Australian College of Nursing

thehive

#14 WINTER 2016 | DISASTER HEALTH

ORDINARY WOMEN IN AN EXTRAORDINARY WORLD
the stories of three women affected by disaster

RECEIVING THE STRANGER
a profile of four refugee health workers

SHINING A LIGHT ON CHRONIC DISEASE IN AUSTRALIA
an ACN policy review

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#14 WINTER 2016 (June – August)
DISASTER HEALTH

PUBLISHING DETAILS

ISSN 2202-8765
Distributed quarterly

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ABN 48 154 924 642

Printing
Elect Printing, Canberra

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Cover: After losing her home in the 2010 Haiti earthquake, Marlene Desir was able to rebuild her life and provide for her family with the help of an urban gardening program.

We love to see member submissions in *The Hive*. If you're interested in having your submission considered for publication, please see our guidelines and themes at **www.acn.edu.au/publications**.
For enquiries or to submit an article, please email **publications@acn.edu.au**

ACN publishes *The Hive*, *NurseClick* and the *ACN Weekly eNewsletter.*

CEO WELCOME

Adjunct Professor Kylie Ward FACN, ACN Chief Executive Officer

Welcome to the winter edition of The Hive, which features some informative and inspirational articles from our members on the theme of disaster health. Whether its disaster preparedness, response or recovery, nurses bring expertise and leadership to many disaster management teams and operations.

As an international aid coordinator, **Suzy McIntyre MACN** sees the effects of disaster and disaster management programs on a personal level. In her article 'Ordinary women in an extraordinary world', Suzy shares three inspirational stories of women who have shown immense strength and selflessness in the face of disaster.

Successful health care delivery in disaster situations relies on nurses who have the knowledge and skills to rapidly and effectively respond. In her 'Review of the ICN Disaster Nursing Competencies', Associate Professor **Alison Hutton FACN** offers some valuable insight into how this framework is used to inform disaster nursing roles.

Both personal experience and nursing competencies come into focus in our 'Receiving the stranger' feature, which profiles four passionate refugee health professionals – **Sandy Eagar FACN**, **Merilyn Spratling FACN**, **Tania Canas** and **Shegofa Zahidi**. As their comments attest, working with some of the world's most vulnerable populations requires a unique and comprehensive set of skills to promote accessible and culturally appropriate support services.

As the size, age and health literacy of our population continues to grow, so does the need for health reform to ensure the sustainability of Australia's health care system. In this issue, our policy team discusses Australia's platform for health reform and zeroes in on progress being made in the chronic disease space with a review of the report on the Inquiry into Chronic Disease Prevention and Management in Primary Health Care.

The past quarter has been a lively one for ACN events with the National Nurses Breakfast for International Nurses Day, the Nursing and Health Expos held in Melbourne and Perth, and the National Networking Roadshow of VIP cocktail functions across the country. I would like to thank all our wonderful Members, Fellows and guests who came together for these occasions and I look forward to connecting with you all at future ACN events.

I hope you enjoy this issue!

PRESIDENT'S REPORT

Adjunct Professor Kathy Baker AM FACN (DLF), ACN President

Since my last report, I am pleased to note that the Australian College of Nursing (ACN) has been extremely busy working on many new initiatives to further drive its leadership and engagement in policy, advocacy and membership.

Advancing the knowledge and skills of nurses and offering them comprehensive support to ensure they work to the best of their abilities is vital to progressing the nursing profession and the health care system. ACN's new partner affiliation opportunities are designed to help organisations further support their nurses by giving them access to a wide range of networking, support and leadership development opportunities through ACN. It is an exceptional opportunity for organisations to take advantage of services that benefit both the business and their nurse employees.

Addressing nursing capabilities from a broader perspective, ACN is developing a white paper to advocate the role of nurses in health reform. As Australia faces a critical period in health care reform, ACN aims to highlight the key role nurses can play as leaders in the development of better integrated and patient-focused health care system. This important initiative will be launched in the coming months to advance it as a high priority on the Australian Government agenda.

Members would be aware that our Advancing Nurse Leadership strategy was launched in 2014. We have faced a number of roadblocks in the ensuing time, however, ACN's strength flows from the experience, expertise and passion of its staff. We are currently in the process of recruiting for two key leadership roles – the Executive Director, Professional and Leadership, and the newly-created role of Leadership Manager. These new staff members will have a comprehensive understanding of the role of nurse leaders in the Australian health care system and will focus strongly on achieving ACN's strategic intent of advancing nurse leadership to enhance health care.

I'm pleased to announce that Mr Neil Haynes, ACN's Executive Director, Corporate Support, has been appointed Company Secretary. With a strong background in finance and a drive to be involved in the organisation's strategic business needs, Neil will be invaluable in ensuring ACN maintains its high standards of corporate governance.

NATIONAL NETWORKING ROADSHOW A SUCCESS

Fiona Entriken MACN, Clare Kennedy MACN, Sharon Pickles MACN and Mary Bronson MACN.

Dr Dale Pugh FACN, ACN CEO Adjunct Professor Kylie Ward FACN with WA Chief Nursing and Midwifery Officer, Karen Bradley MACN.

The Australian College of Nursing (ACN) recently hosted networking cocktail functions for ACN Members and VIP guests across the country as part of its National Networking Roadshow. ACN was honoured to have members of parliament and nursing leaders in attendance at each of the functions.

These events were an excellent opportunity for ACN to engage in discussion with nurse leaders and emerging nurse leaders across Australia from the public, private, aged care and primary health care sectors and to facilitate the opportunity for these exceptional nurse leaders to engage with politicians.

The cocktail functions focused on three key themes:

- The power of nursing as a collective voice
- The top three priorities for the future of nursing
- The top three priorities our Members and Fellows want to see from ACN

These were the first of many networking events ACN plans to host throughout every state and territory in the near future.

Visit www.acn.edu.au for more information and view photos from the events on our Facebook page, www.facebook.com/acnursing

QUEEN'S BIRTHDAY HONOURS

ACN would like to congratulate **Professor Kim Usher AM FACN, of Saumarez Ponds NSW**, on her recent appointment as a Member of the Order of Australia in the 2016 Queen's Birthday Honours. Professor Usher was recognised for significant service to nursing and midwifery education and research, nationally and in the Pacific, and to professional organisations.

Professor Usher has been an active ACN Fellow since her investiture in 1995. She has had articles published in ACN's refereed academic journal Collegian and quarterly publication The Hive. She also held the position of Editor of Collegian from 2007–2014.

Congratulations to the following nurses who were also included on the Queen's Birthday honours list:

MEDAL (OAM) OF THE ORDER OF AUSTRALIA IN THE GENERAL DIVISION:

Mrs Deidre Tuck Taroona, Tasmania
For service to medical research organisations and to oncology nursing.

Ms Anne Patricia Griffiths, Victoria
For service to nursing and to organ transplantation programs.

MEMBER (AM) IN THE GENERAL DIVISION OF THE ORDER OF AUSTRALIA:

Associate Professor Kaye Challinger, South Australia
For significant service to medical administration, to the advancement of nurse education and to quality health care delivery.

DON'T FORGET TO CLAIM YOUR MEMBER BENEFITS

ACN has launched new benefits for its valued members that streamlines the member experience and provides significant value that is greater than the annual cost of our membership fees. These include:

MY ACN:
A new online portal where members can access all of their details, benefits and services. Members can update their profile and preferences, and specify the publications they wish to receive.

If you are a current member and have forgotten your username or password, simply enter the email address that you currently receive your ACN correspondence to, to reset your login.

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Members can now access three free CPD courses each registration year (1 June to 31 May). This provides up to 12 hours CPD to each member.

The courses that will be available are:

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- Deteriorating Patients
- Musculoskeletal and Neurovascular Assessment of the Lower Limbs
- Musculoskeletal and Neurovascular Assessment of the Upper Limbs
- Neurological Assessment
- Physical Assessment
- Respiratory Assessment

To access, simply log in to My ACN, click on the Resources tab, select the CPD course you wish to enrol in and click Claim. You will be taken directly to CNnect where you can start your free CPD course straight away.

DISCOUNTS ON ALL ACN COURSES:
Members and Fellows can now receive a 10% discount on full fees for all ACN Courses. For a full list of courses offered by ACN please visit www.acn.edu.au or contact our Customer Services team on 1800 265 534 or customerservices@acn.edu.au.

To claim this discount, simply quote your member number as your special offer discount code when you fill out the application form for your unit or course.

1. The discount is valid for all full-price ACN courses, excluding CPD workshops and short courses, which are already priced at a reduced member rate.
2. It is not valid with any other discount offer.
3. You need to quote your member number on course enrolment documentation in order to claim the discount.
4. Offer subject to change without notice.

FREE CPD SHORT COURSE REGISTRATION FOR FACILITATORS
ACN will soon be offering the chance for Members and Fellows to volunteer as facilitators at many of our CPD short courses. As a thank you, the facilitator can register for the course for free. The Responsibilities of Hosting Guidelines will be published soon, outlining what will be expected of our facilitators.

If you have any questions or issues with these processes please contact ACN Membership on 1800 061 660 or membership@acn.edu.au

CLINICIAN

MS TOMICA GNJEC MACN

On the 18 January 2003, I awoke at 3pm from a night duty slumber in complete darkness. Initially disoriented and confused about what was occurring, a quick phone call to my parents informed me of the wildfire that had swept through large areas of urban bushland surrounding Canberra and was threatening/crossing the bush-urban interface. Home alone and with no vehicular access, I rounded up our domestic animals and put in place a contingency plan with a neighbour in the event our suburb was required to evacuate.

Disaster by definition is an event that overwhelms available resources. In the case of the health care system, it has a profound effect as it relates to emergency response, mitigation and recovery. Over a period of six hours our local main emergency department was inundated with 139 patients, 75% of which were fire-related problems – largely respiratory and trauma, including burns and ophthalmological (Richardson & Kumar 2004). Not only did this acute health service mount and sustain an incredible response to this disaster given limited time and resources to prepare, it also had to manage numerous other challenges on the day, including power outages and disruption to communication lines such as mobile phone networks (Richardson & Kumar 2004).

The Canberra Bushfires were one of the largest single-day natural disasters in Australian history (Camilleri, P. et al 2010). Fortunately for myself and my family, there was no threat to life or home, though many Canberrans lost homes, suffered injury and, tragically, lives were lost. The urban landscape and its surrounds continue to heal as does the Canberra community.

