in his supervision, assessment and support of junior doctors.

The Wallace review of the obstetric services also concluded that the governance framework at the time failed to ensure that there was any proper evaluation of adverse events nor any investigation of the suboptimal performance of those involved in these cases. This, according to the tribunal, may have contributed to the '… almost systemic complacency and misguided self-congratulations about the quality of the maternity service' held by the staff along with the blindness of those in charge that led to a failure to address what were clear shortcomings in the clinical performance of Benedicto who continued to receive positive performance appraisals despite the adverse events during the deliveries she attended.

The practitioner submitted that given the positive endorsement's of her performance by her supervisor, the tribunal should accept that she was 'understandably oblivious' to the actual standard of her care and could not have recognised the deficiencies in her practice. The tribunal considered these mitigating factors, however concluded that neither working in an environment where poor practices were normalised and where a practitioner has been let down by their supervisor absolves the practitioner from their own responsibility to ensure that they are practising in a safe manner that is consistent with their professional standards.

It was further noted that it would be reasonable to expect that involvement in a number of adverse events, including four stillbirths, would trigger some self-reflection by a practitioner regarding their performance, which in this case, was well below what could reasonably be expected from a practitioner with equivalent experience and education.

The tribunal made it clear that each practitioner has the personal responsibility for ensuring they practice safely within the limits of their competence, noting that a failure to recognise and work within one's scope and level of competence is a 'danger in any field of patient care'.

Self-reflection is a critical component of CPD planning and done well should help practitioners maintain clinical competence.

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AGED CARE ALZHEIMER'S DISEASE AND MANAGEMENT AND PALLIATIVE CARE

Tai Chi and chronic pain: Translation of an effective intervention into community

By Carol Chunfeng Wang

Credit: ECU Holistic Health Research Clinic

Chronic pain is a common and complex condition in Australia, and the symptoms of chronic pain reduce patients' quality of life, mentally and physically.

One in five Australians are living with persistent, ongoing pain.[1] More people are seeing their general practitioner (GP) for chronic pain. In 2018, chronic pain cost an estimated $139 billion in Australia, primarily through reduced quality of life and productivity losses.

Pharmacological treatments are usually recommended to relieve pain, but severe adverse effects related to drug therapy are suggested to be a significant limitation for use.

In this point, discovering and testing the effectiveness and safety of non-pharmacological interventions is necessary for the vulnerable patients who need long term treatment for chronic pain.

Evidence supports Tai Chi as a promising intervention in chronic pain management.[2] However, little evidence on the translation and dissemination of such practices to reach broader community-based settings, especially chronic pain management. Therefore, the objective of this article is to demystify Tai Chi for our Western nursing colleagues.

Tai Chi is commonly used to manage chronic conditions as a mind-body exercise. When practising Tai Chi, slow-motion and weight shifting may improve musculoskeletal strength and joint stability. Concentration and mindfulness meditation may modulate multiple aspects of health, including mood and functions of the immune and autonomic nervous systems.[3] Several trials have documented that Tai Chi showed promise on chronic pain.[4-5] For example, Tai Chi can improve chronic pain in patients with osteoarthritis, osteoporosis, lower back pain, and fibromyalgia.

Nurses in Australia should embrace the philosophy and practices of holistic modalities and include Tai Chi as an additional skill, expanding their already remarkable healing capacity. Students enrolled in nursing programs, especially programs offered for nurse practitioners and advanced nursing specialists, could adopt this philosophy by incorporating Eastern healing and Western medicine elements.

With a focus on integrating holistic health concepts, Dr Wang's research interest is in holistic health-related clinical trials using non-pharmacological therapies (eg. acupuncture, laser therapy, cupping, and Tai Chi exercise) to improve health outcomes, especially chronic pain. There is also an opportunity for nurses to research these areas (c.wang@ecu.edu.au).

(ecu.edu.au/schools/nursing-and-midwifery/ECU-holistic-health-research-clinic/)

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PEPA Mentoring

By Patsy Yates and Kylie Ash

Mentoring is defined as a relationship between an experienced and a less experienced person in which the mentor provides guidance, advice, support and feedback to the mentee to support their future experience and growth.

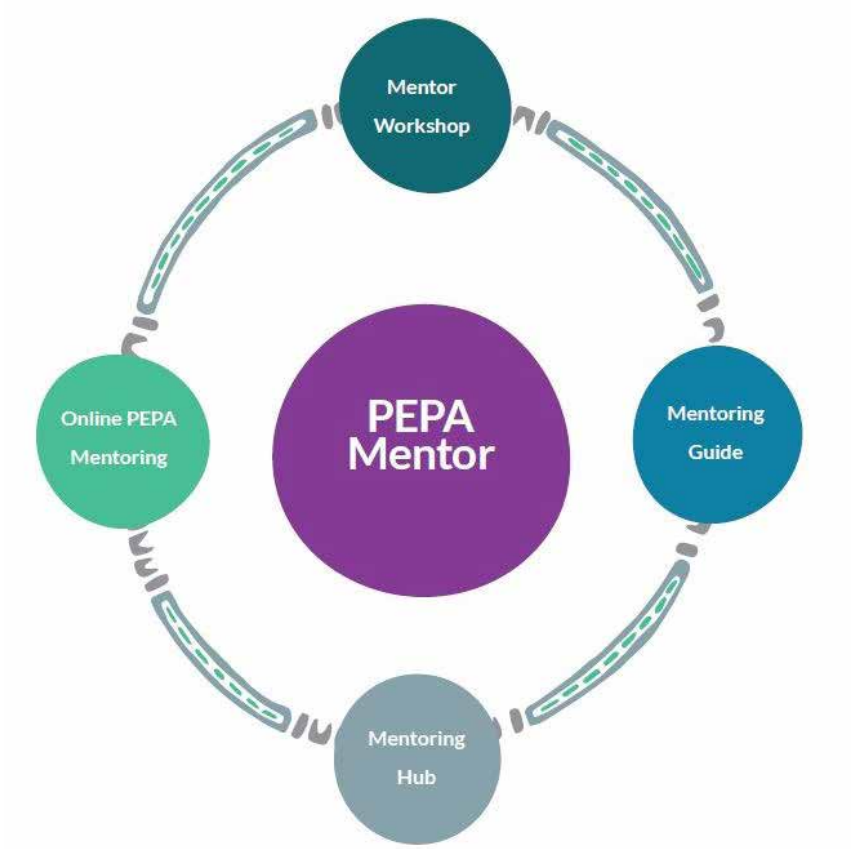
The goal of Program of Experience in the Palliative Approach (PEPA) mentors is to share palliative care knowledge with PEPA placement participants.

