



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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INSIDE

On the edge of fundamental health and welfare reform
A new government promises a new era for Australians. What's been promised and how will the ANMF keep Labor accountable?

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Maggie Beer – the champion for quality food in aged care
Why one of Australia's most iconic cooks is passionate about changing the wellbeing of the elderly through flavoursome and nutritious food.

UNDER VALUED

Inside the ANMF's push to lift wages of aged care workers by 25%



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Annie Butler

ANMF Federal Secretary

There is an air of optimism at the ANMF.

With a new Labor Government at the helm there is a renewed sense of possibility that we can achieve better health and welfare outcomes for all Australians.

After years of struggle to implement change, finally we now think meaningful reform can actually occur.

Pre-election, Labor made significant promises to improve:

- health and aged care;
- act on climate change;
- ensure equality and safety for women, and
- recognise and improve the rights of First Nations people.

Many of these policies align with ANMF's position. This has not happened by chance.

Over the years, ANMF members campaigning and lobbying of Labor politicians, has encouraged them to listen and collaborate with us to enact necessary change.

Most significantly, Labor pledged to act on ANMF's position to implement the key recommendations made by the Aged Care Royal Commission. This includes:

- Every aged care facility having a registered nurse on site, 24 hours a day, seven days a week.
- Increased number of carers and a mandated average of 215 minutes of care per resident per day.
- Aged care providers being publically accountable for where they spend money.
- Improved conditions and funding wage increases

However, the job is far from done. Now that Labor is in power, the real work to hold them to their commitments begins.

Fortunately, the steps taken by the Government so far look promising.

Recently ANMF Federal Assistant Secretary Lori-Anne Sharp and I met with the new Health Minister Mark Butler and Aged Care Minister Anika Wells. Both showed sincere and genuine interest in our concerns and solutions while indicating their intention to implement pre-election policies to improve the health and aged care sectors.

Pleasingly, this included fully funding any pay increases awarded by the Fair Work Commission as a result of the aged care Work Value case.

Minister Butler and Minister Wells have asked the Attorney General's Department to make submissions on behalf of the Commonwealth to assist the Commission on these matters.

In an interview with *The Australian Financial Review*, Minister Wells said allowing the Government to submit to the case was an important first step toward Labor's election commitment to support aged care workers' call for better pay.

"There is not a day to waste on this matter; good people are leaving the sector when we need tens of thousands more to come into it," she said.

The ANMF and its members have been instrumental in submitting evidence to the Work Value case where we are pushing for a 25% wage claim for underpaid and predominantly female aged care workers.

In this issue of the *ANMJ*, we feature the case and our involvement with it, which I encourage you to read.

Additionally, on page 32 the *ANMJ* details Labor's pre-election promises relating to ANMF's priorities, all of which the ANMF plans to keep the Government accountable to.

While feeling hopeful for the future, I want to acknowledge the hardship many, if not most of you, are enduring at the moment.

On the back of COVID and winter's flu season, we know you are stretched, under-resourced, and working in extremely trying circumstances.

While I am so proud of all nurses, midwives and carers who are stepping up to the mark in this tumultuous work landscape, I also want to reassure you that we are doing everything we can to alleviate the pressures you are under.

The ANMF is determined to negotiate and act on your behalf until you are provided with the relief you need.

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Moving state?

Transfer your ANMF membership

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

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ABORIGINAL CULTURAL AND COMMUNITY AWARENESS FOR ANMF MEMBERS

The Australian Nursing and Midwifery Federation (ANMF) is offering an Introduction to Aboriginal Cultural and Community Awareness for members.

The ANMF, who has partnered with Aboriginal owned company Walya Productions, is offering the course at a discounted rate of \$50, a saving of \$60 to members.

Walya Productions, who run the three hour program, will inform and assist with making work environments culturally safe; give a better appreciation of First Australians' culture, community and history, and provide knowledge and awareness for better engagement and understanding of community needs.

Registered nurse and Aboriginal Nurse Advisor to the ANMF's Reconciliation Action Plan Committee, Mel Robinson, recommends the course to all nurses and midwives.

"This is a part of a learning journey... of reconciliation and healing with the Aboriginal and Torres Strait Islander peoples and communities of Australia."

Completing the course will give you CPD credit.

For more information and how to enrol go to walya.com.au/courses/anmf-introduction-to-aboriginal-cultural-community-awareness

Hospital admissions rose as COVID-19 restrictions eased in 2020-21

Public and private hospital admissions rebounded in 2020-21 after a decline the previous year, according to new data from the Australian Institute of Health and Welfare (AIHW).

The latest *MyHospitals* update showed there were 11.8 million hospitalisations in Australia in 2020-21, up from 11.1 million in 2019-20.

After steady annual growth in recent years, before a dip of 2.8% in 2019-20, hospitalisations increased by 6.3% nationally in 2020-21, bouncing back to pre-pandemic levels in most states and territories.

The significant increase in hospitalisations at a national level is attributed to easing of restrictions following the first waves of the pandemic, particularly on elective surgery.

Overall, there were 7.4 million same-day hospitalisations and 4.4 million overnight hospitalisations in 2020-21, an increase of 8.1% and 3.3% respectively.

The length of overnight hospitalisations in public hospitals remained unchanged, while private hospitals

experienced a 4.8% decrease.

Meanwhile, private hospitals experienced a significant increase in admissions (10.5%) compared to public hospitals (3.6%) in 2020-21, largely due to coming from a lower base following the sector's drop in activity during the pandemic.

The largest increase in hospitalisations were for principal diagnoses related to eye diseases and adnexa (19%), likely related to catch-up cataract surgery.

There were over 4,700 hospitalisations involving a COVID-19 diagnosis in 2020-21, with about four in 10 people having one or more comorbid chronic condition such as type 2 diabetes or cardiovascular disease. Of these positive COVID-19 patients, 329 (7%) involved a stay in an Intensive Care Unit (ICU), 180 (3.8%) required ventilation, and 487 (10.3%) died in hospital.

Study shines light on Australia's mental health experiences during COVID-19

The COVID-19 pandemic placed added pressure on an already overburdened mental health system, leaving many Australians without timely and appropriate support, a University of Sydney study has found.

Researchers surveyed over 1,000 Australians aged 18 to 89 during July to December 2020, and again between March and June 2021.

The study identified multiple barriers that prevented people from accessing vital mental healthcare.

It found the COVID-19 pandemic 'pressurised' existing triggers for poor mental health by

amplifying financial stress and reducing social support and connection.

The ability to seek help was prevented by the lack of accessible, robust mental healthcare. Many respondents said accessing the current mental health support system was expensive and difficult to navigate and compounded by community and political stigma.

Other key findings showed the break in social contact during the pandemic has had long-term effects, including feelings of discomfort on socialising again.

Authors say the research provides insights into what policy changes are required for an effective mental health system moving forward. Whole-of government policies, spanning social services and welfare, housing, education, family, community, and workforce are needed to achieve real impacts on Australia's mental health, they argue.





Addressing mental and psychological support to Ukrainian nurses affected by war

A Ukraine delegation, including the country's Deputy Health Minister Oleksii Iaremenko, has recently updated the World Health Assembly on the situation in Ukraine.

The Minister spoke about the huge pressures nurses and other healthcare workers were still under both physically and mentally in the country's war zones. Talks then focused on exploring ways to provide mental and psychological support to Ukrainian nurses and other healthcare workers affected by the war.

The discussions included a new mental health initiative for the country launched by Ukraine's First Lady, Olena Zelenska, who has also called for international support.

Attending the assembly, International Council of Nurses' Chief Executive Officer Howard Catton, said he briefed the minister on ICN's work in Ukraine and the council's campaign #NurseforPeace.

'What our talks underlined was that there are still many nurses and other health workers in Ukraine working under incredible pressure, enduring daily attacks. As well as the physical dangers, their mental and psychological health is being affected both in the short and long term.

"Building on the First Lady of Ukraine's announcement of a new health initiative, ICN is exploring ways to work with the Ukraine Health Ministry and the WHO to respond to Ukraine's urgent need for more mental and psychological support."

Power napping on nightshift could improve safety

Nurses and doctors need 20-minute power naps during night shifts and work no more than three night shifts in a row to keep themselves and patients safe, a study has revealed.

The findings were presented by Consultant Anaesthetist Dr Nancy Redfern of Newcastle Hospitals NHS Foundation Trust, UK at the Euroanaesthesia congress in Italy.

Discussing the potential lethal effects of fatigue on nurses and doctors, and its impact on the quality of their clinical work and judgement when working night shift, Dr Redfern said around half of trainee doctors, consultants and nurses had experienced either an accident or a near miss driving home after a night shift.

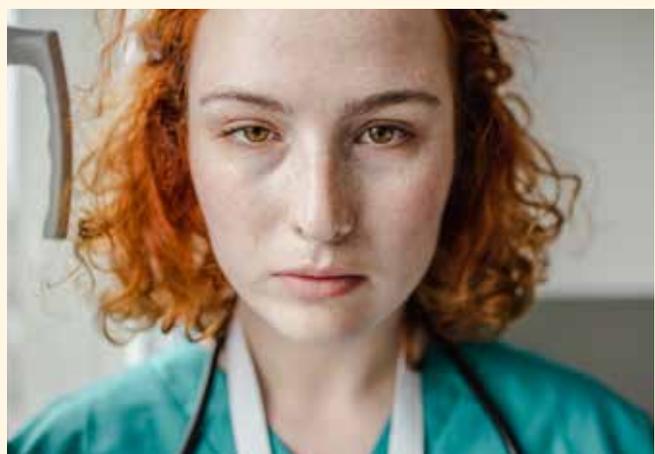
Previous research has shown driving after being awake for 20 hours or more and at the body's circadian low point (in the night or very early morning when it most needs sleep) is as dangerous as driving with blood alcohol levels above the legal limit. And workers who drive home after a 12-hour shift are twice as likely to crash as those working 8-hour shifts.

Dr Redfern said a 'sleep debt' begins building after two or more nights of restricted sleep, and it takes at least two

nights of good sleep to recover from this. Cognitive function is impaired after 16-18 hours awake leading to a deterioration in the medical worker's ability to interact effectively with patients and colleagues.

"When fatigue sets in, we in the medical and nursing team are less empathic with patients and colleagues, vigilance becomes more variable, and logical reasoning is affected, making it hard to calculate, for example, the correct doses of drugs a patient needs. We find it hard to think flexibly, or to retain new information which make it difficult to manage quickly changing emergency situations. Our mood gets worse, so our teamwork suffers. Hence, everything that makes us and our patients safe is affected."

"We hope in the end that regulators will recognise that healthcare workers have the same physiology as employees in every other safety-critical industry and require formal fatigue risk management as part of its overall approach to patient and staff safety."





James Lloyd

ANMF Federal Vice President

Work-life balance

Work-life Balance. This has become a cliché in our society. But despite its frequent use, this concept is still genuinely relevant to the lives of nurses, midwives and care workers.

Many of us are time-poor. We are constantly juggling different commitments in our busy lives, such as work, family, and personal needs. The Covid-19 pandemic has also changed how we live and work, adding that extra ball to juggle. The outcome of a mismatch between work and life commitment is stress - an impact on our physical and mental health - and decreased work performance and satisfaction.

Australia is slowly falling behind the rest of the developed world in our attempts to balance work and personal lives. Simply put, a good work-life balance means that all aspects of living are in equilibrium or harmony - your work supports your non-work life and vice versa.

So, does your work compete with your caring responsibilities? Does it interfere with your need to attend medical appointments? Does work allow you enough time to maintain your social and family commitments as well as free time? Although non-work life stressors can contribute, it is often work commitments, workplace culture and workplace stress that contribute to a skewed work-life balance.

One aspect of being in a caring profession is that we often work odd hours. Our profession is a 24-hour job, and the needs of our patients/clients don't align with standard business hours. Shift work, especially rotating shifts, can disrupt circadian rhythms, resulting in chronic health issues, poor sleep, disrupted social interactions and accidents. In particular, shift work can result in social difficulties and isolation. How many times have you missed a family event or social situation because you had to work outside 'normal' work hours? Burnout from working excessive night duty is known to compromise a nurse's emotional and mental reserves.

When the Covid-19 pandemic hit in 2020, working from home was encouraged. Some found this helped their own life balance, as it eliminated the work commute, allowed them to have more personal time, and fulfilled family responsibilities. But others find the separation between work and home had become blurred and they were not able to effectively leave work behind. But for nurses, midwives and carers, work is essential. It pays the bills and, on some level, provides us with fulfilment and social interaction. But in this new realm of pandemics, how can we balance the demands and obligations of work with our non-work lives?

Self-awareness and the ability to recognise that your work-life balance is skewed are the keys. What are your ambitions? Are you happy overall? Are you accomplishing most of what you want? We cannot

reach inner balance until we become mindful of this equilibrium. If not, what needs to change?

There are many techniques to achieve a suitable work-life balance. Recommended tips include:

Leave work at work When you walk out at the end of a shift, change from 'insert name' the nurse/midwife to 'insert name' the parent, sibling, or spouse. Don't take your nurse persona back home with you.

Say 'NO' when you can Carers are givers and self-sacrificers, so we have the habit of saying yes too often - this can be emotionally draining.

Rest and sleep are critical for maintaining balance Being well-rested allows us to tolerate stress and avoid burnout. People who get enough sleep often have more positive outlooks, greater mental agility and can put a 'space' between a stressor and their response to it.

Exercise is a terrific way to work off stress and rejuvenate Have hobbies and leisure activities, and don't simply flop in front of the TV as the default. You don't have to be a gym junkie, just get out - grab the dog or a friend and go for a walk.

Balance your hours Research has shown that nearly half of all people who have experienced deterioration in work-life balance believed longer working hours were a contributing factor. If so, is it worth dropping your hours at work to achieve a better work life balance? Financial considerations often make this change difficult to achieve but it is worth casting a critical eye in this area.

You are what you eat Our physical and mental health is directly related to our diet. Decrease your intake of fast food, processed foods, and empty calorie fizzy drinks. Eat more complex carbohydrates - they help raise your brain serotonin levels and stabilise your blood glucose levels.

Surround yourself with positive influences Strive to maintain healthy personal work relationships and avoid toxic people who try to drain your energy.

Make time for you Prioritise time for yourself, whether that is reading a book, going to the gym, taking a hot bath, or just doing an activity that feeds your spirit. This concept of 'time for you' may seem a fantasy, but it is a key to personal happiness.

The balance between work and personal life is a constant rebalancing act, and the equilibrium is always shifting with the vagaries of life challenges. But eventually, making small but mindful changes makes all the difference to a life well-lived.

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FEATURE

UNDERVALUED

Inside the ANMF's push to lift wages of aged care workers by 25%



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Aged care RN and NSWNMA member Jocelyn Hofman.
Photo: Supplied NSWNMA

Long hours, poor pay and chronic understaffing are commonplace in aged care. Beginning in late April, the Fair Work Commission (FWC) considered landmark applications by the Australian Nursing and Midwifery Federation (ANMF) and Health Services Union (HSU), supported by the United Workers Union (UWU), for a 25% wage increase for aged care workers. The unions' claim is that the work of aged care workers has never been properly valued and is in fact significantly undervalued. Robert Fedele reports.

Tasmanian registered nurse Irene McInerney enjoys working in aged care because of the difference she can make in the lives of elderly Australians.

"It is not rewarding monetarily but I certainly know I make a difference each and every shift I work," she says in a witness statement submitted to the Fair Work Commission (FWC) as part of the ANMF's push for a 25% pay increase for aged care workers.

Having worked in the sector for decades, Irene has observed considerable changes to the nature of her work and conditions, none more damaging than understaffing and the cutback of RNs.

These days, elderly Australians enter aged care older, sicker, frailer and with more co-morbidities than ever before.

As the only RN on afternoon and night shifts, Irene is responsible for the care of 65 residents.

Their wide-ranging needs, from feeding, wound care, pain management, social support and palliative care, have become increasingly complex.

"Changes in both resident and staff profiles and composition have meant that the work of RNs, ENs and carers have been transformed over the last 15 to 20 years," she explains.

"Carers are substantially more engaged in the delivery of direct nursing care, ENs have taken on more supervisory and clinical responsibility such as medication administration, and RNs' work has become focused on accountability for the overall delivery of care, supervision, and mentoring, while still providing hands-on care."

Paid far less than an RN in a hospital, and with modest superannuation, Irene believes she will have to work well beyond the age of 65 before she can afford to retire.

UNION APPLICATIONS

In its final report, the Aged Care Royal Commission concluded: "the bulk of the aged care workforce does not receive wages and enjoy terms and conditions of

employment that adequately reflect the important role they play".

