ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 27, NO.9
OCT–DEC 2022

INSIDE

Uluru Statement from the Heart

Time for constitutional change: A First Nations Voice to Parliament

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Annie Butler

ANMF Federal Secretary

Reflecting on what has been another tumultuous year, what stands out most is the perseverance of ANMF members to fight for justice which has succeeded in putting us on the road towards better health, aged care and equality for all Australians.

I know for many of you, it may feel like there is no relief in sight as you navigate the daily battle to provide quality care. However, I can assure you that the wheels are finally in motion to fix health and aged care.

We all want these changes to occur now, but unfortunately, it will take time. After years of neglect and mismanagement, the Albanese Government has much work to do to transform our health and aged care systems to a level that all Australians deserve.

While the ANMF will always hold the Government to their commitments, it is encouraging to see this government already working towards fulfilling their promises.

Since elected, the Albanese Government has swiftly introduced new Legislation which ensures every nursing home will have an RN on-site 24/7 and that residents will receive a minimum amount of safe, quality care every day. This historic piece of Legislation marks the first real step towards actually fixing the aged care sector.

Also promising for low-paid aged care workers is the Government's submission to the Fair Work Commission's Aged Care Work Value case. Their submission mostly aligns with the ANMF's application for a 25% across-the-board increase in award wages. The Government's contribution will go a long way in the Commission's decision to recognise the work value of aged care workers.

Other positives include the Government's Legislation to give Australian workers access to 10-days' of paid family and domestic violence (FDV) leave. This notably will provide relief for many females, which is significant for ANMF Members.

The Government has also pledged to strengthen Australia's universal health system. As a first step Health Minister Mark Butler has formed a new Strengthening Medicare Taskforce to identify key recommendations the Government should work on. I have been invited to represent nurses and midwives on the Taskforce, joining a range of other health professionals. In the past, the previous government failed to include nurses and midwives in consultations with health stakeholders, resulting in their voices and input not being recognised in formulating equitable health policies for all Australians. This opportunity recognises our importance in the critical discussions shaping long overdue health reforms.

In this issue of the *ANMJ*, we are highlighting the Governments' intention to give Aboriginal and Torres Strait Islander people a Voice to Parliament enshrined in the Constitution. This would enable First Nation's people to advise the Federal Parliament about laws and policies that impact them. This piece of Legislation is important to nurses and midwives as a First Nations Voice to Parliament will deliver meaningful constitutional recognition and reform for Aboriginal and Torres Strait Islander peoples, which is crucial for health, social and justice outcomes.

Each of these actions taken by the Government is in no small part due to the determination of nurses and midwives to shine a light on unacceptable health and aged care issues and social justice inequality. Your pure grit in demanding change has forced the Government to listen and take action. This is something you should all be incredibly proud of.

Clearly, there is still more work to be done. Many of our members across Australia are taking their state and territory governments to task, fighting for better healthcare systems, which include nurse and midwife patient ratios and improved working conditions for nurses, midwives and other healthcare workers.

Fighting for change is challenging, especially when working under extreme conditions. Yet united, we will not stop pressuring governments until we have fair and equitable healthcare and welfare for all.

To all our ANMF family, thank you for your support over the past 12 months. We look forward to working with you in 2023.

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Moving state?

Transfer your ANMF membership

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

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REGULAR COLUMNS

FEATURE

CLINICAL UPDATES

FOCUS

The *ANMJ* acknowledges the Traditional Owners and Custodians of this nation. We pay our respects to Elders past, present and emerging. We celebrate the stories, culture and traditions of Aboriginal and Torres Strait Islander Elders of all communities. We acknowledge their continuing connection to the land, water and culture, and recognise their valuable contributions to society.

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Focus on occupational violence after three nurses stabbed

The NSW Nurses and Midwives' Association (NSWNMA) has commended SafeWork NSW's introduction of new safety measures to prevent workplace violence following the stabbing of three Sydney nurses in May 2019.

After failing to protect the safety of staff and patients, Sydney Local Health District recently agreed to a $3 million enforceable undertaking, which includes implementing additional work health and safety initiatives such as the development of a Behavioural Escalation Support Team (BEST).

The incident involved two registered nurses and an enrolled nurse being injured at Royal Prince Alfred Hospital in Camperdown after a patient grabbed a pair of scissors during a Code Black response. Another patient was also injured during the event three years ago, while five other staff reported psychological injury after witnessing the attack.

NSWNMA General Secretary, Shaye Candish, said it was imperative that all health staff were afforded a safe working environment and that more needs to be done to eliminate occupational violence.

"Nurses and midwives are continuing to experience violence and aggression in our hospitals and other health settings at significant rates across the state, and this has to end," Ms Candish said.

"This multi-million dollar enforceable undertaking between Sydney Local Health District and SafeWork NSW is a step in the right direction, but this incident, and many others like it, do take a considerable toll on the nurses involved as well as their colleagues who are witnesses.

"The psychological injury to health professionals, who are simply trying to care for their patients safely, is profound. We all must do better in protecting our health workforce."

National Safe Work month runs in October each year, calling on businesses, employers and workers across Australia to commit to building safe and healthy workplaces for all Australians.

MORE CLINICAL PLACEMENTS NEEDED TO MEET HEALTH WORKFORCE DEMANDS

Universities Australia has called for an expansion of clinical placements available to students studying health-related degrees, including nursing, to help maintain and grow Australia's health workforce.

While facing a skills shortage now, it says Australia will also need over 300,000 additional health workers by 2026. Demand for nurses, in particular, is forecast to exceed supply, with a projected shortfall of 85,000 nurses by 2025.

"Roughly 16,000 nurses graduate each year, which falls well short of the number required to meet the projected shortfall," Universities Australia Chief Executive Catriona Jackson said.

"We estimate that this number will need to double. But we need more clinical placements in the health system so that students can complete the qualifications needed to proceed to professional registration.

"We also need to open more places in aged care, primary care, mental health care and disability services so that students gain experience where workforce need is greatest."

Universities rely on health service providers such as hospitals and community-based services to deliver student placements.

"Universities cannot produce more health graduates unless health services open up more clinical placements so people can complete their training." Ms Jackson said.

Universities Australia believes a partnership approach to growing and sustaining the capacity is required.

"We have to work in partnership with government and health service providers to expand the number of clinical places available to students in ways that work for services, clients and students, to ensure our health workforce can keep up with demand," Ms Jackson said.

Gap in pill testing facilities

Most music festivalgoers will discard their drugs if they find out they contain unexpected substances, new research from Edith Cowan University has revealed.

The findings raise doubt over common criticisms that pill-testing facilities give people the green light to take drugs.

Examining the behaviour of festivalgoers in Victoria, the study found almost 11% of the pills tested didn't contain any substance the owner believed they had purchased. Of the people possessing these pills, just 9% said they planned to take the drug after finding out what was in it.

Other festivalgoers' pills were found to contain the expected substance as well as other unknown substances. Less than half of these people said they still planned to take them.

The ANMF has strongly advocated pill-testing facilities and harm minimisation measures.

Researcher Dr Stephen Bright said analysis of some of the discarded pills revealed they contained a dangerous combination of drugs known to have contributed to several deaths in Melbourne in 2017.

As festivals return to Australia's summer calendar after a hiatus due to the pandemic, researchers are calling for governments to invest in more accurate and widely available pill-testing facilities.

After a spate of drug-related deaths in Melbourne in 2021, the Coroners Court of Victoria recommended implementing a drug checking service and an early warning network to alert the public when a dangerous batch of drugs is detected in the community.

However, the public still has no access to substance analysis, which according to Dr Bright, is because of legal uncertainties and political opposition.

"If you had fixed site services in every capital city, that would create an early warning system," he said.

"So when a problematic combination has been picked up, healthcare services in other states would be aware of it and we could track bad batches going around."

Teens connect with seniors to break down digital divide

A new program launched by the eSafety Commissioner is aiming to improve older Australians' digital skills by connecting them with student mentors.

The free Young Mentors program brings teenagers together with older Australians to share digital skills and knowledge and help them gain the confidence they need to navigate the online world.

Under the program, part of Be Connected, an Australian Government initiative to improve the online confidence, skills and safety of older Australians, community organisations and groups will partner with secondary schools to coordinate one-on-one digital mentoring sessions. The weekly one-hour sessions will focus on the needs of the older learners and will be delivered over six weeks.

Research by eSafety found younger Australians were keen to help older relatives get online, with young people more likely to show an older family member how to use technology (59%) instead of doing the task for them when asked (40%).

For young Australians, the program is intended to develop teaching and leadership skills. Meanwhile, all ages who participated in the pilot reported increased social connection and understanding across generations.

It is hoped older Australians who take up the program build confidence in using digital technology, which can lead to greater independence, more access to online services, and reduce feelings of loneliness and isolation.

The Be Connected website provides free information, learning modules, webinars, and podcasts designed to empower older Australians to safely use the internet and digital technology: **beconnected.esafety.gov.au**

ICN CALLS FOR INCREASED INVESTMENT IN NURSE-LED MODELS OF CARE

The International Council of Nurses (ICN) has called for advanced practice roles to be at the heart of nurse-led models of care.

"Nurse-led services should be central to expanding and strengthening health systems around the world," ICN Chief Executive Officer Howard Catton said.

"Now is the time for countries to introduce, increase and grow nurse-led models of care. Nursing is the golden thread that links healthcare policy and practice. It holds the solution to many of the healthcare problems the world is facing, and that is why we are calling for governments to urgently invest in nursing."

Addressing the recent 12th ICN Nurse Practitioner/Advanced Practice Nursing Network Conference, held in Ireland, Mr Catton said nursing had come to the forefront during the COVID-19 pandemic, while the war in Ukraine, climate change pressures, and other global challenges had similarly shown health to be the pillar of safety and security of the planet.

He emphasised the leading role nurses play in responding to these new and ongoing threats but stressed the world is still facing many of the same pre-pandemic health challenges, including access to healthcare, poverty, non-communicable disease (NCDs), infectious diseases, lack of vaccination coverage, humanitarian crises, and an increase in mental health issues.

Mr Catton said many of the issues traced back to underinvestment in nursing.

Addressing the audience of APNs, Mr Catton gave an example from Ireland, where an APN-led cardiology chest pain service was implemented. Within the first year of the service, admissions to the ward reduced by 36% and to emergency department trolleys by 60%, contributing to significant savings for the hospital and timely diagnosis and treatment for patients.

Similarly, a case study from the USA, where 36,000 nurse practitioners graduate each year, showed that APNs are helping to meet demands for the shortfall in general practitioners, thanks to lessening restrictions on APNs during the pandemic to meet demand.

"We have the evidence: we see worldwide how APN roles and nurse-led services are delivering high quality, accessible, timely, people-centred and cost-effective healthcare. And we have the strategy. Now we need to do more to see nurse-led models of care used in health systems."

Sleep disorders common among children in NT's Top End

Sleep disorders are more common and more severe in Aboriginal and Torres Strait Islander children than non-Indigenous children, with First Nations children often having higher screen use before bed, later bedtimes and reduced sleep, according to Northern Territory data.

Authors from Darwin Respiratory and Sleep Health, Darwin Private Hospital, Charles Darwin University and Flinders University NT argue targeted interventions and further resources are needed to address sleep quality issues to improve NT children's health.

Published in the journal *Sleep Medicine,* the study analysed self-reported data and polysomnography (sleep study) data from children referred to a Darwin sleep clinic between 2015 and 2020. Of the total 671 sleep studies assessed, 121 (18%) included Indigenous children.

The analysis found Indigenous children had higher Paediatric Daytime Sleepiness Scale scores, higher screen use before bed, later bedtimes and reduced total sleep time compared to non-Indigenous children.

Prevalence of obstructive sleep apnoea (OSA) was also higher in Indigenous children (55% vs. 48%) and with greater severity than non-Indigenous children. The research also showed Indigenous children with OSA were older, had a higher body mass index (BMI) and lived more remotely compared to their peers without OSA.

"If left untreated, OSA and issues with overall sleep quality can lead to the development of chronic conditions such as diabetes, hypertension, anxiety and depression, in addition to the potential lasting effects of reduced academic engagement in childhood," study senior author Associate Professor Subash Heraganahally, a respiratory and sleep physician based at the Darwin Private Hospital and Royal Darwin Hospital said.

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FEATURE

Time for constitutional change:

A First Nations Voice to Parliament

One of the Labor Government's key election promises was to give a voice to Aboriginal and Torres Strait Islander people. Now in power, Prime Minister Anthony Albanese has revealed a draft set of words to be added to the constitution so as to enshrine an Indigenous Voice to Parliament. But for the planned constitutional change to happen, the majority of people will need to agree through a national referendum. NATALIE DRAGON explores why a First Nations voice in Parliament is crucial and why nurses and midwives and all Australians should care.

Affirming an election promise to progress the Uluru Statement, in enshrining an Indigenous voice to Parliament, Prime Minister Anthony Albanese proposed draft wording for a referendum question at the 2022 Garma Festival in July.

Supporters herald this as an opportunity towards a reconciled and respectful relationship between Indigenous and non-Indigenous Australia.

Realisation of the goals of the Uluru Statement is a unique opportunity in this generation, National Indigenous Officer at the Maritime Union of Australia and co-chair of the Uluru Working Group Thomas Mayor says.

"This Prime Minister is committed to a referendum. We have the shape of a question. After five years of work, we have brought Australians with us. The polling shows about 65% would vote 'yes' for an Aboriginal and Torres Strait Islander voice in the constitution which is the key proposal in the Sacred Heart statement. So that we can have a say about decisions that are made about us."

More than 250 Aboriginal and Torres Strait Islander leaders delivered the landmark Uluru Statement from the Heart in May 2017, following an historic four-day First Nations National Constitutional Convention held near Uluru. The Uluru Statement makes a series of recommendations or 'invitations' to the Australian people for three key reforms: voice, treaty, and truth.

A Kaurareg Aboriginal and Kalkalgal, Erubamle Torres Strait Islander man, Mayor travelled around Australia for 18 months with the Uluru Statement from the Heart canvas to raise awareness and help build a people's movement.

"In the early days there was no money for a campaign. It was decided there should be ongoing representation from the grass roots people that were at Uluru. I went to Gurindji country, the descendants of Vincent Lingiari, to the Pilbara – small towns, big cities and in between."

Mayor wrote of his journey on the ground delivering the message to Indigenous and non-Indigenous Australia in his book *Finding the Heart of the Nation – the Journey of the Uluru Statement towards Voice, Treaty and Truth*. He spoke of his ongoing work more recently with the ANMF Federal Office during NAIDOC Week in early July.

There has been much speculation on what an Indigenous advisory body to guide the federal Parliament on matters relating to First Nations people would constitute.

Mayor says the Uluru Statement is a roadmap, with further consultation and decision making on the powers and functions yet to be determined.

"A body should be representative of First Nations people, but this can be determined in a process that is after the constitutional question. That's normal in a constitutional process."

Its role would be to advise on legislation and programs that impact First Nations people, Wiradjuri woman and Federal Labor Indigenous Affairs Minister Linda Burney says.

"It would mean lawmakers would have a moral responsibility to listen to First Nations people, and to consider our diverse views and experience before making decisions that affect us," she says.

The reason the statement specifies that the First Nations' voice must be written into the constitution is so it cannot be removed by any future governments.

Wiradjuri woman and Federal Labor Indigenous Affairs Minister Linda Burney

"THE VOICE NEEDS TO BE ENSHRINED IN OUR CONSTITUTION SO THAT THE ACCOUNTABILITY IT WILL CREATE IS PERMANENT. AND CANNOT BE SIMPLY SWEPT ASIDE BY A GOVERNMENT IF IT BECOMES INCONVENIENT TO HEAR FIRST NATIONS AUSTRALIANS."

"The voice needs to be enshrined in our constitution so that the accountability it will create is permanent. And cannot be simply swept aside by a government if it becomes inconvenient to hear First Nations Australians," the Minister says.

REFERENDUM

The bar for constitutional change in Australia is high: a majority of people in a majority of states. In October 2017, PM Malcolm Turnbull, Attorney-General George Brandis, and Indigenous Affairs Minister Nigel Scullion rejected the Statement, saying that they did not think that the radical constitutional change would be supported by a majority of Australians.

Minister Burney believes Australia is ready for the national conversation about a voice to Parliament in our constitution.

"I believe Australians will support this modest, but very meaningful change. These steps in the Uluru Statement are fundamental, necessary and urgent, but they are not radical."

There was no single moment that sparked the 1967 referendum, more a growing swell of support for change led by a range of people and organisations. As there is again now.

"That is what happened 55 years ago. In the lead up to the 1967 referendum, Australians came together and decided to vote for change. The result was the most overwhelming 'yes' vote in a referendum in Australia. Ninety percent of Australians voted to count Aboriginal and Torres Strait Islander people in the Australian population," says Burney.

People around the country remember how that vote made them feel, she says. "For First Nations people it meant we knew our country valued and wanted us, in a way we hadn't been wanted for too much of Australia's past."

MAKARRATA

"People's hearts are now changing, which certainly makes a big difference', says Aunty Dr Doseena Fergie, a member of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) Elders' Circle.

Dr Fergie is an Elder descended through Wuthathi, Mabiauag Island and Ambonese ancestry and the inaugural Fellow of CATSINaM.

"There's been a big movement and it's starting to accelerate – people are willing to have a referendum. But it's only the first step. Aboriginal and Torres Strait Islander people, there are many nations, need to sit around that table. Even though we're already tired, we're resilient. It's been a long journey."

The Australian nursing and midwifery professions should join actively with Australia's First Peoples whose reconciliation Makarrata invitation should shed light on the truth for an improved future based on justice and self-determination. CATSINaM's health and justice stance firmly aligns with the formation of a Makarrata Commission, says Dr Fergie.

"For us, health and justice are very relevant because we see our mob and they have been invisible; they haven't had a voice. The movement of reconciliation will not be realised until we have a voice and until there is shared knowledge. Without a voice being enshrined in the constitution or a Makarrata Commission, it's like trudging uphill."

CATSINaM advocates for decolonising healthcare and for healing. "Our motto is unity and strength through caring. Our goal is for self-determination through a strengths-based model with the social determinants of health a priority. Through our healthcare worker and nursing and midwifery workforce we can apply our Indigenous knowledge – our ways of knowing, being and doing," says Dr Fergie.

The proposed Makarrata Commission would oversee a national truth and treaty process and supervise the treaty processes currently in Victoria, Queensland, and the Northern Territory.