Thirteen years on I wonder how effective today's disaster preparedness might be and how do you prepare for a 'disaster' scenario which in itself is just that – a disaster!

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ACADEMIC

MR JAMES BONNAMY MACN

Increasing frequency of extreme weather events and the recent Ebola and Zika outbreaks highlights the importance of nurse preparedness for disaster management. Globally, nurses have an essential and prominent role to play in response to disasters (International Council of Nurses 2006). The role of nurses during a disaster is multifaceted and encompasses coordination and delivery of health care.

Fortunately, to date, Australia has not experienced a nationwide catastrophic event (Rokkas, Cornell & Steenkamp 2014). However, in January 2009, 374 people were killed by extreme temperatures and in the same year 191 deaths were associated with pandemic H1N1 influenza (Department of Health 2012).

Given that the incidence of floods, cyclones, bushfires, pandemics and terrorism are increasing, it is predicted that Australia will have to respond to a nationwide disaster at some point and it is alarmingly recognised that we are currently underprepared to do so (Rokkas et al. 2014).

The role of Australian nurses in disaster health remains elusive with a lack of clear guidelines, inconsistent disaster nursing education and ambiguity surrounding the role of nurses in a disaster (Hammad, Arbon & Gebbie 2011). This is in comparison to countries such as the United States where nurses are the choice health professionals for disaster response due to their ubiquity, well defined role and preparedness (Carpenter 2006).

Considering the literature which has emerged from disaster-struck countries in the past decade and the impact of globalisation of health, there has never been a more important time for Australia to ensure preparedness of nurses for disaster health. Without adequate preparedness, nurses will face challenges in providing safe and effective care during catastrophic events and disasters.

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EARLY CAREER NURSE

MS LAURIE BICKHOFF MACN

American television icon Fred Rogers once said, "When I was a boy and I would see scary things in the news, my mother would say to me, 'Look for the helpers. You will always find people who are helping'." Today, many of those helpers are likely to be nurses. However, the question we must ask ourselves is "who helps the helpers?"

The emotional impact upon our nursing colleagues working within such highly stressful environments is one we cannot afford to overlook. Nurses working during events such as the 2009 Black Saturday Victorian bushfires or the 2013 Boston Marathon bombing spoke of the almost overwhelming scenarios they were confronted with. In the midst of the 2004 Boxing Day tsunami, nurses described how they continued to work after the deaths of their own families and were often faced with the reality of treating their friends and neighbours.

When the urgency of the situation has passed, these nurses need our support. They need to be able to talk about their experiences and debrief with trained professionals. Yet during the recent Ebola epidemic, nurses spoke of feeling ostracised from their communities upon their return home out of fear they might be infected. Health care workers within refugee detention centres have faced legal penalties for discussing the conditions of the people they are helping.

In disaster situations, forcing silence, either through not providing an ear to listen or via legal means, can have devastating long term consequences for those involved. As such, we must lend our voices to those of our disaster health nursing colleagues to ensure they are heard and given the support they need.

(references continued from previous column)

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ORDINARY WOMEN IN AN EXTRAORDINARY WORLD

By Suzy McIntyre MACN

Suzy McIntyre MACN

As a registered nurse for more than 25 years, the difficult decision was made about 15 years ago to shift from working in paediatric and neonatal intensive care to working in areas outside the clinical setting. This journey initially resulted in working in corporate health and travel medicine and then, after completing a Master in International Public Health at the University of Sydney, a move into public health.

After working in an area Public Health Unit, there remained an uneasiness to follow the desire to work in international aid and development. Eventually a position was secured in the sector and almost six years later I am the Program Coordinator for Global Programs and Partnerships within the Humanitarian Emergencies team at Caritas Australia.[1]

Through my work at Caritas, I have had the indelible opportunity to meet many inspiring women, men and children. Their stories have left an indentation on my very soul because of the sense of courage that they possess. They are living in a world that is challenging, that is full of vulnerability, but is also beautiful. Through their courage, they demonstrate that even though they have endured man-made or natural disasters, they exemplify resilience, hope, determination and bravery.

All too often the media focuses on the numbers and the data of disasters, rather than the faces of the very people impacted by disasters. Stories are data with a soul. They tell us of the lived experience and the way adversity disrupts the reality. Through speaking with people participating in programs, it is impossible not to feel a fundamental shift, from knowing that programs do have a positive influence to an understanding that lives can truly make a difference to the future outcomes.

The women profiled through this paper are ordinary women who are living in an extraordinary world that has been shaped by the disasters imposed upon them. From the earthquakes in Nepal and in Haiti, to the crisis in Syria, there is a common story. They do not have superpowers, but are ordinary mothers, daughters and wives who draw on a strength that enables them to show others that, when faced with challenges, there are ways of finding a path to help others. They have inspired me in my everyday life and work, and through sharing their stories, you may too feel inspired – especially on those particularly tough days that we all experience.

MARLENE DESIR FROM HAITI – A STORY OF GIVING...

Haiti has been described as the kind of place that breaks your heart, even as it fills you up. In 2010, a massive earthquake devastated the country. Hundreds of thousands of lives were lost and an already struggling nation was faced with insurmountable challenges. The world responded with massive efforts to assist the fragile and the homeless. Like many disasters, women were disproportionately affected, however, many also found a sense of strength and empowerment.

Marlene Desir

1 Caritas Australia is the Catholic agency for international aid and development and is part of a network of over 165 Caritas agencies that work in over 190 countries and territories – considered one of the world's largest humanitarian agencies. Suzy has responsibility for programs in Haiti, Afghanistan, the Middle East and has worked on disaster programs affecting the Pacific, Asia and West Africa.

“All too often the media focuses on the numbers and the data of disasters, rather than the faces of the very people impacted by disasters. Stories are data with a soul. They tell us of the lived experience and the way adversity disrupts the reality.”

When I met Marlene almost two years ago, she was 66 years of age and living in an extremely impoverished area of Port-au-Prince called Christ Roi. After losing her home in the earthquake, she struggled to provide for her four youngest children (her older four children were living away from home). Nutritious food was hard to come by and it was difficult to earn a living.

Marlene learnt how to grow healthy vegetables for her family through an urban gardening program that was set up in her community. Where there had been a patch of yard outside her temporary tarpaulin walled home, there was now lush green vegetation. She was also able to sell any excess vegetables for a small profit – earning about $2.50 per day. As well as tending to her own garden, she taught the children, the elderly and other women from neighbouring communities how to grow plants from seed, how to tend to the plants through watering and weeding, and how to compost food waste. All grown out of upcycled ‘containers’ – old TV shells, tyres, buckets, and the like.

What was most inspiring about Marlene was how highly motivated, passionate and determined she was in giving to and teaching others. Marlene was the President of the gardening group. By inviting women from other communities to see the group’s work, she hoped that they too could also feel a sense of autonomy and empowerment. This sharing with others was not meant to be part of her role, she did this because she knew she had something wonderful to offer.

SUKUMAYA TAMANG FROM NEPAL – A STORY OF RESILIENCE...

On 25 April last year, Nepal was stuck by a 7.8-magnitude earthquake which was followed by a second major temblor 17 days later. Nearly 9,000 people were killed, more than 20,000 people injured and again, hundreds of thousands of people were made homeless with entire villages flattened. In the aftermath, there was concern about trafficking of girls and women affecting the poorest communities.

Sukumaya Tamang

Last year, I was in Nepal for most of August and September. Whilst there, I visited Balthali village, which is about 40 kilometres southeast of Kathmandu. The region includes luxuriant forests, terraced rice fields and lush green mountain ranges where villagers live side-by-side with their animals. In this small village of about 85 households, there are streets but no street names; there is no power though there is a hydroelectric power station nearby; and they use pit toilets as there is no sewerage system.

In Balthali, I met 37-year-old Sukumaya who was mother to Sushila (15) and Samir (5) and had lost her middle child some years ago. A year before, Sukumaya’s husband died after falling from a tree on a steep slope on the outskirts of the village. He was trying to cut off a tree branch for firewood. To provide for her family, Sukumaya worked tirelessly in the fields where they grew potato and maize and tended to buffalo and goats to provide for her family. When the earthquake struck, Sukumaya was inside her home. Her children were outside playing on the road when the ground started shaking. As she ran outside to check on the children their house collapsed behind her and they lost everything.

In the short time since the earthquake, Sukumaya was again rebuilding her life with the help of programs funded through the Australian Department of Foreign Affairs and Trade (DFAT) and Caritas supporters. She was living in a small shelter with her children, continuing to work the fields, tending to the animals and caring for her children. Sukumaya had endured many challenges and her courage was admirable. Without doubt, Sukumaya would not identify herself as being courageous or resilient. Rather she would see it as her role to do what needed to be done to keep her remaining family together. She was grateful for all she had been given, but most importantly, she was grateful her children were safe.

“Though the techniques and strategies of story writing are important elements, it is crucial to show the dignity of the people who entrust their stories to others.”

BACHIRA AL GOUHMAN FROM SYRIA – A STORY OF HOPE...

The crisis in Syria is considered the largest humanitarian crisis in the world today and many say the worst humanitarian crisis since World War II. There are more than four million people registered as refugees in the neighbouring countries of Lebanon, Jordan and Turkey, and many more millions are internally displaced within Syria. In 2015, this mass movement of civilians extended beyond the borders of the Middle East and into Europe and beyond.

I met Bachira in October 2014 in a distribution centre in Mount Lebanon, where refugees fleeing from the tragedies of Syria are trying to rebuild their lives, mend shattered dreams and accept their current existence. At the time, Bachira was a 40-year-old mother of five children ranging from eight to 20 years. The family had been living a somewhat comfortable life in Daraa in Syria. When the hostilities escalated, their house was bombed and then confiscated for use as a hospital for wounded soldiers, before being taken over by rebels to use as a base to monitor activities of the Syrian army.

Bachira and two of her children walked to Damascus, which was a distance of about 100 kilometres, leaving everything behind. They then travelled by bus to the Lebanese border checkpoint where, under fire, they crossed the border to reunite with her 17-year-old son, who had gone ahead with his father some time earlier as they were concerned about kidnapping. Her husband then returned to Syria to bring back their youngest sons, but she had not heard from them and wondered if they would be reunited.