Responding to the call, the ANMF lodged applications with the FWC requesting a 25% pay increase for aged care workers across three aged care related awards, on the basis that their work has never been properly valued and is considerably undervalued.

The ANMF's submission outlines that in the last decades vast changes have occurred in the nature of work, the level of skill or responsibility involved in doing the work, and the conditions under which the work is done. Much of this change arises from the steady increase in the acuity of residents and recipients of home care, resulting in greater and more complex high care needs.

Common issues facing aged care workers include greater workloads, lack of mandated minimum staffing levels, increasing documentation, more advanced technological requirements, and a higher supervisory burden for RNs. Worryingly, unacceptably high levels of occupational violence and aggression are also widespread.

Importantly, the ANMF contends that current award rates have not been properly set due to decades of gender-based undervaluation of skills associated with nursing and caring work.

In making its applications, the ANMF asked the FWC to examine the work of aged care workers, how it has changed, and how and why it has been systemically undervalued for decades.

HOW THE ANMF ARGUED ITS CASE

Evidence presented for the Aged Care Work Value case by the ANMF, HSU and UWU comprised more than 100 witness statements, the majority of whom gave evidence during the two-week virtual hearing.

The ANMF's claim relied on members working as AINs, PCWs, ENs, RNs, and Nurse Practitioners to describe the work they do on a daily basis and major challenges.

As a collective, they painted aged care as an occupation that is mentally, physically, emotionally, and spiritually demanding. Most workers revealed clocking off shifts feeling exhausted.

Meanwhile, union officials explained how the award and bargaining systems have failed to result in proper wage outcomes for aged care workers, while ANMF experts detailed how and why work carried out in female dominated industries is undervalued.

Opening the hearing, lawyers for both the ANMF and HSU declared that the evidence before the FWC would overwhelmingly demonstrate aged care work is undervalued and that an increase of award wages is justified.

"The current awards, in the HSU's view, fail to provide a fair and relevant safety net, and fail to properly remunerate the workers engaged in aged care, having regard to the skills required and the responsibilities of their work," counsel for the HSU, Mr Gibian said.

"It'll be submitted that an historical undervaluation of the work of RNs, ENs, AINs and PCWs has occurred and one of the significant contributing factors to that undervaluation has been the gender identity of the persons performing that work," counsel for the ANMF, Jim McKenna, added.

WOMEN'S WORK IS UNDERVALUED

Part of the ANMF's evidence showed RNs, ENs, and AINs/PCWs have and use skills of a nature not previously counted when assessing the work value of aged care workers.

ANMF expert witness Associate Professor Anne Junor, an Honorary Professor within the Industrial Relations Research Group of UNSW Canberra, helped develop the 'spotlight tool', designed to identify, name and classify invisible skills on gendered grounds.

Applying it to a sample of AINs/PCWs, ENs and RNs working in aged care, Professor Junor conducted an analysis of the work



Tasmanian aged care NP Hazel Bucher

“AN INCREASE IN THE MINIMUM WAGE WOULD HOPEFULLY ENCOURAGE CARERS AND NURSES TO PRIORITISE THEIR WORK; WE WOULD HAVE BETTER RETENTION AND THEREFORE PROVIDE BETTER CARE.”

Tasmania aged care NP Hazel Bucher

aged care workers do, identifying invisible skills that are taken for granted or viewed as inherent – predominantly because they are performed by women.

Her study found aged care work requires high-level problem solving and solution sharing skills, considerable effort to maintain a respectful and happy environment for residents while being constantly rushed by the pace of work, and skills used under conditions of heavy responsibility for quality of life and death. The hidden skills were under-recognised across all classifications.

“The people performing the work are predominantly women. It’s perceived as a caring job and caring work in society is considered work that is performed mainly by women,” Professor Junor told the Commission.

Questioned about the use of skills in the delivery of care between 20 years ago and today, she said participants revealed their work was more complex and that they were doing more, across a wider range of areas, in a more intensive way.

Equally, ANMF’s expert evidence included a report by Associate Professor Meg Smith, Deputy Dean of the School of Business at Western Sydney University, and Dr Michael Lyons, which outlines the gender pay gap and gender-based undervaluation of work in Australia, and contributing factors.

The report found female dominated occupations are paid less than male dominated occupations. The authors argued that the gender pay gap arises from

historical undervaluation of feminised work in occupations predominantly made up of women and work relating to traditionally female gender roles, including care work.

Examining whether there is a gender-based undervaluation of aged care work covered by the *Aged Care Award* and the *Nurses Award*, the authors concluded the work of PCWs/ AINs, enrolled nurses and registered nurses to be undervalued.

Essentially, the increased complexity of aged care work, depth of knowledge of the work required, and change in demands of the work have not triggered changes to the classification structures, Professor Smith told the Commission.

Similarly, HSU expert Sara Charlesworth, Professor, School of Management, at RMIT University, told the Commission aged care workers are notoriously underpaid for the level of skill, responsibility and judgement they exercise, largely because heavily feminised occupations are undervalued.

“I think that generally the work has been undervalued because it is seen as not requiring particular skills, things that women do for free in the home, and therefore if you’re a woman then you know how to care for older people.”

THE NATURE OF WORK

ANMF members gave evidence that painted a compelling picture of why, and how, aged care work is undervalued and of the dedication, care and skill involved in caring for older people.

Registered nurse and NSWMA member Jocelyn Hofman has worked in the aged sector for over three decades.

As the RN in charge, regular tasks include developing care plans, administering medication, liaising with GPs if residents need urgent attention, wound dressing, monitoring residents, communicating with families, and mentoring and supervising care staff.

Despite increasing workloads, Jocelyn suggests there has been a reduction in RN numbers and hours over the past 20 years.

“Work is challenging due to insufficient staffing levels,” she says.

“We need to have the time and resources to meet our residents’ high care needs.”

This intensified during the COVID-19 pandemic, when nurses and carers like Jocelyn were required to navigate new infection control measures, including having to don and doff PPE, record residents’ temperatures, screen visitors, and deal with widespread outbreaks.

“There is an increased level of sophistication in the level of nursing skills required,” Jocelyn says.

In her witness statement, Hazel Bucher, an NP working across residential aged care facilities in Tasmania, said the nature of work has become “increasingly stressful” during the past decade.

“Nursing work [in aged care] has historically been viewed as less important than nursing in acute care. Aged care is often the second

choice for graduate nurses if they are unable to gain a graduate position in an acute hospital, and is also evidenced by the lower pay rate for nurses in this sector," she said.

"An increase in the minimum wage would hopefully encourage carers and nurses to prioritise their work; we would have better retention and therefore provide improved care."

FALLING BEHIND

During the hearing, Rob Bonner, Director Operations and Strategy at the ANMF (SA Branch) gave evidence of aged care wages lagging behind other healthcare sectors.

Figures show the national average aged care enterprise agreement rate for an RN Level 1 at the top of the scale is \$39.70 or \$1,508.60, 16% lower or \$235.60 less than the national public sector average.

In his witness statement, Mr Bonner said while the ANMF (SA Branch) was able to secure agreements on behalf of nurses employed in the hospital sector, it has struggled to attain similar outcomes for aged care nurses who, over time, have been typically offered inferior rates and conditions.

"Whilst wanting better wages and conditions, staff have generally not exercised their industrial muscle in significant part due to the perceived poor bargaining power but more importantly their relationship with residents. This situation has led to a perpetuation of poor wage rises and little if any progress in relation to conditions in the sector."

MAKING ENDS MEET

Registered nurse and ANMF (Vic Branch) member Lisa Bayram works five shifts a fortnight, including two on the weekend.



NSW AIN Linda Harman

In her witness statement, Lisa said she spends most of what she earns on living costs. On her current wage, she cannot see herself retiring until well into her 60s.

Based on her experience, residents being admitted to the facility now need about 50% more care than those admitted five years ago. They have higher acuity and need more help with feeding, hydration and hygiene. More are being admitted with advanced cognitive impairment, comorbidities or advanced diseases.

Lisa believes the work she does is valued, especially by residents and their families.

"However, I feel that 'value' is not reflected in the remuneration, resources, staffing or education that we receive," she laments.

Queensland AIN Sherree Clarke started working in aged care in 1998 when she was 21 years old. She has remained in the sector because of her passion for residents and the satisfaction she gets from making a difference in their lives.

Still, Sherree admits it's been a constant struggle financially. Because of her limited



Queensland AIN Sherree Clarke

hours and low wages, she has been unable to save a deposit to get a loan to buy a house or unit.

As the FWC considers its decision, Sherree remains hopeful that aged care workers will be finally recognised for the critical work they do.

"I love caring for old people, but I don't do it for the money," she says.

"I think if we want to offer better quality care, people working in aged care need to be better paid."

After winning May's federal election, the Labor Government successfully asked the FWC to extend the submission timetable so that it could be heard in the proceedings. The FWC has given the Government until 8 August to make a submission. Unions and peak bodies will be allowed to file responses to the Government's submissions by 17 August before new public hearings at the FWC in Melbourne on 24 and 25 August. Labor has committed to fully funding any pay increases awarded by the FWC, who are expected to make a final decision by the end of the year.

"I LOVE CARING FOR OLDER PEOPLE BUT I DON'T DO IT FOR THE MONEY."

Queensland aged care AIN and QNMU member Sherree Clarke

"THERE IS AN INCREASED LEVEL OF SOPHISTICATION IN THE LEVEL OF NURSING SKILLS REQUIRED."

Aged care RN Jocelyn Hofman

COMPARING THE NATIONAL PUBLIC SECTOR AVERAGE EARNED AND THE NURSES AWARD RATE SHOWS:

- An RN at the top of the scale (RN1 Level 8) earns on average 48% less under the Award
 - An EN top of the scale – 33% less
 - An AIN Cert III – 21% less
- OR**
- National public sector average (rates at August 2021) v Nurses Award- rates at 1 July 2021
 - An AIN Cert III top of scale \$28.35 v \$23.67 difference of \$4.68 an hour or 21%
 - EN top of scale \$33.69 v \$25.36 difference of \$8.33 an hour or 33%
 - RN Level 1.1 \$34.33 v \$25.79 difference of \$8.74 an hour – or 34%
 - RN Level 1.8 \$45.90 v \$30.99 difference of \$14.91 an hour or 48%

An Australian nurse's journey into Ukraine

By Ben Rodin

Since Russia's deadly attacks on Ukraine, nurses and midwives worldwide are standing in solidarity with their colleagues, including volunteering on the frontline to give support.

The support is desperately needed and appreciated as Ukrainian nurses have been forced to contend with a significant number of serious injuries and lack of supplies on top of fears of attacks.

At the time of this report, the World Health Organization (WHO) stated there had been over 200 attacks on healthcare in Ukraine since Russia's invasion. Despite WHO's calls for an immediate cessation of all attacks on healthcare, the horrific attacks have continued, killing and causing severe injuries to patients and health workers, destroying vital health infrastructure and forcing thousands to forgo accessing health services despite catastrophic needs.

Humanitarian organisations such as Médecins Sans Frontières are also doing what they can to assist.

Nursing Activity Manager for Médecins Sans Frontières (MSF), Suzel Wiegert, has just returned after placement in Dnipro, a city 400kms South East of Ukraine's capital city Kyiv. Her role was to assist the healthcare needs of the influx of Internally Displaced Peoples (IDPs) in Dnipro.

While in Dnipro, Suzel, who comes from NSW, says life in the region was almost "very much as usual".

"You would go to the shops, and all the shelves were stocked; in the street, you had the mums pushing the prams, the lady walking the dog."

"We had the raid alarm going off quite often... but apart from that, it didn't look like there was a war in the country."

However, Suzel says it was a very different story in conflict zones like Mariupol.

"[There, they] needed everything they could get their hands on."

Suzel, who had 19 years of emergency nursing experience before working overseas for MSF, has worked in regions such as Africa, the Middle East and the Caribbean, as well as boat rescues in the Mediterranean Sea. She says that the Ukrainian situation posed unique challenges distinct from her previous work for the organisation.

In Dnipro, Suzel's team focused on running mobile clinics in shelters, addressing the needs of people living with chronic diseases with less immediate needs than those afflicted with physical traumas of conflict.

In particular, there was a focus on preventative health, with steps taken to ensure that IDPs living with chronic illness

could access medication that would help prevent their conditions from worsening.

"[We] provided the medication for the chronic disease, at least to try to avoid the worsening of their conditions... It was challenging because the mind was really set on war nursing, trauma and all those things; it was a complete switch from trauma nursing to chronic disease."

Suzel says the program was running well when she departed back to Australia.

The program in Dnipro is one of dozens of interventions MSF has made across Ukraine, with around 160 international staff and more than 490 Ukrainians working to provide support to people affected by the crisis. The organisation has supplied around 485 tonnes of medical and relief supplies to date.

Suzel, who will return to her role with local patient transfer service AirMed, where she works between stints with MSF, says nurses and midwives looking to work in this space need to be adaptable to the demands that can arise when working in unpredictable and unique situations.

"You have to be very flexible," she says.

Suzel says the dynamic nature of MSF's work can be appealing because of the opportunities for learning and genuine intercultural exchange.

MSF are presently looking to recruit across several roles, including midwifery, to fulfil roles within their overseas missions and has expressed particular interest in the skillset of Australian-trained midwives. If you are interested, please head to MSF's website [msf.org.au](https://www.msf.org.au) to learn more about their work.



Nursing Activity Manager for Médecins Sans Frontières (MSF), Suzel Wiegert
Image Source: Médecins Sans Frontières



View of a mobile clinic run by MSF in front of a shelter for displaced people in Dnipropetrovska oblast. Image Source: Médecins Sans Frontières

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.

COURSE DIRECTORS

Associate Professor David Wells OAM

Senior Education Coordinator,
Department of Forensic Medicine

Dr Maaïke Moller

Adjunct Senior Lecturer,
Department of Forensic Medicine
Forensic Physician,
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‘Offload’ the ambulance – Bed availability and clinical bias in the Emergency Department

By Joshua Wilcox

While increasing burdens on the ambulance services across the country have resulted in escalating pressure to reduce off stretch times in Emergency Departments (EDs), what are the consequences for waiting room patients?

Ramping is the practice of placing ambulance officers in chosen spaces to care for patients in the event of insufficient availability of suitable space to place the patient.

The Australasian College of Emergency Medicine (ACEM) defines ‘Ramping’ in their position statement as:

“Ambulance ramping occurs when ambulance officers and/or paramedics are unable to transfer their patient’s clinical care to the hospital ED within a clinically appropriate timeframe.”¹

Globally the demand for public healthcare has increased, and so too has the complexity of our patients. Patients are presenting to EDs with increased frequency via ambulance and ramping times have worsened.

In the latest audit published by the state of Queensland Audit Office data between July-September 2014 and October-December 2020 showed ambulance arrivals increased by 45.8%. However ‘walk-in’ presentations also increased by 20.5%.²

The detrimental effects of ramping, which includes risks to health consumers, hospital staff and the ambulance service have been shown through research such as the exploratory study examining the phenomenon and practice of ramping study undertaken by Hammond et al.³

Studies such as this one have driven the Australian government to introduce key performance indicators (KPIs) such as patient off stretcher time (POST) to keep track of EDs’ performance.

Yet, through the development of these KPI’s a culture/clinical bias has developed. Departments are viewed as managing primarily by how well ramping is handled. This drives a culture which recognises treating and giving beds to patients arriving by ambulance first over waiting room patients in order to ‘treat’ these KPIs.

Flow throughout the emergency department is a balanced responsibility

by medical and nursing incorporating the demands of the ambulance service and the waiting room. Through collaboration with hospital and ambulance management, flow coordinators are left with pressure to create flow, burdened with KPIs primarily focussed time of stretcher, ramping length and time to disposition within four hours.

To address ramping times new initiatives such as the transfer initiative nurse (TIN) have been developed⁴. The TIN model attempts to address POST times by diverting treatment spaces to ‘off-loading’ spaces, staffed by hospital staff. While treating the POST KPI, these practices impact the department negatively by reducing treatment spaces available to clinicians and has worsened the experience of those in the waiting room.

These practices have also created a culture of treating ‘ramping’ as the problem, despite understanding it is actually a symptom of a larger issue.

Emergency

It is not only new KPIs that drive this clinical bias but clinicians also. Limited treatment spaces to assess patients create pressure on treating clinicians. The additional stress in finding appropriate assessment/treatment spaces prior to even seeing the patient causes additional strain. This additional strain contributes to the selection bias. To prevent bottlenecking clinicians will treat patients in beds to create space for the next patient, this is often patients in TIN spaces as they are prioritised for bed spaces.

The practice of this selection bias places our patients at risk. This practice has implications not only on their safety but triage system itself. For example if two patients who are equally as ill present to ED via opposing methods, the individual as a walk in would have delayed access to treatment despite being equal in triage categories to the patient who arrived by ambulance.