Deputy Chair and Commissioner of Victoria's Yoorrook Justice Commission, Sue-Anne Hunter gave the 2022 Swinburne Annual Reconciliation lecture in July. The Commission is tasked with looking into past and ongoing injustices experienced by Elders and First Peoples in Victoria since colonisation.

'The legacy of our people was a footnote when I was at school. There was no space to learn about the brutality of colonisation, no space to learn about our culture, our history or to celebrate our enduring survival. Our stories were unheard,' Commissioner Hunter says.

A Wurundjeri, Gunung William Balluk & Ngurai Illum wurrung woman, Hunter is committed to self-determination and advocating for the rights of First Nations peoples.

Aunty Dr Doseena Fergie, a member of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) Elders' Circle.

Deputy Chair and Commissioner of Victoria's Yoorrook Justice Commission, Sue-Anne Hunter

Prime Minister Anthony Albanese at the 2022 Garma Festival in July.

"THIS PRIME MINISTER IS COMMITTED TO A REFERENDUM. WE HAVE THE SHAPE OF A QUESTION. AFTER FIVE YEARS OF WORK, WE HAVE BROUGHT AUSTRALIANS WITH US. THE POLLING SHOWS ABOUT 65% WOULD VOTE 'YES' FOR AN ABORIGINAL AND TORRES STRAIT ISLANDER VOICE IN THE CONSTITUTION WHICH IS THE KEY PROPOSAL IN THE SACRED HEART STATEMENT."

Yoorrook commissioners visited 25 locations and met with more than 200 Elders before delivering its first report tabled in the Victorian Parliament in July. Eleven themes emerged, including: dispossession and dislocation; political exclusion, representation, and resistance; disrespect and denial of culture; and legal injustices and incarceration.

"Most shared stories they hadn't shared before – that of dispossession, child removal, abandonment, sadness, and anger, but also of hope, resilience, and laughter," says Commissioner Hunter.

"It starts by ending the silence, for the truth to be heard. It's not about shaming anyone. A lot of people have been heard, and held, and further healed – and not further harmed."

Reconciliation Australia research shows that about one third of Australians are unaware or do not accept aspects of shared history, including the occurrence of mass killings, incarceration, forced removal from land and restriction of movement.

"Historical acceptance is critical to reconciliation. Truth-telling can be uncomfortable, deeply exposing, but it leads to a bedrock of change. There is no treaty without truth. No truth without trust. It's something we must build," says Commissioner Hunter.

HISTORICAL ACCEPTANCE

In the *2016 State of Reconciliation in Australia* report, Reconciliation Australia highlighted historical acceptance must be fulfilled for reconciliation to occur.

Historical acceptance, means that Australians recognise, understand, and accept the wrongs of the past and the impact of these wrongs on First Peoples – to help ensure that the wrongs of the past are never repeated.

Mayor says the need for truth came strongly out of every dialogue at the Uluru Convention. "Our people want the truth to be told about our history, what happened, where the massacres were."

Evidence this year revealed the sheer scale of attacks on Aboriginal and Torres Strait Islander people during pastoral settlement in Australia – which intensified rather than lessened as decades went on.

"More massacres happened in the period 1860 to 1930 than in the period 1788 to 1860. There are more massacres and more Aboriginal people being killed," said study lead and historian Emeritus Professor Lyndall Ryan of the University of Newcastle.

The massacres were widespread and were carefully planned, Professor Ryan says. "They weren't an accident. They were designed to get Aboriginal people out of the way."

The Australian Research Council (ARC) funded project now estimates more than 10,000 Indigenous lives were lost in more than 400 massacres. The data has been corroborated with settler diaries, newspaper reports, Aboriginal evidence, and archives from state and federal repositories.

Violence of the frontier massacres has created lasting trauma for Aboriginal and

KEY POINTS

WHAT IS THE ULURU STATEMENT FROM THE HEART?

As many as 250 Indigenous delegates met at Uluru at the First Nations' National Constitutional Convention in 2017. After days of discussions, they reached a consensus on a 440-word statement, now known as the Uluru Statement from the Heart. The main themes are: VOICE TO PARLIAMENT, TREATY and TRUTH

WHAT WOULD AN INDIGENOUS VOICE TO PARLIAMENT BE?

It would be a permanent body representing First Nations people that would advise government on Indigenous policy.

WHY IS THE VOICE TO PARLIAMENT IMPORTANT?

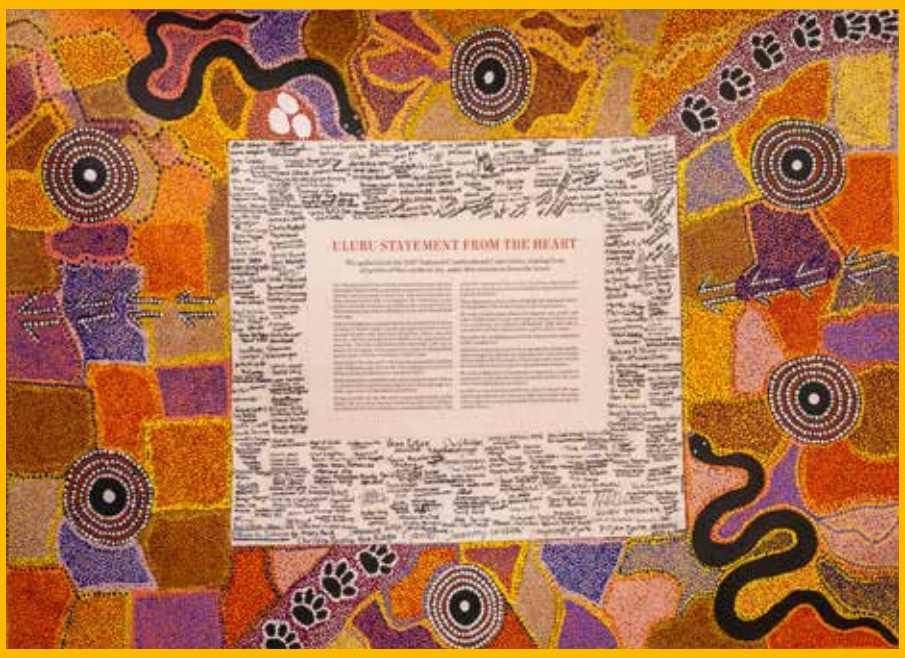
A voice to Parliament provides a practical path forward to finally address the issues that governments have been unable to resolve and provides the foundation for better outcomes for Aboriginal and Torres Strait Islander peoples.

WHAT DOES THE PM WANT TO ADD TO THE CONSTITUTION?

There shall be a body, to be called the Aboriginal and Torres Strait Islander Voice.

The Aboriginal and Torres Strait Islander Voice make representations to Parliament and the Executive Government on matters relating to Aboriginal and Torres Strait Islander Peoples.

The Parliament shall, subject to this Constitution, have power to make laws with respect to the composition, functions, powers and procedures of the Aboriginal and Torres Strait Islander Voice.



Torres Strait Islander peoples, says Professor Ryan. The research project is important to help all Australians change their understanding of the past, she says.

"It's clear that my generation has been protected from this kind of information. Some people don't want to know any more, but many others do. I think we need to know what happened. We need to know more."

TRUTH-TELLING IN NURSING & MIDWIFERY

In Australia, there is growing momentum to explore truth-telling and several significant commissions encompass truth-telling. The report from the Royal Commission into Aboriginal Deaths in Custody, the *Bringing Them Home* report, the Council for Aboriginal Reconciliation's final report, and the Referendum Council's final report highlight the effects of colonisation, dispossession, forced removal and trauma on Aboriginal and Torres Strait Islander peoples, as well as recognising their strength and resilience.

Nursing and midwifery have a history of complicity in colonial practices which is still remembered for many Aboriginal and Torres Strait Islander peoples. Nursing and midwifery leaders published a unified call to action in 2020 in response to Black Lives Matter rallies held across the nation in protest of Australia's record of Aboriginal deaths in custody.

In the paper, Bwgcolman woman and CATSINaM member of the Elders Advisory Council Dr Lynore Geia recalls the nurse officially visiting her family home as a child. Donning a white glove, the nurse would run her fingers over furniture and shelves inspecting the house for evidence of poor hygiene and housekeeping.

"We need to have the difficult conversations that challenge the Australian nursing and midwifery professions to look at ourselves and interrogate our own frameworks of history and our healthcare provision through examining our philosophy, policies and practices in relation to Australia's First Peoples' health," the authors write.

More recently, colonial Inquiries into Aboriginal deaths in custody have examined the professional role of nurses and their care. In the deaths in custody of Yamatji woman Miss Dhu in 2014 in WA, and Mr David Dungay in 2015 in NSW, both colonial Inquiries alluded to a questionable standard of nursing care in the chain of events leading to their deaths.

RACISM IN HEALTHCARE

Ongoing work by the Healing Foundation has highlighted the need for truth-telling to address trauma and racism. Systemic racism in healthcare has detrimental and significant effects on Aboriginal and Torres Strait Islander patients and healthcare workforce.

The Australian Institute of Health and Welfare *Cultural safety in health care for Indigenous Australians: monitoring framework* report released in June, showed that in 2018-19, 32% of Indigenous Australians who did not access health services they needed, reported this was due to cultural reasons including discrimination.

Prime Minister Anthony Albanese at the Garma Festival in July 2022.

WHAT YOU CAN DO:

- Add your name to the Uluru Statement Canvas
- Join From the Heart's call for a voice to Parliament
- Write a letter to your MP

More information can be found From the Heart campaign **fromtheheart.com.au**

To read the Statement from the Heart go to:

ulurustatement.org/the-statement

Finding the Heart of the Nation – the Journey of the Uluru Statement towards Voice, Treaty and Truth by Thomas Mayor ISBN: 9781741176728 can be found in all leading book stores

In 2020, 22% of Indigenous Australian adults or their families reported being racially discriminated against by doctors, nurses and/or medical staff in the previous 12 months.

Addressing systemic and individual racism within nursing and midwifery is fundamental to better health access, care, and outcomes, says Dr Fergie.

"Every nurse and midwife has a role in recognising, confronting and challenging racist discourses in any form ensuring respect for Australia's First Peoples acknowledges and ways of knowing, being, and doing."

Creating a safe health system for Aboriginal and Torres Strait Islander patients and healthcare professionals requires Australians to engage meaningfully with cultural safety.

In addition, CATSINaM advocates the value of increasing numbers of Aboriginal and Torres Strait Islander nurses and midwives to achieve health equality across the country's health system for Indigenous peoples. The number of Indigenous nurses and midwives in Australia increased from 2,434 to 4,610 (324 to 535 per 100,000) between 2013 to 2020. However, this is not enough. "We really need recruitment and retention of our First Nations nurses and midwives. They are the biggest workforce looking after our mob," says Dr Fergie.

CALL TO ACTION

Thomas Mayor says now is the time to get behind the *From the Heart* 'yes' campaign for an Aboriginal and Torres Strait Islander voice to Parliament that is enshrined in the constitution.

"We need unions and willing individuals to get behind the messaging and the campaign. Similar to how unions supported the lead up to the plebiscite for Marriage Equality."

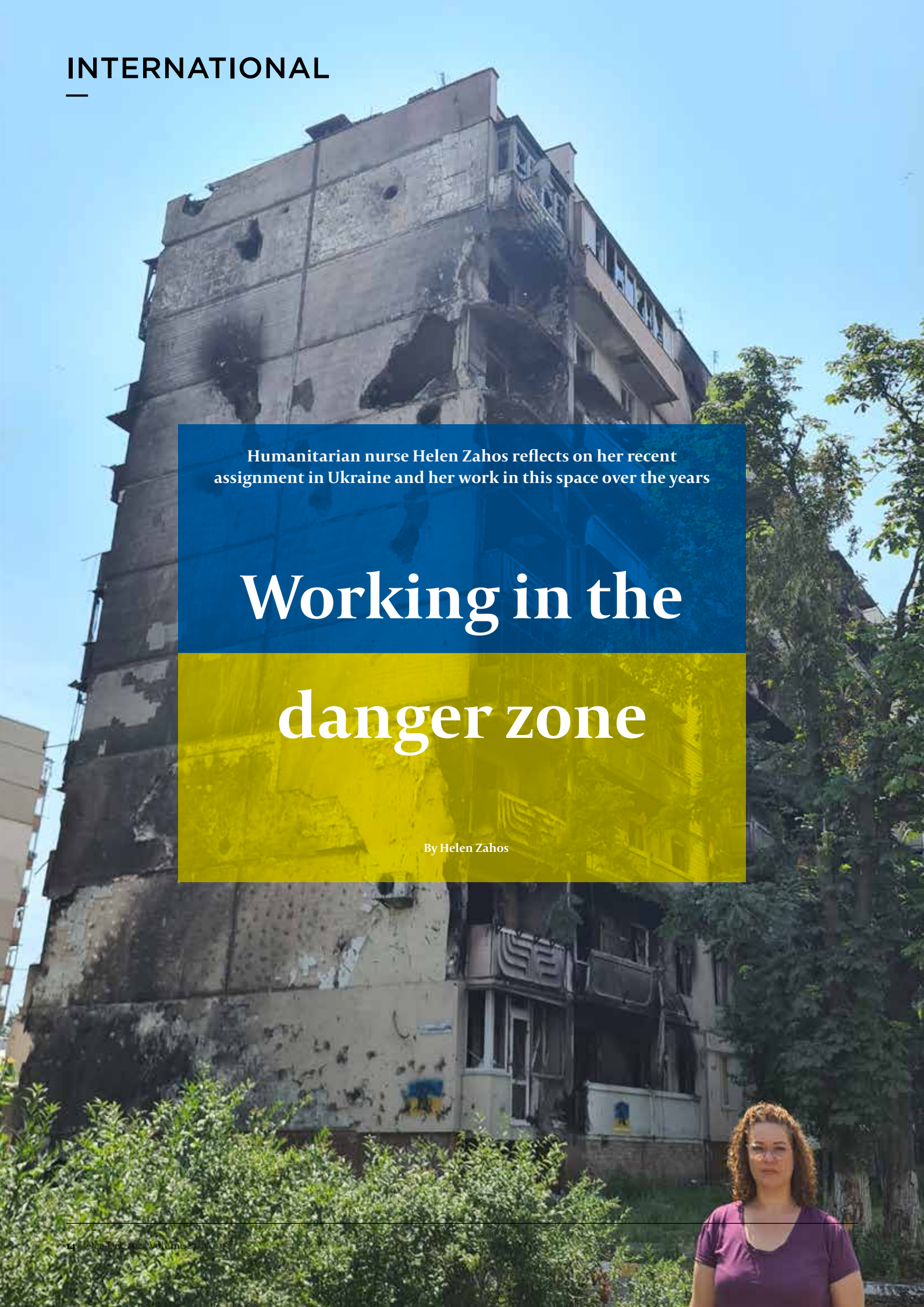
He urges the ANMF and other unions to identify champions amongst its members as leaders and spokespeople to share the message.

"We need people on the ground to work for us for the right outcome. Those networks are important for support. The referendum could be as soon as late next year. That's less than 18 months, it's not a long-time commitment; it's short but intense."

Reconciliation is not a destination, but a journey; and while not an easy or a quick task, few things that are as important or meaningful are, says Minister Burney.

"Because the day we vote yes for a voice to Parliament will be another day we will remember with pride as a moment we together built a better future for Australia."

"EVERY NURSE AND MIDWIFE HAS A ROLE IN RECOGNISING, CONFRONTING AND CHALLENGING RACIST DISCOURSES IN ANY FORM ENSURING RESPECT FOR AUSTRALIA'S FIRST PEOPLES ACKNOWLEDGES AND WAYS OF KNOWING, BEING, AND DOING."



Humanitarian nurse Helen Zahos reflects on her recent assignment in Ukraine and her work in this space over the years

Working in the danger zone

By Helen Zahos

ON AN AEROPLANE A COUPLE OF WEEKS AGO, I WAS SITTING IN A WINDOW SEAT WAITING FOR ALL THE PASSENGERS TO BOARD, READING OVER THE BRIEF IN MY HANDS FOR THE MISSION I WAS ABOUT TO EMPLOY.

The list with Personal Protective Equipment (PPE) caught my eye. For the last two years fighting the COVID-19 pandemic as a nurse in Australia, I was accustomed to the term PPE which meant face masks, face shields, gowns and gloves.

The list for PPE in my brief, however, was slightly different: Bullet proof vest, combat helmet, low burn tactical pants, T-shirt and boots in case of explosives or fire. My destination? East Ukraine.

Nurses often ask me, "can I go and do what you do? Are there any courses I can take?"

So before I go on, I will give you a little background so you can understand where I have come from and also see that humanitarian and disaster responses are not something that just happens overnight.

I completed my nursing and paramedic studies in Darwin, Northern Territory (NT), in 1999. I was working in the Emergency Department at the Royal Darwin Hospital and was involved with the response to the Bali Bombings in 2002.

Since then, I have worked in Emergency Departments in tertiary hospitals around Australia. I have worked in some of the remotest Indigenous communities, including the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in South Australia and Milingimbi in Arnhem Land in the NT.

My nursing took me to Christmas Island and Nauru, where I nursed refugees and people seeking Asylum.

I volunteered in Greece in a clinic during the financial crisis of 2013 and 2014. Being of Greek heritage, I felt bad just going back to have holidays and not giving back to a country that was suffering at the time.

I have volunteered in disaster responses in the Philippines for Typhoon Haiyan and Nepal in Gorkha after the earthquake of 2015. I volunteered in Greece in 2015 and 2016 for the Syrian Refugee 'crisis' that saw up to 5,000 arrivals a day land on the Greek islands by boat.

I have volunteered in Iraq outside Mosul in 2017, in Kenya as the Ambassador for World Youth International's Nurses in Action Program in 2020 and finally, on this volunteer mission in East Ukraine.

The mission in Ukraine lasted four weeks, slightly longer than expected, but anyone who has done any disaster or humanitarian work knows plans change, particularly in unstable and unpredictable environments.

Initially, I had an expert advisor role which included logistics and coordination. Due to safety reasons, I am still unable to disclose my location, but we were near the frontline of the conflict.

THE NURSE IN ME WANTED TO DIVE IN AND DO CLINICAL WORK, ESPECIALLY WHEN I SAW THE AMPUTATIONS AND BURNS, BUT I KNEW FROM THE START THAT THIS MISSION WOULD BE DIFFERENT.

We could hear the bombings during the night. It sounded like a thunderstorm. The imposed blackout was eerie. Lights were out from 11pm to 5am, windows were taped over with an X, and curtains had to be closed. There were three of us on the team, a Doctor, a coordinator and myself.