This sharing of knowledge supports the participants in taking palliative care experiences back to their work environment to integrate into providing care for their patients. Culturally safe, culturally responsive mentoring is part of this process.

The most critical ingredient in effective mentorship is that of relationship.[1] As such, the benefits of mentorship are not and should not be one-directional but are mutual to the mentor and mentee and the organisation (if any) involved in hosting this relationship.[2]

Mentorship is also seen as a crucial component of professional development, as it has the potential to improve the resilience of future generations of healthcare professionals. Among key points, the importance of cultural awareness or competence has been highlighted as having a significant positive bearing on the relationship between mentor and mentee.[3]

PEPA supports PEPA mentors to be lifelong learners and has increased the mentoring educational offerings to achieve this. Through the PEPA website mentoring pages at **pepaeducation.com/pepa-mentoring/** or registering on the Collaboratives Learning Management System (LMS) **palliativecareeducation.com.au/course/view.php?id=2** mentors can complete online modules of learning, monthly hub session webinars or download resources to support the mentor to be developing their knowledge, skill and confidence as a mentor.



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Contact the team at QUT if you have any questions: **pepa@qut.edu.au**

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End of life essentials: An online end of life care education resource

By Kim Devery, Deb Rawlings, Megan Winsall and Huahua Yin

Patients at the end of life commonly experience an increase in the intensity of symptoms and seek assistance from hospitals. Ultimately, every nurse needs to know about end of life care.

End of life Essentials (EOLE) provides free, evidence-based, online education on end of life care for health professionals working in hospitals. The modules were developed from the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Consensus Statement[1] designed to improve quality of end of life care.[2]

Each module focuses on a specific aspect of clinical care, including patient-centred communication, recognising the end of life, goals of care, teamwork, and patient states of mind. Some modules also focus on end of life care for patients in specific settings, including the emergency department, paediatrics, chronic complex illnesses, and patients who are imminently dying.[2]

The modules include self-reflection learning opportunities, which means that no matter how skilled or inexperienced, every clinician can grow and learn more. Interwoven within the education is a focus on clinical compassion, with the recognition that compassion in fast-paced environments can happen. A range of downloadable toolkits assist teams in implementing a unified approach to end of life care.[3]

To date, more than 23,000 health professionals have accessed the education, with nurses making up 71.6% of registrations. Ongoing evaluation shows that the education improves self-perceived knowledge, skill, attitude, and confidence in end of life care,[4,6] and enhances ability to initiate end of life conversations.[7]

The EOLE team are currently developing new education that aligns with the National Safety and Quality Health Service (NSQHS) Standards[8] to assist hospitals with change management, leadership, and governance.

For more information, go to: **endoflifeessentials.com.au**

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Evaluating dementia knowledge, attitudes, perceived skills and competence following dementia education and training in the Namaste Care program

By Sara Karacsony, Claire Eccleston and Melissa Abela

Care programs aimed at improving quality of life for older people with dementia in Australian residential aged care facilities (RACF) are limited.

Generally, few interventions target this population at risk of invisibility, social isolation, and loneliness as they approach end of life.[1] Knowledge of dementia in residential aged care staff is known to be variable and inadequate,[2] which includes knowledge of palliative care and pain assessment of people with advanced dementia.[3,4]

Namaste Care is a multisensory program dedicated to the care of older persons living with dementia as they approach end of life. Underpinned by a palliative approach, Namaste Care is a structured, evidence-based, person-centred and multisensory program for people living with advanced dementia.

Before adopting this program in an aged care facility in Tasmania, academic staff delivered an education workshop on the dementia trajectory and the Namaste Care program.

To date, there has been little evaluation done in the Australian context on workforce education and training to ensure the success of the Namaste Care program or the benefits of education in improving staff's overall dementia care knowledge, skills and competence before program implementation.

This project aimed to evaluate the effects of education and training about the dementia trajectory, person-centred care and the Namaste Care™ program on staff's dementia knowledge, attitudes, perceived skills and competence in end of life dementia care in one RACF in Northern Tasmania.

PROJECT OUTLINE

A mixed-methods design collected pre-test, post-test quantitative data using three validated survey instruments, the Questionnaire on Palliative Care for Dementia (Knowledge and Attitudes) qPAD,[5] the Palliative Approach for Nursing Assistants (PANA_Skills Questionnaire),[6] and the Sense of Competence in Dementia Care Staff (SCIDS).[7] Interviews and a focus group with key staff collected qualitative data following the education intervention. This comprised intensive four-hour workshop sessions conducted over three days to staff (n=35) in one residential aged care facility (RACF) in Tasmania.

RESULTS

After the workshop there were small but significant increases in scores for qPAD knowledge ($z = -2.913$, $p = .004$) and attitudes ($z = -3.001$, $p = .003$), and PANA_Skills ($z = -2.205$, $p = .027$]. The qPAD attitude score increased the most (median 44 to median 50). Median qPAD knowledge and PANA_Skills both increased by 2 points. SCIDS total and subscale scores were not significantly different, except for one subscale Building Relationships ($z = -2.456$, $p = .014$).

CONCLUSION

Raising awareness about changed behaviours and symptoms associated with unmet needs in people with dementia addressed gaps in understanding and learning opportunities for staff to consider residents in their care. Simulation of the experiences that Namaste Care offers taught staff new skills to connect with residents, including how to provide physical comfort, use expressive touch, and engage a person's senses to promote pleasure, happiness and comfort,[8] while preparing staff for the difference a Namaste Care program can make to residents, staff and families when introduced into the service.