The impact this type of KPI driven care has resulted in a 25%-time advantage by arriving via ambulance over walk in⁴. This was discovered in a secondary analysis of an audit on the National Hospital Ambulatory Medical Care Survey in the United Kingdom. The United Kingdom faces similar issues of a burdened healthcare system which has viewed ramping as the problem instead of a symptom.

To drive quantitative analysis of emergency department performance, have we created a culture of the ambulance patient getting treated first?

Author

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Dr Micah DJ Peters

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Money, Power & Respect: The economic case for nurses and midwives

The benefits of nursing and midwifery must be costed and conveyed to decision-makers and politicians to enable workforce reforms.

With growing fiscal pressures at home and abroad, governments and health, maternity, and aged care providers increasingly look to save costs and wring out every iota of value and efficiency from staff, often to the detriment of working conditions and patient outcomes. At an International Nurses Day and International Midwives Day breakfast Dr Rosemary Bryant AO highlighted the growing importance of economically based arguments for the roles of nurses and midwives. While the contribution of nurses, midwives, and the care they provide has garnered much-deserved attention throughout the pandemic, there is a risk that as the pressures on health, maternity, and aged care grind on, the significant demand and detrimental impacts on staff will become normalised and invisible.

Unsurprisingly, nurses and midwives around the world are burning out and leaving jobs and the professions due to compounding effects of COVID-19 upon pre-existing challenges. Aged care is a strong example where decades of evidence for widespread deficiencies have gone unheeded, only to be dealt a crippling blow by COVID-19. A recent US report on aged care substantially echoes that of Australia's Royal Commission, with findings of a sector in dire need of significant and costly reform. In hospitals and maternity care too, nurses and midwives are leaving and may not be replaced fast enough to cope with a rapidly ageing population and rising rates of morbidity caused by climate change, preventable chronic disease, and mental ill health.

Workforce shortages are certainly not new but are likely to intensify if nurses and midwives are not genuinely supported and valued by employers and governments through more than kind words, flowers, and applause. Nursing and midwifery work is tough, complex, challenging, and often dangerous. It must be duly and tangibly rewarded. However, improvements to the remuneration of half of the total health, maternity, and aged care workforce will be challenging, especially when wages are already the largest cost for most employers.

Across every sector where nurses and midwives work, it is more critical than ever that we examine where, how, and to what extent nurses and midwives can add value, efficiency, and cost savings to care in monetary terms in ways that don't result in poorer working conditions and greater burden.

Beyond simply identifying these factors, it is important that this evidence be translated and disseminated to governments and administrators in an understandable and actionable manner. Here, it is often not how something works or why but how much it costs and what costs would be saved that really speaks to politicians and bureaucrats.

The economic case for nursing and midwifery should look to where the existing workforce can be utilised more effectively and to future opportunities where the professions could take the lead. Preventive and primary healthcare is an area where nurses and midwives could add substantial value resulting in significant cost savings by supporting people to be healthier for longer, avoid severe illness, and reducing hospital admissions. Enabling nurses and midwives to work to their full scope of practice in any setting would have considerable impact and can result in shorter length of stay, reduced hospital and emergency admissions, and better patient outcomes. Nurse Practitioners (NPs) and endorsed midwives could also be more effectively supported by regulatory legislation, and their numbers increased. Indeed, NPs are now one of the most common primary healthcare providers in many states of the United States. Expansion of midwife-led models of maternity care, particularly in regional and remote areas and metropolitan districts with poorer access to services, would also result in better, more efficient care for mothers and babies.

Thrust onto the frontlines of the pandemic from what has long been called the coalface of health, maternity, and aged care, many stalwarts are becoming disenchanted. At the same time, new graduates and the future pool of students look onto a sector with small hope of impending improvement. In many contexts, better staffing levels and skills mix are frequently put forward as the solution but often knocked back due to the substantial associated costs. Nursing and midwifery leaders are respected by governments and are increasingly occupying positions of power and influence in politics and health. Making strong, understandable cases for the economic benefit of nursing and midwifery makes it more likely that governments and decision-makers will listen and take heed. We need to demonstrate that investing in nurses and midwives is both a necessary and cost-effective investment into the nation's current and future health and wellbeing.



Kristen Wischer

Senior Federal Industrial
Officer

Historic win – 10 days paid Family and Domestic Violence leave granted

On 16 May 2022, the Fair Work Commission (FWC) handed down a decision advising that its provisional view was that Modern Awards should be amended to include an entitlement to 10 days paid Family and Domestic Violence (FDV) leave.

The decision comes after years of campaigning led by the ACTU and the union movement to enshrine access to paid FDV leave in awards, ensuring all workers can take paid time to deal with and leave violent and abusive relationships. In 2018, in response to ACTU's first application for paid FDV leave, the FWC took a cautious response and agreed that five days unpaid leave should be included in awards. It also agreed that it was appropriate to review whether the leave should be paid in three years.

In line with the initial decision, the ACTU applied to FWC for 10 days paid leave for ongoing and casual employees in 2021. The application was opposed by a range of large employer representative groups, including ACCI and Ai Group. They opposed the application on the basis that paid FDV leave would impose too great a cost and administrative burden on employers.

After considering the parties' submissions and accepting the unchallenged evidence from expert witnesses and professionals working in medicine, law, industrial relations and services supporting people experiencing FDV, the FWC made a number of significant findings in support of granting paid FDV leave.

FINDINGS

The FWC, in its decision, accepts family and domestic violence as a ubiquitous and persistent social problem that disproportionately affects women. It is a gendered phenomenon that has grown worse over the course of the COVID-19 pandemic. It found that women experiencing or who have experienced FDV have a more disrupted work history, are on lower incomes, change jobs more frequently and are more likely to be employed on a casual or part-time basis than women who have not experienced FDV. As a result, employees who experience FDV often experience financial difficulties, such as relocation costs, being sole parents, and disruption to workplace participation.

The FWC also accepted the expert evidence that found the effects of FDV are far reaching and extend beyond the individual to their families and the general community. This, in turn, has a cost to the economy and an estimated cost to employers of up to \$2 billion a year. In granting paid leave, employers will also benefit from a reduction in absenteeism and lost productivity caused by FDV.

Importantly, the FWC recognised that employment is a vital pathway out of violent relationships and paid FDV leave significantly assists employees who experience FDV. It helps individuals maintain economic security, access services and move to a safer life, free from FDV.

In concluding that paid FDV leave is warranted, the FWC looked at existing entitlements to paid leave under enterprise agreements. It observed that there had been a sharp rise in the provision of paid leave over the last five years due to bargaining. This assisted FWC in finding that the provision of 10 days paid FDV leave is an emerging industrial standard that should be recognised as an award safety net standard.

The assertions that paid leave would be too costly to employers were rejected, as was the argument that paid leave would act as a disincentive to employing women. Regrettably, the union claim for the leave to apply to casual employees was rejected.

THE PROPOSED AWARD STANDARD

The FWC decision sets out a provisional view that the new paid leave provision should include:

- Ten days paid FDV leave per year for full-time employees, pro-rata for part time employees
- Paid leave to accrue progressively over the year and to accumulate from year to year, subject to a cap of 10 days at any given time
- Can be available in advance of accrual by agreement
- Paid at the employee's base rate of pay

The parties to the application are now asked to provide FWC with a draft FDV leave clause to be included in all awards.

WHAT DOES THE DECISION MEAN FOR ANMF MEMBERS?

This decision leads the way to make paid leave available to members who are award reliant. Negotiations for new agreements will be required to meet or better the new standard. Most importantly, ANMF members will have the security of knowing essential financial support is available when confronting FDV.

The pivotal role of nurses in pain management

Impacts of a revised definition of pain and review of opioid analgesia practice for the future

Olivia Sonneborn, Annie Williams and Nicole Gauthier

INTRODUCTION

Pain assessment is a critical component of optimum nursing care to enable effective pain management.¹ Advances in the understanding of pain mechanisms and management, as well as increasing concerns regarding an opioid crisis in the developed world, have brought the importance of accurate, valid and reliable pain assessments into focus for the future. The pivotal role of nurses in conducting pain assessment needs to be explored in response to the revised, universally accepted definition of pain by the International Association for the Study of Pain (IASP) in 2020 and evolving perspectives on opioid analgesia in acute pain management.

IASP DEFINITION OF PAIN

The IASP definition of pain has been broadly supported and accepted in the pain field by researchers, educators and practitioners since 1979 and states pain is “An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage”.² The revised IASP definition from 2020 now states pain is “An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage”.² This updated definition reflects recent advances in pain medicine, where it is understood pain may derive from nociceptive, neuropathic or nociplastic sources and that pain may be multi-mechanistic, creating a complex pain presentation requiring multifactorial management.^{2,3,4} The revised IASP definition of pain also aims to reinforce the importance of assessing for pain in patients where verbal description is not the sole behaviour or mode available to express

their pain, which may include neonates, the elderly, intubated or critically ill patients, persons with an intellectual disability or others incapable of verbal self-reporting their pain.²

PAIN MANAGEMENT IN AUSTRALIA

Chronic pain impacts 3.24 million Australians and 20% of the population worldwide.⁵ Chronic pain is projected to have an increased burden to five million Australians by 2050, which is likely to result in an increased demand for health services and nurses to provide expanded care delivery, including patient support, pain education, and to be an integral component of redesigning and implementing innovative, integrated pain service delivery.^{6,7}

Australia has an ageing population that is projected to increase the burden on healthcare resources and result in an incongruity with the supply and demand of acute care nurses in the future.⁸ The prevalence of chronic pain combined with an ageing population will generate a greater reliance on accurate and reliable pain assessments to underpin the demand and advancements in pain management practice.

Chronic non-malignant pain (CNMP) is often poorly responsive to opioid therapy, is associated with a risk of long-term health issues and opioid misuse, abuse, addiction and overdose.⁹ The opioid epidemic and associated mortality rates in the United States of America (USA) since 1999 reflect 44 Americans dying every day from opioid-related deaths in 2016.^{9,10}

In 2018, opioids accounted for just over three deaths per day in Australia- an annual total of 1,123 deaths, with a greater proportion of these occurring in regional areas and with







pharmaceutical opioids contributing to a greater number of deaths in females than males.^{11,12} Multi-disciplinary pain programs with nurse involvement effectively manage chronic pain by generating improved postoperative pain, mitigating analgesic use, reducing psychological distress and improving physical functioning and satisfaction with the patient's health.^{7,13}

The efficacy of pain self-management interventions and cognitive behavioural therapy (CBT) used in chronic pain management are well substantiated by current evidence, with the execution of such programs delivered by nurses due to their insights, experience and patient-centred approach.^{6,13,14}

OPIOID ANALGESIA IN PAIN MANAGEMENT

The use and clinical indication for opioids has shifted due to escalating problematic opioid use over the past 20 years, with the

Faculty of Pain Medicine (FPM) releasing a statement regarding the use of opioids in 2020 on the management of CNMP.¹⁵ The FPM statement identifies that opioid analgesia should only be used for severe pain for which "other treatment options have failed, are contradicted, not tolerated or are otherwise inappropriate to provide sufficient management and which has shown to be opioid responsive".¹⁵ This guidance on the appropriate use of opioids from the FPM highlights the importance of an effective and comprehensive pain assessment to determine the potential nature and source of a patient's pain, to subsequently identify and differentiate the mechanism of pain from nociceptive or neuropathic, as well as the acute, persistent or chronic source of pain.

The FPM statement relies on an effective, consistent pain assessment being undertaken consistently for individuals to ensure that implemented pharmacotherapeutic treatments are evaluated to determine

ongoing pain management plans and identify whether the use of opioids is considered appropriate and effective.¹⁶

The FPM are involved in training and accrediting medical pain specialists and are affiliated with the Australian and New Zealand College of Anaesthetists (ANZCA), which released its own statement in 2018 on the role of slow-release opioids in acute pain management. This statement declared slow-release opioids are not recommended for use in the management of acute pain and "The use of slow-release opioids for the treatment of acute pain can be associated with a significant risk of respiratory depression, resulting in severe adverse events and deaths".^{17,18} Acute pain can transition into chronic pain if untreated or poorly treated, from neuroplastic changes in the nervous system. Timely and effective treatment of acute pain is essential to prevent transition to chronic pain, with accurate, valid and reliable pain assessment fundamental to effective pain treatments.^{5,16}

NURSES' ROLE IN PAIN ASSESSMENT

The evolving demand on pain management care for the future and safety of the Australian population will require a greater reliance on nurses to have a sound understanding and knowledge of pain concepts. Robust and insightful knowledge of pain mechanisms and pain management interventions underpins an accurate pain assessment. With a revised definition of pain by the IASP, due to advancing perceptions and understanding of pain mechanisms, nurses need to consider their role and application of pain assessment into their clinical practice for the benefit of their patients. There are a number of validated and reliable pain assessment tools available for nurses to implement a comprehensive pain assessment, many of which have been used for decades and include assessment of verbal, non-verbal and functional expressions of pain.^{16,19,20}

The importance of the nurse's role in providing patient and clinician education has been recognised in current literature.²¹ Nurses play a pivotal role in disseminating best practice recommendations, providing education, mentoring and engagement with interdisciplinary team members to produce sustainable and innovative changes. Nurses' contributions to the achievement of effective pain management are robustly supported by current literature, with expanded and ongoing pain education fundamental to the development of nurses' and clinician knowledge, understanding and assessment of pain.^{22,23,24} Nurses are in a principal position to work in partnership with patients to optimise safe and effective pain management and identify self-care and nonpharmacological strategies individuals can use to manage their pain sustainably.²⁵

CONCLUSION

The definition of pain has changed, the focus of pain management is evolving, and prioritising pain assessments is a key focus for the future. The role of opioid analgesia in acute management is an area of contention and discussion in the pain field, where their clinical use demands a greater reliance on valid and accurate pain assessments. Nurses have a crucial role in leading and undertaking reliable and appropriate pain assessments to advocate for optimal and evidence-based pain management strategies delivered to patients.

Authors

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Linda Starr

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Paying the price for practising while not registered

The costs of practising whilst not being registered as a health professional can have significant financial, professional and personal impacts on those who fail to meet this registration standard.

Ahpra has prosecuted numerous cases on behalf of professional boards where individuals have held out to be a registered health practitioner when they have either had no qualifications or have not met the standard for registration as a health professional in Australia.

Amendments to the National Law in 2019 saw an increase in the penalty for fake practitioners in terms of maximum fines and the introduction of imprisonment of up to three years for each proven offence.

In January 2022, the first order of imprisonment was imposed under the new law on Zhi Sin Lee when she was convicted of falsely claiming to be qualified to practice medicine when she was not. Lee had partially completed a Doctor of Medicine degree but failed several disciplines and was advised that she would not graduate. Regardless, Lee accepted an intern position working 126 shifts before her employment was terminated, following her employer's discovery that she was not registered. Lee was fined \$10,000, ordered to pay Ahpra's legal costs of \$3,400 and sentenced to two years imprisonment, to be served by Intensive Corrections Order due to her demonstrating remorse for her actions.

In a similar case, Belinda Elwell accepted a position as a registered nurse in a Sydney medical centre following the completion of an unrelated placement there. She told her employer she was a registered nurse, providing them with a false registration number. She resigned after completing 14 shifts when asked to provide a copy of her registration certificate, but not before she had performed ECGs, administered medications, including vaccinations and attended patients' dressings. Elwell was fined \$3,000 and ordered to pay Ahpra's legal costs of \$7,200. In both of these cases, the magistrate noted the deliberate and calculated dishonesty and acts of deceit by the individuals that posed a real risk to patient safety.

However, there are cases where practitioners who have been registered have intentionally continued to practice despite knowing they were no longer entitled to do so.

Alexis Traverro was found guilty of holding out as a registered nurse after attending four shifts in a Melbourne private hospital. This was despite having surrendered his registration following a notification that the NMBA had proposed to suspend

his registration for failing to disclose that he had been convicted of three charges of receiving fees as a migration agent when he was not registered as one.

Traverro was sentenced to a three year adjourned undertaking with conditions including he be of good behaviour and pays \$1,000 to the court fund as well as \$500 for Ahpra's legal costs.

Failing to renew your registration and continuing to work also risks prosecution of holding out, as a Victorian enrolled nurse discovered when she continued to practice despite knowing that she had not renewed her registration. An early guilty plea prevented her from having a conviction recorded and a much heavier fine. As it was, she was fined \$2,000 and ordered to pay Ahpra's legal costs of \$3,500.

The last case concerns a new graduate, Brenda Solis, who worked 10 shifts as a registered nurse in an aged care facility before her employment was terminated after her employer discovered she was not registered.