Bachira was living with her children in an underground water silo at the bottom of a building. Life was difficult – the children were not yet attending school and she had no secure source of income. She was grateful for the mattresses, household items, hygiene supplies and food vouchers given by Caritas. Though she had concerns for their future, she had hope that her children would receive a good education and opportunities for a good life – a life where they will be able to forget the nightmares and the traumas they have witnessed.

Bachira Al Gouhman

STORYTELLING LESSONS

Although there are many lessons learnt from the perspective of improving aid programs, there are also lessons learnt on how we share stories with audiences. When researching the best way to share stories, one quickly learns that there is a plethora of information available about how it is best to write a personal story. The advice ranges from the ethics of storytelling, to how to best structure stories, and to how to write a story with the greatest impact. Though the techniques and strategies of story writing are important elements, it is crucial to show the dignity of the people who entrust their stories to others. Storytelling is one of the most powerful ways of communicating the personal experiences and journeys of people that may otherwise not be heard.

For humanitarians working with large organisations responsible for government grants and supporter donations, it is vital that when we share stories of people’s lives, that they are done in a way that fosters empathy, compassion and appreciation. As a registered nurse in the hospital setting, great care was taken *not* to share stories of the patients that we cared for at risk of divulging confidential or identifying information. As a humanitarian, however, the sharing of stories with their permission is a way of connecting with the Australian community and helping decision makers to understand the impact on people’s lives.

I hope to continue helping others impacted by disasters and learning from people who are willing to share their experiences. The challenge is in finding a balance of telling stories that inspire and motivate, but are respectful to the courageous people with whom supporters may never have the opportunity to share a personal conversation.

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REVIEW OF THE ICN DISASTER NURSING COMPETENCIES

By Associate Professor Alison Hutton FACN

Alison Hutton FACN

Alison is an Associate Professor at Flinders University in the School of Nursing and Midwifery. She is the chair of the World Association Disaster Emergency Medicine Nursing Executive Committee and a board member of the Flinders University Centre Disaster Research Centre.

It has been five years since the inception of the *ICN Framework of Disaster Nursing Competencies* (ICN Framework). Therefore, it was considered appropriate for the ICN (International Council of Nurses) to review how nurses are using the competencies worldwide (ICN & World Health Organization (WHO) 2009). The nurse who is intended to acquire these competencies and demonstrate them in practice is at the level of pre-registration nursing, although the competencies might be applied to other nurses, depending on the specific needs of individual countries.

The existing ICN Framework, published in 2009, formed the starting point for this review. The key target audience for this process is members of the nursing disaster community concerned with pre-service education for professional nursing and the continuing education of practicing professional nurses.

To minimise risk in disaster nursing practice, competencies have been identified as the foundation of evidence based practice and standard development. Disaster nursing competencies were first developed in the United States of America (USA) by the International Nursing Coalition for Mass Casualty Education (INCMCE) at Vanderbilt University to promote leadership and awareness of the nurse's role in mass casualty incidents (Daily, E., Padjen, P. & Birnbaum, M. 2010).

Nursing has not been the only discipline to develop disaster nursing competencies. Over the years many health care organisations have developed their own set of competencies for different professions. However, there is a lack of terminology standardisation and definitions in this space (Wright, D. 1998).

In 2009 the ICN proposed a framework of disaster nursing competencies for disaster nursing education for 'general' nurses, now generally considered the 'gold standard' of disaster nursing competencies. The goal of the ICN framework is to work as a common set of competencies in disaster nursing for the global nursing workforce and to provide clarification of nurses' role in disasters (ICN & WHO 2009).

A steering committee was established by the World Association of Disaster Emergency Medicine (WADEM) – Nursing Section to discuss how to initiate a review of the ICN Framework. The steering committee then worked via email to develop a survey to send out to disaster/emergency groups that may have nurse members who work/respond in a disaster. Disaster nursing organisations were identified through the networks of WADEM and ICN. Thirty-five organisations worldwide were identified, with all continents being represented.

Thirty-five invitations were sent out with 20 responses (57%) received. Ninety-five percent of respondents knew of the ICN Framework, with the majority accessing the document via the internet. Because the review process was to be as wide-reaching as possible, people could respond as individuals or representatives from an association or group. The questionnaire included 43 questions in three sections (individual; association and/or practice organisation), with the wording of the questions reviewed by the steering committee before distribution.

Of the individuals who responded, the majority were nurse educators. Associations stated they responded to one or two disasters a year, although for organisations this could be up to six a year. Most of these responses were national exercises, the most common being earthquakes, with others referring to technological disasters, industrial accidents or international issues where nurses are deployed.

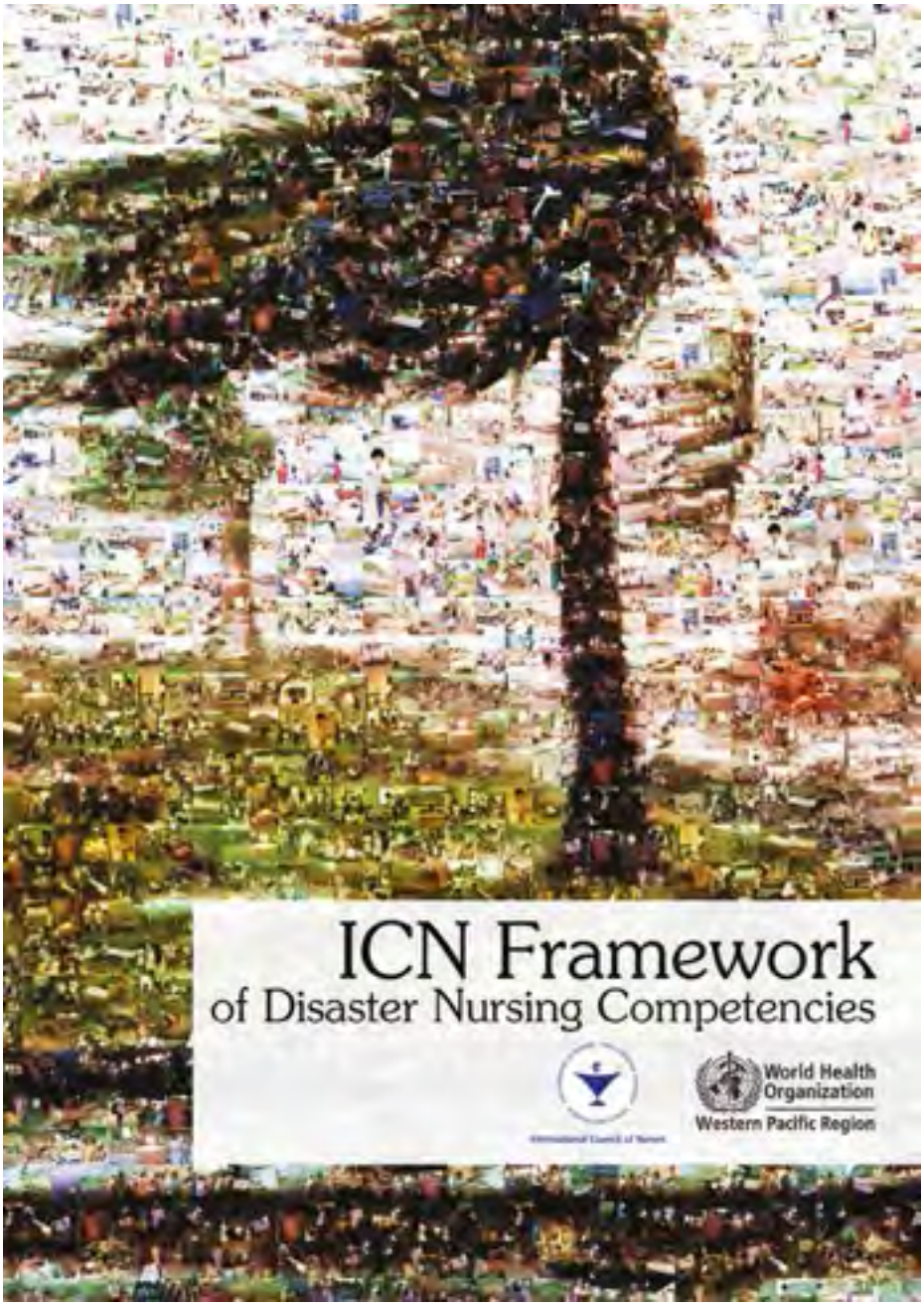
The majority of those who responded said that they make use of the ICN Framework with the most common use being for educational purposes. Education was done at a local, national and international level. The ICN Framework was valued by these organisations as the cornerstone of their disaster education. However, the competencies were also used to inform and establish standards of care, develop ethical/accountable practices and to plan the organisational structure of the association.

The competencies were also identified as an important resource for risk reduction, disease prevention, policy and planning, education and preparedness, caring of vulnerable populations or people with special needs and providing organisation and structure to the new discipline of disaster nursing. Lastly, respondents believed that the disaster nursing role was so important that we need to have competencies to guide and develop the roles that nurses are playing out in the field.

It is evident from the above, that the competencies are held in high esteem and are used for the continued professional development of disaster nursing. However, respondents stated that five years on from their development, the ICN Framework should also include the psychosocial elements of nurses caring for themselves and their colleagues. These could include self-care and mutual care, and support of others in all phases of deployment, the need for reflection during preparation, stress management in all phases of deployment, personal protection during deployment and mental health post deployment. Lastly, respondents stated that the impact of disasters on global health also needed to be considered.

The location and identification of disaster/emergency organisations were more challenging than the steering committee anticipated. As this project was governed through the nursing section of WADEM, it was expected our membership would have a wide spread of international contacts. Unfortunately, the majority of identified and participating disaster nursing groups were from Australia or the USA. However, further representation was provided by disaster nursing groups from each continent through the assistance of the ICN and attendance at two international conferences (19th World Conference WADEM, Cape Town, South Africa and the ICN Conference, Seoul, South Korea).

This study suggests there is more work to be done with respect to advancing global nursing use of the ICN Framework. For example, there may be a need for further discussion around what level of nursing education and practice the competencies should address and whether or not advanced skilled competencies are needed for those who respond often or are specialised. Further study should explore if there are other areas related to disaster nursing practice (in addition to psychosocial concerns) that may be missing or not fully developed.