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"Yilawura - Pleasant place to camp"

First Nations People of Australia – End of life care at Calvary Riverina

By Brooke Wichman and Krishna Lambert

Palliative Care Australia[1] believes quality end of life care can only be realised when it is culturally appropriate to the needs of the individual and their family.

Australian First Nations people, comprise of hundreds of cultural groupings with distinct languages and histories, as such, it can be difficult for non-Indigenous healthcare workers to successfully provide culturally appropriate end of life care.

To provide culturally appropriate services, it is essential healthcare providers engage with local country Elders and Aboriginal Liaison Officers to guide and support end of life care.[1]

For First Nations families experiencing an end of life journey, the gathering of family and community members is a mark of respect. The gathering is associated with the person's position within the community.[2] Therefore, it is important to ensure an appropriate large enough space to support participation in this cultural tradition.

At Calvary Riverina, it was identified that there was not a large enough space for families to come together. The family room, typically used for family meetings, did not provide a culturally aware environment, nor did the space cater for larger extended families to gather and grieve. As a result, an outdoor gathering place called Yilawura - 'Pleasant place to camp' was proposed. The space was designed in consultation with local Elders and a young Aboriginal artist. Yilawura incorporated existing trees but featured Wiradjuri Country native plants, seating for 12 people, access steps, disability access pathway, rock features, and interpretative and directional signage. Yilawura has provided a space for **healing, hope, nurturing and a connection to Wiradjuri Country.**

Australian First Nations people are underrepresented in accessing palliative care services.[3] This reluctance to engage in the western medical model of healthcare stems from a number of factors, including a lack of culturally appropriate services. However, with the right resources, training and awareness, we can hope to alleviate some of the barriers to providing culturally informed support to First Nations people and their families accessing end of life care.

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Engaging families and healthcare professionals working at acute hospitals in Goals-of-Care conversations

By Eun Hee Shin, Hazel Maxwell, Sharon Andrews and Christine Stirling

When healthcare professionals (HCPs) initiate timely Goals-of-Care (GoC) conversations for incapacitated patients, they can help support families in making healthcare decisions in their patients' best interest.

HCPs are well positioned to initiate GoC conversations that can help patients nearing 'end of life' avoid aggressive, costly, and non-beneficial medical treatments.[1,2] However, avoiding these GoC conversations, including advance care planning and end of life conversations, remains one of the most frequently stated problems in research literature in this nursing context.[3,4]

This study seeks to identify factors that may influence these GoC conversations. This study targets seriously ill older adults with acquired brain injury (ABI). Much less attention has been paid to brain-injured older patients in acute care settings than cancer patients and aged care residents with dementia.[5,6] The perspectives of HCPs and family members in an acute hospital setting in Australia is the focus of this work. ABI is associated with short-term mortality and poor functional outcomes in older adults.[7,8] The number of older adults with ABI is expected to grow with the rapidly increasing ageing population,[9,10] exerting a substantial social and economic burden on societies worldwide.[11,12]

Qualitative research methods involving case studies were adopted to elicit an in-depth understanding of complex issues in a real clinical setting.[13,14]

Twelve semi-structured interviews and document reviews from two case studies have been conducted thus far. These suggest that GoC conversations rarely occur and, if they do occur then the conversations happen only between the neurosurgeons, neurosurgical registrars, and the families of patients. All decisions around patients' GoC are discussed at the neurosurgeon and the registrar level, and the registrars do not believe they need input from nurses and allied health teams. Nurses and allied health team members firmly believe that initiating or engaging in GoC conversations is not part of their scope of practice and do not actively engage in GoC conversations.

The interviews with the family members of patients indicate that the doctors keep families updated, but they focus on treatment options and do not ask families about patients' values, wishes or preferences for end of life care. Nurses and allied health professionals agree on the need for systematic support at the organisational level so they can speak up and facilitate interprofessional GoC conversations to improve the quality of life for patients and their families.

This study will involve two further case studies and it is envisaged that the study will generate valuable findings by exploring in-depth the experiences of both multidisciplinary HCPs and patients' families. It will also contribute to filling the knowledge gap by examining the conditions which influence communications around GoC decisions, which will inform practice change.

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Last days of life: Paediatric and Neonatal Toolkit

By Sandra Coombs

"Care of the dying is urgent care",[1] yet many clinicians feel unsure about what is best practice.

This uncertainty is magnified when the patient is a child or baby. The Last Days of Life: Paediatric & Neonatal (LDOL: P&N) Toolkit was developed to support clinicians when caring for a paediatric or neonatal patient in an acute care setting during the last days of life.

Consisting of eight documents and 13 information sheets, this resource provides best practice guidance by strengthening the three key domains to support high-quality end of life care.

These include: recognising dying and initiating last days of life management, symptom management and information and communication for families. The LDOL: P&N Toolkit promotes a standardised, equitable, and safe approach to end of life care. A standardised approach enables a child to receive a high level of care regardless of the clinician's experience, the patient's location, ethnicity, religion, or social status.

Documents developed for the Toolkit include: *Initiating the LDOL: P&N, Medication Guidance Documents (Anticipatory Prescribing, Pain, Breathlessness and Nausea and Vomiting) and the LDOL: P&N Comfort Observation and Symptom Assessment Chart*. The information sheets are available to support communication. Topics include; 'Arranging a funeral for a baby', 'Siblings and the last days of life' and 'Taking your child home to die'.

The LDOL: P&N is based on the NSW Clinical Excellence Committee's Last Days of Life (Adult) Toolkit, modified for the neonatal/paediatric population by a multidisciplinary working group with representation from neonatal and paediatric clinicians including medical, nursing, allied health and pharmacy.

The LDOL: P&N Toolkit has been informed and tested through a NSW wide consultation, seven simulation scenarios, consumer feedback, and a six-month quality improvement pilot. Clinicians' feedback was obtained through an online survey or semi-structured interviews. Nine sites were involved in the pilot, during which the LDOL: P&N Toolkit was initiated on 12 occasions. Twenty-five staff volunteered feedback, which helped refocus care to what was important, assisted with language, and a good prompt to ensure key elements of care were not missed. For less experienced clinicians, the LDOL: P&N Toolkit provided guidance, whereas it provided reassurance for the more experienced clinicians. Overall, the LDOL: P&N Toolkit was identified as a valuable resource that increased clinicians' confidence and changed the focus of care to support best practice.