Despite this, she continued to work 157 shifts in a private hospital until this employer also terminated her employment upon realising she was not registered.

Pleading guilty to all charges, Solis was fined \$3,300 and had a Community Corrections Order imposed for the work undertaken in the aged care facility, however, the court imposed a seven-month sentence of imprisonment to be served in the community as an Intensive Corrections Order as well as being fined \$1,100 for each count and ordered to pay Ahpra's legal costs of \$6,529.60.

The magistrate, in this case, believed a term of imprisonment was necessary as Solis was dealing with some of the most vulnerable people in aged care, noting this was not a technical breach but a clear disregard for the regulation laws.

Ahpra has an online public register of all health practitioners who meet the requirements for registration in their profession. It is up to employers to make use of this to verify the registration of not only new staff but also current staff to ensure they have maintained their registration and are licensed to practice without restrictions (Ahpra, 2022)

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Dr Jane Douglas

ANMF Federal Professional
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Facing challenges and discovering opportunities

Have you ever commenced work in a new area of nursing practice, one where you have no previous experience? You may have felt nervous with a sense of trepidation, unsure, excited, and motivated all at the same time. If you have found yourself in such a situation, you are not alone.

Whether commencing work as a new graduate, embarking on a career change, or being deployed, for most people, the transition from one clinical area to another is a time of upheaval often impacting a person's identity, role, relationships, and behaviours regardless of their previous experience. Factors influencing the transitioning of nurses between clinical areas include global nurse shortages, particularly in specialist areas,¹ through to changing community needs, for example, the COVID-19 pandemic.

I have spoken with many nurses over the last two years who have experienced such transitions due to the COVID-19 pandemic. A maternal, child and family health nurse, Jenny was asked to work in a mass vaccination clinic. Scott began working in a community nursing position, only ever having worked on a ward. Chris returned to work in intensive care after 10 years working as a registered nurse (RN) in general practice, and Chitra joined the virtual COVID-19 care team who worked remotely using telehealth to assess and monitor people isolating at home.

What was common amongst this group, apart from being RNs, was their fear of the unknown and how best to prepare for and work in a new area of practice. Essentially this is about how we define and expand upon our scope, ensuring we have the education, the competence, and the authority to practice.

Scope of practice is defined in broad terms by the NMBA as

... that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practices, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.²

Determining how to manage changes associated with a clinical move is vital for each nurse. As educated health practitioners, nurses aim to deliver safe, evidence-based care; the Decision-Making Framework (DMF)³ for nursing and midwifery is part of the regulatory framework and can assist nurses in doing that. It is designed to help nurses make decisions regarding their scope of practice, their delegation of responsibilities and to reflect on the current and changing needs of their practice.

Jenny, Scott, Chris and Chitra used the DMF to reflect on their scope of practice before and on commencing in their new area. They offered the following thoughts and suggestions for others experiencing transition.

Nurses have transferrable skills. Even when moving to another area, during pre-registration education and with prior experience as a nurse, you develop the skills and knowledge to reflect, think critically and make evidence-based clinical decisions. This is about the way we think, not what we think, and can be transferred to many contexts.

Critically reflect on what you know and what else you need to know to safely extend your scope of practice. Sure, there may be new skills you need to learn, but this can be interesting as well as challenging. Engaging in clinical supervision or mentorship can help you reflect and develop strategies to work through challenges as they arise.

Talk to your manager and colleagues to learn about the area of practice. Use the early period of your employment to discover as much as possible about the role and develop a plan for what else you need to learn and how to achieve that.

Speak with the nurse educator/s about learning opportunities that can help you expand your scope of practice. Don't be afraid to say you are unsure or need further assistance. That is how nurses make sure their practice is safe.

Understand your rights and obligations, particularly if an employer expects you to work beyond your scope of practice. Nurses are protected under section 136 of the *Health Practitioner Regulation National Law Act 2009* (the National Law), making it an offence to incite unprofessional conduct or professional misconduct.⁴

Reflecting critically on practice, identifying transferrable skills, understanding your scope of practice, and working with others to identify learning needs, can help you meet and address the challenges associated with a clinical move and at the same time, reveal exciting opportunities.

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Reproductive health planning – A potential new role for comprehensive fertility nursing care?

By Gillian Homan and Kelton Tremellen



Attempting conception at an appropriate age, weight and nutritional status can impact reproductive function for both men and women,¹⁻⁴ optimising the chances of conception and healthy pregnancy outcomes.

Although there are standard health guidelines for those attempting pregnancy,⁵ limited research has been conducted into whether Australian women and couples seek advice on appropriate lifestyle measures before attempting pregnancy or whether they adhere to the recommended preconception guidelines outlined (see table 1 and table 2).⁶⁻⁸ Furthermore, it has been reported that there are more barriers than facilitators to preconception healthcare, including lack of detailed knowledge and clarity regarding whose role this is, plus most women not seeking assistance from a health professional before pregnancy.⁹ The time when couples often seek health advice and assistance is when a woman is already pregnant or has trouble becoming pregnant.¹⁰

The preconception period provides an important opportunity to counsel couples regarding factors affecting fertility and pregnancy. Couples contemplating pregnancy could benefit from a reproductive health assessment to provide information about their specific circumstances and enable informed decision-making. For example, intercourse timing to optimise chances of conception, lifestyle modification and whether they should seek further medical advice or assistance. We suggest that experienced fertility nurses are best positioned to provide a comprehensive Reproductive Health Assessment and Plan (RHAP).

An Adelaide based fertility Clinic offers a “Fertility Health Care Check” (FHCC) to

people seeking information about their reproductive potential. This includes testing ovarian reserve and a semen analysis, followed by discussing the results and lifestyle in relation to the chance of healthy conception and pregnancy. Ovarian reserve, the number of oocytes left within the ovary, can be assessed by serum Anti Mullerian Hormone (AMH) measurement. While there have been conflicting reports regarding the usefulness of AMH in predicting natural fertility potential,¹¹ a very low AMH result is a negative prognostic indicator for IVF success.¹² In our experience, women with a low AMH result often bring forward their plans to start a family, or initiate infertility treatment earlier if they have already been trying for pregnancy for at least six months.¹³ Sperm quality is an important factor in the chance of natural conception, and a semen analysis can provide useful information regarding the likelihood of conception.¹⁴

We conducted a retrospective study to investigate whether couples perceived the FHCC as helpful 12 months or more after their visit. Unfortunately, due to a poor

response rate (10%), it is impossible to make firm conclusions regarding the value of the FHCC, but our results do provide some insight into overall preconception health, plus how respondents perceived and acted on information provided in their FHCC.

OUR RESEARCH

The aim of the research was to investigate whether Fertility Health Care Checks were helpful to couples in making decisions regarding starting a family - so called "reproductive health planning".

This was a retrospective study of 241 couples who completed a FHCC in 2018 and 2019. Participants completed an online survey, and their clinical notes were reviewed for documented details of the FHCC, including AMH and semen analysis results. The survey included a series of questions about the couple's lifestyle, plans for starting a family, discussion at the appointment, and whether they changed their lifestyle or reproductive health plans in response to the FHCC advice.

Most couples were already trying for a pregnancy at the time of their appointment (90%). Of concern, 53% of the women trying for pregnancy were still drinking alcohol, against current recommendations. Furthermore, 30% were not taking prenatal vitamins. On the male side, 17% of men were still smoking despite the known adverse effect of cigarette smoking on sperm quality and the resulting child's health. Twenty-five percent of men in our study cohort consumed alcohol levels above national safety guidelines. Following the FHCC consultation, most individuals (70% of females, 63% of males) made positive lifestyle changes to improve their chance of conception.

Furthermore, half of the cohort stated that the FHCC had been useful in helping them better plan for starting a family. Changes to their plans included becoming aware that IVF or further testing was needed, and for some, "a sense of urgency to start trying". Comments included "we left the appointment knowing our options for the future", "a simple and smooth process". Eleven couples (45.8%) progressed to assisted reproduction within six months of the FHCC due to concerns identified in the FHCC, such as abnormal semen analysis and low AMH levels.

WHO IS BEST PLACED TO CONDUCT REPRODUCTIVE HEALTHCARE ASSESSMENTS?

Fertility nurses are highly skilled in reproductive health and are therefore in an ideal position to provide this type of assessment for couples considering pregnancy in the future.¹⁰ Nurses have a

Table 1: Preconception guidelines: Females

	Recommendation	Reason
Weight	BMI 18.5-24.9	Low BMI (< 18.5) and high BMI (>25) are associated with anovulation, increased miscarriage, and pregnancy complications. ¹
Diet	The Mediterranean diet which is high in omega-3 rich foods. High in vegetables, fruits, whole grains, legumes, nuts, and low in red meat. Low in saturated fats and high in antioxidants. Also low in processed meats and low-quality canned fish that may contain mercury.	The Mediterranean diet has been shown to be beneficial to fertility and pregnancy. ²
Supplements	Folate 500mcg daily Iodine 150mcg daily	Preconception folate reduces the risk of Neural tube defects. Preconception Iodine is important for the normal thyroid function and development of a baby's brain and insufficient iodine has been associated with reduced IQ in offspring. As dietary intake may be insufficient; a supplement is recommended for women when planning pregnancy. ¹
Alcohol	No alcohol	Alcohol is associated with adverse pregnancy outcomes and birth defects. ³ There is no established 'safe' level of alcohol consumption for the developing foetus and abstinence is advised in the preconception period and during pregnancy.
Caffeine	Minimise daily caffeine to no more than 200mg of caffeine a day (1-2 cups of coffee or 2-3 cups of tea).	There is no definitive evidence that caffeine affects fertility, but some studies show large amounts of caffeine makes it harder to conceive and leads to a higher risk of miscarriage. ⁴
Exercise	Exercise for 30 minutes per day and avoid excessive high impact exercise.	Exercise is beneficial, however excessive high impact exercise may reduce fertility, especially if associated with low BMI. ⁵
Smoking	Do not smoke and avoid passive smoke exposure.	The many chemicals in cigarettes cause damage to oocytes. Infertility is more likely in smokers. ⁴
Recreational drugs	Do not take recreational drugs	The use of recreational drugs is likely to have a negative impact on fertility and pregnancy outcomes, both directly and indirectly via poor lifestyle choices. ⁶
Environmental exposures	Avoid exposure to potentially toxic chemicals where possible (solvents, noxious cleaning agents, inhalational anaesthetics pesticides). Avoid ionising radiation. Avoid intense heat in early pregnancy (very hot baths/spas).	Environmental chemicals and toxins such as lead, heavy metals and solvents/cleaning products can be harmful to fertility and pregnancy. If chemical use is mandated, appropriate PPE should be worn, and procedures conducted in full ventilation. Ionising radiation also have adverse effects on the reproductive system and should be avoided completely. ³ Intense heat in early pregnancy can be harmful, possibly increasing fetal malformation risk ⁷
Regular medications	Discuss with your doctor	Some medications are harmful to fertility and pregnancy. This can be checked at: mothertobaby.org
Pre genetic screening	Discuss with your doctor	Discussion screening for genetic conditions (eg. Cystic Fibrosis and Fragile X) is important. If known high risk (genetic abnormality in immediate family) appropriate screening and counselling can be accessed.

diverse range of skills and have effectively conducted healthcare assessments and planning in many areas, including obstetrics and fertility.¹⁵⁻¹⁷ Assessments would be performed with the support of a fertility physician and we are hoping that our pilot study findings will be a "conversation starter" regarding the use of nurses in this very important area: Fertility nurse-led "Reproductive Health Assessment and Planning" (RHAP) appointments with couples considering pregnancy in the future.

See following page for table 2 and references.

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Table 2: Preconception guidelines: Males

	Recommendation	Reason
Weight	BMI 18.5-24.9	Obesity has been shown to adversely affect sperm quality in males, plus potentially offspring health. ¹
Diet	The Mediterranean diet which is high in omega-3 rich foods. High in vegetables, fruits, whole grains, legumes, nuts, and low in red meat. Low in saturated fats and high in antioxidants. Also low in processed meats and low-quality canned fish that may contain mercury.	There is evidence of an association with the Mediterranean diet and improved semen quality. ¹
Supplements	Antioxidant supplements may be beneficial if a couple is having difficulty conceiving – especially in men with poor sperm quality parameters	Infertility is known to be associated with oxidative stress, with “free radicals” potentially damaging sperm quality. Antioxidant supplements have been shown to improve semen quality and pregnancy outcomes in some, but not all studies. ²
Alcohol	Adhere to safe drinking guidelines – an average two drinks per day maximum, with several alcohol-free days each week and no more than four standard drinks in one session.	Alcohol can cause impotence and damage sperm quality. ¹ Hard for a female partner to abstain from alcohol while trying to conceive if the male is drinking (“solidarity”).
Caffeine	Minimise daily caffeine to no more than 300mg of caffeine a day (1-3 cups of coffee or 2-3 cups of tea).	The literature suggests that caffeine intake, possibly through increased levels of sperm DNA damage, may negatively affect male reproductive function. ^{1,3}
Exercise	Exercise for 30 minutes per day and avoid excessive high impact exercise.	Exercise is beneficial, however excessive high impact exercise may reduce fertility, especially if it results in heating of the testicles. ⁴
Smoking	Do not smoke	Smoking can cause erectile problems in men and damages the DNA in sperm. There is an association with smoking and infertility as well as childhood leukaemia in offspring. ^{1,5}
Recreational drugs	Do not take recreational drugs	The use of recreational drugs is likely to have a negative impact on fertility and pregnancy outcomes. ¹
Environmental exposures	Avoid exposure to environmental chemicals where possible. Males should avoid excessive heat exposure to genitals - avoid tight underpants, prolonged sitting, intense cycling. Avoid laptops & phones near groin.	Environmental chemicals and toxins such as lead, heavy metals and solvents can be detrimental to fertility and pregnancy. ⁶ Radiation and excessive heat to the male genitals can negatively affect sperm production. ¹
Regular medications	Discuss with your doctor	Some medications are harmful to reproductive health and fertility.
Pre genetic screening	Discuss with your doctor	Discussion screening for genetic conditions (e.g., Cystic Fibrosis and Fragile X) is important. If known high risk (genetic abnormality in immediate family) appropriate screening and counselling can be accessed.

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A Nurse Practitioner-led community perinatal mental health service

A nursing governance approach

Simone T Harvey, Jennifer Bennett, Erica Holder and Marianne Wyder



INTRODUCTION

Perinatal mental illness is common, and barriers to access and engagement with health services prevent many women from receiving effective treatment and support.¹ Nurse-led clinics can assist in addressing some of these barriers. Nurse-led clinics provide specialist services to vulnerable populations, with nurses having increased autonomy, specialist skills and their own caseloads. The clinics are led by registered nurses of varying levels of experience and role classification and can include a Nurse Practitioner (NP).^{2,6} While there has been an increase in nurse-led clinics in mental health, mental health services continue to be predominantly based on the traditional model of hierarchical leadership whereby clinical governance and accountability are considered the medical profession's responsibility. Within this approach, processes that guide case reviews are led and finalised by psychiatrists.

OVERVIEW OF THE ISSUE

An NP is an advanced practice registered nurse, educated at master's level and endorsed to practice in an extended clinical role in a specialty area.^{7,8} While clinical leadership is a core feature of the NP role, it has not been described in terms of having clinical authority for a patient group or clinical team.^{7,9} NPs are required by legislation to have formalised collaborative arrangements with a medical specialist.⁷ This is often misunderstood to equate to a supervisory relationship whereby the medical specialist holds ultimate responsibility for patient care.⁹ This is despite well-established principles based in law that healthcare delivered by nurses remains their responsibility and professional and criminal liability remains with each individual health practitioner.^{9,11} As a result, mental health nurse-led teams (including those with an NP) generally remain under psychiatrists' authority.¹²

BACKGROUND

The publicly funded perinatal mental health service in this study was established in 2015 and is a NP-led model with a full time, equivalent (FTE) NP and 1.6 (FTE) clinical nurse consultants (CNCs). The service provides specialist community based, non-urgent, perinatal mental health assessment, brief interventions and treatment based on a nursing philosophy within a biopsychosocial framework for up to six appointments per woman per episode of care.¹³ Women can be referred by a range of people and modalities, and all women who want an appointment are offered



one. The treatment plan was developed in partnership with the woman and her supports, including psychoeducation, psychological, social, and family-focused interventions. The NP's role includes prescribing antidepressants and ordering diagnostic tests and pathology. There is in-kind support for case review from a Consultation Liaison (CL) Psychiatry service psychiatrist. An evaluation of the service indicated it is clinically effective and safe.¹³

PROJECT OUTLINE

In the original model, the NP had the authority to make and approve most team decisions, including referral acceptance, case allocation and treatment planning. However, the supporting psychiatrist, as per the service-wide protocols, was delegated authority by the clinical director for the formal case reviews. For women to be discharged from the service, their care needed to be reviewed with the psychiatrist. Case review meetings occurred twice a month, with 10-12 cases being discussed within a 1.5-2-hour time slot, and as such, limited the opportunity for meaningful discussion. Due to the discharge process, referrals remained open longer than required, affecting the nursing team's workloads and their ability to respond in a timely way to new referrals. Furthermore, the number of cases and allocated time meant the psychiatrist's expertise was not

used in a focused and meaningful way and time to discuss complex cases in detail was limited. This process did not support a nurse-led model of care or enable the nurses to work to full scope of practice.