This review affirmed that the ICN Framework is providing a foundation for the education and training of many nurses. A wider network of nurses and nursing groups should be developed to participate in the planned 2017 review. That review should also be structured in such a way to help differentiate between competencies that are core to all nursing practice and those that are needed for advanced or specialised disaster-related practice. Finally, the authors recommend that future research explore how the ICN Framework does or does not assist in maintaining best practices in this field and improves outcomes for victims of disaster.

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RECEIVING THE STRANGER

FOREWORD

Dr Ruth DeSouza MACN

Ruth is Stream Leader: Research, Policy and Evaluation at the Centre for Culture, Ethnicity and Health (CEH) at North Richmond Community Health. She has held a wide range of academic, clinical and governance roles, including Senior Lecturer in Nursing at Monash University, Melbourne (2013–2015) and AUT University, Auckland (2005–2012) where she coordinated the Centre for Asian and Migrant Health Research. Ruth's mission is to develop research that translates to improved outcomes for marginalised groups, with a particular focus on cultural safety, consumer participation and health literacy.

"If one agrees that the manner in which a society receives refugees (the stranger) and upholds their rights is a fairly accurate barometer of the extent to which human rights are generally respected, it follows that an investment in promoting the rights of refugees is a an investment in a more just society for all." (Harrell-Bond, 2002, p.80).

This special issue on disaster health acknowledges the relational aspects of being a human. A disaster is "the widespread disruption and damage to a community that exceeds its ability to cope and overwhelms its resources" (Mayner & Arbon 2015, p. 24). At times of disaster, people need help, and nurses are often on the front line. This is because even outside of what we usually understand to be a disaster, nurses typically work with people and communities who have exhausted their own resources or who need infrastructural and systemic support to galvanise their resources and strength.

The call to care that we associate with nursing practice is often juxtaposed with an uncaring social and political context. This leads many nurses to experience moral distress, defined by Jameton (1984) as "aris(ing) when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action".

The lack of care in our border discourse reflects how devoid of context the issue of migration is in political debates. Fleeing bodies are objectified and dehumanised by politicians who trumpet xenophobic and alarmist discourses of fear. These discourses are oriented toward a mass media for distribution to people as a proxy for actual engagement with refugees and asylum seekers, underpinning cruel deterrence policies and for-profit detention of vulnerable people.

For the practitioner, even if one is concerned, the dominant economic order of neo-liberalism keeps us focused on outputs rather than relationships; we keep our heads down to keep up. Our working situations often pull up the drawbridges to our hearts and selves so we can survive.

The work of the three refugee health nurses and an arts practitioner working for refugee support organisation RISE provides important lessons for us, even if we do not work directly with former refugees. These profiles emphasise the relational aspects of nursing: skilled, empathetic, compassionate care that is tailored, solution-oriented, flexible and seen as safe by the recipient. Care that is delivered by providers who are skilled communicators who use interpreters as needed. Cultural competence is not about being of a particular culture but of knowing how to bring resources to a new cultural situation where one has limited expertise.

The practitioners profiled here continuously attempt to improve through evaluation and overcome resource constraints to work toward models of care that facilitate shared decision-making. And outside the clinical relationship, these practitioners articulate and demand strategic interventions to disrupt institutionalised discourses and practices that have a marginalising effect on vulnerable communities.

Paradoxically, this move from individual to collective and community responsibility – demanding in an individualist culture – can resource our weary hearts, minds and bodies. The critical perspectives foregrounded here draw on new understandings of intersectionality as a key issue in addressing health inequity.

They show how categories of difference such as race, gender and class intersect with broader social, economic, historical and political structures to shape experiences of health care. They allow us to look "upstream" (Clark et al 2015) and to critically evaluate the virulent anti-asylum seeker rhetoric made by politicians and media that refugees and asylum seekers are "trying to take over", are not "genuine", are not using the "proper channels". They surface the often overlooked truth that the Geneva Convention — to which Australia is a signatory — provides people in fear of their lives with a legitimate and legal right to seek asylum.

Intersectionality might allow us to engage in cultural safety, to see how our 'selves' intersect with the institutional, geopolitical and material aspects of our roles; to consider the investments and conditions that enable us to care and to interrogate the constraints and accountabilities that influence our practice.

Much of the history of critical nursing practice has focused on the "reflective practitioner" (Schön, 1983). However, in the real world there's rarely time to reflect and institutional demands often preclude reflective time. And reflecting by ourselves assumes we can be fully aware or conscious of ourselves and the social relations that we are a part of. This kind of deliberation cannot adequately address the messy unpredictable nature of nursing contexts.

We might need to start talking to each other again, working in partnership to take part in more socially engaged knowledge practices, where we recognise the limitations of our own knowledge so we are better able to work across difference. Nurses are already skilled at building relationships with clients. We need to extend our therapeutic alliances to families, communities, service providers and community resources.

The Australian College of Nursing and nursing's other professional organisations have taken up the challenge, speaking out against Australian policies and practices that impact on the health outcomes of detainees, asylum seekers and refugees — the secrecy provisions of the Australian Border Force Act of 2015 being a key example. What are our collective responsibilities now? As they have always been: to conduct ourselves with a duty of care.

However, in this increasingly complex world, effective care is no longer a matter of caring only for the individual, but requires partnerships that transcend the boundaries of clinical practice, research, education and political advocacy to work more collaboratively and improve the wellbeing of those marginalised by our nation's unhealthy policies.

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SANDY EAGAR FACN

Nurse Manager, NSW Refugee Health Service

"Refugee nurses place the patient in the centre of the care plan and work with trust, respect and time."

Tell us a little bit about your background and why you decided to work in refugee health?

I have been nursing for over 30 years, with a background in emergency nursing and education. In 1999, I was seconded to be the Nurse Manager for "Operation Safe Haven", which was the temporary shelter offered to 4,000 Kosovar Albanians. I managed the reception centre in Sydney and then stayed on to manage the reception and care for 1,200 East Timorese who had escaped the slaughter following the vote for an independent East Timor.

Following that work, I was nominated by ACN (then the Royal College of Nursing Australia) to represent them on the newly formed Detention Health Advisory Group, providing advice, policy frameworks and inspection capability in the immigration detention health networks across Australia, including Christmas Island. I am very proud of the work we achieved and saddened when the advisory body was disbanded by the incoming Immigration Minister in the Abbott government.

In 2012 I was appointed as the Nurse Manager at the NSW Refugee Health Service to introduce a nurse-led model of care called the Refugee Health Nurse Program.

Can you describe a typical day in your role?

I manage 11 nurse-led clinics across the Sydney metropolitan region. The program does early health assessments and care planning for newly arrived refugees in Sydney, ensuring that they are linked into services they require. So a typical day maybe reviewing offshore medical assessments (which enables me to triage for appointments), liaising with a myriad of stakeholders and/or representing the service at a variety of levels, including statewide and national meetings.

What are some important attributes a nurse should possess for working in refugee health?

Due to the vast range of health conditions that may present, refugee nurses need advanced clinical assessment skills; the ability to work in a cross-cultural context, including working with interpreters, and an understanding of the psychological trauma that their patients may have endured and how that trauma may manifest in day to day practice. Refugee nurses need to be keenly aware of the current political situations across the globe and must have an understanding of past world events that has led to this unprecedented movement of people across the globe.

Why is it important to have specialist nurse-led health services for refugees?

Refugees are particularly vulnerable and, when they arrive in a sophisticated first world country like Australia, they are often overwhelmed and bewildered. Nurses, with their holistic view of health, understand that settlement issues, such as housing, language, welfare and enrolment in education, are all competing priorities. Refugee nurses place the patient in the centre of the care plan and work with trust, respect and time. A 15-minute GP appointment is just not

sufficient time to do a comprehensive physical, psychological, dental, vaccination history and catch-up and mental health assessment that all refugees should receive when they arrive on our shores.

Do you think the current support services for refugees are sufficient?
Australia does have the best humanitarian resettlement program in the world. The Commonwealth Government recognises that upfront support services, such as allocated case managers, some supported (temporary) accommodation, access to interpreters, Medicare and English language classes is a best practice model that other countries are now emulating. Health is a priority in the settlement journey and all refugees have a health assessment within 28 days of arrival in Australia.

However, not everyone settles in the same way and for some families the settlement journey is fraught with difficulties. The six month support window needs flexibility to cater for those who require more time to find their way.

What do you hope to achieve throughout your career as a health care professional?
Great question! I hope, by the time I retire, that we see the launch of the professional interest group, the Refugee Nurses of Australia. I hope that by lobbying and appeals, the draconian Australian Border Defence Act 2015 is repealed. This act threatens two years' jail to nurses and doctors who speak out about the sexual and other abuse they have witnessed and or reported whilst employed in immigration detention centres. And, I want Nauru and Manus Island closed.

I hope that I have been a positive role model to my staff at the Refugee Health Service and that I have helped to raise the profile of both refugee health and the role that nurses play across Australia.

What are your hopes for the future of health care in Australia?
Despite our complaints, we do have a fantastic health system in Australia. I hope that we continue to produce graduates that represent this great multicultural community, that health gets all the funding it needs to run their systems and that the Department of Defence has to hold the cake stalls to raise the money for a new submarine!

MERILYN SPRATLING FACN

Refugee Health Nurse Practitioner/Refugee Health Nursing Coordinator, EACH Social and Community Health; Volunteer Nurse Immuniser, Asylum Seeker Resource Centre.

Tell us a little bit about your background and why you decided to work in refugee health?
Since completing my nursing training, I have mostly worked in community/primary health clinical settings. I enjoy this aspect of nursing because I believe community health enables me to better apply a holistic approach to nursing care. I have worked as a district nurse with the Royal District Nursing Service (RDNS), a community health nurse, a remote area nurse in the Northern Territory and a clinical nurse with the Victorian Aboriginal Health Service. For many years I worked in the Aboriginal Health Worker training program at the Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

I find working with people from different cultural backgrounds professionally challenging. It is not enough to apply the nursing skills I use in a 'mainstream' clinical setting, I have to problem solve with every person I care for so that their needs are appropriately addressed. It is necessary also to ensure my care is culturally sensitive and appropriate.

When the opportunity arose in 2009 to establish a new refugee health nursing program in the east of Melbourne, it meant I would have the additional challenge of establishing a program that would best meet the specific and particular needs of people of refugee-like and asylum seeker backgrounds, both newly arrived and those who have lived for some time in Australia.