We were there to do a needs assessment and establish where a mobile field hospital should be situated. Government officials met us at the border and made us pass through checkpoints much quicker. Our phones were constantly being checked. We were not allowed to take photos, and anything we were to post on social media had to be approved by the military and the health department to ensure no important information was being passed on.

We all communicated via the 'Signal' application on our phones, especially with army commanders. We met with the Minister for Defence and the Deputy Minister for Defence, hospital directors and disaster coordinators, the health department and the Mayor of the regions.

The hardest thing for me being a nurse was that I could not nurse patients in the hospitals we visited, especially the army and the children's hospital, which was the worst.

The nurse in me wanted to dive in and do clinical work, especially when I saw the amputations and burns, but I knew from the start that this mission would be different. Hospitals in Ukraine were targeted and bombed. Because of this, there was an abundance of highly trained staff.

What Ukraine needed was infrastructure and supplies. We looked at bomb shelters, visited all of the regional hospitals, and assessed the needs. The mobile field hospitals that were brought in by Adventist Help, an organisation registered with the World Health Organization, included x-ray equipment and surgical capabilities.

There were a couple of issues that we faced. The Ukraine Government looked at the area and the set-up of the field hospital through a disaster management lens. The reality was, after meeting with the commander of the Ukraine army from the frontline and assessing the needs in that location, it was clear that the need was far greater for the army right now on the frontline.

One day at a checkpoint, I had a scary moment. I had handed over my passport, and I was actually feeling quite calm and safe, but this suddenly changed when the soldier at the checkpoint raised his voice, pointing at me sternly and began speaking with the driver in Ukrainian. I thought this must be something to do with me having a Greek passport as well as an Australian passport. He was serious, the driver's voice changed and he became serious. They were both speaking and pointing at my passports that were in my money belt. The driver interpreted with google translate. The message was simple and clear 'You could get shot for that, no questions asked. This is a war, people will shoot first and then ask questions later. You need to be careful and get rid of that right now before you drive away!'

As I read it, a wave of heat came over me. I responded with, 'What do you mean? Because I am Australian or Greek? Is this because I have two passports?'

The driver typed into Google translate again, 'No, the tag on your passport bag, that could get you shot here, you need to be more careful'. I looked down at the passport bag I had purchased from Zellows in Australia. The tag showed a 'Z' with a circle around it. The tanks that the Russians were driving had 'Z' on them as well. I was aware of this but did not even notice the tag on my money belt.

One thing I have always taught others before going into an unstable environment such as a conflict is to learn a bit about the history or the reason behind the war, and the political instability, because something really small can offend people, so much that they could kill you.

Words I never thought would be needed in my nursing vocabulary: Bomb shelter, imposed blackout, air strike alarm, heavy artillery, missile strike and crossfire.

This is a war. There is scarce food on the shelves at the grocery store, the air raid sirens are constant, and the hospitals have run out of consumables. For example, they have a dialysis machine, but they can't dialyse anyone because they don't have the plastic tubing.

The trucks are loaded in Kyiv, but the drivers are too scared to come so close to the frontline. Nothing is sacred. I have seen churches damaged by rounds of bullets shot at close range, civilian housing destroyed by bombs, and home security video of Russian soldiers invading and destroying civilian housing. Apartment blocks in a suburban neighbourhood were destroyed. I got goose bumps walking through those areas picturing what the innocent people went through running for their lives.

As nurses, we are trained to be impartial, to be advocates, and not enter political arguments when caring for human beings.

While in Ukraine, two things happened. Firstly, I was asked, 'If you come across an injured Russian soldier, would you help them?' Secondly, a gun was placed beside my bed in case I needed to use it.

As nurses, we care for all human beings. I don't enter the political backdrop of what is happening in Ukraine. It is not my place to. This war has been going on for eight years; it didn't just randomly start this year. It is not up to me to decide who is right or wrong.

As a nurse, I see a human being in need in front of me, and I help them. Am I pro-Ukraine? Am I pro-Russian? It does not matter. I am in a war zone, risking my own safety to help human beings. Either side has innocent victims being used as pawns in a game we ultimately had no control over.

Have you seen severe injuries like amputations and eviscerations? Have you seen people that have died? Did you see many dead children? These are questions that fellow nurses and paramedics have asked me from Australia. Questions that make me pause. Does it really matter? Would I be more worthy of being a nurse if I said yes? When you know someone has been in a war zone, try not to ask unthoughtful questions. You don't need to re-traumatise people to satisfy your own curiosity. A nurse is not validated by the demise of others. I got just as much satisfaction from helping to cook and clean at a refuge, helping families that had escaped Mariupol that had been stuck in bomb shelters for two months. The children, too scared to look out the window at sunlight, only drew pictures with dark, bland colours; most pictures were of soldiers, military convoys and houses with blacked-out windows. Feeding people, nurturing them and providing them with a safe space. This is caring for humanity.

People have asked if this experience differed from the Iraq war. It was very different. This is the largest major land war to happen in Europe since World War 2. In Iraq, there were many allies fighting and helping, and there were many American soldiers and Australian soldiers in the area on the ground. In Ukraine, foreigners were seen

WORDS I NEVER THOUGHT WOULD BE NEEDED IN MY NURSING VOCABULARY: BOMB SHELTER, IMPOSED BLACKOUT, AIR STRIKE ALARM, HEAVY ARTILLERY, MISSILE STRIKE AND CROSSFIRE.

as targets, so I only saw local fighters. It was a lot scarier than what I felt in Iraq, I have to say, the unpredictable nature of the war that's happening meant that you were that much more hypervigilant and on guard than I ever felt when I was in Iraq.

The unpredictability of this war meant that a completely different approach was made compared to other missions. The risk was high, and each step taken on the mission was assessed, so no unnecessary risks were taken. I had a solicitor draw up paperwork.

There were 15 community leaders in Australia to be notified if I was taken hostage, taken by insurgents and held captive, killed or critically injured and left on life support. If my solicitor did not hear from me for 24 hours and knew of bombing in the area, she was instructed to initiate a rescue mission, which had been planned as part of the exit strategy.

I have just returned and have hit the ground running. To be honest, I have not had time to process fully or recover from jet lag yet. Two days after arriving, I presented up in Brisbane to 200 people at a conference. This week I have been asked as the expert consultant for the Dart Centre Asia Pacific, in collaboration with the International Committee of the Red Cross (ICRC), to sit on a panel for the ICRC International Media Summit on war reporting. I will then help facilitate the Melbourne and Sydney workshop on Humanitarian storytelling.

Once I have returned and the dust has settled, I will probably pick up some agency shifts on the Gold Coast, Queensland. If there is one thing this mission has shown me is that you don't have to be on the frontline in a clinical role as a nurse to make a difference, it can happen through advisory roles, research or through policy and teaching.

Nursing is such an incredible career. It is only as restrictive as you chose to make it. The world is out there, your skills are needed, and chances are it is you that is stopping yourself from getting there. Chase your dreams and give it a go. If I can get out there and achieve some pretty incredible things as a nurse, so can you.

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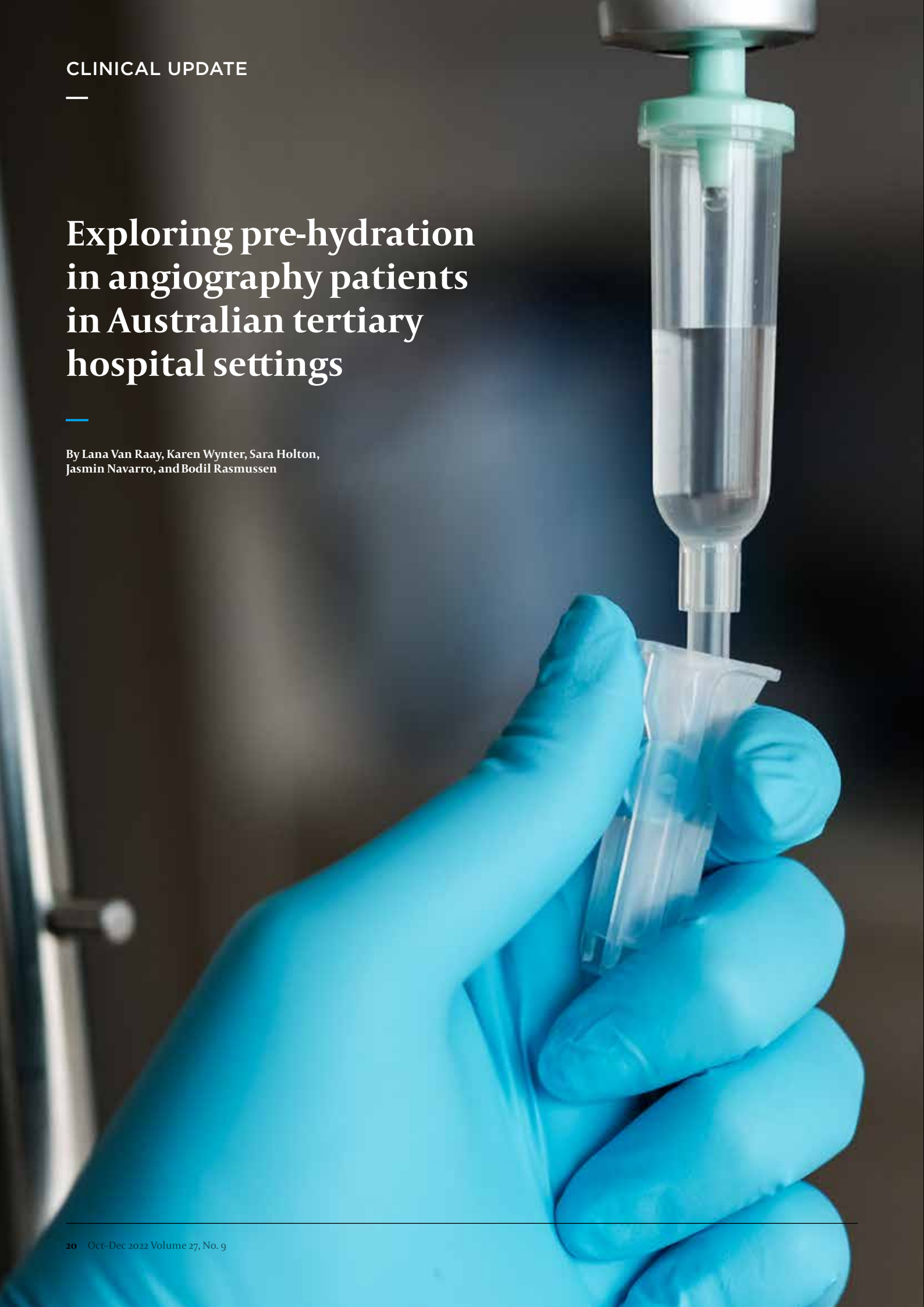
Exploring pre-hydration in angiography patients in Australian tertiary hospital settings

By Lana Van Raay, Karen Wynter, Sara Holton, Jasmin Navarro, and Bodil Rasmussen



INTRODUCTION

Current evidence supports the need for hydration of angiography patients to prevent Contrast Induced Nephropathy (CIN) or Contrast Induced Acute Kidney Injury (CIAKI) which can be caused by the contrast dye used during the angiography procedure.[1]

Patients in the high risk category for CIN or CIAKI (eGFR 30-60mL/min) are commonly hydrated at a rate of 1ml/kg/hr for 12 hours prior to the procedure,[2] whereas patients in the medium risk category (eGFR 60-90mL/min), are often hydrated intravenously at a rate of 1mL/kg/hr for six hours prior to procedure.[3,4] Both medium and high-risk patients are also infused for 12 hours post procedure. Very high risk (eGFR <30mL/min) patients are also given either N-acetyl cysteine (NAC) or Sodium Bicarbonate in 5% dextrose to supplement hydration, in order to prevent CIN.[5,6]

Recent evidence from a randomised controlled non-inferiority trial, the "A MAstricht Contrast-Induced Nephropathy Guideline" (AMACING) study in the Netherlands, indicated that not giving any pre-hydration to non-emergency high-risk patients with eGFR 30–59 mL/min/1.73 m² is safe, even in the long-term, compared with same-day hydration.[7,8]

Similar results emerged in an Italian study of patients with acute kidney injury after primary angioplasty,[9] which concluded that adequate intravenous volume expansion may prevent CIAKI in patients undergoing prima percutaneous coronary intervention. However, overnight hydration is still common for medium to high-risk angiography patients internationally.

OVERVIEW OF THE ISSUE

The first author is a Clinical Nurse Specialist at Western Health, a large metropolitan health service in Melbourne. She noticed that of the peripheral vascular (lower limb) angiography cases with no known end stage renal impairment requiring an Arteriovenous (AV) Fistula at Western Health, many were being admitted overnight for pre-hydration.

Overnight admission is associated with significant financial burden for the hospital, workload for the vascular unit staff, and for the patients, an increased risk of falls and infection associated with a longer hospital stay.[10] There was no evidence that high risk patients could be hydrated for less than 12 hours prior to procedure without adverse consequences. Given the disadvantages of overnight admission for the health service, and the risks and inconvenience for the patients who otherwise tend to be in good health, the aim of this study was to determine if same-day intravenous hydration is a non-inferiority option for patients at high risk of CIN as compared to overnight intravenous hydration in terms of clinical effectiveness.

PROJECT OUTLINE

To investigate whether same-day hydration is a non-inferiority option as compared to overnight pre-hydration in vascular angiography, a pilot study was undertaken using a retrospective control group at Western Health.

RETROSPECTIVE CONTROL GROUP

Of 102 peripheral vascular (lower limb) angiography cases with no known end stage renal impairment requiring an AV Fistula at Western Health who received lower extremity vascular angiography between April and June 2016, 17 (27%) received overnight pre-hydration due to eGFR 30-60 mL/ min/ 1.73m² as per the hospital protocol at the time:

- Patients' eGFR was tested by means of a venous blood sample one week prior to contrast administration;
- Patients were admitted overnight, the night before the angiography procedure;
- Hydration with one litre of IV fluids occurred from midnight to 10h00 prior to the angiography procedure (10 hours of hydration);
- Patients were discharged home after the procedure; and
- Patients were asked to arrange a venous blood sample to provide a follow-up eGFR reading one week post procedure.

This group formed the retrospective control group. None of these cases had an eGFR of less than 30mL/min/1.73m². Between April and July 2016, 10% of angiography procedures were cancelled due to the lack of overnight hospital beds for patients requiring pre-hydration as per hospital protocol at the time. For some patients this meant that their angiography was rebooked several times.

PILOT STUDY

We followed a similar protocol to a large non-inferiority trial (no hydration versus short-term hydration for patients with compromised renal function) conducted in the Netherlands.[7,8] The same inclusion criteria were used: participants were women and men aged 40-95 years scheduled for abdomen or lower limbed vascular angiography. Other inclusion criteria were predetermined eGFR 30 -60mL/ min/ 1.73m², appropriate support at home and reliable transport to and from hospital. This information was collected at the time of booking appointment, as per routine questioning. All participants were offered a taxi voucher if required to cover travel costs to the hospital.

Patients were excluded if they had a known contrast allergy, or a history of congestive cardiac failure (CCF) or daily fluid restrictions.

Between July 2017 and July 2018, among the 198 patients scheduled for lower extremity vascular angiography, 25 patients were approached and invited to participate in the study. Of these, 24 gave their consent to participate. The one patient who did not give consent stated they did not want to be at the hospital at 07h00.

These 24 participants formed the trial group who received same-day IV hydration, as per the following procedure:

- Patients' eGFR was tested by means of a venous blood sample one week prior to contrast administration, to determine whether the patient was eligible for the trial;
- On the day of the procedure, patients were admitted to the Medical Imaging Department at 07h00. A health service staff member obtained written consent to participate in the research study prior to the procedure;
- Patients were cannulated and administered the IV fluids via an Alaris IV fluid pump, prior to and during the procedure;
- Upon completion of the procedure, patients were escorted to the Day Procedure Unit to recover. Hydration continued until 17h00 (10 hours of hydration);
- Patients were discharged home after the completion of the hydration; and
- Patients were asked to arrange a venous blood sample to provide a follow-up eGFR reading one week post procedure. This is standard practice for vascular cases of angiography at this health service.

STATISTICAL ANALYSIS

The outcome variable was incidence of CIN, measured by difference in eGFR in each group. The number of other adverse events and bed cancellations owing to lack of availability of hospital beds is also reported for each group. Differences in the incidence of these events between groups were tested using X^2 tests.

ETHICAL APPROVAL

This study was approved by the Western Health Low Risk Ethics Panel (LNR/17/WH/19).

RESULTS

The sociodemographic characteristics and pre-hydration eGFR distributions of the control and trial groups were similar; no significant differences between groups were identified (Table 1).

In the control group there were no cases of CIN; in the trial group there was one incident of CIN (Table 2). This patient was previously unwell with the flu and did not disclose this prior to angiography.

In the control group, there were four cases of procedures being cancelled owing to lack of overnight bed availability in the hospital, compared to none in the trial group (Table 2).

DISCUSSION

The project has provided preliminary evidence that there may be no need for overnight beds for IV pre-hydration for angiography patients with an eGFR of 30 -60mL/ min/ 1.73m², and no known contrast allergy, a history of cardiac failure, CCF, or daily fluid restrictions.

In this pilot study, we have demonstrated that same-day pre-hydration is non-inferior to overnight hydration; we found no significant difference in incidence of CIN between the two groups.

Our results align with the findings of Nijssen et al.[8] who found no prophylaxis to be non-inferior and cost-saving in preventing contrast-induced nephropathy.

Our findings have resulted in a policy change for angiography procedures at

TABLE 1:
Demographic characteristics of participants in control and trial groups

		CONTROL GROUP	TRIAL GROUP	DIFFERENCE
Sex n %	Male	12 (70.6)	19 (79.2)	X^2=0.068, p = 0.794
	Female	5 (29.4)	6 (20.8)	
Age Mean (SD, Range)		76.8 (7.2, 68 – 92)	76.6 (9.2, 58 – 89)	t*=0.074, p=0.941
Pre-hydration eGFR Mean (SD, Range)		50.4 (16.7, 35 – 90)	52.2 (8.5, 30 – 61)	t=-0.399 p=0.694

*Student's t-test considered appropriate as distributions were normal

TABLE 2:
Incidence of CIN and bed cancellations in each group

		CONTROL GROUP	TRIAL GROUP	DIFFERENCE
CIN n %	No	17 (100)	23 (95.8)	X^2=0.726, p=0.394
	Yes	0 (0)	1 (4.2)	
Procedures cancelled n%	No	13 (76.5)	24 (100)	X^2=6.258 p=0.012
	Yes	4 (23.5)	0 (0)	

Western Health: patients with eGFR 30-60 mL/min/1.73m² no longer require an overnight stay pre-procedure for pre-hydration purposes.