A revised model of care where the governance was primarily with the NP was trialled for six months from 1 March to 30 September 2020 and evaluated as part of a quality improvement activity. The nursing team consisting of the NP and CNCs commenced weekly nursing team meetings to review the care of women seen one to four times with the individual nurses presenting their own cases. A 45-minute case review with the psychiatrist was scheduled twice a month to discuss cases with five or more face to face appointments, open for 91 days, or identified by the nursing team as complex. The NP held clinical responsibility for most clients, collaborating as per the pre-determined criteria above with the psychiatrist.^{14,15}

The new model of care is described in figure 1. This highlights the different nursing roles and responsibilities, the governance arrangements between the NP and psychiatrist and the professional support from the Nursing Director.

METHOD

To ensure the service remained effective, the pre and post scores of Edinburgh Depression Scale (EDS) scores routinely



collected at first and last appointments for women seen more than once were used as an outcome measure for evaluation. These were compared to those previously reported for the service. The EDS is a 10-item self-report tool that measures the presence of depressive symptoms over the previous week and has shown good validity in both the antenatal and postnatal periods. Scores ≥ 12 indicate the depression is likely.^{16,17} The EDS was only used as an outcome measure with a comprehensive clinical interview and mental health assessment used to inform diagnosis and treatment plan and length.

The distribution of the EDS scores was first assessed for normality which indicated that the data were not normally distributed ($P < .05$). As such, the median scores of the EDS were calculated with differences between the initial score and final scores using the Wilcoxon Rang test. The number of women reviewed, the time taken for these reviews (both with the psychiatrist and the nursing team only), the number of complaints and sentinel events during the trial period were also compared to those previously recorded. The reflections of the nursing staff involved in the trial gathered as part of the evaluation (SH, JB & EH) are also reported. These reflections were obtained through a facilitated discussion with a person external to the team (MW) and then refined through the process of writing the current paper. As part of the evaluation

process, the psychiatrist was consulted. The endorsed model and his comments were noted. The quality improvement project was approved by Metro South Addiction and Mental Health Services (MSAMHS), Brisbane, Queensland. It was assessed by the Metro South Human Research Ethics Committee as not requiring a full research committee review and received a negligible risk ethics approval (No. 72632) sanctioning publication of the data.

RESULTS

During the six-month trial, a total of 133 women were seen by the service. While two slots of 45-minutes were allocated per month with the psychiatrist, during the trial seven women were reviewed with the psychiatrist for a total time of 75 minutes and all others by the CNCs and the NP. All of these fell within the 91-day review cycle.

The pre and post EDS for the 54 women that attended more than once indicated statistically significant clinical improvement (Score reduction from 16.5 to 6.32, $p < 0.001$). These results were comparable to those prior to the trial.¹³ There were no adverse events or complaints.

WHAT WORKED

During the trial, there was improved efficiency in the review process, as noted by nurses' reflections and a significant

reduction in the psychiatrist's time. The changed process allowed the nursing team to practice more autonomously in reviewing care, to work to their full scope of practice and more efficiently attend to discharges. Furthermore, increased time within the nursing review meeting provided opportunity for focused discussion and learning. Similarly, the psychiatrist spent less time away from his primary clinical role and was more focused within the case review meeting. As part of the MSAMHS review process of the model, the psychiatrist was asked to comment on the new model. No concerns were raised, and as a result, the new model was endorsed by senior medical leadership and the service. The well-established positive working relationship with the psychiatrist was noted to contribute to the trial's success.

PROBLEMS/CONSTRAINTS

While there were many positives, a major drawback is the current absence of suitably qualified NPs to backfill the role. Currently, if the NP is on leave, the psychiatrist must fulfil the role of the main clinical leader. This highlights the need for succession planning and the benefits of funding an NP candidate role to plan for future backfill. This issue is relevant when considering the longevity of the model and its long-term application. The issue of developing and sustaining NP roles has been identified elsewhere.³

DISCUSSION

Nurse-led clinics can provide high quality, accessible, cost effective and safe care that patients highly regard.^{2,18} The NP role has additional benefits that positively impact healthcare, including autonomy, clinical leadership skills, expanded scope providing secondary consultation, diagnosing, treatment planning, ordering of diagnostic testing and pathology, and prescribing and reviewing medications.^{7,29} The focus to date, however, has been on nursing teams delivering specialised clinical care under medical direction or individual NPs providing a specialised service rather than an NP-led service. There is also limited literature on NPs and clinical governance despite leadership being a core domain for NP practice.⁸

NP roles in mental health in QLD are relatively new, and there have been limited opportunities to challenge the current systems around clinical governance. The current study showed several positive outcomes of the NP having clinical authority. Importantly, the nursing team reflected that the revised model improved the quality of case reviews. The extended

time spent discussing and reviewing care helped ensure evidence-based practice and facilitated upskilling in contemporary perinatal mental healthcare. The nursing team also reported that this process had improved waiting time for women to receive the service after being referred.

CONCLUSION

The quality activity of implementing and evaluating a revised NP-led model of perinatal mental health using a revised governance approach showed improved efficiency, treatment planning and review, which benefited patient care. This occurred while maintaining a high standard of clinically effective, safe care. The model allowed the nursing team to work more autonomously, continuing to collaborate as needed, with the NP being supported to function to their full scope in the domain of clinical leadership.

While traditional medical models remain the norm in mental healthcare, this unique and contemporary model provides an effective alternative option. As health services continue to change in response to emerging challenges, NPs are well positioned to take on clinical leadership and governance roles. The study provides an

example of an NP-led model of care that can assist others in developing new nursing models.

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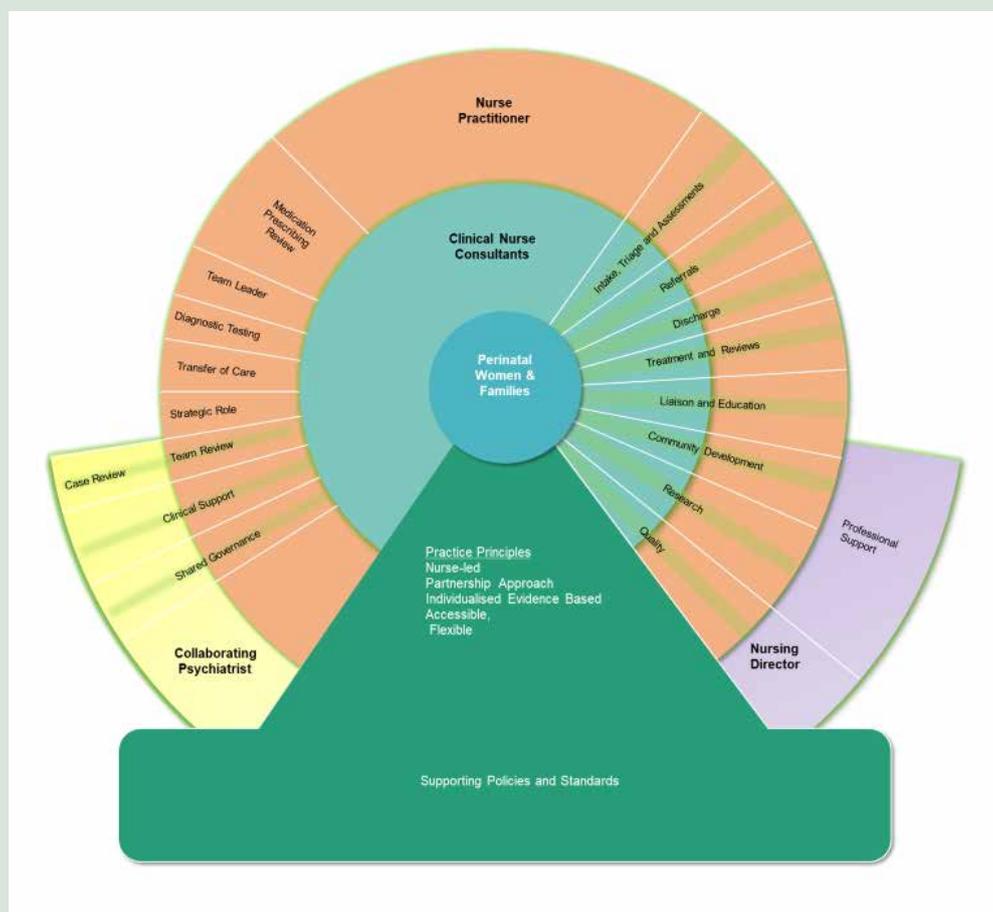
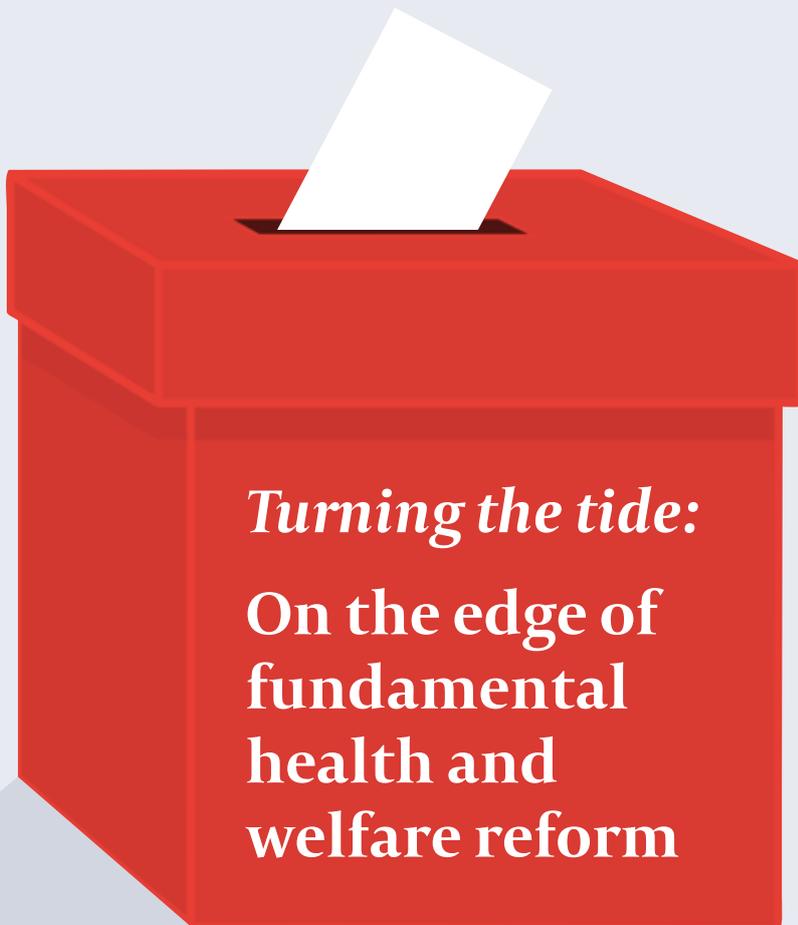


Figure 1. Team roles and the NP governance model diagram



Turning the tide: On the edge of fundamental health and welfare reform

With a Labor Government now settled in at the helm, what reforms can Australians expect, and how do they match up with the expectations of the ANMF and its members?

Pre-election, the Labor Government made a number of significant assurances to deliver real solutions to ensure fair and equitable outcomes in health and aged care for all Australians.

ANMF Federal Secretary Annie Butler said the union looked forward to working with the new Labor Government in developing these strategies.

“Mr Albanese and his team, including Mark Butler, Anika Wells and Ged Kearney, have already listened to the ANMF and have committed to working with us to develop a health workforce ready and able to respond to Australia’s health needs.

“This federal government has a real plan to fix the systemic issues in health and aged care, and the ANMF will ensure they will deliver on these solutions as promised.”

While the Government has started to deliver on its promises, commitments to health, aged care and social justice include:

HEALTHCARE

To alleviate the pressure on healthcare, the Labor Government has promised to work on access issues, particularly in outer suburbs and regional and rural communities.

This includes instigating at least 50 Medicare Urgent Care Clinics to take pressure off emergency departments and allowing Australian families to see a doctor or a nurse when they have an urgent, but not life threatening, need for care. The clinics will be based in existing GP clinics and Community Health Centres and provide bulk billed services delivered by doctors and nurses in every state and territory.

The Government has also promised to boost workforce incentives for rural and regional GPs and support the engagement of nurses, allied health and other health professionals and provide multidisciplinary team-based care.

Additionally, they plan to expand the Innovative Models of the Collaborative Care program across rural and regional Australia to attract, support and retain rural health professionals.

Other actions to improve healthcare include:

- Improving pandemic preparedness and response by establishing an Australian Centre for Disease Control.
- Strengthening Medicare Taskforce.
- Cutting the cost of medications.
- National Melanoma Nurse Network.
- Strengthening First Nations health through working with the National Aboriginal Community Controlled Health Organisation (NACCHO), community-controlled and other health services to close the gap in First Nations health outcomes.

AGED CARE

The Labor Government has pledged:

- That every aged care facility will have a registered nurse on site, 24 hours a day, seven days a week.
- An increased number of carers and a mandated average of 215 minutes of care per resident per day, as recommended by the Royal Commission.
- Government support for workers’ and unions’ calls for better pay at the Fair Work Commission and a commitment to funding the case’s outcome.
- Residential care providers will be made to report what they are spending in detail. Labor will also give the Aged Care Safety Commissioner new powers to ensure greater accountability and integrity.
- The Government will also work with the sector to develop and implement mandatory nutrition standards for aged care homes.

NURSE AND MIDWIFE SUPPORT

The Albanese Government has promised nurses and midwives around the country who are concerned about their stress levels, feel exhausted, anxious or struggle with their mental health access to a National Nurse and Midwife Health Service. The service, to be implemented across States and Territories, will provide free, confidential and independent support, with information, advice, treatment and specialist referrals.

The program is based on the successful Nursing and Midwifery Health Program model already available in Victoria. Services will deliver holistic, case-managed support focusing on early intervention so nurses and midwives can avoid unnecessary burn-out.

SUPPORTING WOMEN

CHILDCARE

The Government has promised to increase the maximum childcare subsidy rate to 90% for families with their first child in care. They will also increase subsidies for single-child families earning less than \$530,000, which will extend to after school hours care.

CLOSING THE GENDER GAP

Labor says they will close the gender pay gap by changing the Fair Work Act to include gender equity. It will also set up two new expert panels within the Fair Work Commission backed by research units to advise on equal remuneration cases, one specialising in the care and community sector and the other specialising in gender pay equity.

The Government says this will make pay increases easier for low and middle-income female workers and enforce a Secure Australian Jobs Plan to support women with insecure work.

WOMEN'S SAFETY AND DOMESTIC VIOLENCE

The Labor Government says they will provide the investments and national leadership necessary to end family, domestic, and sexual violence.

They have promised to tackle these issues with 10 days of paid family and domestic violence leave, safe and affordable housing, and creating hundreds of frontline worker positions for women and children in crisis.

They will establish a new Family, Domestic and Sexual Violence Commissioner, fund 500 community workers to support women in need, and invest \$77 million for Australian school students to gain high quality, age-appropriate consent and respectful relationship education.

The Government is looking to offer a separate plan for First Nations people to end violence against women and families. They will reinvest in First Nations communities with \$79 million dedicated to reducing incarceration rates and early intervention for family violence.

They have also promised to implement all 55 recommendations from the Respect@ Work report.

FIRST NATIONS PEOPLE

The Government plans to instigate the Uluru Statement from the Heart in full. The statement calls for Voice, Treaty and Truth and will help create a reconciled Australia. Additionally, they have committed to

progressing a referendum to enshrine a First Nations Voice to Parliament in the Constitution. They will establish a Makarrata Commission to work with the Voice to Parliament on a national process for Treaty and Truth-telling.

The Government also plans to:

- Work towards Closing the Gap.
- Abolish the punitive Community Development Program.
- Turn the tide on incarceration and deaths in custody through landmark justice reinvestment funding.
- Improve housing in remote Indigenous communities.
- Invest in First Nations management of land and waters.
- Strengthen First Nations' economic and job opportunities.
- Get rid of the privatised Cashless Debit Card.