The LDOL: P&N Toolkit can be viewed on the New South Wales Paediatric Palliative Care Programme website.

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ELDAC: End of Life direction for aged care

By Patsy Yates, Jennifer Tieman, Deborah Parker and Karen Clifton

End of Life Directions for Aged Care (ELDAC) is a national specialist palliative care and advance care planning advisory service funded by the Australian Government Department of Health.

The second phase of ELDAC (2020-2023) will incorporate five workstreams:

Information and Advisory Services (Workstream 1) provides a suite of capacity building resources and access to a web-based navigation service. Environmental scans inform the development of information and advisory service resources. The five toolkits developed in the previous phase of the project (residential aged care, primary care, home care, legal, and working together) will continue to be improved and updated to incorporate the latest evidence and changes in the field. Three new toolkits will be developed to address priority needs and emerging issues.

Technology Solutions (Workstream 2) will continue the rollout of the ELDAC digital dashboard to provide aged and primary care services with direct measures of palliative care and advance care planning in their service. Additional technology-based tools, including a careworker app, an online self-care plan, and search filters and databases, will provide frontline aged care providers essential information. The technology will also service systems managers to optimise access and quality in palliative care and advance care planning for older people in all aged care settings.

Workforce Capability (Workstream 3) will build on the frameworks for developing health and aged care provider workforce capability established through the Palliative Care Education and Training Collaborative. This workstream will involve maintaining a database of education activities relevant to the aged care workforce, developing learning pathways that guide health and aged care providers to relevant learning resources, and designing and developing education and training activities that address identified gaps. This workstream will also continue a range of evidence-based implementation activities to promote active use of existing and new ELDAC toolkits.

Service Partnerships (Workstream 4) will continue to map local service networks to identify capacity in specialist palliative care and advance care planning in terms of knowledge, skills, and resources. Using the ELDAC suite of resources, national linkage facilitators will continue to work with aged care/palliative care/primary care local partnerships and regional networks, including Primary Health Networks, to implement a range of evidence-based, sustainable linkage strategies.

System Capability (Workstream 5) will develop responses and solutions to emerging issues in the sector. Topics to be addressed will be identified in collaboration with the Department of Health. An engagement plan will be developed in consultation with Commonwealth, State and Territory government representatives to ensure that ELDAC activities are integrated within existing activity.

The ELDAC project is administered by a consortium of three universities: Queensland University of Technology (QUT), Flinders University of South Australia (FU), and University of Technology Sydney (UTS); and five national agencies: Palliative Care Australia (PCA), Aged & Community Services Australia (ACSA), Leading Age Services Australia (LASA), Australian Healthcare and Hospitals Association (AHHA), and Catholic Health Australia (CHA). For more information please visit: **eldac.com.au**

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Palliative care program broadens to build capacity for Aboriginal and Torres Strait Islander people

By Patsy Yates and Kylie Ash

The Program of Experience in the Palliative Approach (PEPA) has grown and broadened its focus and launched the Indigenous Program of Experience in the Palliative Approach (IPEPA).

In 2003, the Australian Government Department of Health (DoH) funded the Queensland University of Technology (QUT) to deliver a national palliative care project called Program of Experience in the Palliative Approach (PEPA), which forms part of the Palliative Care Education and Training Collaborative. This Collaborative takes a strategic approach to education and training of the health workforce and delivers programs for priority healthcare provider groups across primary, secondary and tertiary settings.

In 2011 after recognising the instrumental role that Aboriginal and Torres Strait Islander health professionals play in breaking down the barriers to accessing palliative care for Aboriginal and Torres Strait Islander communities, a tailored program to support and build the capacity of this workforce was established.

In March 2019, PEPA engaged Aboriginal and Torres Strait Islander communities across Australia to understand, consult and co-design palliative care measures. Elders and community members in each jurisdiction, both urban and rural, contributed to this important conversation, and IPEPA was born.

IPEPA is a grassroots approach to breaking down the barriers to palliative care for Aboriginal and Torres Strait Islander peoples across Australia.

Informed by the community, for community, IPEPA is embedding Indigenous knowledge across all PEPA resources and facilitating two-way learning dedicated to:

- Building the capacity of our Aboriginal and Torres Strait Islander workforce to deliver palliative care;
- Developing Aboriginal and Torres Strait Islander communities with knowledge of palliative care, their rights and local services; and
- Supporting the cultural responsive capabilities of the mainstream service providers to provide holistic and safe palliative care to Aboriginal and Torres Strait Islander peoples.

IPEPA's vision is to break down the barriers to accessing palliative care experienced by Aboriginal and Torres Strait Islander peoples.

IPEPA's goal is to achieve the vision by preparing mainstream and Aboriginal and Torres Strait Islander health professionals to deliver high quality, holistic and culturally responsive palliative care to Aboriginal and Torres Strait Islander people and their loved ones.

For more information about IPEPA and the resources, go to **pepaeducation.com/about-ipepa/** Contact the team at QUT if you have any questions: **pepa@qut.edu.au**

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Just launched! PaCE – the Palliative Care Education Directory App

By Patsy Yates and Kylie Ash

The PaCE app provides the right resources, for the right people, with the right approach to develop the right palliative care capabilities.

PaCE is a resource directory for educators and health and aged care providers in the form of a mobile-responsive web-based app. PaCE helps you find learning and teaching resources that support the development of specific palliative care capabilities for a variety of professions and practice contexts. The directory includes information about learning approaches and modes of delivery for each resource. PaCE is free to use, and all learning resources are free to access.

So why should you use the PaCE App?

COMPREHENSIVE RESOURCES

The directory houses almost 200 resources that National Palliative Care Projects have developed. The selected resources are high quality and well-developed. You can see a resource, its learning outcomes, duration, certifications, capabilities, filters, and keyword tags in one place. The resource is then one click away.

SEARCHABLE CONTENT

Every resource has been reviewed and richly attributed with tags and keywords to improve the accuracy of your search result.