This represents a large reduction to the nurse workload especially overnight when nurse-patient ratios are already high. This policy change has also reduced the workload of the preadmission clinic (PAC) booking nurses as there is now less need to rebook or reschedule cancelled appointments, which can be a lengthy procedure including informing medical units, bed managers and the patients themselves. PAC nurses often previously experienced the frustration and stress of the patients who needed to be rebooked.

The findings of this study have substantial implications for patient care. Anecdotally, many patients have expressed that they prefer to sleep at home, in a comfortable and familiar environment, the night before their procedure. Compared to overnight admissions which are frequently cancelled or rebooked owing to lack of bed availability, day admissions are associated with significantly reduced need for rescheduling. Thus, patients who are admitted on the day of their angiography are less likely to suffer inconvenience and frustration due to being rescheduled.

A strength of the study was it followed a similar protocol to a large trial conducted in The Netherlands,[7,8] however, the Dutch trial compared short term hydration to no hydration whereas we compared overnight pre-hydration to same-day pre-hydration. However, we used the same rigorous inclusion criteria as the Dutch trial; in our study there were no significant differences between participants in each group in terms of sex, age or pre-eGFR results.

The major limitation of this study was the small sample size. The retrospective control group included 17 participants recruited within a four month period. Despite aiming to recruit 30 participants for the trial, only 25 participants were recruited during the 12-month study period. The difficulties in recruiting were due to the strict inclusion criteria, recruitment from a single site, patient illness over the winter months, and a refurbishment of the angiography facilities which rendered them unusable for four months. In addition, complete data were not available for all participants; two participants did not have the seven days post angiography blood test. Patients may have been reluctant to have another blood test due to inconvenience, fear of another needle, or a lack of knowledge about its importance in assessing kidney function. Finally, there was no randomisation or adjustment for confounding variables due to the scope of a pilot study and the limited timeframe for this study.

Further research including a statistically powered trial, with multiple health services, would assist in providing further evidence of the feasibility and non-inferiority of conducting same-day hydration prior to vascular angiography. Patients' preferences and experiences of same-day hydration should also be assessed. Evidence generated in such research may be applicable to other procedures or operations such as CT scans that currently require overnight pre-hydration of patients. Comparison of the cost effectiveness between the same-day and overnight hydration would also be beneficial. We note that the study sample size is relatively small so further research with a larger sample size is required to confirm these findings. Further research should also investigate the use of oral (rather than intravenous) pre-hydration among medium- to low-risk patients; there is preliminary evidence that this may also be effective in the prevention of CIN.[11-13]

CONCLUSION

This study provides preliminary evidence that same-day hydration is non-inferior to overnight pre-hydration in patients requiring vascular angiography; removing the requirement of an overnight bed in a public hospital has potential advantages for the patients and the hospital. These include but are not limited to improved patient care, shorter hospital stays, and lower risk of hospital acquired infections and injuries, as well as lower cost to the hospital.

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Smoking, vaping and harm reduction

By Melise Ammit

Smoking accounts for one in nine deaths in Australia. Smoking is the single most preventable cause of disease.

The physical effects of tobacco smoking include heart attack, stroke, cancer, respiratory disease, premature ageing, impotence and miscarriage.

The societal effects of smoking are caused by smokers being generally sicker than non-smokers. Smokers have higher use of medical care services, increased risk of complications after surgery, are more likely to require longer hospitalisations and take more sick leave than non-smokers.

Many substance users also smoke tobacco – in fact they are more likely to die from a tobacco-related disease than from their primary drug problem.

Nicotine is the drug that smokers becomes dependent upon. However, nicotine is relatively low risk and does not cause cancer or disease – tobacco does. Burnt tobacco releases tar, carbon monoxide and carcinogens that cause disease.

Nicotine is a very short-acting drug – it has a half-life of only 20 to 40 minutes. Nicotine is inhaled, delivered to blood and hits the brain within 10 seconds. The brain is 'switched on' by nicotine, releasing the feel good chemical dopamine. This means smokers need to be constantly topped up. The cycle of smoking, feeling good, withdrawal, then topping up with another cigarette, reinforces addiction.

Smoking associated environmental cues also play a role in reinforcing addiction. Cue conditioning and behavioural rituals can be reasons for continuing to smoke though the dependence on nicotine is the real driver.

The health message regarding smoking has shifted from cessation to harm reduction over the past few years. This approach aligns with the Australian Government policy of harm minimisation that applies to all other drugs. Harm minimisation is a three-tiered approach of supply reduction, demand reduction, and harm reduction. Tobacco harm reduction recognises that abstinence, or never using tobacco, is the ideal outcome but accepts there are other ways to reduce harm among tobacco users.[1]

The most effective smoking harm reduction treatment includes a combination of nicotine replacement therapy (NRT) and behavioural therapy.

Electronic cigarettes (vapes) are also a smoking reduction and cessation aid.

E-cigarettes are devices that make vapour for inhalation that simulates cigarette smoking. Other terms for e-cigarettes include e-cigs, electronic nicotine delivery system (ENDS), personal vaporisers and vapes – they all mean the same thing.

E-cigs emerged around 2000 from China. Anecdotal sources cite the coming indoor Beijing Olympics as the precursor to development of an alternate non-combustible option for the cigarette loving population!

Vaping can be less harmful than smoking because it does not contain the tar, carbon monoxide and other toxic chemicals from burning tobacco. Personal vapes heat a liquid nicotine or flavourant solution into an aerosol which is inhaled and exhaled in visible mist.

However, nicotine vaping products are not approved by the Therapeutic Goods Administration (TGA) and they remain a second line treatment for smoking harm reduction.[2] Since October 2021 a GP prescription is needed for liquid nicotine. Adjunct Professor John Skerrett from the Health Products Regulatory Group explains the rationale for this is to formalise that quitting cigarettes can be done under supervision, and importantly, to close the loophole of school-aged children and adolescents already accessing vapes.

The National Health and Medical Research Council (NHMRC) states that there is currently insufficient evidence to support the claim that electronic cigarettes are a method to assist smokers to quit, or that they are a safe alternative to tobacco cigarettes. Conversely, the Drug and Alcohol Nurses of Australasia (DANA) position statement supports use of e-cigarettes, stating that switching to vaping is likely to lead to health improvements for smokers.

Similarly, Professor Hayden McRobbie from the National Drug & Alcohol Research Centre presented data that supports use of e-cigarettes to cease smoking in a recent webinar.[3] He says that efficacy to quit with vapes may be better than NRT as e-cigs are more satisfying. Vaping e-cigs replicates smoking behaviour, the hand to mouth action, throat hit and the sensation of 'smoke' going into the lungs.

The safety profile of e-cigs is still emerging. It took 50 years to prove the health effects of smoking and the long-term risks of inhaling heated propellants that may contain cancer-causing agents such as formaldehyde, acetaldehyde and acroleine, is still unknown. However, the level of potentially toxic compounds in vapes and the respiratory cell damage caused by them is significantly lower than combustible cigarettes.[4]

The increasing use of vapes by people who have never smoked, and especially adolescents, may be problematic – a possible 'gateway' behaviour to real cigarettes. Importantly, non-smokers should not be enticed to use these products.[5]

In summary, vaping is an appropriate smoking harm reduction strategy. But, if you don't smoke you shouldn't vape.

Author

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Lori-Anne Sharp

ANMF Federal Assistant Secretary

Unifying voice – Tribute to Archie Roach

Like so many people across the country I was deeply saddened to hear of the death of Archie Roach on 30 July this year, at age 66, a premature death, tragically a story too common for First Nations people.

Archie Roach, Guditjmara (Kirrae Whurrong/Djab Wurrung), Bundjalung Senior Elder, was part of the stolen generation and is well known for his powerful and generous storytelling through song.

Heartbreakingly, we have witnessed a number of prominent musicians leave us in recent months, Archie Roach, Judith Durham and Olivia Newton-John. Coincidently, all of who have had some connection with the ANMF. Both Judith Durham and Archie Roach have performed at past ANMF delegate conferences and Olivia Newton-John recently spoke at the ANMF Medicinal Cannabis conference. ANMF delegates may recall Archie Roach singing at the 2019 ANMF biennial delegates' conference. Despite ill health, Archie managed to amaze delegates as he sang 'Old Mission Road' and other sweet tunes.

Listening to music is one of the simple pleasures in life, a very common shared experience to relieve stress and connect with friends. As ANMF members across the country have and are continuing to withstand high levels of work pressure in responding to the pandemic, listening to music can be one saving solace. Instantly uplifting, relaxing or simply just a way to escape and unwind.

Archie Roach's music offered much comfort and healing, widely described as a unifying voice, his tunes captivated audiences and shed light on the injustices experienced by First Nations people. Part of the stolen generation, Archie was taken from his family at the age of three. Much of his storytelling speaks to the effects of colonisation on his people. A powerful and generous man, Archie was committed to helping others and set up the Archie Roach Foundation in 2014 to support young Indigenous individuals in the justice system by promoting the arts.

In the early 1990s and as a young student nurse in my third year of nursing, I was fortunate to spend some time down at Framlingham (South West Victoria) working in community health with the local Aboriginal Health Service. It was part of a transcultural nursing elective at the time. Framlingham, now a protected Indigenous area was once the location of the Framlingham mission and where Archie Roach resided in his early years before being forcibly removed by government authorities. A story reflected in his famous song 'They took the children away'.

I recall this time at Framlingham fondly and not just for the many koalas spotted regularly in the manna gums of the Framlingham Forest, but also for the many connections made with the local community and I was fortunate to experience their generosity first-hand. It was also a great surprise when I had a chance encounter with Archie Roach when he visited briefly during my time there.

As many of us pay tribute to the legendary song man Archie Roach and reflect on the impact his music and storytelling have had on our nation, we should be reminded that much needs to be done to address the inequality that still exists for First Nation Australians.

Acknowledging the effects of colonisation and addressing the inequity/disadvantages experienced by First Nation Australians in regard to life expectancy, chronic disease, education, employment, incarceration rates, deaths in custody and racism must be a priority for this nation. The Uluru Statement from the Heart, endorsed by the ANMF Executive, calls for an independent voice in the Constitution with full inclusion of the Aboriginal and Torres Strait Islander voice through voice, treaty and truth-telling. With a new ALP government elected in May, our nation will now be given an opportunity to unite and vote yes in a referendum to recognise a First Nation constitutional voice in Parliament.

Archie's sons Amos and Eban Roach, have given permission for Archie's name, image and music to be used so that his legacy will continue to inspire.

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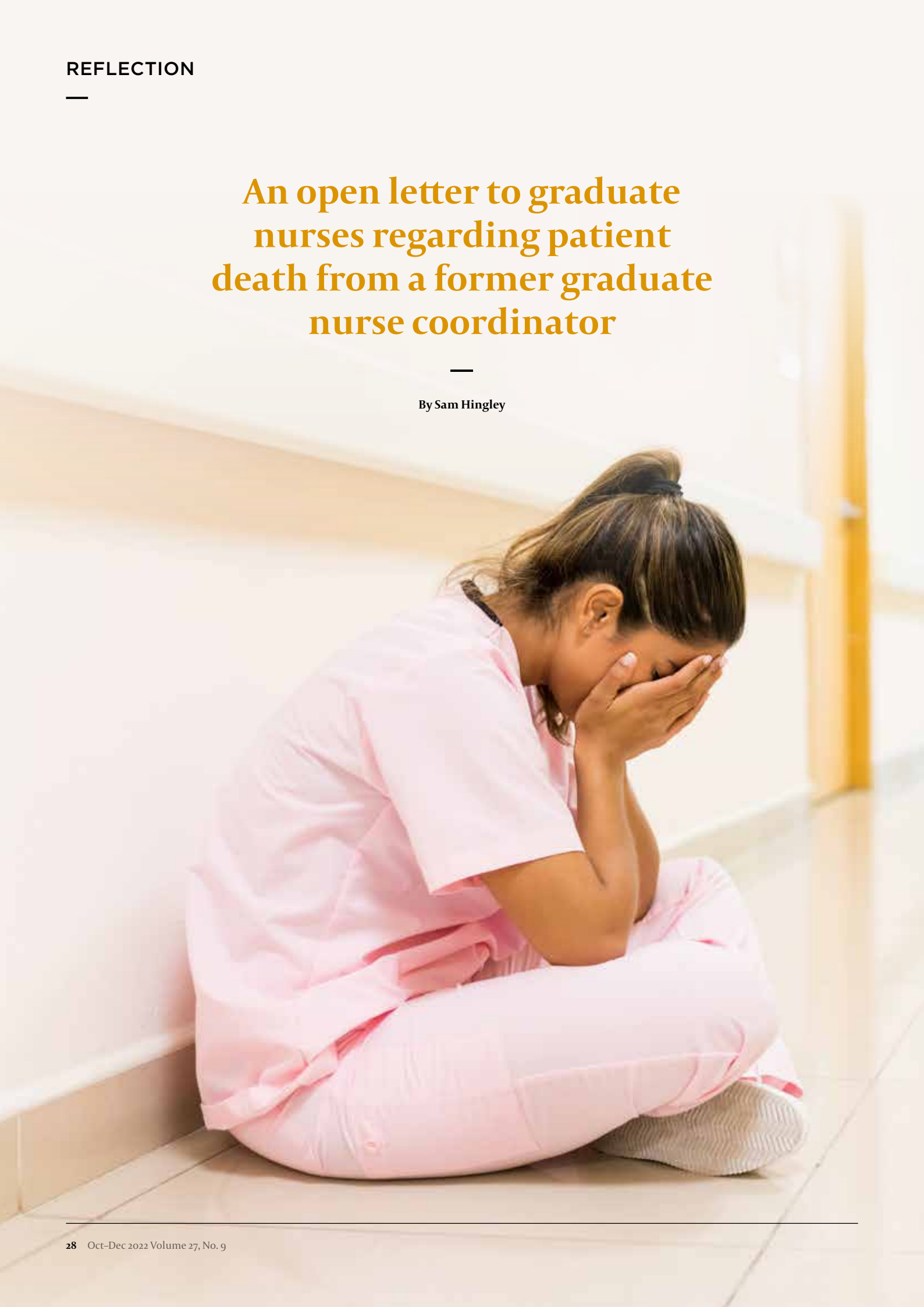
An open letter to graduate nurses regarding patient death from a former graduate nurse coordinator

By Sam Hingley



Dear new nurse,

Death is inevitable, and preparation for the first emotionally painful death you experience is challenging. Here I offer you a shared experience and knowledge that I have previously shared with new graduates.

Anne was no different to other patients who had died acutely. It was Anne's husband, Peter, who made the experience different. Peter was unable to accept that the love of his life was dying. When Anne was close to death, a phone call to Peter reached his answering machine. But Peter arrived too late.

He was not prepared for the news. The grief, disbelief, and heartache he displayed created a lasting memory. After accompanying Peter to Anne's room, a hasty retreat was made to the pan room to hide tears from Peter.

Communication with Anne and her family was not adequate. Despite attempts to convey the imminence of death, Anne's family were not prepared. Nurses are accustomed to difficult conversations, but not death conversations. Nurses often feel awkward, fearful, or lack the skill to effectivity discuss end-of-life care.[1]

Had discomfort been pushed aside, effective communication may have made a difference.

What could have been done differently

- Allocate time to be present and openly discuss end-of-life. Time given to your patient and family can be empowering, ensuring they are prepared and aware of their choices.[2] This promotes patient-centred care.
- Avoid miscommunication using clear, simple language, not euphemisms, to soften death and dying. 'She is gone' may be clear to one family but confusing to another. A recent Australian study, 1,183 unique euphemisms were identified for describing death or dying.[3]
- Practice using uncomfortable words such as death and dying, so you are not afraid to say them.

Active listening promotes information sharing. What is needed to help them understand or cope? Recognise when you are out of your depth and know who to contact in your organisation to support the family. Anne was aware that she was dying, which caused distress when her family would not talk about it.

Increasing your ability to communicate effectively is the most essential skill you will possess; however, this will not protect you from the challenging days on the ward.

Reflection, such as Gibbs[4] reflective practice, is taught as a formal means of unpacking an experience or consolidating knowledge and is an ongoing national competency for registered nurses.[5]

The process of reflecting, even informally, is beneficial. Reflection will allow you to make sense of events.

Considering both the positives and negatives in the day, understanding the emotions felt and building a plan for self-improvement professionally and personally. By acknowledging emotions, the risk of burnout is decreased and resilience is improved.[6]

Finally, **self-care**. Be kind to yourself. Work-life balance is incredibly important, and self-care assists balance. Many self-care strategies are available; choose a strategy that resonates with you.

Here are three frequently used strategies:

Walking and acknowledging. The act of noticing helps empty the mind of other worries and allows focus on only what is being experienced in the moment. This form of mindfulness helps to reduce stress and builds resilience instantly.[7]

Gratitude, for resilience building and reframing your thoughts. Every day, share three gratitude moments for the day. On a difficult day, finding three positive events will help shift your mindset and build resilience and emotional intelligence.

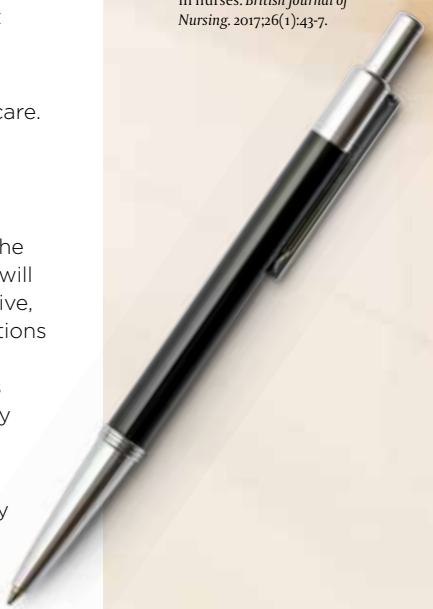
Brunch. Perhaps because a normally busy schedule is on hold, or because time is being shared with family or friends and, for that moment, everything is less important.

Nourishing yourself with food and maintaining positive relationships is self-care.

Being a nurse is a privilege. Personal journeys are shared with patients on both their best and worst days.

The skills shared are aimed at caring for the dying and their family. However, mastery will improve general nursing skills also. Effective, clear communication in challenging situations is a skill that requires practice. Care and communication shared in these moments have a significant impact, and the mastery of self-care and reflection will guide you to make the difficult days more bearable.

Good luck new nurse, may you have many wonderful and memorable years ahead.