Can you describe a typical day in your role?
The morning of a typical day for me will usually involve the assessment of a newly arrived refugee family, or two to three individuals who have arrived alone (people arrive as 'singles' commonly because they have been separated from their family members during their refugee experience, or they are reuniting with their family. This can be a happy time but not always, so I can never assume that reunions are always going to be positive experiences). The assessment may also be for a person or family of asylum seeker background or someone who has been in Australia for some time but has been referred for further assessment.

I will have arranged with the family's AMES (Adult Migrant English Service) case manager a suitable date and time of appointment (In the eastern region of Melbourne, all newly arrived people are referred by AMES settlement to the EACH refugee health nursing program for an initial refugee health assessment by a refugee health nurse). After arranging the appointment I book a professionally trained interpreter to attend the assessment appointment with me. The use of professional interpreters in all assessments is essential to ensure safe, effective practice even if people can speak some English.

The assessment is never predictable but my goal is to determine each person's needs in a safe environment. Establishing a degree of trust is essential, so time at the start of the assessment for thorough and careful explanations is essential. At the conclusion, referrals are discussed, including which general practitioner (GP) the person would like to attend. Referrals to other services such as optometrists, physiotherapists, MCH (Maternal and Child Health) nurses, audiologists, dentists and women's health clinics will depend on the needs arising from the assessment. Consent for any referrals are obtained before the end of the assessment.

"It is not enough to apply the nursing skills I use in a 'mainstream' clinical setting, I have to problem solve with every person I care for so that their needs are appropriately addressed."

In the afternoon of my typical day I may write the assessment report of the family I have seen that morning, a report for the GP which identifies each health issue including the supporting evidence, and make the referrals either internally to another EACH service or to other 'external' providers.

At other times, I could be administering Mantoux skin tests or reading the results (EACH refugee health networks conduct monthly clinics for all eligible people of refugee-like backgrounds), providing health education sessions (such as 'prevention of cancer' for a group of Iranian women), attending a meeting of the Victorian Refugee Health Network or its subcommittee on vaccination, or providing catch up immunisation (all newly arrived people will need some or all vaccinations to meet the Australian National immunisation schedule).

My role as a nurse practitioner (NP) continues to develop and in addition to what has been described involves leadership and teaching activities for a range of service providers including nurses, both at EACH and across the state. In collaboration with the two sessional EACH GPs, I manage a clinic that involves treatment of health issues within my scope of practice such as low vitamin D, positive schistosomiasis, strongyloides and Helicobactor Pylori. I also order follow-up pathology.

What are some important attributes a nurse should possess for working in refugee health?
I use every nursing skill I have almost every day. Refugee health care offers a variety of opportunities for nurses with different interests and skills. Some nurses focus on speciality areas such as women's health and mental health, however, it is valuable to have a broad range of skills as you will be supporting people from across the lifespan and their care needs are broad and varied so the holistic approach is a good working model of care for a refugee health network (RHN). The ability to recognise when to involve other health care providers when additional care needs outside a nurse's scope of practice is also needed.

Practice attributes for working with people of refugee-like backgrounds include:

- cultural safety and sensitivity
- belief in the rights of an individual to self-determination, especially in decision making about health care
- high-level physical, psychological and social assessment skills
- diagnostic skills
- clinical judgement skills within a care context that is often unpredictable
- ability to prioritise needs given that needs are normally complex and numerous
- knowledge of available health care and how to be resourceful when access is impacted
- ability to incorporate preventative health care into complex presentations
- commitment to health literacy for all
- a comprehensive understanding of family functioning and dynamics

Do you think the current support services for refugees are sufficient?
Client health outcomes would be further enhanced by developing the current professional development program for nurses, which includes the sharing of practice processes and outcomes. RHNs (and other health care providers) are a huge untapped resource who can be better supported to undertake research programs that identify and promote evidence based practice. Through the improvement of practice, client health care outcomes will be better supported.

Models of care which ensure that people of refugee-like backgrounds all receive early, comprehensive health assessments and then appropriate management and follow-up must be adequately funded. With the higher intake of people of refugee-like backgrounds predicted over the next few years, resourcing will be even more necessary to provide enough adequately trained and prepared health care providers to support these vulnerable groups. Resourcing, especially in mental health, including torture and trauma care, is also essential to better support people of asylum seeker background in the current political climate.

What do you hope to achieve throughout your career as a health care professional?
While not yet ready to retire, I am happy to report that I have achieved most of my goals in my health care career, especially gaining NP endorsement in a field of nursing that is immensely satisfying both professionally and personally. I do, however, have two more goals: I still want to further develop the model for the refugee health NP at EACH so the role is more clearly defined, operational and resourced, and provides a clear model for future NPs taking on this role. My second goal is to support and mentor other RHNs to achieve NP status.

TANIA CANAS

Arts director, RISE Refugee & Centre for Cultural Partnerships (VCA)

“We need more support services that shift from the ‘fixing’ model to a ‘flourish’ model.”

Tell us a little bit about your background and why you decided to work in refugee health?
I am not sure it was ever a conscious decision to work in this area. I think it was something I fell into because I was constantly negotiating and navigating a socio-political landscape and temporalities.

I often found myself in spaces that demanded dichotomised versions of me, demanded a performativity, whilst ignoring other aspects altogether. I saw how all this had health implications for myself, family and community. Thus, I sought ways to understand the confusion, contradictions and paradoxes that I kept encountering. I wanted to understand. I needed to understand. It was the difference between attributing to the personal, as opposed to attributing to the systemic and structural. It was the difference between the label of ‘refugee’ and that of contextual refugeeness.

My parents, sister and I came to Australia on the humanitarian program. At the time of leaving, my father had been a final year psychology student. Latin America, in particular Central America (most of which were in civil wars at the time), was developing liberation psychology. This type of psychology took a conceptual and practical look at the psychology of the oppressed by understanding the socio-political context in which they existed, whilst resisting the dominant western lens.

Therefore my family, Liberation Psychology (along with other theories from the global south), as well as Nueva Trova music, were major influences. Art, existence and being were always intertwined with the social and the political. My family, my background, my history and very existence in Australia are testimony to that.

This led to my interest in doing an undergraduate degree, with a major in both theatre and psychology, much to the amusement of my father who used to tease me about the western-centric psychology training I was undertaking. He would jokingly ask, “Oh, let me guess, you learned about Freud today, right?”

So it is this history, encountering contradictions and a whole lot of confusion that led me to the intersection I find myself in today: performance, advocacy, research and a more holistic, social-determinate understanding of health.

Can you describe a typical day in your role?
There is never a ‘typical day’ in my role, because I am juggling the demands of a research degree, independent arts projects and advocacy (which entails a lot). That is what keeps it interesting though, because the focus/aims are the same, they just manifest differently.

If I’m working on the research, it is pretty much sitting at the computer, buried in books and surrounded by a lot of caffeine. If it is more RISE based work, it is a lot of emailing, phone calls and admin related things. If its independent art projects I get a little more wriggle room and find no-academic, creative spaces to work, such as art centres or quiet cafes.

What are some important attributes a nurse/practitioner should possess for working in refugee health?
As with arts practitioners, I think it requires an understanding beyond the method, mechanics and techniques. These are all important but without a theoretical, contextual understanding as to how these are applied, one can never create reflexive or safe spaces.

I believe one should also value intersectionality, acknowledging human existence as socially and politically complex as opposed to falling into simplistic, dichotomous, pre-determined framing and subsequent modes of expression (or symptoms!)

Do you think the current support services for refugees are sufficient?
No. Often health models follow neo-liberal demands and restrains with a very customer-service, individualised, momentary interaction approach with regards to understanding health. Services for refugees often, ironically, do not centre the voice of the community – unless it is to pathologise.

The approach often materialises being to mechanics. This often means materialistic-welfare-based approaches without fundamental understanding of processes that are self-determining or self-actualising. We need more support services that shift from the ‘fixing’ model to a ‘flourish’ model.

What are your hopes for the future of health care in Australia?
I hope the future of health care in Australia starts to unpack its own definition, set of assumptions and historical moulding and in so doing understand its limitations, restrictions, incapacities but more importantly its potential.

I hope the future involves opening up to other definitions of scientific, medical, knowledge, voices and ontologies as well as its relationship with the socio-political. I hope the future goes beyond technological advancements and seeks to understand the more complex, messy, unknown grey area of holistic practice. I hope it begins to prioritise communal-self-actualisation.

THE NATIONAL NURSING FORUM

26–28 October 2016

THE POWER OF NOW

Melbourne Park Function Centre

PRELIMINARY PROGRAM AND SPEAKER PROFILES

This year's National Nursing Forum, THE POWER OF NOW, in Melbourne will provide nurses from around the country the chance to hear from an international and local speaker line up highlighting current issues, challenges and opportunities faced by today's nurse leader. The Forum program includes highly topical sessions for attendees and will open up discussions on important and complex matters for nurse leaders who play a critical role in delivering health services to the community.

LIFT OUT

Preliminary program

DAY ONE – WEDNESDAY 26 OCTOBER

9:00am	**MC introduction** **Brian Dolan MACN (Associate)**
9:05am	**ACN President welcome** **Adjunct Professor Kathy Baker AM FACN (DLF)** *Board President, Australian College of Nursing*
9:10am	**Opening address**
9:30am	**Keynote session:** ***Free to be me; supporting nurse leaders to reach their full potential*** Hear from industry experts on how they are leading the way as health care professionals. **Dr Louise Schaper** *Chief Executive Officer, Health Informatics Society of Australia (HISA)* **Fiona Brew MACN** *Interim CEO, Goulburn Valley Health* **Adjunct Professor David Plunkett MACN** *Executive Director – Acute Health and Chief Nursing and Midwifery Officer, Eastern Health*
11:00am	**Morning tea and exhibition**
11:30am	**ACN Talks – Concurrent Session One** Presentations from leaders across the nursing profession in the areas of health and aged care, education, management, academia, clinical and research that will address the most current and topical issues affecting nursing today.
1:00pm	**Lunch and exhibition**
2:00pm	**Nursing and Midwifery Board of Australia Update** An update from the Nursing and Midwifery Board of Australia in relation to registration standards, codes and guidelines.
2:30pm	**Refugee Nurses of Australia** **Sandy Eagar FACN** *Nurse Manager, NSW Refugee Health Service* **Lindy Marlow** *Chair, Refugee Nurses of Australia*
2:40pm	**Keynote session** **Professor Christine Duffield FACN** *Director of the Centre for Health Services Management (CHSM), University of Technology Sydney*
3:00pm	**Afternoon tea**
3:30pm	**Speed leading session** A unique opportunity for delegates to interact, seek advice and establish new connections. Delegates will be able to nominate themselves as either a mentor or mentee for this session.
4:30pm	**ACN AGM**
5:15pm	**Drinks with the ACN CEO and Board Members** A special function open to all delegates, offering an opportunity to get together and network with your fellow ACN members, fellows and colleagues.