DYNAMIC FILTER FUNCTIONS

You have the option to refine your search to resources only relevant to you using filters. You can select specific capabilities, target healthcare provider audience, types of education or learning approach and modes of delivery.

EASY NAVIGATION

Navigation prompts to support your search journey.

SAVE AND SHARE SEARCH RESULTS

Registered users can save results for future reference and share resource links.

MULTIMODAL INTERFACE

Accessible on all devices, including smartphones, tablets and desktops.

The app has been developed and will be maintained by the Palliative Care Education and Training Collaborative at Queensland University of Technology (QUT). PaCE will support the activation of a whole-of-workforce approach to building the capacity of the health workforce to provide quality palliative care to all Australians.

Development of the PaCE directory app has been achieved through collaboration with National Palliative Care Project partners. A full list of project partners is available on the partner's page of the PaCE website. PaCE is funded by the Australian Government Department of Health and delivered by QUT.

PaCE is live now and available for you to access via the website: **pace.org.au/** To assist users in understanding how to use the PaCE app, we have developed a short instructional video **(youtube.com/watch?v=lnk6sUfLrFU)** which is available on the website. We hope you enjoy using this resource and find it a great support for your learning, teaching and clinical practice in palliative care.

Contact the team at QUT if you have any comments or feedback: **pace@qut.edu.au**

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Reinvesting nurse time in the quality of resident care – digital efficiency might be the answer

By Kasia Bail, Bernice Redley and Diane Gibson

Documentation is often cited as the 'least favourite' task of nurses in aged care. It can be compounded by duplication of items in accessible formats and locations and the sense of doing more 'paper-focused care' rather than 'person focused care'.

A recent study by the University of Canberra evaluating a new, co-designed aged care ecosystem (ACE) has found that using an implementation process that involved ground-level staff to create the system was highly valued by staff and residents.

ACE is a point-of-care documentation, decision-support and clinical workflow IT system to support care delivery. It can be applied in a variety of clinical environments. The deployment of ACE in aged care and the evaluation by the University of Canberra was supported by the Australian Government.

The independent mixed-method evaluation[1] collected data from 260 residents, visitors and residential aged care staff over two years and found that ACE was easy for staff to learn, use and navigate, and resulted in less time spent on 'waste' activities such as searching for information or documenting.

Nurses (RNs and ENs) spent less time on 'hunting and gathering' activities and the distance they travelled (steps) per shift was reduced. Care workers spent less time multitasking which helps to reduce their cognitive load. Nurses spent less time on documentation. With the additional reduction in time saved on 'hunting and gathering', the mean time saved by nurses following implementation of ACE was reinvested into more time with residents.

While time spent on documentation decreased, the quality of documentation improved across legibility, completeness and accessibility. ACE implementation was associated with increases in completion of:

- resident assessments;
- documentation of the nursing process;
- resident-focussed goal setting; and
- nursing evaluations of care.

The overall quality of resident care increased, with staff reporting being able to spend more time with residents; more able to respond to individual resident needs, and better equipped to manage the 'delicacies of dignity'.

Digital systems in aged care are often considered laborious, imprecise, counter-intuitive, and lack person-focused details. The improvement in both quality and completeness of documentation, coupled with time savings achieved by using ACE, is an important advance on earlier forms of electronic-based health records

Jindalee residents and staff using ACE

for residential aged care. This new research found that staff from various backgrounds and with different digital skill levels could use the new ACE with relatively short training, thereby reducing a major cost barrier to uptake. The many positive findings highlighted by this evaluation, and their potential for genuine improvements in the residential aged system, are particularly significant in the context of the Royal Commission into Aged Care Quality and Safety, and the Federal Government response in the May Budget.

The many positive findings highlighted by this evaluation are particularly significant given that the deployment was during the outbreak of the COVID-19 pandemic when staff and residents reported significant stress and behavioural issues as a result of the lockdowns.

We know that improving resident access to nurses improves the rates of unfinished care in aged care.[2,3] High quality, comprehensive data at the point of care would also assist clinical decision-making and further improve care. The results show major improvements in health can be achieved by streamlining the administration load on nurses and giving them back time to care.

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Gerontological nursing: A holistic approach to the care of older people

By Caroline Vafeas and Susan Slatyer

Upon graduation, nursing students in Australia and globally will spend more time caring for older people, who when they require care, will be frailer, more unwell, and present with more complex chronic and acute care needs.

With the Royal Commission's final report into Aged Care Quality and Safety presented in February 2021, a webinar highlighted 10 areas of concern addressed in a new text, *Gerontological Nursing: A holistic approach to the care of older people*.

Key areas identified for attention in the Royal Commission Summary include dementia care, mental health, elder abuse, mobility/falls, palliative care, nutrition/oral health, skin care, incontinence, medication and infection control. Dr Vafeas and Dr Slatyer share insights on how their new text addresses these areas of concern and how the resource can be used to prepare students to navigate the complexities of older people's healthcare across the care continuum.

Watch the webinar recording here: **youtu.be/n7cUszu5EQY**

If you are an academic and are interested in finding out more about *Gerontological Nursing* for potential course adoption, please request an inspection copy via **bit.ly/GerontologicalNursing_IC**

If you are a student or a nurse and wish to purchase a copy of the text, please visit **bit.ly/3utPTHt**

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A novel approach to understanding and improving the nutritional wellbeing and health of older people in hospital: The MEALS project

By Hui Chen (Rita) Chang, Chell Ataiza and Victoria Traynor

Dementia prevalence increases each year, with an estimate of 386,000 to 472,000 Australians living with the condition in 2021.[1]

Symptoms of dementia, including memory loss and issues with judgement, can greatly affect the activities of daily living of people living with the condition, such as eating and nutrition.[2] As the condition progresses, the level of care required for people with dementia (PWD) also changes and increases.

Nurses and other allied health staff are tasked to address the different needs of these patients in healthcare settings. Clinicians must provide individualised care to cater to specific considerations and preferences of PWD while managing their behavioural and psychological symptoms of dementia (BPSD) during mealtimes[3] to increase their food intake and overall meal experience.