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James Lloyd

ANMF Federal Vice President

Empathy in healthcare

***"Empathy is about finding echoes of another person in yourself"* – MOHSIN HAMID**

Empathy, simply, is seeing the world as others see it, understanding another's feelings, not judging, and communicating our understanding of that person's feelings.

Empathy is a process of listening rather than reacting – the ability to walk in another's shoes and understand their experience. Empathic people are in touch with their emotional self-worth and sense of their place; typically, they have strong boundaries and can listen without comment or judgement.

Empathy is not the same thing as sympathy. Sympathy is feeling pity without understanding what it is like to walk in another's shoes. But empathy is experiencing another's emotions, ideas, or opinions. Empathy is more powerful than sympathy, expressing, "*I understand and feel your distress*" rather than "*I pity you; here is a solution*". Empathy acknowledges and builds connection; however, sympathy just acknowledges the pain.

People often misunderstand empathy and see it as a weakness, but it is, in fact, a strength. Being empathic does not mean you're a pushover but firm yet flexible about your boundaries. Empathic people are self-aware, and their boundaries are enforced and respected. Being empathic means that you don't always need to have the last word or win an argument in a conversation. You are sure of who you are yet are open to having your views changed.

Empathy is crucial to the healthcare worker. We work with people who are physically and emotionally vulnerable. Empathy helps nurses and midwives to build a connection with those in their care. Patients can often feel overwhelmed, anxious, and even terrified. Research indicates that an empathic carer can improve patient experience, shorten length of stay, contribute to positive patient responses, such as relief from pain, and reduce anxiety, depression, and hostility.

Empathy is inherently a function of our professions. In your hospital or healthcare facility, I will bet there is a ward that has had almost no industrial issues. Staff are happy, turnover is low, and they are a 'can do' group of nurses or midwives. I will also bet that this department is led by an empath - someone who invests their time paying attention to staff, sets boundaries and makes it their goal to listen actively.

A workplace led by an empath is also more productive and supportive. An empathetic leader may inspire co-workers to address others in the same way. By practising empathy in the workplace, nurses can reduce stress for patients, co-workers, staff, and other healthcare professionals. In fact, it supports ethical interactions among all employees and forms respectful and constructive working relationships.

Can empathy be learned? Not everyone is born a natural empath. Most of us learn as we grow through observing the interactions of those around us. Those with a high level of empathy are associated with healthy relationships and pro-social behaviours. To learn this, first seek new perspectives and experiences. Because empathy means putting yourself into another's shoes, this is difficult if you don't know much about the other person. Start a conversation and be curious – ask about another's background or culture. Actively listen and reflect on what you have heard, and empathy will develop.

Second, take the chance to connect with another person emotionally. Simply hearing them does not forge an empathic connection. View this as an opportunity to be vulnerable and identify with their concerns. It is not easy to be open, especially when you're having a conversation dealing with negative situations. But practice will increase your emotional intelligence and hence empathy.

Lastly, we inherently all have biases commonly centred around race, gender, age, sexuality, and physical abilities. They come from how we are raised, educated and from our socioeconomic positions. These biases curb our ability to empathise. To become a true empath, you need to acknowledge your biases exist, no matter how slight.

The value of empathy can be highlighted in the *Campaign for the Indigenous Voice to Parliament*. Aboriginal and Torres Strait Islanders ask us to see their unique points of view. They are asking us to walk in their shoes and understand their culture, which was established through thousands of years of wisdom and experience. Non-Indigenous people in Australia are being asked to use empathy to bridge the cultural gap and support this voice to Parliament referendum.

You may not think you're an empath, but it is likely you are. You're a member of a healthcare trade union – empaths by default, as we use collective action to stop the exploitation of workers who have no voice. To be a union member is to be part of an empathic collective. And that is something we need more of in the world.

Linda Starr

An expert in the field of nursing and the law Associate Professor Linda Starr is in the School of Nursing and Midwifery at Flinders University in South Australia

Restrictive practice – a change in name only

Amendments to the *Aged Care Act 1997 (Cth)* have changed reference from a restraint to a restrictive practice which is any action that restricts the rights or freedom of movement of a care recipient (s 54-9).

Whilst the Act refers to five forms of restrictive practice, physical, environmental, chemical, mechanical and seclusion; it is also important to remember that a psychological restraint can be just as harmful.

Regardless of the term used, employing restrictive practices is still considered to be a potential breach of human and legal rights and should only be used in exceptional circumstances to avoid causing harm to the individual or others. It is also important to ensure that the measures taken are proportionate to the conduct and are in place for the minimal amount of time needed.

There is no doubt that some clients exhibit challenging behaviours that need to be managed for their own safety and that of those around them, including staff. In fact, it is important in cases where there is known potential for a resident/patient to assault another that the risk of harm is assessed, adequately managed and well documented. Unfortunately, there have been a number of cases where resident on resident assault has resulted in a vulnerable resident being harmed or even killed (Inquest into the Death of Mavis Baum (2018) SA; Inquest into the Death of Graham Rollbusch (2017) SA; Non-Inquest findings into the Death of Betty Christine Quayle (2019) QLD).

A common theme in these cases was the knowledge that the assailant had a history of aggressive/violent behaviour and was sharing accommodation with vulnerable people. These deaths could have been prevented if sufficient measures had been in place to protect each victim. In the latter case, the coroner noted that whilst there were a number of strategies focused on managing the assailant's behaviour, there were no evident strategies focused on the safety of other residents. This serves as a reminder that whilst behaviour management plans and de-escalation plans should rightly focus on the needs of the resident displaying challenging behaviour, there is a wider duty to consider – to those sharing the environment, determining who is most vulnerable and at risk of harm.

Providing the right environment for those displaying severe physical aggression and violence can be difficult when there are finite resources and specialists available to provide for their special needs.

This was noted in the Inquest into the Death of Raymond Beahl (2021) SA, where a specialist geriatrician determined that Mr Beahl received poor quality of care in the last phase of his life where he was frequently restrained to manage his challenging behaviour during both hospital and nursing home admissions even though this was in accordance with policy and understandable from a staff safety point of view.

Nonetheless, the restraints were regarded as being inappropriate as was the environment, concluding that Mr Beahl needed one on one specialised care for his behaviour and palliative care needs.

This highlights the difficult position clinical staff face when dealing with a client with specialised needs, balancing their rights to quality safe care and freedom of movement with the care and safety needs of those around them and the need for the expansion of these services.

Furthermore, it reinforces the need to have sound documentation around the use of restrictive practices, including the rationale and consent for implementing restraint and evidence of adhering to policy requirements in caring for the client during this time, to support the clinical decision making.

Whilst these cases focus on the aged care sector, the principles apply across all areas of health. As there is no uniform approach to the legal regulation of restrictive practices in health settings across the jurisdictions outside of mental health, the disability sector and aged care, clinicians must rely on a range of policy-based frameworks, directives, statements and regulatory codes to guide this practice in general healthcare settings. It is important to be familiar with these and ensure they reflect current best practice to avoid infringing the client's common law right to freedom whilst maintaining a safe environment for all who use it.

Nursing and the law: In conversation with Linda Starr

Nurse academic Linda Starr has always been intrigued by crime. She likens her longstanding research into nursing and the law to reading a good thriller where you sit back and wait to see how the story unfolds.

By Robert Fedele

Associate Professor in the School of Nursing and Midwifery at Flinders University in South Australia, Linda says nursing and the law are inextricably linked.

"The law underpins everything that we [nurses] do," she explains.

"Even saying that we're a registered or enrolled nurse or midwife is governed by a law that says if you meet certain criteria, and become registered with the NMBA you are entitled to call yourself a nurse or midwife. So, even our title is regulated, which demonstrates how pervasive the law is without us thinking every day that when we get up and go to work, that we're actually operating under a law just by doing that."

The *ANMJ*'s resident expert in the field of nursing and the law, Linda has written columns for the journal, exploring topical and important issues, for more than a decade.

"I'm always looking to find a case or an issue related to practice in newspapers, court or tribunal reports, or through tracking amendments in relevant legislation that I think is important and relevant to as many health practitioners as possible," she reveals.

"It doesn't have to be nursing or midwifery focused, because the critical incident and principles of practice are likely to be relevant to nurses and midwives even if it involved another health professional."

"I hope that when nurses and midwives read the column they reflect on what they do, or what happens in their workplace, and either recognise where self or workplace practice could be improved or be satisfied that they are operating at a satisfactory level," she adds.

"Hopefully it will reinforce the value of CPD and keeping up to date with what is safe practice."

Hailing from South Australia, Linda became a nurse in the early 1970s and enjoyed working in many clinical areas in country and metropolitan hospitals. A decade later, she had the opportunity to move into education at the North West Nurse Education Centre in Whyalla.

Linda was fortunate that her colleagues were not keen on teaching law and she willingly took up the challenge and became hooked, going on to study law to boost her knowledge.

"I could see a link to health and nursing in nearly every topic in the law degree because it's about people, people's rights and advocacy, learning how to work through a framework, in this case a legal framework, of how what we do impacts on other people and how this framework guides us to prevent negative impacts on people, and promote wellbeing."

These days, Linda works mostly as a nurse academic and a health law and ethics education consultant designing seminars to meet specific practitioner and workplace needs.

Common areas of interest are communication (documentation, confidentiality, social media) practice issues (medication management, restrictive practices, duty of care, consent and end of life issues) and conduct issues (bullying, harassment, professional boundaries, supervision and delegation). Communication is one topic Linda says regularly features in coroner's court findings and tribunal reports.

"Whilst communication can reflect one's duty and obligation in regards to meeting professional and employment standards in keeping good records, it can also reflect the standard of care that you've given," explains Linda.

"Documentation is such a fundamental part of what we do and there is so much written about what happens if it's not done correctly, yet, we just don't seem to learn the lessons here. Many coroner's cases that I've looked at have some comment about the poor standards of documentation and communication that has in some way contributed to the adverse outcomes of care. Flaws in this area range from poor detail to absent records, fraudulent entries, poor or absent photo documentation, and poor management of electronic records."

After delving into nursing and the law for decades, little surprises Linda. However, cases such as those involving professional boundaries, concern her.

"The number of boundary violation cases continues to rise across the professions which is a concern given the education we have around crossing this line knowing the potential harm to the patient and to the reputation of the profession."

Writing about health practitioners who have breached professional boundaries or failed to meet professional standards in some way can leave an impression that nurses and midwives make the news for doing the wrong thing. While in the minority, Linda believes these cases should be identified and openly discussed.

"If we're not exposed to these issues, we're missing opportunities to learn cues to identify at-risk situations." Linda argues.

"It's very easy, as human beings to explain away poor performance, or bad behaviour, or think I couldn't possibly have seen or heard that, because we're always looking for the good in people. However, failing to identify and manage poor behaviour does not help the practitioner and increases the risk of adverse outcomes of care."

Crime has always intrigued Linda; in the early 1990s, she spent three months touring the United States looking at forensic nursing. She explored forensic nurses working as coroners, sexual assault nurse examiners, in death investigation, legal nurse consultants and those working with the forensic medical examiner where nurses have skills in identifying and collecting evidence to support the criminal justice system.

"Having a forensic focus never replaces your role as a nurse, where your primary purpose is caring for the individual, however, healthcare professionals are often the first to meet the client, giving them the opportunity to identify and preserve evidence that would otherwise be lost."

When Linda returned to Australia, she began promoting and advocating for forensic nursing.

Flinders University then supported her to develop the first graduate certificate courses in forensic and correctional nursing in Australia.

Linda says forensic nurses in Australia primarily work as sexual assault nurse examiners and in corrections, noting that the recognition and development of the discipline has been slow but progressive.

"It's not a mainstream area even though I would love to see it be. We've got some very dedicated forensic nurses across Australia who are very active and committed, working really hard at pioneering their own roles in forensic nursing."

When Linda conducts a seminar on nursing and the law, she likes to remind people that whilst they're going to look at many cases highlighting poor behaviour the reality is that every day, there are thousands of interventions performed by dedicated and competent practitioners that make a positive impact on patient outcomes across the country.

Ultimately, Linda considers professional codes and standards the benchmark for guiding nurses and midwives when it comes to doing the right thing.

"The best thing for nurses and midwives to do is to be familiar with your workplace policy and your professional codes and standards because that really is the framework that helps to set the expected standard of practice," she says.

"I think we underestimate the importance of these documents and how they provide practitioners with a framework to guide their practice and give them the confidence and authority to do the work that they do."

Importance of connecting researchers, women and clinicians in a longitudinal study

By M. Culhane, E. Emmanuel, C. Aggar, C Harris, S. Jedrisko, M. Johnson, J. Felsch and S. Cooper

The novelty of research is the collaborations that takes place, its impact, and processes that occur at the local level.

It bridges a wide spectrum of individuals in an interactive space involving a diverse group of people who want to share their information. This reflection relates to a longitudinal study investigating screening rates and health outcomes for women in a regional NSW health district.

The objective is to investigate if antenatal clinical factors predict adherence with glucose screening and postpartum conversion rates of Gestational Diabetes Mellitus 1 (GDM1) to Type 2 Diabetes Mellitus (T2DM).[1]

Postpartum women will be followed at three, 18 and 36 months post-delivery. A good reason to follow up, as motherhood is a busy time in a woman's life.

For researchers, this is exciting and an amazing experience to talk to women, but also a nervous time as the project unfolds. As one of the researchers noted:

> *The best thing for me was being able to speak with the women and discover their story, their journey, and their valuable insights on how well our systems are working and what we could do to improve. This encouraged me and together with the clinical midwifery consultant for clinician engagement across the Local Health District to improve service delivery.*

However, there are always some difficulties that one can encounter. Nonetheless, the researcher stated, 'I have put this against lessons learned'. Some difficulties included finding dedicated time to contact participants; time management in an environment where the caring workload is of priority; and collecting data from women during the busiest and most tiring time of new motherhood. Another problem involved finding the right program for data entry. Nonetheless, these challenges increased engagement amongst the researchers. As suggested by Ciemins et al.,[2] such involvement fulfils an intellectual curiosity as well as meeting the need to contribute toward clinical evidence. When clinicians become key stakeholders in the research process, investment and benefits for the individual, health system and population increase.[3]

An added threat to the project was external environmental factors such as the COVID Pandemic, followed by bushfires and floods in the region. The researcher noted:

> *I was nervous about contacting women for the first questionnaire, which was at the beginning of the covid pandemic. I became reassured as I rang more women, as most were very willing to participate. And then the nerves returned when the bushfires hit us, followed by the severe flooding. What more could go wrong!*

Despite this, the midwives in the local health district rallied together to support the research project and its progress. Communications through consistent messages and updates kept the researchers' spirits up. Collectively, efforts to keep going stimulated further interest and awareness, which would lead to health gain for women and the health service. As identified by Chan et al.,[4] diabetes can be silent and progressive. Therefore identifying subgroups at risk for diabetes and its complications reduces the growing health burden for women diagnosed with GDM.

There are similar research projects nationally. However, the concern for this research team is to ensure that evidence-based guidelines be updated to ensure that pathways are user-friendly for clinicians and childbearing women. The easier it is for the women to have oral glucose tolerance tests (OGTT) postpartum, the more likely the uptake will be. What is important is to ensure that women with GDM clearly understand the need to adopt a lifestyle program to limit the risk of developing type 2 diabetes in the future.

The project protocol was presented at the local health district symposium in 2019, where an award for Excellence in Nursing and Midwifery Research was received. To date, 236 surveys have been disseminated, and 54 (22.9%) responses received. Of these respondents, 96% of the women received instruction to have a postpartum OGTT. However, slightly over half (57%) of the women reported having an OGTT following childbirth. Women's overall general health showed a significant positive association with the likelihood of meeting physical activity and dietary guidelines. There was also a significant negative correlation between BMI and poorer general health. Of most concern, data show only 28% of women were in the healthy rate range, with most women "overweight" or "obese" (68%), and 83.8% of women who were overweight or obese rated their overall health as good to very good.

Early days yet to confirm major findings! However, results show an opportunity to implement health promotion activities to prevent T2DM and related complications and to have some impact on women's health in the local health district. As practitioners in research, we also need to not only reflect on the actual active research process but also on the meanings we gain (such as in research, connections and women) that help construct and reconstruct our practice.

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Time for primary healthcare transformation

Australian primary and preventive healthcare need immediate action to reduce risk and burden of disease from both chronic conditions and other causes, including infectious disease outbreaks.

Around half of all Australians live with one or more chronic conditions. Around 20% have two or more. Chronic conditions contribute approximately 60% to the national burden of disease, around 40% of hospitalisations, and almost 90% of deaths.

With COVID-19 becoming an inescapable fact of life, almost every sector and policy within and beyond healthcare has been affected by the pandemic. In many cases, COVID-19 has had a disastrous impact. However, even extremely dark clouds can have silver linings. Amid tragedy come important opportunities to learn from experience and prepare for the future. COVID-19 has shown us how unprepared Australia (and the world) was to deal with a global pandemic without considerable loss of life and widespread health and wellbeing impacts. There is no time to waste in putting our new knowledge and pre-existing evidence to work to build a strong, resilient healthcare system that prevents similar disasters from occurring again.

While advocating for a stronger national focus on addressing chronic conditions is not revolutionary, with a new Federal Government that is already demonstrating a genuine desire and commitment to working with experts, clinicians, and health workforce representatives, there exists an opportunity to put in place the necessary policy, legislative, and practical reforms to better place Australians to be healthier for longer and avoid or reduce the impact of chronic ill health. With proper targeting, the benefits of improving our preventive and primary health sector would also be felt the most by many of our most vulnerable community members, so it would go far in terms of closing the gap between First Nations people and other groups with health and wellbeing disadvantages and 'mainstream' Australians.

With the development of many chronic conditions occurring before birth and influenced by genetics, parental factors such as diet and behaviour, addressing chronic illnesses must occur across the entire life course.

Nurses and midwives are ideally placed at the forefront of efforts to tackle the challenges of responding to chronic conditions in every setting. Preventing and mitigating the severity and impacts of chronic illness and thus reducing the potential for chronic disease to put people in greater danger of other risks such as infectious diseases and mental ill-health should be a key priority for governments and the community more broadly. Investing in the workforce and sectors that influence and support community health and wellbeing is therefore fundamental and more urgent than ever. Proactive reforms that pave the way for a community that is better able to avoid developing chronic conditions and diminish the severity of existing conditions should necessarily include significant investment and engagement with the nursing and midwifery workforce. Working to their full scope of practice, nurses and midwives in primary healthcare can and do offer effective and feasible chronic disease prevention, care, and treatments. Nurse practitioners are also heavily underutilised in Australian preventive and primary healthcare as advance practice nurses who provide additional expertise and access to prescriptions, assessments, treatments, and referrals to specialists.