DAY TWO – THURSDAY 27 OCTOBER

9:00am	**MC Recap** **Brian Dolan MACN (Associate)**
9:10am	**Keynote session:** ***The importance of nurse leadership in Australia*** Prominent nurse leaders will discuss how we as a profession can keep nursing relevant into the future and ensure the longevity of the workforce. **Adjunct Professor Debra Thoms FACN (DLF)** *Commonwealth Chief Nursing and Midwifery Officer, Australian Department of Health* **Adjunct Associate Professor Lydia Dennett MACN** *Chief Nurse and Midwifery Officer, SA Health* and *Chair, Australian and New Zealand Council of Chief Nursing and Midwifery Officers* **Ms Ann Maree Keenan** *Chief Nurse and Midwifery Officer, Department of Health and Human Services Victoria*
10:45am	**Morning tea, exhibition and poster presentations**
11:30am	**ACN members and colleagues session** An interactive session to hear the latest updates from ACN and an opportunity to take part in regional based activities.
1:30pm	**Lunch and exhibition**
2:30pm	**ACN Talks – Concurrent Session Two** Presentations from leaders across the nursing profession in the areas of health and aged care, education, management, academia, clinical and research that will address the most current and topical issues affecting nursing today.
3:30pm	**Afternoon tea and exhibition**
4:00pm	**ACN Talks – Concurrent Session Three** Presentations from leaders across the nursing profession in the areas of health and aged care, education, management, academia, clinical and research that will address the most current and topical issues affecting nursing today.
5:00pm	**Close of Forum day two**
7:00pm	**Forum Gala Dinner** A special evening is planned for delegates to unwind and celebrate our profession. The Gala Dinner will incorporate the prestigious ACN Oration, Awards and Investiture of Fellows.

DAY THREE – FRIDAY 28 OCTOBER

9:00am	**MC Recap** **Brian Dolan MACN (Associate)**
9:10am	**Keynote session:** ***The power of now in nurse education and research*** Prominent nurse leaders will discuss how we as a profession can keep nursing relevant into the future and ensure the longevity of the workforce. **Professor Wendy Cross FACN** *Associate Dean, Nursing and Allied Health, Monash University* **Professor John Daly FACN** *Dean, Faculty of Health and Head of the UTS/World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development, University of Technology Sydney*
10:30am	**Nurses influencing policy** An interactive session providing delegates with an opportunity to discuss their needs with the Shadow Minister for Health, Victoria. **The Hon. Mary Wooldridge MP** *Shadow Minister for Health, Victoria*
11:00am	**Morning tea and exhibition**
11:30am	**Masterclass session one** Delegates will choose from four masterclass topics.
1:00pm	**Lunch and exhibition**
2:00pm	**Masterclass session two** Delegates will choose from four masterclass topics.
3:30pm	**Afternoon tea and exhibition**
4:00pm	**The Power of You** **Dale Fisher** *Chief Executive, Peter MacCallum Cancer Centre*
4:45pm	**Forum close** Prizes will be drawn and delegates are invited to stay and join the team for a farewell drink.

Speaker profiles

Brian Dolan MACN (Associate)
Director, Health Service 360

Fiona Brew MACN
Interim CEO,
Goulburn Valley Health

Adjunct Professor David Plunkett MACN
Executive Director – Acute Health and Chief Nursing and Midwifery Officer, Eastern Health

Professor Christine Duffield FACN
Director of the Centre for Health Services Management (CHSM), University of Technology Sydney

Adjunct Associate Professor Lydia Dennett MACN
Chief Nurse and Midwifery Officer, SA Health and Chair, Australian and New Zealand Council of Chief Nursing and Midwifery Officers

Dr Louise Schaper
Chief Executive Officer, Health Informatics Society of Australia (HISA)

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Associate Dean, Nursing and Allied Health, Monash University

Professor John Daly FACN
Dean, Faculty of Health and Head of the UTS/World Health Organization Collaborating Centre for Nursing, Midwifery and Health Development, University of Technology Sydney

Dale Fisher
Chief Executive, Peter MacCallum Cancer Centre

The Hon. Mary Wooldridge MP
Shadow Minister for Health, Victoria

Forum registration fees

ACN MEMBERS	
Early bird full	$650.00
Standard full	$750.00
Day delegate	$400.00
NON-MEMBERS	
Early bird full	$850.00
Standard full	$950.00
Day delegate	$500.00
STUDENTS	
Early bird full	$450.00
Standard full	$550.00

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SHEGOFA ZAHIDI

Refugee Health Nurse, Monash Health Community

"Having a passion to make a difference and being a positive role model for my fellow asylum seekers and refugees was the perfect combination for me to get into the asylum seeker and refugee health sector."

Tell us a little bit about your background and, if applicable, how it contributed to your decision to enter the health care sector?
I was born in Afghanistan and migrated to Pakistan when I was three years old. I was living in Pakistan as a Hazara refugee until 2005 when I migrated to Australia. My father came to Australia via boat as an asylum seeker under the leadership of John Howard 15 years ago.

I always wanted to help people and make a difference in people's lives – health care is an area where you an to do that. I do believe my background influenced me to work in the health care sector.

What division of the health care sector are you currently working in? Why did you decide to work in this particular area?
Currently, I am working as a refugee health nurse. Being from a refugee background, speaking six different languages, having a passion to make a difference and being a positive role model for my fellow asylum seekers and refugees was the perfect combination for me to get into the asylum seeker and refugee health sector.

Were there specialist support services for refugees when you arrived in Australia? If so, did you access these and what was your experience?
When I first came to Australia there was not much support for refugees – or maybe I was not aware of them – to help us settle in our new home. When I first started my Bachelor of Nursing in 2009, people would occasionally question my scarf and my religion. I did my practical placement in multiple public hospitals where people would criticise me for wearing a scarf and practicing my culture and religious beliefs, as there was not much awareness of my point of view. I do feel that we have come a long way in regards to acceptance of each other, however, we still need to work more in this area. I also think that culture awareness competencies should be part of the training in every health care sector.

It is very important to have specialist refugee services, as they need more comprehensive support in settlement and learning about the health care system and way of life because of their traumatic past experiences. The specialist services would be able to provide comprehensive support within social determinants of health which would encourage and promote independence.

What do you hope to achieve throughout your career as a health care professional?
I hope to keep providing health education and promotion to refugees and asylum seekers to increase health literacy, improve access to services and promote independence. I also hope to increase awareness among my health care colleagues as well as wider communities about asylum seeker and refugee needs and concerns, and promote access and advocacy for the most vulnerable individuals. We all need to appreciate the resilience and strength of asylum seekers and refugees who are ready to make a difference and be part of Australian society if given the opportunity.

What are your hopes for the future of health care in Australia?
I hope that in the future, health care in Australia would be more accessible and inclusive of needs of very vulnerable individuals in our communities.

HUNDREDS OF NURSES DOWNLOAD NEW PALLIAGEDNURSE APP

Nearly 500 nurses around Australia downloaded the new palliAGEDnurse app in the first 10 days following its launch on International Nurses Day on 12 May. Many more nurses are expected to download the free app during the coming months.

palliAGEDnurse is designed for nurses caring for older people near the end of life and provides access to current clinical advice at the point of care. Available through Google Play and the Apple Store, the app has been developed as part of the Decision Assist program for aged care staff in residential and community settings. It provides clinical advice based around three key areas – advance care planning, case conferencing, and terminal care.

The app was developed by the CareSearch Project Team at Flinders University, following the production last year of the palliAGED app for general practitioners (GPs).

SUITE OF TWO PALLIAGED APPS

The positive response from GPs to the palliAGED app (which has had about 3,200 downloads since its launch in April 2015) has led Decision Assist to produce this second app for nurses, marketed through app stores as a suite of two apps – one for GPs and one for nurses.

CareSearch Director, Associate Professor Jennifer Tieman from Flinders University, identified several reasons for the palliAGEDnurse app development. “With the rapidly expanding knowledge base for clinical practice it can be challenging for health professionals – including nurses – to keep their knowledge and skills up to date,” she said.

There are more than 20,000 registered nurses, 13,300 enrolled nurses and more than 106,000 personal care assistants practicing in residential aged care and community care across Australia. The variety of locations in which these nurses are providing care to older people raises the need for portable resources for them to consult at the point of care, said Associate Professor Tieman.

For example, increasingly older people are enabled to live at home through the provision of Australian Government home care packages and many are spending some or all of the last year of their life at home. Nurses will therefore need to be able to recognise and address their palliative care needs on the spot. “Web based resources that are constantly updated are helpful for this, and the growing use of apps prompted Decision Assist to explore different ways to share clinical knowledge and encourage its use in practice,” said Associate Professor Tieman.

Whatever the location for care, nurses usually need similar information as well as some setting-specific ideas which are provided through the app.

A PALLIATIVE CARE APPROACH

Being able to recognise that an older patient may die within the next 12 months is an opportunity for nurses to plan for changing care needs. Using a palliative care approach, the palliAGEDnurse app provides four key sections:

- Understanding a palliative approach (and identifying older people needing a palliative approach)
- Advance care planning
- Palliative care case conference
- Terminal care planning

APP KEEPS UP TO DATE AND WORKS ANYWHERE

CareSearch has designed the app to constantly update the advice that it gives nurse users. Being web based, the app goes to the website – where new evidence is published – to read its content. This content can also be viewed on a computer or a tablet. “This means that you don’t have to use the app to access the information if you don’t have a smartphone or if your smartphone is a bit older and does not work with some of the new standards,” said Associate Professor Tieman.