We hypothesise that implementing our novel comprehensive model – Meals, Education, Action, Learning and Simulation (MEALS) – will improve staff knowledge, skills and attitudes and the way that mealtimes are addressed by RACFs and lead to the improved wellbeing, health and quality of life for people living with dementia.

Aim: This study is part of the 'needs assessment' stage of the MEALS project. We aimed to understand nursing and allied health staff's knowledge, attitude, and intention in assisting PWD during mealtimes. To achieve this, we adapted an existing questionnaire from a dissertation that investigated mealtime difficulties of PWD.[4]

Questionnaire: The 62-item survey comprised questions relevant to participant demographics, *knowledge* about dementia and assisting PWD with eating, *attitudes* regarding supporting PWD in mealtimes (ie. 'I do not know how to deal with the food intake difficulties of PWD'), and *intention* scales that quantified the likelihood of staff employing new feeding assistance skills or techniques.[4]

Participants: The study included 109 respondents from three (acute and sub-acute) hospitals in the Illawarra region, the majority of which were female (92%), registered nurses (75%), postgraduate degree holders (53%), and in their 40s (mean = 43).

Findings: The study found that staff knowledge and attitude were positively correlated with each other, suggesting that staff with further knowledge about dementia and mealtime assistance have more positive attitudes about assisting PWD with their meals. Multiple regression results show that staff attitude towards supporting PWD during mealtimes is a moderate significant predictor of knowledge, indicating that improved attitudes can lead to greater knowledge or education about dementia.

Additionally, the professional role of staff (ie. enrolled nurse), years of professional experience, and knowledge are significant predictors of the attitude variable. These specify that certain roles, longer work experience (years), and extended knowledge about dementia care may develop better staff attitudes toward helping PWD during mealtimes.

Implications: These survey results reinforce the importance of dementia and mealtime assistance education in developing more positive staff attitudes in supporting PWD during mealtimes that may help increase the food intake and nutrition of patients.

We launch the second stage of the MEALS project in 2022, which will develop and implement a simulation education program based on these needs assessment results.

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Gerontological nursing competencies goes national

By Victoria Traynor, Nicole Britten, Kasia Bail, Karen Strickland and Tracey Moroney

The Royal Commission highlighted what nurses in aged care already know: that workforce is the most critical aspect of aged care reform.[1]

Caring for older people living with multiple chronic illnesses, including acute exacerbation, while ethically responding to individual preferences in end of life or acute treatment trajectories, can be the most complex work a nurse can do. Yet, many people aren't aware that aged care nursing is a specialty in its own right, known as gerontology nursing.

The Universities of Wollongong and Canberra are pleased to present their contribution to increasing the awareness and enablement of the specialised knowledge and skills for nurses working in aged care through the Gerontological Nurse Competency (GNC) program. This year we are excited to announce the government funding, making the program free for participants.

The GNC program is an evidence-based mentoring and leadership program based on gerontological nursing competencies developed in the USA by the Hartford Institute for Geriatric Nursing[2] and developed in conjunction with aged care providers and gerontological nurses in NSW and ACT.

The GNC has been running for more than six years and has 11 core competencies:

- Promoting mental health and psychological wellbeing;
- Partnering with family carers;
- Providing evidence-based dementia care;
- Communicating effectively;
- Facilitating choices within legal and ethical frameworks;
- Providing palliative care;
- Providing optimal pain management;
- Maximising health outcomes;
- Facilitating transitions in care;
- Enabling access to technology; and
- Promoting mental health psychological wellbeing.

A previous multimethod study with five national providers, five Delphi rounds of surveys and focus groups with 68 participants found that the program was a positive experience and related to achieving competence in practice, improving their individual development and helping them realise their leadership responsibilities. The program specifically helps articulate the role of a new graduate and early career nurse in aged care, provides the crucial aspects to guide mentoring activities, and complements a strategic approach to recruitment, retention, education and quality strategies. Nurses can explore the 11 competencies through the Essential program (six months) and/or the Enhanced program (six months), which combined are equivalent and recognised as a graduate certificate.

The government-funded program in 2021–2022 will be evaluated with a mixed methods design, including a survey with components of key aspects of knowledge and care provision deficits identified in the Royal Commission, such as nutrition, dementia and palliative care knowledge.

We are looking for early-career nurses (one to two years after graduating a degree) interested in improving their confidence and competence in caring for older people in residential aged care. Experienced nurses committed to supporting the next generation of aged care nurse leaders are also wanted to support the program and remunerated for their time. Organisations who can support their workforce in this development are also encouraged to apply.

To express your interest in being a mentor, mentee, or organisation participating in the program, please go to **uow.info/gnceoi**

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Postgraduate students' perception of aged care knowledge, attitude and intention to work in aged care

By Hui Chen (Rita) Chang and Zhoumei Yan

Australia has been facing a shortage of aged care nurses for decades. More well-qualified nurses must fill the gap (approximate 13,000 shortfalls, a 26% gap in 2030) and forge a stable nurse workforce pool[1].

Therefore, nurses with advanced aged care knowledge, skills and competencies are crucial to providing quality and safe care services for older Australians in all settings[2]. However, little is known about postgraduate students' perception of aged care knowledge, attitude and intention to work in aged care. Therefore, a cross-sectional study was conducted by researchers from a public-funded university in New South Wales to explore the perception of aged care knowledge, attitude and intention to work in aged care before and after the postgraduate aged care curriculum among students in 2020.

The findings showed that postgraduate students showed a high level of aged care knowledge, attitude and intention to work in aged care before and after the aged care curriculum. The possible explanations might be that two-thirds of the participants had previous unfinished tertiary education relative to aged care subjects and one-fifth of the participants had previously worked in aged care settings. Besides, the results also found that age, years of working experience, enrol mode online learning (Australian domestic student) and on-campus learning (international student) and perception of aged care knowledge was positively associated with students' attitude towards aged care. In addition, the results revealed that international students are generally younger, have less work experience, lower level of aged care knowledge and negative attitude but a higher work intention than Australian domestic students.

The study made a significant contribution to filling the gap in knowledge, attitude and work intention of postgraduates in aged care. Although the aged care curriculum itself made limited impact on aged care knowledge, attitude and work intention towards aged care, it is not necessarily relative to the curriculum itself because students had a high level of aged care knowledge, attitude and work intention before enrolled in aged care curriculum and maintain it as high after the curriculum.