CLIMATE CHANGE

The Government has committed to developing and implementing Australia's first national strategy on climate.

Labor plans to reduce Australia's pollution by 45% on 2005 levels by 2030, and to reach net zero pollution by 2050, consistent with our obligations under Paris of keeping global warming to well-below two degrees above pre-industrial levels, and informed by independent Climate Change Authority advice.

The Government promises to work with industries to bring down pollution, while protecting competitiveness and jobs, and building the industries of the future.

Some of the Governments plans include:

- Upgrade the electricity grid to fix energy transmission and drive down power prices.
- Make electric vehicles cheaper with an electric car discount and Australia's first National Electric Vehicle Strategy.
- Roll out 85 solar banks around Australia to ensure more households can benefit from rooftop solar.
- Install 400 community batteries across the country.
- Demonstrate Commonwealth leadership by reducing the Australian Public Service's own emissions to net zero by 2030.
- Invest in 10,000 New Energy Apprentices and a New Energy Skills Program.
- Re-establish leadership by restoring the role of the Climate Change Authority, while keeping decision-making and accountability with Government and introducing new annual Parliamentary reporting by the Minister.



A black and white photograph of a person with long, dark, messy hair sitting on a couch. They are covering their face with both hands, suggesting distress or emotional pain. They are wearing a dark jacket over a button-down shirt. A large, semi-transparent dark blue circle is overlaid on the center of the image, containing the text.

MENTAL HEALTH
AND
ALCOHOL AND
OTHER DRUGS

Reach out

By Amy Faden

In July 2021, Canberrans were quite smug when it came to COVID. It seemed there really was a Canberra bubble, as we had successfully avoided community transmission for over 12 months. And then Delta came to visit...

As in other places around the country, it was apparent that many people who tested positive or had been in contact with someone who had tested positive for COVID-19 in the ACT were situated within vulnerable populations.

As such, a specialist team of primary health, mental health and alcohol and other drug

senior nursing clinicians was established to meet the needs of this community and to assist in spreading containment through in reach supported healthcare. REaCH was born.

The Rapid Evaluation and Care at Home (REaCH) team's goal was to limit COVID positive Emergency Department presentations, hospital admissions and to prevent deterioration within quarantined homes and formal settings.

In practice, REaCH was able to demonstrate that the divisions between mental health and AOD that have persisted for so long were irrelevant, as nurses worked together to support people with comorbid conditions and create positive outcomes. REaCH used quarantine as an opportunity: to stabilise the substance use and assess and treat the mental health condition. Many patients who had been lost to mental health follow up or who only saw services when in crisis were able to finally receive appropriate holistic care.

As Canberra is a small jurisdiction, partnering with NGO groups and GPs was easy – everyone knows everyone – so follow up and ongoing care after quarantine (whether medical, social or housing support) was facilitated.

The work was interesting and rewarding, but the best part was learning from each other and seeing that we aren't so different after all. No job was too great or too small, no question too strange or complicated. Within our respective services, REaCH has shown that AOD and mental health nurses working together can achieve amazing things.

Author

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The role of a nurse navigator in ED

CONTEXT

I work at Princess Alexandra Hospital (PAH), one of three tertiary level facilities in Queensland, providing care in all major adult specialties, except for obstetrics.

The PAH Emergency Department (ED) manages 69,000+ presentations each year, including complex patients headed to our specialist toxicology unit from local correctional services and a huge range of social and cultural backgrounds. Meeting individual patient needs requires flexible and adaptable nursing care. I commenced this role in 2017, excited by the opportunity to design and implement a new Nurse Navigator (NN) model of care to deliver safe, consistent and coordinated care for patients who present to our ED more than five times a month.

SO, WHAT IS A NURSE NAVIGATOR?

In Queensland Health, NN roles are held by experienced nurses with expert clinical knowledge and an in-depth understanding of the health system. Their professional focus is to directly support patients with complex healthcare needs. These nurses have the breadth and depth of clinical skills required to identify and monitor the healthcare requirements of high needs patients, identify the appropriate action/s necessary and facilitate timely access to appropriate services: health.qld.gov.au/ocnmo/nursing/nurse-navigators

NNs play a key role in supporting and coordinating a patient's entire healthcare journey, rather than focusing on a specific disease or condition, or a single episode of care. Their role is underpinned by the principles of delivering coordinated and patient-centred care, creating partnerships across different health providers and sectors, improving patient outcomes and enabling improvements across the system: health.qld.gov.au/ocnmo/nursing/nurse-navigators

NURSE NAVIGATING IN THE ED SETTING

My ED NN portfolio focuses on frequently presenting patients who demonstrate complex mental health co-morbidities, chronic disease, homelessness and alcohol and other drug issues. I also support a cohort of patients who repeatedly present with behaviours such as self-harm, medication overdose and suicide attempts, often apparently linked to a diagnosis of borderline personality disorder (BPD). BPD patients often struggle to engage with ongoing psychological and mental health services as well as becoming the “unpopular” patient in the ED setting due to their challenging behaviours.¹

Navigating health journeys for such complex patients draws on my experience in mental health, addictions, and health policy. I am passionate about challenging staff attitudes and reducing stigma around this population group, including tackling negative terminology such as “frequent flyers”. The Complex Users of the ED (CUED), NN model provides non-judgemental identification of, connection to and links for our vulnerable patients across the ED acute and mental health services, as well as to wider community psychosocial supports. I engage patients, explore

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their motivation to change, deliver solution focused therapies and improve health literacy so that together, we can support a new journey of recovery.

Many CUED patients present with generalised anxiety disorders with re-occurring psychosomatic symptoms (such as chest pain and abdominal pain). Some patients continue to present more than five times a month and/or choose not to engage with NN services, mental health services and GPs, risking increased police and ambulance call outs. Some patients demonstrate behavioural challenges (verbal aggression and violence) in the ED. Part of my job is to work with the multidisciplinary health team to develop a complex management plan enabling an individualised, consistent, treatment approach every time the patient is in the ED. The ED management plan supports a patient centred; Stop, Consider and Consult approach. This enables ED clinicians to reduce a patient's distress and unnecessary medical investigations (such as over exposure to chest X-rays, reduction of unnecessary pathology testing and adjustments to eating disorder admission criteria) and non-therapeutic mental health inpatient admissions.²

My day as a NN varies hugely. It ranges from delivering suicide prevention, safety planning, improving patient and staff health literacy, to conducting higher-level strategic work such as data reporting, service redesign and quality improvements. Holding portfolios such as prisoner health, suicide prevention and acting as a clinical supervisor to other clinicians all adds to the mix. Recently I added an ED mental health related patient complaints process which helps us all find better ways to create a positive patient experience. The unique role of the NN then allows the ED to respond to feedback and creates new opportunities to reduce service fragmentation and patient disconnection.

My NN role includes capacity building with internal and external (community) agencies so our team can support patients' right across their healthcare journey. Patients with complex needs are often expected to navigate themselves across medical, mental health, disability, and psychosocial service providers, sometimes an overwhelmed and disengaging task. Supporting a patient's motivation and advocating on their behalf across the silos of care often produces improved healthcare outcomes for the patient and reduces presentation to the ED. The NN role is only possible because of the unwavering support of ED senior management and active collaborations with the multidisciplinary ED and community health teams.

Tai Chi: Body & mind medicine program for Australian nurses' mental wellbeing

By Carol Chunfeng Wang

Australian nurses have experienced higher anxiety levels during the COVID-19 pandemic than before. This may have affected their long-term mental health and intention to stay in the profession, resulting in a workforce shortage that impacts the health system and community. Management is urgently required to improve nurses' wellbeing.

Tai Chi is a moderate exercise known as a moving meditation. Tai Chi is commonly used to manage mental health. Studies have documented that Tai Chi showed promise to mental wellbeing.

The ongoing Tai Chi: Body & mind medicine research program is approved by the ECU's Human Research Ethics Committee (No. 2021-03042-WANG). This is an ongoing 12-week training program that runs three times a week. Each session lasts 45 minutes. Participants are required to commit themselves to at least two sessions per week for 12 weeks (24 sessions in total). They will receive a certificate confirming their training. Currently, we are running the

program for ECU gym members; nurses who are ECU gym members can contact Dr Wang for more details. There is also a possibility of running the program specifically for nurses in WA.

Essentially, we use Tai Chi as a safe, sustainable non-pharmacological approach to managing chronic disease and mental wellbeing.

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. Tai Chi, acupuncture, laser therapy, cupping) to improve health outcomes, especially chronic pain and mental health. 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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ECU Holistic Health Research Clinic



The role of the nurse in caring for carers: Ways to enhance mental health and wellbeing

By Zahra Almoaber, Christopher Patterson and Lorna Moxham

A recent integrative literature review conducted by the authors of this article regarding respite care among carers or relatives responsible for caring for individuals with a mental illness revealed some recommendations that can help decrease carer burden.

There are several pragmatic strategies that nurses, who are used to fulfilling many diverse roles, have an important part in contributing to.

One such role is that of a health educator. Mental Health consumers are often the recipient of health education, but the same cannot always be said of carers and or relatives. Having accurate and adequate information is empowering, and nurses can help carers explore their own needs by educating them about mental health. Ensuring the education is culturally safe and appropriate is something that nurses will consider. Enhanced carer education will contribute to better consumer outcomes. Education can also be extended to staff working in respite care as they are the core of service delivery. Enhancing their competence will positively impact the experience of utilising respite care services.¹ The provision of training programs and regular education will enhance the experience of using respite.

Nurses are aware of the importance of collaboration and inclusiveness, and in this regard involving carers and relatives when making decisions related to consumers ensures holistic care. Fundamentally, getting everyone on the same page is beneficial to consumer care and carer wellbeing.

Enhancing the carer's awareness and acceptance through the nurse's role as an advocate can provide carers with 'permission' about the need for utilising respite care.

In this regard,² suggests that it is important to encourage carers to utilise respite before times of crisis and to use it regularly to maintain their own wellbeing. Jardim and Pakenham (2010) also remind us that the early engagement in using respite care decreases the carer's burden.

Encouragement by nurses for carers to use respite regularly can improve relations between carers and relatives.

Given that nurses are engaged in constant reflective practice, they react positively to feedback. By encouraging carers to utilise respite care, they can seek feedback on their experiences and use this information to improve the quality of services. This kind of evidence can also be utilised to seek more funding. Nurses can also influence and develop appropriate and enjoyable activities for consumers whilst in respite which are relevant to diverse groups and people with various mental and physical health conditions.

Holistic seamless care is a core element of how nurses provide practice to ensure the best outcomes for health service users. Encouraging healthcare providers to consider respite care as a crucial part of mental healthcare and including the utilisation of respite care in discharge plans and rehabilitation programs is something that should be considered

Nurses are central to the provision of safe, effective and quality care. With the many roles that nurses play, they should be in leadership positions to influence, advocate, innovate and evaluate. Using the skills that nurses possess will ensure a positive difference.

Authors

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Nurse led project - SCOT: developing a shared care model of service for the treatment of opioid dependence

By Tracey Veitch, Peter Cochrane and Hoiyan Karen Li

INTRODUCTION

Nurses working in the alcohol and other drug (AOD) sector provide physical and psychological support to those with a range of AOD concerns. We work closely with our clients to achieve their goals and advocate for non-judgemental and client-focused care. Because of this close relationship, we are well placed to lead projects for change within this area.

Opioid dependence “is a chronic medical condition most effectively treated with medication and counselling” in Opioid Treatment Programs (OTP), which are proven to reduce the cost and impact of opioid use to both the individual and the community.^{1,2} Nurses play a key role in the management of clients on the program.

PROJECT OUTLINE

The SCOT (Shared Care for Opioid Treatment) project was a nurse proposed and led project in response to the QLD Government’s rollout of OTP within all prisons, which would likely have a significant impact on the public Alcohol and Drug Services (ADS).¹ We aimed to establish a sustainable model of shared care for OTP patients which would see stable clients move into a more appropriate

treatment setting – predominantly GP clinics, in line with local guidelines and strategic plans, increasing the ADS capacity.

Research showed a shared care model of treatment improved uptake of preventative health screening/treatment, management of chronic health conditions^{1,3} and importantly, reduced stigma around those who use substances - without impacting OTP adherence.⁴ However, past efforts to engage GPs in OTP had been largely unsuccessful, and we sought to understand the barriers to this engagement. Research showed commonly reported barriers were a lack of confidence in discussing alcohol and other drug (AOD) use, unfamiliarity with AOD use and a lack of support from specialist services.⁵ Other barriers included a lack of remuneration for the perceived workload and the perception that AOD patients are difficult to manage.⁶

Surveying our clinicians, we found initial reactions to a new model were quite negative due to past efforts to engage GPs as prescribers. To combat this, we ensured clinicians’ concerns were acknowledged and respected and that they were involved in the procedure development through a series of surveys.

RESULTS

Using a collaborative approach within our AOD service, seeking buy-in from the

local Primary Health Network, delivering education to GPs, pharmacists, and other community health professionals, we developed and implemented the desired shared care procedure. Feedback from AOD clinicians, GPs and pharmacists has been largely positive, with ADS nurses noting no increase in their workload and no push back from clients or GPs when approached to participate in this model of care.

SCOT has now been adopted as business as usual within the Metro North Drug and Alcohol Service in Queensland Health, with a permanent fulltime nurse coordinator overseeing day-to-day management.

OPPORTUNITIES AND CONCLUSION

A free toolkit now exists on the Insight website⁷ and nurses across other public alcohol and drug services are encouraged to explore opportunities for partnerships with general practice.

Authors

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C the whole story: Hepatitis C in homelessness, AOD, and mental health settings

By Michelle Kwok, Lucy Ralton, Megan Hughes and Melinda Hassall

The World Health Organization set a goal to eliminate viral hepatitis as a major public health threat by 2030.¹ At the end of 2020, 117,814 Australians were living with chronic hepatitis C virus (HCV)², with an estimated 47% of people having received HCV treatment by the end of 2020.^{2,3}

The Fifth National Hepatitis C Strategy identified several priority areas to guide Australia’s response from 2018-2022.⁴ This included the development of a highly skilled and responsive workforce and identifying key settings that include homelessness, alcohol and other drugs (AOD) and mental health facilities.

Nurses, needle and syringe program (NSP) workers and Peers play a crucial role in providing HCV education, treatment and care to people attending these services.

Considering the priorities outlined in the National Strategy, the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) held a multi-disciplinary forum for Peers, NSP workers and Nurses working in homelessness, AOD, and mental health settings across Australia. The forum aimed to share strategies for success and innovative approaches to providing treatment and care to people living with HCV who access these services. The forum was co-designed by the workforce it was created for, with a Steering Committee

of Nurse and Peer representatives from each setting. The Steering Committee contributed their expertise to developing the intended learning outcomes, program format and topics, suggestions for speakers and the target audience.

The forum was delivered via a virtual platform and showcased models of HCV care which were led by either nurses, NSP workers, and/or peers.

An interactive session using breakout rooms encouraged participants to network and evaluate the feasibility of implementing alternative HCV testing and treatment approaches in their own service. Digital functions such as the chat box allowed presenters and participants to contribute to the live discussion. A major theme arising from the forum was the importance of engaging and building rapport with the target community.

This includes listening to community voices, adapting services in accordance with their expressed needs and reducing barriers to HCV testing and treatment.

To reach HCV elimination by 2030, Nurses, NSP workers and Peers must continue to collaborate to provide better access to HCV treatment and care to people who attend homelessness, AOD, and mental health services.

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One of the five breakout rooms during the interactive session to discuss key takeaway points

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Nurses saving lives through opioid overdose prevention: A pilot study

By Louise Durant, Hoiyan Karen Li, Jeremy Hayllar and Niall Higgins

In Queensland, take home Naloxone (THN) is available over the counter at pharmacies for a fee or with a prescription. However, financial and legal difficulties are seen as barriers to accessing Naloxone.¹

The aim of this pilot was to design, implement and evaluate a roll-out of a model of care for THN for services that are in contact with people at high risk of opioid overdose and those with a history of opioid dependence.^{2,5}

The team designed a brief opioid overdose prevention educational package^{6,7} and provided free naloxone to at risk populations with the goal of preventing avoidable opioid deaths and morbidity.⁸ Similar interventions are generally focused on people who use injected drugs or those who present to an emergency department.^{9,12} The main concern with this is that typically, those prescribed medically-assisted opioid treatment programs are at

increased risk of an opioid overdose and are not routinely provided with opioid overdose prevention education or given the antidote naloxone.¹³⁻¹⁷

PROJECT OUTLINE

Without existing procedures to provide opioid overdose prevention to patients in alcohol and drug services in Queensland, nurses took the lead. This evaluation was approved by The Prince Charles Hospital HREC (HREC/2020/QPCH/61924).