The ANMF continues to be vocal and active in our support for enhancing the Australian primary health sector and advocating for nurses and midwives to play a central role in the sector's future. We see priorities to be facilitating the utilisation of nurses' and midwives' full scope of practice, growing the workforce in terms of ensuring a sufficient number of qualified nurses, nurse practitioners, and midwives, supporting and sustaining nurse and midwife models of care, and addressing the readiness of workplaces in primary health to employ and support nurses and midwives with suitable workplace conditions, recognition, and remuneration.

We know that chronic conditions put people at higher risk of experiencing severe COVID-19 and worse outcomes, and we know that this pandemic and future infectious disease outbreaks pose serious risks in the future. Recent reports show that around three-quarters of Australians that have died of COVID-19 also had pre-existing chronic conditions. We know that the risk of infectious disease outbreaks is increasing, amplified by climate change and human impacts on the environment. We also have unprecedented knowledge of the aetiology and treatment of chronic conditions. Combing our knowledge of effective approaches to prevent and treat chronic disease with our understanding of infectious disease outbreaks and the need to enhance our public health and primary healthcare capacity, there should be no delay in enacting change that protects the community now and in the future.

Kristen Wischer

Senior Federal Industrial Officer

New Parliament's first piece of legislation

Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022

It is fitting that the first piece of legislation passed by the newly convened 47th Parliament of Australia initiated the start of long-overdue aged care reform.

The new legislation implements several key recommendations from the Royal Commission into Aged Care Quality and Safety. While a great deal is still to be done, including introducing more legislation to establish the details of how the reforms will operate, this legislation establishes the framework and authority for further reform.

The legislation, passed on 2 August 2022, provides for amendments to the Aged Care Act 1997 which will enable the following reforms:

ACFI to AN-ACC: Funding for residential aged care via the Aged Care Funding Instrument (ACFI) will be replaced by the new funding model, the Australian National Aged Care Classification (AN-ACC), from 1 October 2022. The new model will change how funding is calculated and reflect the independent assessment and classification of each resident according to care needs.

Star Rating system: The Department of Health and Aged Care will be required to publish information about the new Star Rating system, which will allow members of the public to see how residential aged care facilities are rated. The publication of Star Ratings will be based on measurable indicators of quality and available data. It is intended to assist older Australians and their families to make meaningful comparisons of quality and safety between residential services and approved service providers.

Code of conduct and banning orders: The Aged Care Act will require compliance with a Code of Conduct by approved providers and their aged care workers, including all personal care workers and governing persons. The Quality and Safety Commission will be given powers to take action concerning compliance with the Code. The Commission will be able to take enforcement action for substantiated breaches, including making 'banning orders'. These orders could, for example, result in an aged care worker being restricted or not allowed to work in aged care for a period of time if found to have breached the Code.

Extension of incident management and reporting: The Serious Incident Response Scheme (SIRS) will be extended to cover not only incidents in residential aged care but also home care and flexible care delivered in a home or community setting from 1 December 2022.

Governance of approved providers: From 1 December 2022, approved providers will be required to meet new governance responsibilities in relationship to the membership of their governing bodies as well as measures to improve leadership and culture.

Information sharing: This amendment provides for greater information sharing between Commonwealth bodies across aged care, disability and veterans' affairs sectors. It also allows information sharing concerning non-compliance with the Code.

Refundable deposits and accommodation bonds: Creates stricter reporting and accountability on the use of accommodation bonds.

Independent health and aged care pricing authority: The Hospital Pricing Authority will be expanded to include aged care pricing. The authority will have power to provide advice on aged care pricing and costing matters.

Restrictive practices: Interim measures will be introduced concerning who can provide consent where a care recipient does not have the capacity to consent. These changes are intended to address inconsistencies between federal law and state and territory laws.

What do the changes mean for aged care?

The ANMF broadly supports each of the above changes to the Aged Care Act, particularly as they reflect recommendations of the Royal Commission. Nevertheless, the devil will be in the detail and how the changes are implemented. Particular matters to consider will be the smooth transition to the AN-ACC funding model in a short timeframe. The development of the Code of Conduct will be of strong interest, and it will be important to ensure any banning orders are supported with procedural fairness. The expansion of SIRS to home and community aged care settings will need training and resources to allow all participants to understand their obligations.

Much of this change sits in the context of other aged care reforms, and the work ahead for the ANMF will ensure the detail achieves the right outcomes for older people and is fair for members. We are looking forward to working to address long outstanding issues and moving the aged care reform agenda along.

Naomi Riley

Federal Professional Officer

Midwives under pressure

Midwives are facing significant issues with staffing across Australia. ANMF Branches have reported unmanageable workloads in postnatal wards, poor staffing skill mix, midwives being replaced with other health practitioners, burnout, decreasing job satisfaction, moral injury and vicarious trauma.

There are concerns these issues are resulting in increased intrapartum intervention, insufficient and fragmented postnatal care and suboptimal short and long term outcomes for the health and wellbeing of families. With decreasing hospital lengths of stay, particularly for uncomplicated presentations, women, babies and families are missing out on essential midwifery care. Midwives are having to rely on providing the bare minimum, interventionist and procedural aspects of care to avoid serious adverse events and outcomes. The holistic, woman-centred aspects of midwifery care are being lost to the high pressured, fragmented and short staffed environment. To rectify this situation, action is needed.

We need to enable midwives to get back to being midwives. Working together we must ensure that midwives are the ones providing care in midwifery contexts of practice; the workload of caring for newborns is recognised in postnatal ward midwifery staffing; students and new graduate midwives are supported by midwives; and there is midwifery leadership at all levels within organisations providing maternity services and at all levels of government.

The *Count the Babies* campaign is an example of our collective effort to improve maternity services and midwifery practice environments led by midwives.

All neonates born in hospital are admitted patients. However, they are not counted as patients in midwifery allocations (where midwife to patient ratios/ frameworks exist). Midwives are allocated a workload based on the adult/mother in-patient numbers.

Newborns are further classified as unqualified or qualified for national based funding purposes. Qualified newborns are those that are nine days old or less and are:

- the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care; or,
- admitted to, or remain in hospital without their mother.

Newborns who do not meet these criteria, regardless of the interventions or treatments they require (such as blood glucose monitoring, intravenous antibiotics and phototherapy treatment), are classified as unqualified. Unqualified newborns are not considered in scope for admitted patient data collections or activity based funding. The additional care provided by midwives beyond routine neonatal care for unqualified newborns is invisible despite often requiring considerable time and resources. The funding of unqualified newborns is bundled with the mother and allocated a one size fits all pricing.

In July 2022, several ANMF Branches conducted an audit of neonates in postnatal wards as part of the *Count the Babies* campaign. Instigated by the QNMU, the campaign aims to raise awareness of, and lobby for, additional funding for midwives to care for women and neonates in postnatal wards with increasingly complex needs.

The campaign highlights the currently invisible workload of caring for unqualified newborns and the impacts of this on unsafe, unmanageable and unsustainable working conditions for midwives. It is a call to governments to protect women, babies and the midwifery workforce. By revising the funding methodology for unqualified newborns at a national level, state and territory governments will be supported to amend midwifery staffing to include newborns in patient allocations. In doing so, safer and higher quality midwifery care can be delivered to women and their families, and the midwifery workforce can be sustained and fostered.

The campaign is one action we're taking with your help.

What else can you do? Report midwifery staffing shortfalls in your workplace via incident reporting mechanisms; review the NMBA Decision Making Framework and your obligations for working alongside practitioners who are not midwives; and support your state or territory Branch in activities to address midwifery workforce and practice environment challenges such as the campaign audit.

WOUND CARE, DIABETES, CARDIAC CARE & RESPIRATORY CARE


Credit: University of Tasmania image library

Translating positive first-year student nurses' pressure injury prevention attitudes into knowledge and action

By Carey Mather and Sarah Prior

A three-year intervention study of first year undergraduate nursing students found additional online and simulation resources improved pressure injury prevention attitude scores, however, knowledge scores remained low. [1]

Findings from this study provide opportunities to invigorate the undergraduate wound management curriculum by focussing on assessment, aetiology, mechanical or shear prevention, risk management, and wound care management.

During 2016–2018, on completion of their wound care learning, first-year nursing students were invited to complete a previously validated questionnaire about their knowledge and attitudes about pressure injury prevention.[2-3]

Students in the 2016 cohort were part of a national study[4] and considered the baseline cohort. Additional online educational resources were provided in 2017,[5] with further simulation activities delivered to support learning during 2018. Comparison across the cohorts found that although demographic variables were similar, knowledge scores remained low. Attitude scores across the years improved, so there are opportunities to engage and better prepare students on campus before going on professional experience placements. The quandary is how to harness this high attitude and translate positive intention into improved knowledge and action in practice.

Risk assessment and management of pressure injury prevention need to be overtly included within an already overcrowded curriculum. Decision-making during educational preparation regarding when, what and how to include reinforcement of pressure injury prevention needs discussion. Inclusion of the consequences of pressure injury in case studies or scenarios could scaffold learning about the potential for added complexity of care if pressure injuries develop.

Clinical facilitators and preceptors also have an opportunity to augment student understanding by supporting students to link risk assessment for pressure injury more overtly into the assessment of patients, clients, or consumers. Learning about negative health outcomes and the financial burden of pressure injury may also improve understanding of the importance of vigilance in preventing pressure injuries.[6-7]

Translating student attitude into higher levels of knowledge and action in practice is a challenge that needs to be embraced both on and off campus to assist students in becoming educationally prepared at graduation.

Authors

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National Diabetes Week 2022 in the School of Nursing at QUT

By Sandra Johnston, Christina Parker, Karen Theobald and Ibi Patane

"Diabetes is the epidemic of the 21ST century and the biggest challenge confronting Australia's health system".[1]

There is strong international evidence indicating diabetes prevention programs can help prevent up to 58% of type 2 diabetes mellitus cases.[1]

The Queensland University of Technology (QUT) third-year undergraduate nursing students and academic staff eagerly took up the challenge of confronting diabetes prevention during national Diabetes Week 2022. The team offered a fully subsidised service for QUT staff and higher degree research (HDR) students. The program consultations were delivered on the two QUT campuses (Gardens Points and Kelvin Grove) to allow ease of access for those who engaged. The program ran across three days, operating from 9am to 4.30pm daily, providing 22.5 hours of community service.

The fifteen (15) minute consultations were conducted by QUT nursing students who worked in pairs and who were fully supervised by a Registered Nurse. Diabetes prevention screening included biometric assessments (blood pressures, blood glucose levels, waist girth measurement) and the use of the validated Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK) to assess and document the risk of developing Diabetes Type 2.[2]

The completed individualised assessment was provided to each participant at the end of the session. Nursing students explained the results of the AUSDRISK screening and information on how to follow up if the result was of concern. Any attendee whose AUSDRISK score indicated risk was recommended to follow up with their GP.

Over the three days, 150 people attended the clinic, and 89 (59%) completed service evaluations. Attendees were asked to indicate their reason for attendance, level of satisfaction and likelihood of recommending service to others.

Most attendees (58%) wanted to know their risk factors, 19% had a family history, 11% wanted motivation for a lifestyle change, 8% attended with a colleague for a general check, and 4% had previous gestational diabetes.

QUT nursing students providing risk screening during Diabetes Week.

Satisfaction with the service was high, with 83% indicating they were very satisfied, and 84% were likely to recommend the service to a colleague. Students also benefitted from this experience and demonstrated clinical performance in a primary care capacity aligned with ANMAC standards of practice.

In summary, the data collected about the diabetes prevention screening program indicates a very high level of satisfaction with the service. There was clear interest noted to recommend the program to a colleague and for the future operation of the program.

The 12 students involved in delivering the program benefitted from the opportunity to provide a service in a primary care setting.

We would like to acknowledge the contribution of the QUT nursing students involved in this initiative and the QUT staff who supervised the students.

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Inspired nurse doyens contributing valuable experience to the multidisciplinary team in diabetes research

By Jacqueline Bulbrook and Gaynor Garstone

We are Diabetes Educators currently working together as Clinical Research Coordinators on a long-term industry-supported study of a diabetes injectable medication, while we also continue to work clinically.

We each have over 40 years of nursing experience under our belts. Neither of us had previously seen ourselves working away from acute care, especially not online or in research.

Gaynor comes from a background in WA rural health and NT remote healthcare. It was after working on Torres Strait Island, which gave her insight into how diabetes touches lives, that she undertook Diabetes Educator training.

Jacqui's background in acute health left her wanting to change the focus from fixing things when they go terribly wrong, to helping to prevent them.

The study we are involved in is an international Phase III double-blinded Clinical Trial comparing cardiovascular outcomes of two injectable weekly diabetes medications on patients with diabetes. We started our roles in early 2020 and participant recruitment is now complete. The trial continued despite Covid-19, as all clients involved in the study are currently on maintenance doses and are required to have uninterrupted medication regimes.

Jacqueline Bulbrook (left) and Gaynor Garstone (right)

While we fell into the world of research by accident, we have found it immensely satisfying. The long-term relationships we have developed with our trial patients have deepened our understanding of their day-to-day challenges. We are privileged to see a much broader view of their struggles and grasp a richer appreciation of the role their home and social circumstances play in their ability to manage a chronic and debilitating condition.

Nurses bring many skills to the role of a Clinical Research Coordinator. We are used to working with multidisciplinary health teams but working on this large trial has taken our collaboration skills to a higher level. We collaborate with medical officers, industry monitors, research ethics and governance personnel regularly. There needs to be a high level of respect for the knowledge and expertise of all people involved in clinical trials. As Clinical Research Coordinators, we combine our extensive nursing knowledge with a person-centred approach to walk with and guide patients participating in the trial.

This study also requires us to work digitally and use telehealth. The associated challenges have stretched our brains and, regularly, our patience. However, we both feel that in overcoming our initial hesitancy, we have developed great pride in our new skills. You can teach old dogs new tricks, and we are now fairly certain that if we were one person, we would be next to brilliant! Being of the same vintage and similar build and colouring, our patients often have difficulty deciding which of us is which.

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Routine screening for type 1 diabetes in newborns and young children: The Australian type 1 diabetes national screening pilot

By Kara Mikler, Maria E Craig, Kruthika Narayan, Amanda Henry and Kirstine Bell

Type 1 diabetes often develops in childhood following autoimmune destruction of the cells that produce insulin, the hormone that regulates blood glucose levels.

Three Australian children are diagnosed daily and at least one in three are diagnosed late, presenting with life-threatening diabetic ketoacidosis (DKA) requiring emergency medical care.

DKA is traumatic and results in complications such as cognitive impairment and is associated with severe diabetes complications from early adulthood, such as blindness and kidney failure.[1-3]

A simple, quick and safe screening test could virtually eliminate this risk of DKA at diagnosis, with international studies showing DKA presentations below 5% with screening and follow-up.

Type 1 diabetes was long thought to appear rapidly with little or no warning. However, this traditional symptomatic diagnosis point is now considered Stage 3 type 1 diabetes. Formal recognition of two silent, pre-symptomatic stages (Stage 1 and 2) that can be present for months or years prior to symptom-onset[4] makes screening for early stages of the condition possible.

However, 90% of children with type 1 diabetes don't have a family history, so the majority will only be identified through population-wide screening. Countries such as Germany, the UK, Scandinavia and USA are now looking towards population screening as part of routine healthcare.[5]

The Type 1 Diabetes National Screening Pilot,[4,5] is part of the vision of a new national screening program for type 1 diabetes for all Australian children. The pilot seeks to establish how screening should be offered in Australia by comparing three different screening strategies. Each method is based

on international evidence and is safe, simple and clinically effective. Screening is being provided to newborns to assess genetic risk via a heel prick dried bloodspot (Model 1).

Genetic screening will also be offered as a saliva swab to children aged 6-12 months via an at-home test kit (Model 2). Islet autoantibody screening test via an at-home fingerprick dried bloodspot test kit will be offered to children ages 2, 6 and 10 years (Model 3).

Children with early-stage type 1 diabetes from any screening model will be referred to a paediatric endocrinologist for ongoing care and monitoring.