Our results showed that international students have higher work intention towards aged care. Therefore, it is suggested that a specific tailored postgraduate aged care curriculum can equip international postgraduate students to have sufficient knowledge, skills, and competencies to work in aged care and meet the nurse workforce demand in Australia.

Besides, the result also revealed that age, years of working experience, enrol mode, and perception of aged care knowledge was positively relative to attitude. Thus, we highly encourage those who have had the experience of studying or working in an aged care setting to continue their advanced studies in a postgraduate aged care course. As such, they would be able to continue to thrive in their career and demonstrate their leadership in the area of practice and inspire and influence the new undergrads to enhance the retention and productivity of the aged care workforce.

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The role of the registered nurse in aged care

By Rajkumar Cheluvappa and Selwyn Selvendran

In its explanation of "healthy ageing", the World Health Organization (WHO) connects wellbeing in ageing individuals to developing and maintaining their functional ability.[1]

Functional ability is 'about having the capabilities that enable all people to be and do what they have reason to value'. It refers to attributes of health that make ageing individuals able to meet basic requirements, build/maintain relationships, ambulate well, and contribute to society in some way.[1] Functional ability involves ageing individuals' inner abilities (sensory, pathologies, psychological elements, biological predispositions, etc.), their environment (society, family, residence, neighbourhood, pets, etc.), and the intricate interactions between them.[1]

The devastating ramifications of loneliness or isolation become more pronounced with ageing.[2] Older individuals engaged in strong social groups with more interactive activities experience less cognitive declines than their socially isolated counterparts, empowering them with support, cohesion, and interdependency.[3] Ageing individuals with strong social support networks have lesser mortality and morbidity.[4,5] The differences in health-related behaviours/outcomes of ageing individuals between nationalities, cultures and ethnic groups can be significant.[6,7] Artistic expression through music and spiritual activities was shown to increase the zest for life and improve health indicators in ageing Americans.[8] Self-identifying spiritual practices augment the holistic wellbeing of older Aboriginal individuals.[9] For optimal health and mental wellbeing, ageing

individuals must be empowered to choose (autonomy) their daily activities, nutrition, transport, therapy, rehabilitation, home modifications, etc.[10,11] Identification and reporting elder abuse empowers suffering, ageing patients.[12]

Promotion of healthy ageing at an individual level involves provision of tailor-made care with meticulous holistic factoring in both physical and psychosocial health.[11,13] Promotion of healthy ageing by nurses at the community level involves careful scrutiny of the physical and social environment in which the ageing individual lives, and carefully meeting the need for mateship, community interactions, philosophical discussions, and corporate spiritual practices.[14] There are several programs and resources promoting holistic wellbeing in ageing.[10,13] Long waiting times for accessing government-subsidised home care packages (**myagedcare.gov.au**) increase risk of death and necessity of transfer to residential aged care facilities.[15,16] Whilst waiting, family members and friends can be encouraged to roster and assist their ageing relatives in need of home care to enhance their functional abilities and to empower them to stay healthy longer at home.[17]

The Nursing and Midwifery Board of Australia (NMBA) Code of Conduct (COC) outlines the key role of the nurse in promoting quality clinical practice, including nursing practice involving healthy ageing.[18] It includes patient-centred, consultative, holistic, evidence-based practice (NMBA COC 2), culturally sensitive, respectful, practice involving privacy/confidentiality (NMBA COC 3), and equitable practice involving family/community (NMBA COC 7).[18] A nurse should ideally promote a positive, empathetic perspective of ageing without falsifying details or compromising facts.[10,11,13,19]

The ideal nurse is expected to have a good grasp of referral possibilities, multi-level aged health services (community/primary/secondary/tertiary), and aged care legislation to promote quality holistic healthcare.[10,11,13,19]

Communication lapses may be present, considering the health issues that an ageing individual might suffer from (dementia, cardiovascular issues, pain variations, hearing loss, etc.) or the sociocultural and linguistic background of the patient. Effective communication abilities and flexibility are a necessity for the nurse to identify and vary communication approaches efficiently/promptly relative to the complexities of these differences.[11,13,19]

Exposing ageing individuals to efficient use of electronic devices, medical gadgets, and communication technologies may improve communication promptness and accuracy, and promote a feeling of wellbeing as a result of instilling a positive perception of 'quick reach-out accessibility to someone who cares for me' in the ageing individual.[13]

Elder abuse of any kind (physical, mental, financial, etc.) can occur in a home, aged care facility, hospital, or rehabilitation centre and is frequently inflicted by a close relative.[20] Elder abuse is most common in community settings.[12] A good nurse should keep an eye out for tell-tale and/or subtle signs of elder abuse (especially behavioural changes), identify/report suspicions, and take steps to minimise further occurrences.[12]

A good nurse is expected to develop holistic but consultative patient-tailored care approaches (may involve patient's relatives/friends) and reflective practice to optimise quality care for ageing/aged individuals with health issues.[11,13]

Maintaining appropriate professional distance without losing the caring empathetic touch is a difficult but worthwhile nursing art to master.[13] The nurse should empower ageing individuals/patients by offering choices in activities of daily living, nutrition, transport, therapy, rehabilitation, home modifications, etc., as permitted by the care plan and applicable rules/regulations/law.[10,11] An ageing patient's cognitive/functional decline, health condition exacerbations, and new clinical issues are too keenly watched for by a good nurse.[13,19] A nurse should develop the clinical acumen to exercise discretion as to when to directly intervene and/or when to escalate to other clinicians.