“The linked website has a responsive design, which means you can just view it on your phone screen and the presentation will adjust for your type of device. One valuable addition has been developing a solution that enables you to still have a version of the app if you go out of internet range. In the past, this would generally mean that the app dropped out and couldn’t be viewed until you were back connected to the internet.

“Now, we have enabled a solution that holds a version locally in the phone, so if you go out of internet range, the app still works. And if something changed while you out of range, when you come back it will automatically update.”

To download the palliAGEDnurse app, go direct to Google Play or the App Store.

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SHINING A LIGHT ON CHRONIC DISEASE IN AUSTRALIA: ACN REVIEWS INQUIRY REPORT ON CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PRIMARY HEALTH CARE

By Anita Pak, Stacie Murphy MACN and Stefan Wythes, ACN Policy Team

In August 2015 the Australian College of Nursing (ACN) and four other nursing organisations – the Australian College of Mental Health Nurses (ACMHN), the Australian Primary Health Care Nurses Association (APNA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), and Maternal, Child and Family Health Nurses Australia (MCaFHNA) – collaborated to produce the Joint Submission to the Australian Parliamentary Standing Committee on the Health Inquiry into Best Practice in Chronic Disease Prevention and Management in Primary Health Care (the Inquiry) (ACN et al. 2015).

The House of Representatives Standing Committee on Health (the Committee) was referred to inquire into and report on "best practice in chronic disease prevention and management in primary health care" (The Parliament of the Commonwealth of Australia 2016, p. xiv), including opportunities to support improvements in chronic disease prevention and management via Medicare, Primary Health Networks (PHNs) and considering the roles of private health insurers, and state and territory governments. The Inquiry was also referred to examine innovative models and best practice multidisciplinary teams working in chronic disease prevention and management in primary health care and hospitals, as well as models of primary health care that improve outcomes for regular users of health services (The Parliament of the Commonwealth of Australia 2016, p. xv).

The Joint Submission presented a range of recommendations to the Inquiry, underpinned by the view that "Australia must have a strong, well-connected and well-resourced primary health care system, where prevention and health promotion are prioritised and where the workforce is effectively developed and utilised" (ACN et al. 2015, p. 11). The Committee's final report on the Inquiry into Chronic Disease Prevention and Management in Primary Health Care (the Committee Report) was released on 5 May 2016.

ACN reviews the Committee Report recommendations and considers whether it offers a way forward for addressing chronic disease in Australia.

OVERALL ASSESSMENT OF THE COMMITTEE REPORT

The burden of chronic disease in Australia is increasing, with the Australian Institute of Health and Welfare (AIHW) report Australia's Health 2014 identifying that more than one third of Australia's population report living with at least one chronic disease, with many people having more than one chronic disease (AIHW, 2014). With this in mind, ACN believes, overall, the findings of the Committee Report represent a positive step towards health reform in Australia but do not offer the transformational change sought by the recommendations outlined in the Joint Submission.

ACN was pleased to see the Committee Report emphasise and reflect a clear understanding that prevention is critical to addressing the impacts of chronic disease, and that care coordination and multidisciplinary approaches are required to effect substantive change.

The Committee Report's overall assessment was that these approaches could only be pursued if supported by "cooperation, coordination, evaluation and adequate data and records to support Primary Health Networks in fulfilling their important role as coordinators of care" (The Parliament of the Commonwealth of Australia 2016, p. x). In line with the Committee's assessment, our organisations' Joint Submission specifically recognised that there is opportunity to broaden the purview of PHNs in coordinating chronic disease prevention and management, particularly building cross-sectoral local-level stakeholder partnerships (ACN et al. 2015, pp. 29-32).

While largely in support of the Committee Report findings, ACN would have preferred to see a breakaway from the restrictive dependence the Committee Report recommendations maintain on existing funding arrangements and general practice in the provision of coordinated chronic disease prevention and management. Our organisations' Joint Submission calls for bolder reform recommendations to encourage the Australian Government "to examine how Medicare/government funding can support the integration of a more comprehensive suite of services, including community-based social services, aged care services and disability care" (ACN et al. 2015, p. 5). In addition to calling for wider Medicare review and reform processes, the Joint Submission advocated for the government to explore alternative funding arrangements to create access to chronic disease prevention and management services provided by nurses through block or grant funding (ACN et al. 2015, p. 5). The Committee Report did not incorporate these broader expectations.

MULTIDISCIPLINARY CHRONIC DISEASE PREVENTION AND MANAGEMENT MODELS

The Committee Report appropriately recognises that health care for chronic disease in Australia

ACN believes that improving prevention and care for chronic conditions requires substantive reform to primary health care policy and funding arrangements.

should be a "cohesive and coordinated cycle" but is often lacking in effective coordination. In line with this, a key finding of the Inquiry was the need for a "patient-centred holistic care model" to support the prevention and management of chronic disease (The Parliament of the Commonwealth of Australia 2016, p. 37). The Committee Report expressed the strong view that trials of Health Care Homes, with the intent of promoting closer service integration, are an essential move in the right direction for better coordinated multidisciplinary care for people with chronic conditions.

Independently, ACN offered principle support for the establishment of Health Care Homes to improve approaches to chronic disease prevention and management. ACN argues, however, that care coordination can be led by health professionals other than general practitioners (GPs) such as, nurses through dedicated nurse clinics (ACN 2016, Australian Primary Health Care Nurses Association (APNA) 2015). The Joint Submission provided the Inquiry with examples outlining the merits and benefits of nurse clinics in chronic disease prevention and management (ACN et al. 2015).

Access to well-coordinated multidisciplinary health care is a central theme in the Committee Report.

Our organisations' Joint Submission also emphasised that people with chronic and complex health conditions require collaborative multidisciplinary approaches to care and service delivery. ACN welcomes the Committee Report Recommendation 4 – that the Australian Government "examine the process for a chronic disease patient to be referred for initial specialist assessment by a Medicare Benefits Schedule registered allied health professional without the need to get a referral for their general practitioner" (The Parliament of the Commonwealth of Australia 2016, p. xxiv). If adopted, this policy option that goes some way to recognise the scope of practice of relevant allied health professionals, would drive systems efficiencies through more effective utilisation of the allied health workforce.

ACN notes, however, that the recommendation firmly commits to maintaining current service model restrictions, albeit less rigidly, by stating the policy would apply "only when: the patient was originally referred to the allied health professional by their general practitioner; and the original referral indicates that specialist assessment may be warranted if the allied health professional agrees it is warranted" (The Parliament of the Commonwealth of Australia 2016, p. xxiv). While this effectively limits the autonomy of the allied professional by ensuring the GP maintains significant control over decision-making, it would be a positive step toward reducing unnecessary dependence on GPs in the primary care context and could potentially set foundations for framing future reform.

ENHANCING THE ROLE OF NURSES

An overarching message our organisations provided to the Inquiry was that with enabling policy and funding arrangements in place, nurses could make a greater contribution

"Improving prevention and care for chronic conditions requires substantive reform to primary health care policy and funding arrangements, including arrangements that support enhanced nursing roles."

to addressing chronic disease. Our Joint Submission clearly outlined how nurss, as the glue that holds the health system together, have significant reach and wide-ranging skills make the nursing profession "the most efficient and effective means of delivering and coordinating chronic disease prevention and management in Australia" (ACN et al. 2015, p. 13). In this vein, the Committee Report Recommendation 5 promotes the greater utilisation of nurses but, similar to allied health professionals, on the proviso that GPs maintain control. The Committee Report recommends that the "Australian Government explore ways to expand and better utilise the role of nurses in the provision and coordination of care for chronic disease management within a general practitioner-led system" (The Parliament of the Commonwealth of Australia 2016, p. xxiv).

ACN stresses that a consistently GP-led system will, in some circumstances, maintain existing barriers to service access: for example, in providing chronic disease prevention and management services for hard-to-reach individuals, groups and communities, and to communities where there are no GPs. If Australia's health systems are going to cope with the challenges of increasing rates of chronic disease, ACN believes there needs to be a more significant shift from existing models of care, particularly fee-for-service arrangements, which can incentivise unnecessary provision of services. This means examining opportunities to enhance the role and contribution of nurses in the provision and coordination of chronic disease prevention and management across the full breadth of primary health care services.

FUNDING MODELS

The Committee Report outlines several reform recommendations that promote expanding particular Medicare items and the Practice Incentive Program to increase access to allied health services for people with chronic health conditions (The Parliament of the Commonwealth of Australia 2016). While these measures would contribute to the broadening of service access, they do not represent substantive reform. Our organisations' Joint Submission highlighted that systemic change of the health system can be achieved to improve health outcomes for people with chronic health conditions. It advocated that exploring new funding models could integrate services across siloed areas of the health system and help develop new ways of delivering services: for example, the Joint Submission advocated for broader systems funding reform through a blended or mixed payment method (ACN et al. 2015, pp. 4-5).

COMMITTEE REPORT GAPS

Our Joint Submission articulated a clear argument that recognised that Social Determinants of Health (SDH) are often key contributing factors to the development and advancement of chronic diseases, and that they must be addressed to bring about effective and sustainable prevention and management of chronic disease. The Committee Report acknowledges submissions received that point to the impacts of the SDH and noted the impacts of SDH, including links with primary health care policy. While the Committee Report places appropriate focus on the utilisation of primary health care services and primary prevention to address chronic disease, disappointingly there are no specific recommendations addressing the SDH.

A major gap in the findings of the Committee Report is the lack of specific recommendations that refer to the management and care pathways of Aboriginal and Torres Strait Islander (ATSI) people with chronic and complex health conditions. ACN believes that greater utilisation of the primary health care sector in the provision of ATSI health services is integral to reducing the burden of chronic disease in ATSI people.

It is broadly agreed that there is a growing issue of chronic disease management and prevention in Australia. ACN believes that improving prevention and care for chronic conditions requires substantive reform to primary health care policy and funding arrangements, including arrangements that support enhanced nursing roles.

The Australian College of Nursing (ACN) is committed to ensuring that the expertise and experiences of nurses are represented in policy development throughout the Australian health system. ACN is regularly invited to provide input and advice to government and non-government consultations on a number of nursing and health-related matters. In order to provide the most comprehensive responses, ACN seeks input from members in their relevant areas of expertise. Additionally, ACN sets its own policy agenda by actively identifying, examining and advocating on priority issues for the nursing profession. To view the Joint Submission to the Standing Committee on Health's Inquiry into Best Practice in Chronic Disease Prevention and Management in Primary Health Care or other consultations that ACN has participated in, please visit www.acn.edu.au/policy-submissions.