The main components of the nurse-led opioid overdose training were to (i) recognise the signs and symptoms of an opioid overdose; (ii) how to respond in the event of an opioid overdose; and (iii) understand what naloxone is and how to administer it.^{18,19}

RESULTS

Registered nurses from three outpatient public medically-assisted opioid treatment centres in Queensland were trained. The educational intervention took between 15 and 45 minutes to complete depending on the level of knowledge that the patient already had; 100 education sessions to

patients were delivered amid COVID-19 disruptions. There was a measured increase in opioid overdose prevention knowledge²⁰ sustained at three months follow up, and four opioid overdose reversals with naloxone nasal spray supplied during the pilot. We also received positive feedback received from patients:

“You never know when you might just need to save someone’s life, and by having the naloxone nasal spray, I have it with me everywhere I go as you never know when you need it, and with the right training I now know how to use it and feel confident to do so.” (Female, 24 years)

“I found that it is important to know what to do during an overdose, you never know who or when it could happen. Training session was good, it was thorough.” (Female, 18 years)

OPPORTUNITIES AND CONCLUSION

Seminar presentations on this project and its outcomes have opened doors for existing initiatives of QuIHN to partner with Queensland Health to develop a training package that is accessible for all health professionals to learn about opioid overdose prevention. Nurses who led this study have inspired introducing other opioid overdose prevention programs in Queensland, both within and outside the public service. This all started with one nurse in one team having the vision to save one life.

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A therapeutic environment for discussion. Credit: Recovery Camp

Let's talk about suicide

By Taylor Yousiph

Every year, approximately 800,000 people die due to suicide.¹ In Australia alone, there are nine deaths from suicide per day, with suicide rates alarmingly increasing for young people aged 15-24.²

As risk factors increase, such as loneliness and isolation following the COVID-19 pandemic,³ a safe space to talk about suicide is needed to expose the devastation of this global epidemic.

Research currently suggests that help-seeking behaviours and disclosure for suicidal ideation to healthcare professionals are low,⁴ which consequently prevents providing the right help at the right time. While individuals with suicidality generally fear rejection and burdensomeness in vocalising their thoughts,⁵ a recent survey found that talking to a spouse was the most common avenue for disclosure, followed closely by friends and family members.⁶ Sadly, only 45% of suicide victims sought contact with a primary healthcare provider within a month of a suicide attempt,⁷ due to fear of stigma and not being heard by mental health professionals.⁸

In light of this, more research into creating a safe space for individuals with suicidality to share their thoughts and be transparent to healthcare professionals and students is needed to reduce judgement and stigma. While alternative avenues, including participation in creative workshops and nature-based activities, have aided in disclosing mental health struggles,⁹ a deeper understanding of how to

construct a therapeutic environment to assist disclosure to healthcare professionals is needed.

We can confidently say that health professionals might not be the first to hear of loved one's thoughts of suicide – it might be you. Do not be afraid to ask how they're really going, to listen to the details of their thoughts and provide the time to listen. The only way we can address the tragedy of suicide is to first hear about it. So let's talk about suicide.

Author

Taylor Yousiph is a PhD student at the University of Wollongong, NSW

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Workplace factors that concern mental health nurses because of perceived quality of care impacts

By **Norah Alyahya, Cheryle Moss and Ian Munro**

A recent study undertaken in the Kingdom of Saudi Arabia (KSA) has implications for mental health nursing in Australia. As a component of her PhD research, **Norah Alyahya (2022)** explored with nurses working in mental health about their experiences of caring for women with psychosis.

While a number of findings were KSA specific, several have international implications for mental health nursing teams and leaders. The nurses in the study shared concern about three key workplace factors that they felt affected the quality of their care delivery.

The first factor was related to the multi-national and multicultural composition of the nursing workforce. A key aspect of mental health nursing is the provision of therapeutic relationships with patients.

The nurses felt that achieving therapeutic care was more difficult when there was an impoverished cultural and language

fit between the nurses providing care and those receiving care. The finding challenges clinical team members and team leaders to consider the language and cultural skills needed in the staffing mix to achieve the relevant care goals. As both the nursing workforce and the client population in Australia are culturally and linguistically diverse, creating mechanisms to achieve a sound fit for therapeutic care is an important aspect of mental health nursing work and leadership.

The nurses also demonstrated concern regarding the importance of them having sufficient knowledge to deliver the care and support needed by women with psychosis.

The nurses' believed that their level of education and knowledge needed to be matched closely to the clinical acuity of the women with psychosis for highly effective care.

They hoped that more knowledge would assist them in providing more informed and targeted care to the women. Aligned to this concern was the realisation that staffing considerations in the care delivery models need to be relative to the nurses' knowledge and educational levels and aligned to patient acuity. This finding is relevant to the Australian context of mental health nursing as it informs clinical teams, clinical educators, and nurse managers about workforce development needs and educational confidence relevant to care delivery.

A third area of nurses' concern related to the perceived impacts of the workplace environment on the quality of mental health experience and care.

The nurses believed that in health settings, the physical space and environment need to be conducive to the health and wellbeing needs of women with psychosis and for themselves as health workers. For example, the nurses felt that wards could be symbolic of jail-like environments if there were insufficient open space, greenery and other home like elements within the environment. The implications for this in the Australian context of mental health care are that it highlights the potential investment of nurses as stakeholders concerning decisions related to the physical environment in which they work and provide care.

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Fast water and fast times in South East Queensland: Wrap around emergency toxicological, addiction and mental healthcare amid a pandemic and natural disaster

By Todd Sellwood

The COVID-19 outbreak has certainly changed the landscape of emergency services in the last two years.

The recent floods in South East Queensland compounded the challenges to communities and community members, leading to a spike in people presenting with comorbid Alcohol and Other Drug (AOD), Mental Health (MH) and Homelessness issues for emergency care and support. The same conditions have challenged capacities for care delivery, impacting crisis support centres and community based AOD and MH care services. It has fallen to Emergency Services to meet these challenges and provide innovative, effective, and comprehensive services to these care consumers.

These clients represent a significant challenge to all staff involved in their care. They often have compounding medical, social, and psychological factors that can make managing them in a manner that meets their needs somewhat problematic. Evidence suggests those presenting with co-occurring mental health and medical conditions are more likely to cost HHS more due to representation rates, increased length of stay and associated medical costs.¹

Establishing responsive, timely and meaningful intervention is imperative to reducing the burden and ensuring that care delivered is focused on optimising safety and high quality. Princess Alexandra Hospital emergency department (ED) created a collaborative multidisciplinary team that offers clients presenting under a ‘Toxicology’ banner, a person-centred approach that can address many factors contributing

to (and often complicate) a care pathway. Timely engagement of a range of specialist nursing and other care is recognised as paramount in ensuring safe and evidence-based treatment that includes supportive passage through and out of ED.

Specialist teams involved in this “wrap around service” can be engaged when patients first present at triage. Clients are met and monitored by the ‘Response to Occupational Violence in Emergency’ (ROVE) team, which is comprised of CNCs and Security staff. Once the risk of occupational violence to staff, patients and fellow patients has been managed, a comprehensive toxicological assessment is undertaken. All factors precipitating patient presentation are identified and patients are afforded access to services to address perpetrators of use. These include but are not limited to Homeless Liaison Officers and Mental Health and Addiction Services. This shift from a biomedical focus to a biopsychosocial model of care affords this vulnerable patient cohort the opportunity to engage with community-based partners who are equipped to provide ongoing AOD, crisis accommodation and MH support.

The overarching goal of this initiative is to preserve finite healthcare resources by addressing all factors driving the need to access emergency support in a holistic, consumer-focused, responsive, and compassionate manner.

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Connecting the head to the body – trauma-informed care in practice

By Rachel Tolan, Adam Blake and Femke Buisman-Pijlman

Nurses and midwives are the largest workforce in healthcare and have an important impact on patients through their clinical care and the time they spend with patients and their families. Independent of their specialty, nurses and midwives share a common purpose and responsibility to deliver safe, effective, person-centred care whilst mitigating any potential harms.¹

Avoiding harm is not only the absence of clinical errors or near misses. The relational aspect of healthcare also needs to be considered. That is, how we interact and behave with patients, their families/carers/parents and each other. Recently, how health professionals understand and engage with patients and their families has been gaining increased attention.

Trauma-informed care (TIC) refers to a way of working that is mindful of what people have experienced, including trauma, and how they will respond to the treatments we provide. TIC promotes safety, connection and managing emotion or healing.^{2,3} How we behave and care for people in our day-to-day work can prevent unintended harm.

Twenty years of extensive international research has increased awareness of the negative impact of trauma on physical health, mental health, behavioural and social problems. Early adversity can have an

extra strong impact because it happens in a sensitive time window. The adverse childhood experiences or ACEs might be abuse, neglect, maltreatment or household dysfunction and medical trauma.^{4,5} Soberingly more common than we would like to consider and independent of socioeconomic status, ACEs increase the predictive probability of life-long health risks. For example, an adult with four or more ACEs is almost three times more likely to have type-2 diabetes or six times more likely to have had an unintended teenage pregnancy.^{4,5}

How can we use TIC in socialised or general clinical settings? It is not always clear how to implement a TIC approach in the workplace, even though there is an understanding that it will have a positive impact.^{6,8} The Children's Campus Mental Health Strategy recognises the need for all-encompassing universal precautions approach to TIC from a multi-organisational perspective, coordinating clinical, research

and educational opportunities to help deliver practical changes to address trauma.^{6,7}

It is a new joint effort between the Royal Children's Hospital, University of Melbourne and the Murdoch Children's Research Institute and supported by the Royal Children's Hospital Foundation. The overall vision of the Strategy is that all infants, children and adolescents and their families can access high quality, equitable and consistent prevention and mental healthcare where and when they need it to achieve sustained, optimised developmental, health and wellbeing outcomes.

Tello (2018) invites us to first recognise how common trauma is in all of society, to assume an individual may be impacted by trauma, much like the universal precautions approach to infection control. This includes providing opportunities to explain why sensitive questions or a physical examination may be necessary, asking if there is anything in their history that may make things difficult and what could make it easier.

Also looking out for signs of anxiety or dysregulation and responding with compassion, patience and kindness. We need to acknowledge there is a power differential. By relating in a way that emphasises safety and a holistic trauma-informed approach, we can mitigate the risk of further harm and positively impact the people we work with.

Authors

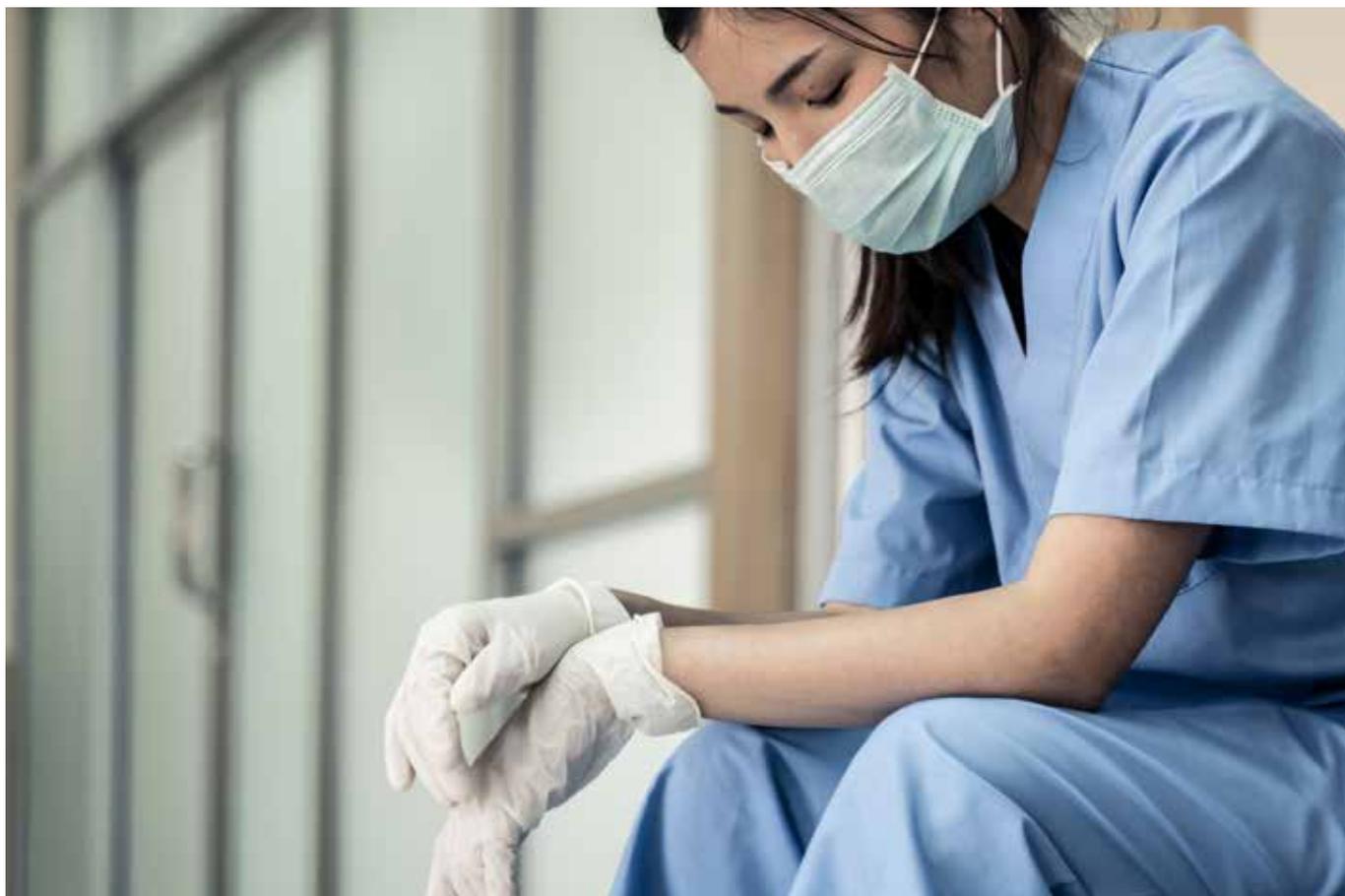
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The mental health of healthcare workers in the hospital setting during COVID-19

By Lorna Moxham, Ritin Fernandez, Nqobile Sikhosana, Heidi Green, Elizabeth J Halcomb, Rebekkah Middleton, Ibrahim Alananzeh, and Stamatia Trakis

The World Health Organization (WHO) declared COVID-19 a global pandemic on 11 March 2020. With limited knowledge about the virus at the time, the inability to ‘contain’ it, its ability to mutate quickly and the high rates of mortality around the world, it’s no wonder the SARS virus has had a significant impact on mental health.

In the thick of it all, providing frontline care, day-in day-out were (are!) healthcare workers, most of whom are nurses. The WHO declared their commitment and

professionalism throughout the pandemic to be extraordinary and described them as “extraordinary people, performing extraordinary work”. Alarmingly though, the WHO also estimates that there have been about 115,500 deaths between January 2020 to May 2021.¹

Frequent exposure to the virus, challenges accessing appropriate and enough PPE, job stress related to increased work demands and rapidly changing infection control protocols, takes its toll. Add to this the risk of personal infection, the fear of infecting their families, and the decline in immunity due to physical and mental exhaustion. This has meant that anxiety and depression among healthcare workers have risen, which is of particular concern given that resilience fatigue that healthcare workers (HCW) feel.

Given that nursing is an evidence based profession, the nurse authors of this article wanted to see the real picture and analysed the evidence relating to the prevalence of anxiety and depression among HCW during the COVID-19 pandemic. They gathered the evidence by completing an umbrella review using the Joanna Briggs Institute methods.²

Like most approaches in nursing, working together saw the collaborative nurse author team, search numerous databases, such as PsycINFO, CINAHL, Embase, Cochrane Database of Systematic Reviews, JBI Evidence Synthesis, MEDLINE and Web of Science, for reviews that reported the prevalence of anxiety and depression among HCWs during the COVID-19 pandemic. Various validated instruments were used to measure anxiety and depression in the reviews found.

After following a rigorous process, 10 systematic reviews, including 100 unique studies involving 169,157 HCWs from 35 countries, were included in the umbrella review. The quality of the studies identified was assessed by the nurse author team using the JBI critical appraisal tool for systematic reviews. This process enabled the team to calculate the degree of overlap in primary studies.

The sample sizes of HCWs in the reviews ranged from 57,382.3 – 58,565.24. All reviews focused on HCWs in the hospital setting. HCWs included physicians, nurses, allied health, administrative and ancillary staff.