The research is being led by the University of Sydney and is funded by JDRF, with a national team of researchers including endocrinologists, obstetricians, neonatologists, credentialled diabetes educators, midwives, genetic counsellors, GPs and pharmacists. Results are expected to be released in late 2024.[4]

In the meantime, all healthcare professionals and the wider community must be aware of the four common symptoms of type 1 diabetes associated with Stages 3/4. These symptoms include increased thirst, increased urination, fatigue and weight loss. If a person, especially a child, develops these symptoms, a fingerprick blood glucose check needs to be organised as soon as possible. Identifying type 1 diabetes at Stages 1 and 2 via general population screening offers an opportunity to significantly reduce the risk of a child presenting with potentially life-threatening Diabetic Ketoacidosis (DKA), associated with poor immediate and longer-term health outcomes.[3-5]

Authors

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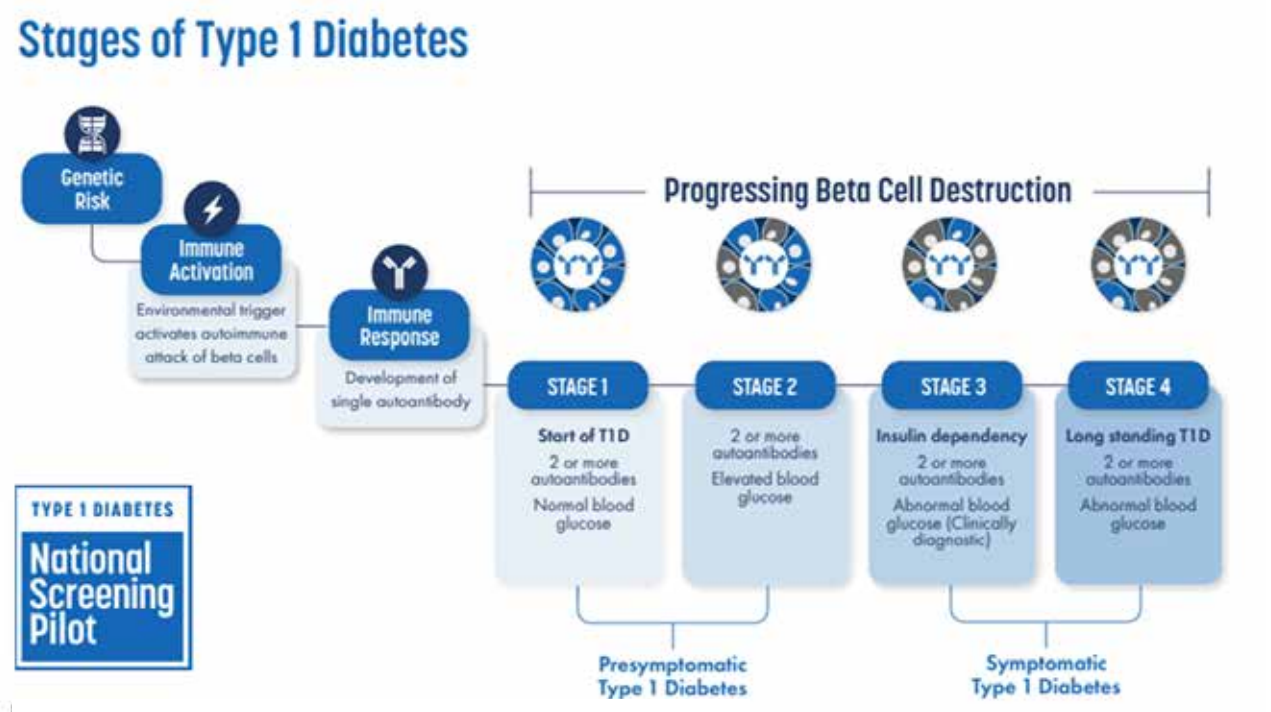


New staging classification system for type 1 diabetes[4]. Adapted from Greenbaum et al. 2018

Developmental rounds for paediatric cardiac patients

By Eun Ju (Jenny) Kim and Felicity Donaldson

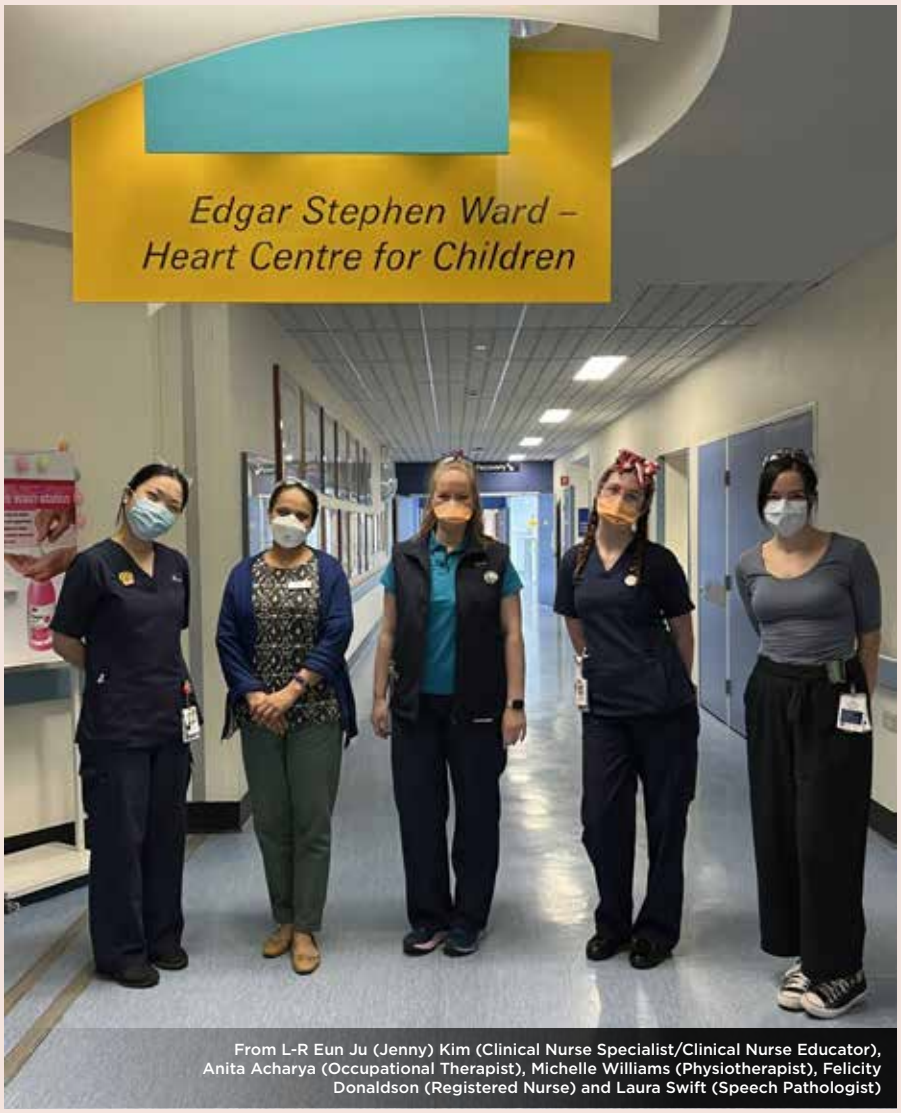
Neurodevelopmental disability is the most common complication for infants with congenital heart disease that can persist throughout adolescence and adulthood.[1]

This finding is consistently observed in the paediatric cardiac patient cohort on Edgar Stephen Ward (ESW) at The Children's Hospital at Westmead, Sydney Children's Hospitals Network.

Developmental care refers to a wide range of individualised interventions that aims to reduce the stress experienced by infants and optimise neurologic development.[2]

Implementing such interventions is the main purpose of the developmental rounds on Edgar Stephen Ward that are organised and facilitated weekly by a multidisciplinary team. The developmental team consists of an occupational therapist, a speech pathologist, a physiotherapist and nursing staff.

The developmental rounds were inspired and modelled on the neurodevelopmental rounds conducted at the Grace Centre for Newborn Care (GCNC) at The Children's Hospital at Westmead. Through the collaboration of the developmental team and with the support of the GCNC staff, the developmental rounds commenced on ESW in October 2020.



From L-R Eun Ju (Jenny) Kim (Clinical Nurse Specialist/Clinical Nurse Educator), Anita Acharya (Occupational Therapist), Michelle Williams (Physiotherapist), Felicity Donaldson (Registered Nurse) and Laura Swift (Speech Pathologist)

METHOD

In partnership with the caregivers, the developmental team establishes developmental goals that can be achieved through certain targeted and individualised strategies. These strategies are categorised into three key focus areas: sleep, settling and procedures, and awake.

The current criteria for an infant to be seen on the developmental rounds include infants less than 33 weeks gestation or three months of age, a hospital stay greater than seven days, infants in the at-risk category (infants with pre-existing conditions that predispose them to developmental delay eg. congenital heart defects and genetic syndromes), infants requiring follow up by the GCNC neurodevelopmental rounds, an identified feeding issue or neurological condition and parental and/or staff concerns.

The introduction of developmental rounds on ESW was supported with education for nursing staff in the form of in-services to encourage their participation and involvement. Following the commencement of the developmental rounds, caregiver satisfaction was evaluated via surveys. Moreover, nursing staff were asked to provide feedback on the developmental rounds.

RESULTS

From October 2020 to July 2022, 102 infants with congenital heart defects were seen on the developmental rounds on ESW. A total of 10 caregivers completed the evaluation survey. Out of the 10 respondents, 100% (10 respondents) felt the information provided on the developmental goals was easy to understand, while 80% (eight respondents) agreed that the developmental rounds helped provide information to caregivers.

A caregiver stated, *"We love them. It is good to feel like a team is working together towards our developmental goals, a holistic approach".*

In 2021, the in-services on the developmental rounds were delivered alongside evaluation surveys, whereby 13 nursing staff completed the pre- and post-evaluation surveys. For the pre-evaluation survey, 61.5% (eight respondents) rated their understanding of developmental care as good, 30.8% (four respondents) ranked their understanding of developmental care as average, and 7.7% (one respondent) rated their understanding of developmental care as poor. For the post-evaluation survey, 76.9% (10 respondents) rated their understanding of developmental care as good, and 23.1% (three respondents) rated their understanding of developmental care as excellent. When asked to rate how often they found the information from

the developmental rounds useful to their nursing practice, 80.8% (21 respondents) felt it was always useful, 7.7% (two respondents) thought it was mostly useful, and 7.7% (two respondents) felt it was sometimes useful.

The nursing staff found the collaboration of the multidisciplinary team helpful, stating, *"It is great to see the multidisciplinary team come together and provide suggestions to make our babies and parents stay as comfortable as possible"*. The nursing staff have also seen an improvement in nursing practice and knowledge surrounding developmental care, stating, *"Developmental rounds are super impactful and important for nurses and parents alike. Developmental rounds have changed ward culture on safe sleep practices and provided standard care amongst all patients. It helps us remember developmental growth but also gives us tips on settling"*.

CONCLUSION

Over the next several months, we will continue to collect caregiver feedback to evaluate and improve the developmental rounds and to develop resources for caregivers. Overall, the developmental rounds on ESW have proven beneficial for patients, caregivers and staff. The information provided on the developmental rounds is easy to understand and helpful in guiding and empowering caregivers to support their baby's developmental needs. Moreover, the developmental rounds contribute to better nursing practice and awareness of developmental care vital to improving developmental outcomes for paediatric cardiac patients.

Authors

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Calls to ease the diabetes mental health epidemic

Almost 700,000 people living with diabetes experience a mental or emotional health challenge every year, according to the latest data from Diabetes Australia.

Diabetes Australia Group CEO Justine Cain says diabetes mental health challenges are the most prevalent, yet least recognised diabetes complication.

"Concerningly, the latest figures show that about 400,000 people living with diabetes report difficulties accessing mental healthcare. That's a lot of people who aren't getting the help and support they need," she said.

The new data has prompted Diabetes Australia to launch its new *Let's Rethink Diabetes* campaign as part of National Diabetes Week in July this year.

Ms Cain said there is an urgent need for change to both community attitudes and the way Australia's health system delivers diabetes mental health support.

"Diabetes mental health challenges are widespread, but they are rarely discussed as part of routine diabetes care. They really are a silent diabetes complication,' Ms Cain said.

"We want people to know that diabetes mental health challenges are real and encourage people with diabetes and their healthcare professionals to explore options for mental healthcare."

Ms Cain called on all Australians to rethink how they think about diabetes.

"More than 1.1 million Australians report being blamed or shamed for living with diabetes and more than 360,000 say this impacts their ability to live well with the condition," she said.

"Nobody chooses diabetes and nobody should be blamed or shamed for living with it."

Ms Cain said there was no silver bullet but there were some key areas of action that could significantly improve outcomes for people with diabetes.

- Better awareness of diabetes mental health issues like diabetes distress and burnout;
- Putting mental health support at the centre of diabetes healthcare; and
- Calling out diabetes-related stigma wherever it happens.

Leading GP Dr Gary Deed, who specifically is involved in providing healthcare to people living with diabetes, said he was seeing more people with diabetes experiencing mental and emotional health challenges.

"Living with diabetes can be complex and unrelenting. That daily management, on top of the worry about long-term diabetes-related complications, can become a real burden," Dr Deed said.

"It's important that health professionals understand the reality of living with diabetes and I'd encourage people working in the field to undertake relevant training to support all people with diabetes."

Sebastian Harris, 19, whose younger brother was diagnosed with type 1 diabetes three years before him, says the constant management of his condition can be overwhelming.

"I sometimes feel that no matter what I do, my diabetes can be extremely hard to control.

"Some weeks my blood glucose levels can be unreasonably low or unreasonably high and it doesn't make any sense, no matter what you do.

"It makes me question whether I am managing it well. I know in the long run it will be fine but, in that moment, it's hard not to feel defeated.

"You want to switch off and forget about it, but you can't do that with diabetes. There's no holiday from it.

"The consequences if you do try to ignore it can be life-threatening. We need to make sure people are aware of the issues, both physical and mental," he said.

Discovering the heart

By Eun Ju (Jenny) Kim, Monique Dixon and Hayley Bergin

Discovering the Heart is a one-day workshop focusing on caring for infants and children with congenital or acquired heart disease.

The workshop has been running annually for over a decade. It explores congenital heart defects, acquired heart conditions, heart failure, an introduction to cardiac surgery, complications of cardiac surgery, cardiac catheterisation, electrocardiograms, and arrhythmias.

METHOD

Discovering the Heart is organised and facilitated by the Clinical Nurse Educators from Edgar Stephen Ward, the cardiac inpatients' ward at The Children's Hospital at Westmead, Sydney Children's Hospitals Network. The topics are presented by a diverse range of healthcare professionals within SCHN, including Registered Nurses, Clinical Nurse Specialists, Clinical Nurse Consultants, Nurse Unit Managers, Cardiology Fellows, and Cardiologists.

Discovering the Heart is aimed toward nursing and allied health staff interested in or involved in caring for paediatric cardiac patients. The virtual platform has enabled health professionals both within and outside of the SCHN to attend the workshop, including staff from Central Coast Local Health District (LHD), Far West LHD, Hunter New England LHD, Illawarra Shoalhaven LHD, Mid North Coast LHD, Murrumbidgee LHD, Nepean Blue Mountains LHD, Northern Sydney LHD, South Eastern Sydney LHD, South Western Sydney LHD, Southern New South Wales LHD, Sydney LHD, and Western Sydney LHD.

Due to COVID-19, *Discovering the Heart* was offered virtually for the first time in 2021, whereby a total of 50 staff internal and external to SCHN attended the workshop. In 2022, the workshop was offered face-to-face for internal staff and virtually for external staff, whereby a total of 71 staff attended.

RESULTS

An online evaluation survey was conducted at the end of the workshop using the Quality Audit Reporting System (QARS).

In 2021, a total of 46 attendees completed the survey. Out of the 46 respondents, three had previously attended the workshop and 42 had not participated, and one chose not to respond. All 46 respondents felt that the workshop met their learning objectives. When asked to rate the workshop overall, 69.6% (32 respondents) ranked the workshop as excellent, 26.1% (12 respondents) rated the workshop as good, and 4.3% (two respondents) rated the workshop as fair. When asked if the attendees felt more confident in caring for a child with congenital or acquired cardiac disease, 17.4% (eight respondents) felt completely confident, 56.5% (26 respondents) felt fairly confident, 28.3% (13 respondents) felt somewhat confident, and 4.3% (two respondents) felt slightly confident. Moreover, 92.8% (45 respondents) agreed they would recommend the workshop to others.

In 2022, a total of 45 attendees completed the survey. Eight of the 45 respondents had previously attended the workshop, and 37 had not participated. Forty-four respondents, 97.8%, felt that the workshop met their learning objectives. When asked to rate the workshop overall, 55.6% (25 respondents) ranked the workshop as excellent, 35.6% (16 respondents) rated the workshop as good and 8.9% (four respondents) rated the workshop as fair. When asked if the attendees felt more confident in caring for a child with congenital or acquired cardiac disease, 4.4% (two respondents) felt completely confident, 57.8% (26 respondents) felt fairly confident, 28.9% (13 respondents) felt somewhat confident, and 6.7% (3 respondents) felt slightly confident. Moreover, 97.8% (44 respondents) agreed they would recommend the workshop to others.

Some additional feedback we received includes: *"Thank you so much for the opportunity to attend. Fabulous day"; "I enjoyed this workshop and will encourage all my colleagues to attend this workshop when able, and I would love to have the opportunity to attend this workshop again"; "Thank you for a great course and making it available to those outside of SCHN"*; and *"Inspiring study day"*.

CONCLUSION

Through the breakout of COVID-19, the potential of virtual education and training has been recognised. Over the next few years, we hope to continue offering *Discovering the Heart* virtually and face-to-face to reach more LHDs by optimising the use of available technology, such as Zoom and interactive online quiz platforms. Overall, the workshop has demonstrated to be beneficial to equipping nursing and allied health staff with the knowledge and skills to become more confident in providing care to paediatric cardiac patients, which is pivotal to patient and caregiver outcomes and experiences.

Authors

Eun Ju (Jenny) Kim is a Clinical Nurse Specialist/ Clinical Nurse Educator

Monique Dixon is a Clinical Nurse Educator

Hayley Bergin is a Clinical Nurse Educator

(left) From left-to-right Hayley Bergin (Clinical Nurse Educator), Eun Ju (Jenny) Kim (Clinical Nurse Specialist/Clinical Nurse Educator) and Monique Dixon (Clinical Nurse Educator)

(above) Discovering the Heart 2022 (Lorimer Dodds Lecture Theatre, The Children's Hospital at Westmead)

These boots are made for walking: Looking beyond the risk factors for lower limb amputations in patients with diabetes

By Marcelle Ben chmo, Lisa Matricciani, Saravana Kumar and Kristin Graham

Type 2 Diabetes Mellitus (T2DM) is a growing health concern that causes considerable morbidity and mortality.[1,2]

Lower extremity amputations (LEAs) are amongst the most serious and costly complication of T2DM.[1,2] Diabetic foot complications, including peripheral vascular disease, neuropathy and structural foot deformities, account for most LEAs.[1,3] A multidisciplinary approach aimed at early detection and management of diabetes-related foot complications has been shown to reduce amputation rates by 39-56%.[3] Although most diabetes-related LEAs are thought to be largely preventable, the rate of LEAs has risen.[1,2]

In Australia, rates of diabetes-related LEAs are higher than the global average.[1,2] These findings are somewhat surprising given that Australia has a universal health insurance scheme (Medicare) that guarantees all Australians access to a range of health services at low or no cost.[4] This raises an interesting question – despite access to and availability of health services, why do LEAs continue to occur in Australia?

To answer this question, we undertook a qualitative descriptive study to explore patients' perspectives of risk factors for LEAs resulting from T2DM. Competing priorities and awareness were perceived as important risk factors that influenced a patient's ability to manage their risk of LEAs. Competing priorities included finances and family care. These commitments were perceived to be of higher importance than their own health. Accordingly, patients neglected self-care when they perceived competing priorities existed. In our study, although the median length of diabetes was 26 years and 53% of patients were admitted for their second amputation, awareness was also identified as an important risk. Participants often demonstrated a poor understanding of their condition and were sometimes unaware of the purpose of their treatment, while others were outright critical of the lack of education from healthcare professionals. Some participants perceived that their risk of further complications was reduced once they had recovered from an amputation.

Collectively, this study identifies risk factors that extend beyond the typical biological and modifiable risk factors for LEAs. In understanding patient-perceived risk factors for diabetes-related LEAs, nurses may be better equipped to identify and address factors that impede efforts to prevent LEAs and provide individualised, patient-centred care. This study suggests that competing priorities and awareness may be important issues that need to be addressed.