Key elements of good care to ageing individuals are risk management and commensurate assessment of their immediate environment and community. Functional, cognitive, and motor deteriorations (current/anticipated) in ageing individuals should be factored in whilst assessing their environment and initiating steps to modify it towards minimising hazards/risks.[13,19]

Basic help at home can be accessed by applying for government-subsidised home care packages (**myagedcare.gov.au**). The waitlists are long. As of 31 March 2020, there were 59,071 applicants on the national prioritisation queue for a home care package (approved level) who do not have a lower level package; and 44,528 (approved level) who already have an approved lower-level package.[15] Longer waits for home care packages raise mortality risks or transition to residential aged care facilities.[16] The quicker specialist home assistance/reablement (restorative) services are accessed, the healthier the ageing process and the better the functional ability of the individuals concerned.[21]

As elder abuse is common and predictable, preventing/identifying/reporting elder abuse promotes healthy ageing.[12] No specific Australian elder abuse laws exist. The new Australian Capital Territory Elder Abuse legislation (passed on 13/08/2020) is set to come into force in April 2021.[22]

The Roper-Logan-Tierney model is widely used to optimise quality nursing care for ageing individuals.[23] This evidence-based model is founded on the ageing individual's capability to perform 12 basic activities

of daily living (ADLs): "… safe environment, communication, breathing, eating … drinking, eliminating, personal cleansing … dressing, controlling body temperature, mobilising, working and playing, … sexuality, sleeping, and dying".[24] Holistic patient-centred care, empowerment, empathy and reflective practice improves the quality of quality care for the ageing.[13] Close scrutiny/reporting and management of an ageing patient's cognitive/functional decline, health condition exacerbations, and new clinical issues promote healthy ageing.[19] Active social groups maintain/improves cognition and lessen mortality/morbidity.[5] Music and spiritual activities improve functional ability.[8] Empowerment with the ability to choose enhances functional ability and promotes healthy ageing.[25]

To summarise and reiterate, healthy ageing pertains to functional ability, empowerment (and abuse-minimisation), sociocultural interdependence, and autonomous or collaborative decision-making.

The nurse has crucial preventative, therapeutic, sociocultural, and advocacy roles in promoting healthy ageing and holistic patient-centred care. There are several healthcare approaches to promoting healthy ageing, including the Roper-Logan-Tierney model of ideal nursing care.

Keywords: Advocacy; ageing; dementia; elder abuse; healthy ageing; nursing.

Abbreviations: AIHW, Australian Institute of Health and Welfare; ADL, Activities of Daily Living; COC, Code of Conduct; NMBA, Nursing and Midwifery Board of Australia, WHO, World Health Organization.

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Overdue normalisation of nurse-led advance care planning interventions in Australia

By Magnolia Cardona and Steven Pitman

When life is irretrievably coming to an end from progressive chronic illness in advanced age, patients aspire to have time and opportunity for conversation on quality enhancement by compassionate and talented health professionals.

Clinicians who have had adequate capacity building on communication know how to start a discussion on our choices, manage fear, support anticipatory grief and guide decision-making on transition to supportive and palliative care to enable a good death.

The pressures of the COVID-19 pandemic on hospitals and residential aged care have led to a diminished opportunity for these considered end of life discussions. Health systems, including the US, the UK, and Hong Kong, are likely better prepared than Australia as they have for several years proposed and trialled not just the contribution of nurses to physician-initiated conversations but incorporated responsibilities for nurse-led end of life discussions with proven success.

In the Australian health system, the traditional gatekeeping role of physicians sometimes constitutes a bottleneck where precious time for transition out of active management into supportive care is needlessly wasted for dying patients. There is no doubt that generalist and specialist nurses spend many hours as advocates with patients and their families and understand the patients' needs beyond the physical to help preserve their autonomy toward the end of life. Nurses are a key to their seamless navigation of the health system from the time patients receive bad prognostic news to the family support in the aftermath. However, the lack of well resourced and coordinated communications training to enhance nurses' confidence in initiating the discussion in the emergency department is one of the widely acknowledged – but not insurmountable – barriers.

A culture change could facilitate difficult conversations and documentation of choices and decisions not only in times of global crises and instead become an integral and sustainable component of the modern healthcare system. While it is early days and wider implementation has not eventuated, recent attempts at expanding the role of nurses and piloting proactive ED nursing engagement in palliative care discussions are emerging in Australian urban and rural settings and community health to fill this practice gap with promising consumer acceptability. Since there is also nursing motivation, we need to explore more the translational effectiveness of these findings across settings.

Searching for nurse-led models of service is becoming inevitable due to both the increasing demands on acute hospitals from an ageing population surviving longer with chronic illness, and the COVID-19 pandemic. Let's take these opportunities to normalise nurse-led advance care planning in our health system by incorporating ACP training and motivational interviewing in all nursing streams. A system where nurses can put patient care preferences in motion with an initial (and ongoing) discussion will save time and spare grief to families; it will assist treating communication with clinicians during their patients' subsequent unplanned emergency visits; it will re-shape the way we perceive dying from natural causes and accept the inevitable. Above all, it will reduce decisional conflict, prevent unnecessary suffering, and minimise administration of low-value care.

Welcome to Healthy Eating

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

Anzac biscuits

INGREDIENTS

- 1 cup plain flour
- 1 cup rolled oats
- 1 cup shredded coconut
- 3/4 cup brown sugar firmly packed
- 1 lemon zested
- 125g butter melted
- 2 tbsp golden syrup
- 2 tbsp Verjuice
- 1/2 tsp bicarbonate of soda

METHOD

1. Preheat oven to 160°C.
2. Mix the flour, rolled oats, coconut, brown sugar, and lemon zest in a medium bowl.
3. In a small saucepan, melt butter with golden syrup and Verjuice. Once the butter has melted bring the mixture to a simmer before adding the bicarb soda. Stir to completely dissolve.
4. Add the hot butter and sugar mix to the dry ingredients and fold through.
5. Roll mixture into even-sized balls and place onto a lined baking tray, leaving 2-3cm between each biscuit. Using your fingers, squash to flatten slightly.

6. Place into preheated oven and bake for 18–20 minutes, or until golden brown.
7. Remove from the oven, allow to cool slightly, then transfer to a wire rack to cool completely.

We invite you to try Maggie's recipes.

Send 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. Send your entry to: **healthyeating@anmf.org.au**

Well done, Helen Thomson, on making Maggie's spiced parsnip and carrot cake with ginger cream cheese icing, published last issue. We hope you enjoy your $50 Maggie Beer voucher.

***"I love this generous sized recipe with its country-style cooking,"* says Helen.**


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