The prevalence of anxiety among all HCWs ranged from 22.2% to 33%. More specific

data showed that the prevalence of anxiety among physicians (n=5820) was between 17% and 19.8%, and for nurses (n=14938), it was between 22.8% and 27%. The prevalence of depression among all HCWs ranged from 17.9% to 36%. Again, a deeper dive revealed that the prevalence of depression among physicians (n=643) was 40.4%, and for nurses (n=8063), it was 28%.

There was quite a bit of variability in the prevalence rates of anxiety and depression, which could be related to the lack of universality in the experience and expression of anxiety and depression. Indeed, HCWs provide care across diverse global and discipline settings. These variances could also be associated with the differing mortality and infection rates between the countries where the primary studies were conducted. Perceptions of anxiety and depression among HCWs could also be influenced by working conditions, previous exposure to epidemics and pandemics, the adequacy of PPE and the perceived and actual levels of support.

What is clear is that the COVID-19 pandemic has placed HCWs at a substantially increased risk for anxiety and depression due to the enormity of the situation. And we know this has not ended.

We need to look after our healthcare workers and urgently find strategies to reduce the incidence of anxiety and depression in this exceptionally important and valuable sector of the workforce. The strategies need to emanate from the grassroots by asking the HCW what they need and want instead of making assumptions about what is 'thought' they need. HCWs have lived experience – tap into it. That way, the strategies identified truly will be beneficial for those who need them.

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Nurses hold the key to improving outcomes for people who present with self-harm

By Natalie Conley, Christopher Rouen, Tanya Park and Caryn West

Self-harming behaviours are complex, multifaceted and are increasingly acknowledged as a significant public health concern.¹

An act of self-harm is considered the strongest indicator of future suicide. Individuals who have self-harmed over 30 times are more likely to die by suicide in the year following a self-harm event than individuals who have not self-harmed.²

Self-harming behaviours and intentions range from superficial cutting and conscious recklessness that may cause harm to more damaging and lethal events that require urgent medical attention, such as hanging and severe cases of self-poisoning.³

After a self-harm event, individuals are most likely to receive their initial care from a nurse when presenting to health facilities.

However, evidence suggests that interactions between nurses and people who have self-harmed are not always positive. Nurses can lack understanding, lack knowledge, carry entrenched negative attitudes and a reluctance to engage with people who self-harm.^{4,5}

Unfortunately, such perceptions and attitudes can cause feelings of worthlessness, distress and guilt, contribute to poorer health outcomes, and even discourage these individuals from actively seeking care if they self-harm again.

However, some individuals have reported positive experiences when nurses

demonstrate understanding, empathy, and compassion that assists in alleviating the shame that is often associated with acts of self-harm.⁶

In Far North Queensland (FNQ), the population exhibits demographic characteristics consistent with an increased risk of self-harm, including a higher proportion of the population who identify as First Nations people, who are socio-economically disadvantaged, and live in remote and very remote areas.

Recent research from the authors has found that during the period 2012-13 to 2018-19, there were 3,899 self-harm hospitalisations involving 2,817 individuals over 15 years of age in the region.⁷ This corresponds to an incidence rate of 254 per 100,000 population, which is considerably higher than the equivalent national rate for the same period of 146 per 100,000.⁸

These findings highlight not only the significant impact of self-harm in FNQ but also the importance of the role of nurses in the delivery of optimal care to those who present with self-harm.

While we need to continue to develop an understanding of the causes and nature of self-harm, this must be complemented by a welcoming and understanding approach

from frontline nursing and midwifery staff that acknowledges distress, person centred care and offers hope.⁶

Given the complex relationship between healthcare services and people who self-harm, first impressions are essential to better health outcomes and reducing self-harm incidence rates. Relational practice is the foundation of nursing and midwifery practice. We are aware of the importance of first impressions and the impact on the nurse/midwife patient relationship. Highlighting the life changing impact of first impressions is needed. Improving health outcomes using the foundational nursing and midwifery skill of relational practice is key to improving the health outcomes of people who self-harm, both in FNQ and elsewhere. Nurses and midwives are the key to changing this first impression experience.

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The mental health echo pandemic: Are nurses and midwives ready?

By Caryn West, Tanya Park, Christopher Rouen and Natalie Conley

What started as a mystery disease in December 2019, Sars-Cov-2 or COVID-19 as it is now commonly known, swept the globe at a staggering rate. By 2020, the COVID-19 pandemic had exposed vulnerabilities.

No longer could we ignore when hospitals were overflowing, when ventilators were not available for everyone, when decisions on the value of a life were made and when marginalised groups received suboptimal or no healthcare.^{1,2,3}

Never had healthcare witnessed such crippling outcomes and ongoing high-level stresses. Family, friends and volunteers were banned from visiting loved ones. Nurses and midwives were the lone support of patients at the end of their life. Feelings of fear and anxiety overwhelmed the world, and throughout, nurses and midwives continued to show up and be present.

Two years on, it is critical that we start preparing for the echo pandemic of mental health related issues.

To respond, we must understand what an echo pandemic is. In its simplest form, it is a repetition of an event, an echo. In relation to the COVID-19 pandemic, it is an echo of the increase of mental health related issues caused by and experienced during the pandemic.⁴

Isolation, loss of connections, feelings of stress, anxiety, grief, loss, and limited touch can all impact our feelings of wellbeing and our mental health. These experiences were and continue to impact many.

For some, it was their first experience of a mental health issue. For many with an existing or underlying mental health diagnosis, the impact of COVID-19 exacerbated their health issues.

So what can we do? It is critical we acknowledge that we are facing ongoing and unparalleled times, and as such, we do not know how our coping skills will hold up.⁵ How resilient are we? How we manage stress, anxiety and change are impacted by many factors; access to support, previous experiences, and previously developed coping strategies.

Australians are considered resilient to a crisis.^{6,7} We experience regular natural disasters – cyclones, bush fires, flooding, and drought. But how is the COVID-19 pandemic different?

1. **Time.** Most natural disasters are time limited. The pandemic has now surpassed its second year of global contagion.
2. **People.** For the first time in recent history, the global population has been impacted. Travel, goods and services have been disrupted.

These disruptions, although necessary, will be discussed and examined for years to

come. The critical question for nurses and midwives is what do we do now? An already tired and extended workforce will once again bear the load. So how do we prepare?

We must be self-aware and include mental health assessment in our practice. Mental health issues are experienced on a continuum. Nurses and midwives are often the last to attend to their own mental distress. Fatigue, overthinking, worrying, lack of appetite, and decreased pleasure can be job-related and lead to mental health issues. Including mental health assessment in all our patient and family assessments will lead to early intervention and support, the foundation of good mental healthcare.

Nurses and midwives are resilient, but for how long? Self-awareness and improving health assessment are two ways to change the outcome of the echo pandemic that we are living in.⁸

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Mental health consumers and nursing students engaging in art making together. (Reproduced with permission of copyright owner. Further reproduction prohibited without permission.)

The power of art making

By Elissa-Kate Jay, Lorna Moxham and Christopher Patterson

Visual arts-based activities are powerful accomplishments in the context of mental healthcare.

Through these activities, mental health consumers' can explore and express their own ideas about health, illness, and personal recovery. Also, when the activities are done in a group, the relational aspects benefit all.

In a recent systematic review, submitted for publication by the authors, several opinions were communicated on art-making as a therapeutic practice. Consumers discussed that by creating paintings, drawings, graphic images, and sculptures, they learnt more about themselves and their journey to recovery. Consumers reported that the identity struggles they have – experienced by many in mental health recovery – could be worked through using artwork to express and clarify a more positive identity.

In two of the studies included in the review, participants spoke of how they had redefined a sense of self with their ongoing creation of sculptures - moving away from a disability focused identity.¹ They externalised through their art making that they were valuable, holistic individuals with much to contribute. Their art brought rich personal benefits.

Consumers also expressed that they value inclusion in groups and communities and identify a need to progress through loss. Both of these things can be enhanced through art-making. Art can be carried out with another person or in a group, and emotions that need to be expressed, including sadness and anger associated with loss, can be expressed through artwork. Through feeling the emotions as the lines and colours are applied in an image or by using visual metaphors to express what they cannot express in words, sadness is processed and worked through constructively.

From our review, it is clear that nurses should consider art activities in their work with people with mental health issues. Nurses can encourage art-making as a private hobby or assist mental health

consumers in finding and joining an art group if this is something that interests them. Nurses are also in a position to lead an art group for mental health outpatients, and many studies have shown that participants find these highly rewarding.²

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If it doesn't exist form a team and make it – Creating education and training to support clients and nurses

By Ben Learmont and Ben Horan

Like many nurses, we have struggled with managing patients and families who are agitated, aggressive, sometimes violent and are clearly not coping with the care environment, despite their obvious need for care.

This is particularly common in the emergency department. Preventing behavioural escalation is the first part of our role in managing these clients. Luckily for us, our workplace supported the development of 'ROVE' (response to occupational violence in emergency) training to help with this process.¹

This, coupled with the development of an evidence-based occupational violence risk assessment tool, helps keep us, my colleagues, the clients and other service users safe in our health setting.

It became clear that some of these patients are under the influence of alcohol and other drugs,² and that best management would include identifying and dealing with some of the factors (like intoxication) that lead to both unacceptable behaviours and even the cause/s of the presentation.

But toxicology is not a common specialty care area for nurses. Again, luckily we work in a setting where problems and limitations are identified, and practical solutions developed.

A consultant-led multidisciplinary team, including educational specialists and senior nurses, developed specialist nursing toxicology courses to address the existing knowledge and skill gap.

Partnership with a local University ensured that these courses were recognised at Master's level and contained advanced skills and content that fell within nursing domains.

While it's early days, these courses enable nurses and others like us to offer targeted and highly specialised care to a particularly problematic and vulnerable group of emergency care clients. The solutions developed by the multidisciplinary team ensure better patient care by upskilling and empowering staff and creating a more patient and staff centred working environment. This 'can do' approach makes for a great place to work.

Authors

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What's it like working as a nurse in an Alcohol and Drug Service: Shifts in stigma

By Jacquie Yang and Hoiyan Karen Li

My name is Jacquie. I've come from a background in Emergency and Corrections and have been working in the Alcohol and Other Drugs (AOD) field (substance withdrawal management, OTP in both not-for-profit and public sectors) for the last eight years.

My roles often involve assessing a client's mental health status, substance use, substance withdrawal experience, crisis management, client advocacy, brief intervention and blood borne virus management.

AOD nurses also conduct health promotion activities and refer to other services where required.

Substance dependence is often seen by members of the public to be a lifestyle choice or a moral weakness, therefore stigmatising those who reach out for support.¹ Some of the most rewarding moments come from helping break down the effect of stigma and its barriers to clients getting the help they need, who often don't know how and what to ask for. Workers who take time to understand the biopsychosocial issues behind substance dependence tend to remain non-judgemental and develop a better rapport with clients.

I particularly enjoy taking nursing students through an AOD placement. When the students develop an understanding and respect for the clients, they can respond with compassion equally to irritated clients who may have turned up on the wrong day to their appointment; or are experiencing symptoms of withdrawal; or may be having a trauma response; or have come to an AOD service well dressed and well versed.

Authors

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Ben Horan (left) and Ben Learmont (right)

Maggie Beer – The champion for quality food in aged care

By Kathryn Anderson

As one of Australia’s most iconic cooks, Maggie Beer is passionate about changing the wellbeing of the elderly through access to food full of flavour and nutrients.

“It should be everyone’s right to have good food, and I believe that no one group of people need it more. My hope is that every meal can give comfort and pleasure, always something to look forward to,” Maggie says on the Maggie Beer Foundation’s website.

Maggie created the Foundation in 2014 as a driving force to improve diet in the aged care sector.

Speaking at ANMF’s (Vic Branch) 2022 Health and Environmental Sustainability conference last month, Maggie said she believed that a beautiful meal was the “quickest route to wellbeing”.

While nutrition was one of the many issues plaguing the aged care sector, Maggie said it was possible to fix.

She said that affecting the quality of food residents were being served was the lack of specialised training for aged care cooks or chefs.

“There is no minimum standard of education, so cooks and chefs are thrown in without support, without training. It’s an incredibly specialised skill.

“We need to raise the bar. We need to elevate the skill and the respect of cooks or chefs. We need to give them the tools they need. . . Give them fresh food. I know it will work.”

To help inspire aged care kitchens, Maggie runs master classes across Australia, where over two days, she brings 30 cooks and chefs together to impart her knowledge.

“I cook with them, I hear what they encounter, and I bring in experts such as a dietician and an auditor that can debunk myths that circulate about what you can and can’t do.

“If you can grab them and give them the feeling of how worthwhile they are, give them the skills and help them find a champion within their home, they will go back, knowing they can do beautiful food where the residents are so happy, and they are so proud.”

According to Maggie the other essential key to good food is fresh ingredients when preparing meals to ensure flavour.

“So if the home has a garden, you can supplement with fresh produce.”

Despite Maggie’s solutions, there are still many brick walls to improving dietary standards, which she said she is determined to break down.

“The brick walls are usually management and budget. Two-thirds of homes in Australia have a budget of \$12.43, whereas one third have a budget of more like \$8 a day per resident for three meals, morning and afternoon tea.

“You see, when there is a budget like that, what can you do?”

With knowledge, Maggie said the food budget should sit at \$12.50 to \$15 a day per resident.

“When a cook or chef has their knowledge and has a garden to pull from like the citrus they need, fresh herbs that make a difference, where they easily grow greens that can be

repeated again and again, then you can actually do good food for that amount.”

“With knowledge, they can make their own stocks, the base of soups. They can use legumes because they are full of goodness and inexpensive. You see, it’s not just cooking methods, it’s what ingredients are used.”

But Maggie said under \$8 per resident, this would be impossible to achieve.

The Labor Government have offered the Maggie Beer Foundation \$5 million over three years, where they plan to build on the existing specialised online education modules they recently released for cooks and chefs.

“But more, what I want to do, is have a group of cooks and chefs from aged care that I can train. I know how to impart this knowledge, I know how to give them the ideas and then they go out as trouble shooters to homes – because I don’t know many or any homes that want to change but don’t know how to do it.

“So my concept is to have this group who can actually physically be on the kitchen floor, so to speak and work with the team.”

According to Maggie, the funding will also support the ‘Alliance of the Willing’, a group of over 120 people from all areas of aged care who are working on the solutions to improve diet and nutrition in the sector.

Maggie said gaining direction and support from the previous government had been a battle where it should not have been.

“That’s why it’s important to continue to raise our voices. We need to push the issues more, and I’m pushing.”

For more information about Maggie’s Foundation, visit maggiebeerfoundation.org.au



Maggie Beer speaking at ANMF (Vic Branch) Health and Environmental Sustainability conference. Photographer: Penny Stephens



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.

Cauliflower, kale and parmesan cake

Packed with flavour, this hearty versatile savoury cake can be cut as a wedge and served with salad as a main meal or cut into finger food sized portions

INGREDIENTS

20g coconut oil
1 (130g) onion, finely chopped
½ tsp sea salt flakes
3g garlic, finely chopped or grated
½ tsp of fresh rosemary leaves, finely chopped
½ tsp ground turmeric
½ tsp ground cumin
300g cauliflower, finely chopped florets
¼ cup verjuice
30g kale leaves, finely shredded
¼ cup flat leaf parsley, finely chopped
60g self-raising flour
75g grated parmesan
black pepper milled
4 eggs

METHOD

1. Pre heat a fan forced oven to 180c
2. Grease and line with parchment paper, 1x 18cm round pan or similar
3. Place a medium pan on the stove to warm, add the coconut oil, onion and salt, cook without colour until soft, 8–10 minutes.
4. Add the garlic, cook out for 2 minutes, then add the rosemary, turmeric and cumin.
5. Place the finely chopped cauliflower with a splash of water into a microwave safe dish, cover and cook on high for 2–3 minutes or until just cooked, add to the onion mix.
6. Deglaze with verjuice, stir in the kale, allow to wilt and liquid to absorb, then remove from the heat, add parsley and pepper, check the seasoning.
7. In a bowl mix the flour and parmesan, add to onion mix along with the eggs, mix to combine, then pour into the prepared baking dish.
8. Bake for 40–45 minutes or until golden and cooked through, allow to cool for 10 minutes, before cutting and serving. (Note: Oven temperatures vary. If cooking in a larger dish the cooking time will be less due to the thickness.)
9. Makes approx. 700g raw mix – 4 x 160g pieces (1 x 18cm round)



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 Janet Luckett on making Maggie's, Anzac Biscuits published last issue. We hope you enjoy your \$50 Maggie Beer voucher.

"I'm a sucker for anything with lemon zest plus I love Maggie and her plan to improve the nutrition, taste and presentation of the meals served in aged care. My family loved these Anzac biscuits." – JANET LUCKETT



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