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Four C's: The key to supporting paediatric cardiac care closer to home

By Elizabeth Ingold, Lindsay Meltz, Gabbie Scarfe, Jessica Vitellaro and Nicole Dinsmore

For families of children with Childhood onset Heart Disease (CoHD), the burden of care they carry is a heavy one, often continuing into adulthood.[1]

The mental toll it takes on the carer and the child extends to the greater family unit, and is compounded by practical challenges in accessing care.[1] In NSW, inpatient paediatric cardiac services are centralised through the Sydney Children's Hospitals Network (SCHN).[2] So for families living in regional and remote areas are at a greater disadvantage.

Specialist hospital admission equates to higher rates of work and school absenteeism[1] and more significant financial implications[3] for this population.

Cardiac care is not limited to the inpatient setting, which was highlighted by a family who advocated for better support for those who live outside the daily reach of SCHN.

They described the stress and pressure of navigating different healthcare systems, a lack of transparency in information provision and variability in service availability. It was proposed that the burden of care could be eased if input from the specialist cardiac service was available as close to home as possible. Facilitating this is the aim of the Cardiac Care for Kids Regional and Remote Program. This article outlines how the project team determined the scale of the issues and what has been learnt about optimal care provision.

It is easy for nurses to focus on hospital discharge as the end of a child's healthcare experience, but to understand what needed to change, the project team had to look beyond the hospital walls to the families and local care providers.
A combination of surveys, interviews and working groups was used, but engagement was not a simple process. The challenges faced by the project team were mirrored by the issues highlighted with cardiac care provision across NSW. Identifying consumers and key stakeholders was needed to ensure appropriate representation and equal voice – a challenge that is ongoing. COVID-19, floods, staff deployments, workforce strikes and sick leave then impacted the capacity for healthcare providers to be involved in working groups. Be they staff or families, everyone had competing demands, so maintaining engagement was difficult, especially when care of children with CoHD makes up such a small volume of a regional and remote clinicians' workload. Finally, it is often easier to identify an issue than determine how to fix it, so maintaining goals of solution design were challenging, with key stakeholders expressing frustration at the historical lack of progress despite the advocacy for change not being new.

Facilitating children with CoHD remaining supported close to home for as long as possible, four areas of improvement were identified: consistency, consideration, communication and collaboration. Consistency in care provision and access to resources regardless of where a person lives relies on accountability and ownership of care planning, in both the in and outpatient settings, by people familiar with the required processes. Consideration and respect for families and their experiences need to be taken into account, not simply what is easier for the clinician or the quickest path to discharge. This consideration extends to local service capacity, their needs and geographical challenges impacting the potential for optimal place based care

delivery. Communication pathways also require optimisation to promote openness, and be reciprocal beyond the inpatient services. Involving the right people at the right time and prioritising the right information delivered by the right means is imperative. It is only through a collaborative approach to care provision, however, that positive change will be possible. Families and local staff working together with a tertiary centre in healthcare delivery not only fosters empowerment, but the transparency of this coordination has been observed to build the families' trust in their local service that remaining supported closer to home may be achievable. The benefits of minimising travel and avoiding hospitalisation where possible are well recognised by families and healthcare providers,[4] however, there is a need for cardiac nurses particularly to play a greater role in achieving this through coordination of care.[1,2]

While this program focuses on caring for children with CoHD, these principles of consistency, consideration, communication and collaboration are not unique to cardiology and could be considered pillars for equitable healthcare provision by other paediatric tertiary health services. Similarly, these principles could also be applied to the care of metropolitan based families, with care close to home being a goal for everyone, regardless of if they live 50 or 550 kilometres from SCHN. However, it is one thing to know what the issues are, but another to translate solutions into meaningful and sustainable change.

Using this as a foundation, the program team is developing a nurse-led model of care to make cardiac care more accessible and support care closer to home. To be world leaders in cardiac care with children and families at the heart of all we do, there is more work to be done.

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New drug target for the treatment and prevention of chronic obstructive pulmonary disease (COPD)

Researchers at the Centenary Institute and the University of Technology Sydney have identified a new drug target for the treatment and prevention of chronic obstructive pulmonary disease (COPD), an inflammatory lung disease that causes airway blockage and that makes it difficult to breathe.

Secreted by mast cells, a part of the immune system, the drug target is an enzyme known as mast cell chymase-1 (CMA1).

CMA1 was found by the researchers to actively promote and progress the development of COPD. Inhibiting the equivalent enzyme in mice was shown to provide protection in experimental models of COPD. New drugs targeting CMA1, said the researchers, could offer up a new therapeutic approach to tackling COPD which affects more than 300 million people globally.

Dr Gang Liu, the study's lead author and researcher at the Centenary UTS Centre for Inflammation said that COPD was caused by cigarette smoke, air pollution, as well as bushfire smoke and other particulate matter.

"Over time the lungs breathe in toxic material and become inflamed. Lung function is subsequently impaired leading to breathing difficulties which can then turn fatal," said Dr Liu.

In their new study, the researchers discovered elevated CMA1 levels in the lung tissues of patients with severe COPD – the CMA1 levels were approximately double that found in the lung tissue of mild-COPD patients and healthy individuals.

"CMA1 induces macrophages (a type of white blood cell) to release pro-inflammatory cytokines in the lung. It's this increased inflammation that can drive the development of COPD and poor outcomes for patients," said Dr Liu.

Subsequent investigation of the equivalent CMA1 enzyme found in mice – an enzyme known as mMCP5 – confirmed the enzyme's pivotal role in COPD.

"We were able to show in experimental COPD, that inhibiting mMCP5 provided protection against inflammation and macrophage accumulation, harmful structural changes of the lung, emphysema and impaired lung function," Dr Liu said.

Professor Phil Hansbro, the study's senior author and Director of the Centenary UTS Centre for Inflammation said the team's research offered up a new therapeutic target to help combat COPD.

"There is currently no cure for COPD and effective therapies to treat and manage the disease are urgently needed. Our study suggests that developing new drugs to inhibit CMA1 and reduce cytokine inflammation may be a novel treatment for this devastating disease that affects so many lives," Professor Hansbro said.

The study was published in the *European Respiratory Journal*.

Wound care is the missing piece of the puzzle in aged care reform

Wounds Australia is raising awareness and pushing for long overdue reform to aged care.

"Wound care is the missing piece of the puzzle in the Federal Government's aged care reforms," Wounds Australia Chair Hayley Ryan said.

"Wounds Australia is calling for the Federal Government to adopt its 11 Point Plan that will save hundreds of millions of dollars and prevent thousands needing medical treatment each year.

"Wounds Australia and its 18,000 members and supporters are ready to help drive the policy change needed. But we need national leadership to solve this hidden epidemic."

Perth's Yvonne Buters watched her elderly father die painfully in residential aged care when pressure injuries on his feet were not diagnosed and treated correctly. She feels there were missed opportunities to prevent and treat her father's wounds before they became life threatening.

The majority of pressure injuries are preventable. Yet these painful ulcers cost the Australia health budget almost $1 billion each year and result in over 500,000 lost hospital bed days.

Yvonne's experience shows staff in aged care need support, information and increased wound education and training to provide the right treatment at the right time.

Wounds Australia Chair Hayley Ryan said there have been too many missed opportunities to improve the health of older Australians. This can be remedied with simple affordable actions.

Wounds Australia is calling for the Minister for Ageing the Hon Anika Wells MP to use Wounds Australia as the primary resource for designing and adopting best practice in wound management.

IMPORTANT NOTICE

ANMF National Online CPE Closure

Following an executive review of the ANMF's Continuing Professional Development (CPD) offerings nationally and consideration of how to ensure high quality CPD offerings for ANMF members into the future, the ANMF's Federal Executive has made the decision to cease the National Online CPD offering and instead offer CPD directly to members through each state and territory ANMF Branch.

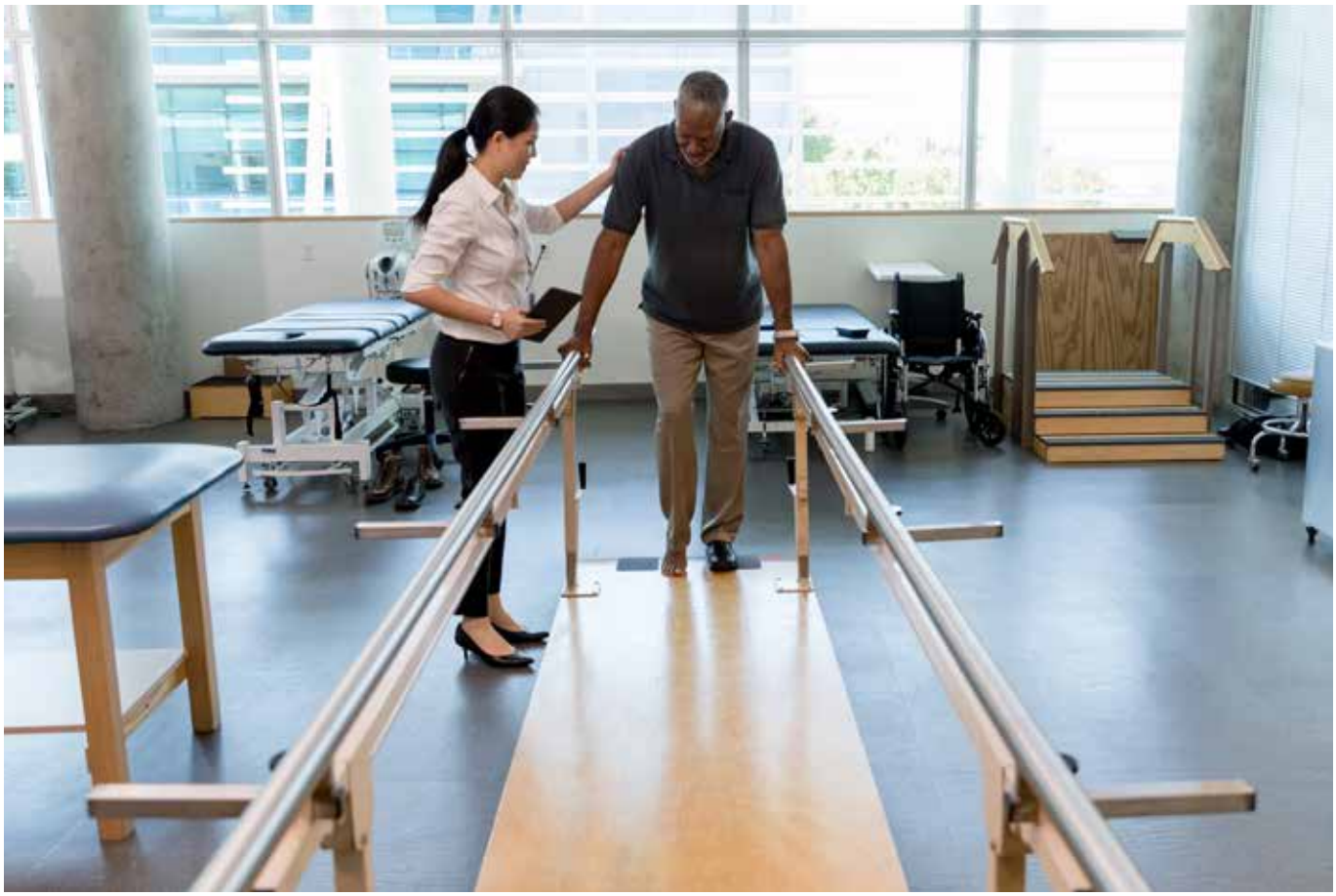
This notice is to inform all ANMF members and CPE users that the ANMF Federal Continuing Professional Education (CPE) website at anmf.cliniciansmatrix.com will close permanently on 1 November 2022.

ANMF/NSWNMA members should now contact their State or Territory Branch for information regarding CPD offerings for members, you can find a link to their website at **anmf.org.au/join-anmf**. QNMU members should go to **qnmu.org.au/QNMU/PUBLIC/MEDIA_AND_PUBLICATIONS/News_items/2022/Were_improving_our_CPD_Portal_090822.aspx** for more information.

For users of the ANMF Federal CPE site, please ensure you complete any courses you are enrolled in and download your full CPD record before the close of the website. You can find assistance on how to do this by visiting our solutions database at **anmfcpe.freshdesk.com/support/solutions** or email **education@anmf.org.au**.

Please note no new course enrolments will be possible from 30 September 2022.

Thank you for your participation in and patronage of the ANMF's national online CPE offerings. We hope you enjoy the new offerings from your Branch and apologise for any inconvenience the changeover may cause you, please don't hesitate to contact us if you need assistance.



Stroke survivors left with inadequate support and services

Long-term survivors of stroke in Australia have 'fallen into a black hole', left with lifelong disability with 'inadequate' ongoing services and support, according to the authors of a Perspective published by the *Medical Journal of Australia*.

"People living with ongoing disability after stroke may not have the opportunity to achieve their preferred life goals. It is time to focus on the individual burden of disease and how we can best support people with stroke in the long term," wrote Dr Kate Scrivener from Macquarie University and colleagues.

"Stroke is a chronic, lifelong health condition, but it is managed like an acute condition in Australia. Typically, a person after stroke is admitted to an acute hospital for early management; they then receive inpatient rehabilitation if they meet the selection criteria, followed by outpatient rehabilitation.

"In reality, the amount of rehabilitation provided by the hospital sector is limited," Scrivener and colleagues wrote.

"Recent moves towards early discharge and rehabilitation in the home have been shown to be less effective in maximising function than inpatient rehabilitation, whereas functional gain is possible with investment in subacute and community rehabilitation (eg. Council of Australian Governments national partnership agreements).

"After hospitalisation, 64% of people after stroke are referred for community rehabilitation; however, the actual amount of community rehabilitation that occurs is profoundly low."

Part of the problem, according to the authors is that people after stroke are caught between the health, disability and aged care sectors.

"People after stroke report feeling forgotten and neglected once their allotted rehabilitation quota has finished," they wrote.

Unlike other chronic conditions, such as heart disease, stroke survivors are rarely the beneficiaries of interventions that can prevent further strokes.

"It is time for people with long term disability after stroke to have access to the services they need, when they require them," wrote Scrivener and colleagues.

"We suggest a new model of long-term support for people after stroke who experience ongoing disability. The cornerstone of the model is a deliberate move to the disability sector from the health sector.

"The current system is disjointed with multiple funding sources, leading to inequality in who receives which services and when. People after stroke need the ability to have regular ongoing check-ups with services implemented where required, more support for ongoing lifestyle changes such as text reminders, person-centred tools such as self-management, habit-forming exercise, ongoing gym memberships, and strategies for meaningful social interactions.

"We support the urgency for a national rehabilitation strategy to move the rehabilitation focus from the hospital to the community," they concluded.

One in five search results for diabetes reveal misinformation, IDF warns

"Education to protect tomorrow" is the theme of International Diabetes Federation's (IDF) campaign to mark World Diabetes Day in November this year.

Activities will highlight the need for improved access to reliable diabetes education for people living with diabetes and healthcare professionals.

One in five Google searches for terms related to diabetes reveal inaccurate information about the condition and how to manage its complications, according to IDF.

Research carried out by IDF found that searches for terms including 'diabetes', 'how to manage diabetes' and 'diabetes symptoms' featured results and answers to questions from non-medical sources including Wikipedia, Amazon and Facty – the last of which showed an article on home remedies for diabetes.

Out of 30 search results (the first results page for each search term), six links directed users to unverified information. In one case, for the search term 'diabetes', users were displayed an advert from an organisation that aims to 'wean people living with diabetes from insulin.' Without an uninterrupted supply of insulin, type 1 diabetes is a death sentence. Many people with type 2 diabetes also need insulin to manage their condition. Any decisions to reduce insulin treatment should be taken in close consultation with a qualified healthcare professional, preferably a specialist in diabetes.

The number of people living with diabetes continues to rise around the world, with the latest IDF estimates indicating that one in nine adults will be affected by 2030. This is putting added strain on healthcare systems that, following two years of a global pandemic, are already struggling. Healthcare professionals must know how to detect and diagnose the condition early and provide the best possible care; while people living with diabetes need access to ongoing education to understand their condition and carry out the daily self-care essential to staying healthy and avoiding complications.

According to IDF figures, an estimated 44.7% of adults living with diabetes (240 million people) across the world are undiagnosed. The overwhelming majority have type 2 diabetes. When diabetes is undetected and inadequately treated, people with diabetes are at higher risk of serious and life-threatening complications.

"Many people now turn to Google and the internet for advice, so it's worrying that misinformation about diabetes is still rife online. With the prevalence of diabetes showing no signs of declining, ensuring that healthcare professionals are equipped to provide the best possible care and that people with diabetes can make informed decisions about their self-care is more important than ever. We need quality education today to help protect tomorrow," says Professor Andrew Boulton, IDF President.

IDF is committed to facilitating learning opportunities for all people concerned by diabetes. A new online platform (**understandingdiabetes.org**) has been launched providing free interactive courses to help people with diabetes and their carers to understand and manage their condition. The first course available provides an introduction to diabetes, explaining what it is, how it works and the common warning signs and risk factors. For healthcare professionals, the IDF School of Diabetes (**idfdiabeteschool.org**) offers a selection of free and premium online courses that help them to keep up-to-date with various aspects of diabetes management and treatment.

Supporting materials for World Diabetes Day 2022 are available at: **worlddiabetesday.org**

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.

Potato, leek, lemon and parmesan soup

Make this soup to enjoy with some crusty bread

Preparation **20 mins**
Cooking **40 mins**
Makes **2.5L soup (10 serves)**

INGREDIENTS

50g olive oil
50g unsalted butter
180g white onion, diced
6g chopped fresh garlic
1kg (3) leeks rinsed and finely chopped
12g fresh thyme leaves
40g lemon juice (this may need to be reduced when upscaling)
625g white potato – skin on, inch chunks
1.25L vegetable stock
250g whipping cream
Sea salt flakes and pepper to season
Shaved parmesan to serve

METHOD

1. Place the oil and butter in a large pan over medium heat, add the onion and sweat for 10 minutes without colour.
2. Add the garlic, leeks and thyme, sweat down until leeks wilted, season with salt and pepper.
3. Deglaze with lemon juice.
4. Add potatoes, stock and seasoning, bring to the boil and simmer, covered until potato is tender. Add cream and remove from heat.
5. Blend (adjust consistency if required) and serve warm with shavings of parmesan, drizzle of cream and a warm roll

Best served fresh, may be frozen

We invite you to try and make 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 Margaret Stewart on making Maggie's, Cauliflower, kale and parmesan cake published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"Good nutrition is the basis for positive health outcomes and Maggie Beer's Cauliflower, kale and parmesan cake is full of nutritious ingredients and the combined flavours tasted fantastic. Easily cut into finger sized pieces, hot or cold, it is a flavoursome snack for busy nurses 'on the run'," says Margaret.

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