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AUSTRALIA'S PLATFORM FOR HEALTH REFORM

By Liza Edwards MACN and Stefan Wythes, ACN Policy Team

BACKGROUND

Health has been a significant issue at every federal election in Australia since the mid 1940s, however, now more than ever, the need to reform and modernise Australia's health care system is critical. While reform did indeed emerge as a priority on the government's agenda after the federal election in 2013, yet another election has since passed and Australia is still awaiting for new and significant health policy platforms required to take the 'lucky country' into a future supported by a sustainable, world class health system.

The ongoing political game played within Australia's health care system has Australians watching endless plays back and forth over the 'big ticket items' including hospital funding agreements, Medicare rebates, changes to incentive payments for pathology providers, private health insurance and changes to primary care, particularly health care for people with chronic disease. The run up to the federal election presents an interesting space within which the Australian community will learn and may influence exactly what Australia's political leaders believe to be the priorities for our health system, as evidenced by the recent backflip by the government on its general practitioner (GP) co-payment proposal.

However, this has not always been the case. Prior to federation in 1901, the only health portfolio controlled by the Commonwealth Government was quarantine, with the overall responsibility for health care resting with the States (Department of the Prime Minister and Cabinet 2014). Over ensuing decades, health care in Australia has become increasingly politicised, with the Commonwealth intervening to ensure equitable access to health care for Australian citizens, particularly since the end of WWII. Inevitably, as a result, there has been an increasing blur in the lines of responsibility for the delivery of health services between the Commonwealth, and States and Territories (Department of Prime Minister and Cabinet 2014).

Australia's health system has evolved over more than 70 years and, in many situations, no longer meets the needs of Australia's communities whose needs have diversified enormously and well in advance of our health care system. Factors including geography, gender, culture, age, lifestyle choice and socioeconomic circumstance all add to the difficulty of ensuring a multidimensional approach to the provision of a wide range of services, including acute, primary, emergency and community health services.

While for many Australians, their interaction with Australia's health system can seem as simple as a visit by a community nurse or to a GP, the system at large can best be described as an increasingly complex and confusing maze of services, providers, recipients and organisations, all of which are linked by an overlying web of legislation, policy, funding mechanisms, regulation and governance. In addition, the overall responsibility for service provision rests with various levels of government, yet the planning, coordination and delivery of services is shared between both government, business and the not-for-profit sector (Australian Institute of Health and Welfare (AIHW) 2014).

It is therefore seen as no surprise that our evolving system has inevitably created problems, particularly with equitable access to adequate, high quality health services, fragmentation and duplication, inadequate service provision in areas such as mental health, and the prevention and management of chronic disease. The need to address these issues, including examining the way services are organised, utilised, funded and delivered is essential.

A system of this scale and complexity is expensive. Spending on health care in Australia was estimated at $140.2 billion in 2011-12, equivalent to 9.5% of our gross domestic product (GDP). The amount was more than 1.5 times higher than in 2001-02, with expenditure rising faster, rather than in line with, population growth (AIHW 2014).

While growth and ageing of our population is certainly a contributing factor, this has realistically attributed to only about 25% of expenditure above the Consumer Price Index (CPI) since 2002-2003 (AIHW 2016). Utilisation of health services is also determined by the growing capability of a system fed by advancing technology and an increasing expectation from the community that services are freely available. Quite simply, as our population grows and becomes increasingly literate in health care, more episodes of service delivery are being generated; whether these are visits to specialists, nurse practitioners (NP), GPs or allied health professionals, the result is increasing numbers of consultations, diagnostic investigations, prescriptions and treatments, all of which result in increasing costs to our health care system (Duckett & McGannon 2013).

The concept of health reform in Australia is far from new. Early reform efforts to establish a national insurance scheme in Australia in 1928, 1938, 1946 and 1950 remained unsuccessful in the face of opposition from stakeholders unwilling to face competition, accept set remuneration and contribution arrangements (Gray 2004) to the implementation of the initial scheme known as Medibank in 1975, and finally the revised universal health insurance scheme known today as Medicare in 1984. Successive federal governments have since identified many initiatives to progress the efficiency of Australia's health care system, however, many have never come to fruition due to complex and intertwined fiscal responsibilities, poor design and or implementation, inadequate funding or absence of the necessary political resolve (Productivity Commission 2015).

“Australia needs to engage in deep and rigorous reform throughout all levels of its health care system to make it better and fairer for all, and to ensure our health system reflects the values of our community.”

In 2008, the Prime Minister and the Minister for Health and Ageing announced the establishment of the National Health and Hospitals Reform Commission established to develop a long-term health reform plan for Australia (Department of Health and Ageing 2009). In 2009, the National Health and Hospitals Reform Commission released its final report, *A Healthier Future for all Australians*, which posed a reform agenda centred on the needs and interests of the Australian people that needed to:

“Address the major access and equity issues facing communities; redesign the existing health system to meet emerging challenges; and create an agile, responsive and self improving health system for future generations.”

(National Health and Hospitals Reform Commission 2009)

The report made 123 recommendations based on four themes:

Taking responsibility

Individual and collective action to build good health and wellbeing — by people, families, communities, health professionals, employers, health funders and governments

Connecting care

Comprehensive care for people over their lifetime

Facing inequities

Recognise and tackle the causes and impacts of health inequities

Driving quality performance

Leadership and systems to achieve best use of people, resources and evolving knowledge

Five years after the National Health and Hospitals Reform Commission was established, the chair of the commission, Christine Bennett, undertook a review of progress against the recommendations of the report and found that despite a positive response to the report, key challenges continued to inhibit progress. These included the vertical fiscal imbalance between federal and state governments, a need for system-wide leadership, the ability to access the right care at the right time, and to reduce inefficiency and waste, together with an urgent need to increase the focus on preventative care and addressing the social determinants of health (Bennett 2013).

Today, almost another five years later, these issues continue to summarise ongoing challenges in today’s health care reform efforts.

It may be said that while the life expectancy and health status of populations in many countries are continually improving, technology advancing, and drugs and medical approaches becoming more accessible, that the current state of play is successful, but Australia needs to engage in deep and rigorous reform throughout all levels of its health care system to make it better and fairer for all, and to ensure our health system reflects the values of our community.

Such reform will be incredibly difficult to design and implement, and with so many stakeholders to engage and bring to the table, all with competing interests, there will always be the temptation to just tinker at the edges, implementing reforms or ideas known to have been successful elsewhere. With an ageing population and increasing demand for appropriate care, and the need to ensure that every dollar spent on health care delivers maximum value, governments must progressively implement strategic health policy platforms that address current complex funding mechanisms, promote prevention and care coordination, reduce fragmentation and that implement flexible and evidence-based health workforce reforms.

How does policy underpin health reform? Watch out for the next issue of The Hive as the policy team continues to examine important health policy issues.

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JILL AND TERRY: A STORY ABOUT SUPPORTING SEXUALITY IN HEALTH CARE

"It was clear to me in writing this book that it was very much Jill and Terry's story as much as it was a tale of how health professionals deal with human sexuality."

Author David Stanley MACN recalls his journey in writing Jill and Terry, *and the lessons behind their story*

David Stanley MACN

David is a nurse and midwife with more than 35 years' experience in the nursing profession in management and leadership positions. He has taught in higher education institutions around the world since 2001.

INTRODUCTION

"The circumstances described in the book *Jill and Terry* are based on real events and the author's actual experiences. Although all the names used throughout the book have been changed."

This is how the book starts and the real events within are indeed based on the recollections of the author. These events took place in Adelaide in the late 1980s and early 1990s and are recounted in the book as a reminder of a time when conservative views and practices held less sway in society.

The book was also written to bring into focus issues of sexual health and how nurses and health professionals deal with (or fail to deal with) a central aspect of health care – human sexuality.

The story is set in a residential care facility and describes a love story, of sorts, between two residents; Jill and Terry. Jill and Terry each lived with serious disabilities and, while this impacted on many aspects of their lives, they were able to build a loving relationship that led to their marriage and eventual co-occupancy in a ward at the residential facility.

They faced many hurdles and barriers from ignorant or biased health care staff, but also found an administration willing to embrace a new way of dealing with resident sexuality. With the support of a small group of courageous staff. The Sexual Therapy, or ST, Group helped Jill and Terry as fully as possible. Specifically, the book details how the ST Group was formed and how the members worked together as a genuinely multidisciplinary group to help Jill and Terry address their sexual needs.

HOW THE BOOK CAME ABOUT

I had been working on the book for about 15 years on and off. It had a number of false starts and faced a number of challenges in terms of detail and storyline emphasis. After tinkering with various chapters, I was motivated to complete the book because of my encounters with a number of undergraduate nursing curricula in Australian and the UK.

It became evident that little of any of the curricula focused on addressing or providing information about human sexuality and how nurses could support or deal with the challenges this area of health care presented. I had written an article about my experiences with Jill and Terry in 1998 ("Hot Potatoes" The Agony and the Ecstasy, Nursing Times, June 17, Vol. 94, No. 24, under the pseudonym Hilary Francis) and had been using this in various teaching events to address topics of disability, client choice, ethics and human sexuality. However, I had always thought that the article raised more questions than answers and the book was a way of filling in the missing parts and fleshing out the scope of the ST Group activities and telling Jill and Terry's story. For it was clear to me in writing this book that it was very much Jill and Terry's story as much as it was a tale of how health professionals deal with human sexuality.

EXCERPT FROM CHAPTER 4

In this chapter, John (the principle character and ST Group member) has gone home after being invited to join the ST Group. Before he agrees he feels it is important to discuss this invitation with his partner and he is reflecting on his own experience of dealing with issues of human sexuality as a nurse.

As John waited for Sophie and Grace to return, he thought about the topics and issues raised in the sexual therapy workshops. The fact that although sexual health is a common feature of a nurse's assessment, it was often overlooked or poorly considered because some nurses were too shy or embarrassed to ask the often difficult or personal questions that relate to a person's sexual health. John wondered too if it was because some nurses commonly failed to see the relevance of a person's sexual health when they were dealing with someone who was ill or in hospital, for reasons other than sexual health related issues. John had often listened to the students' stories of residents' or patients' expression of sexual frustration. He also knew from listening to the residents who participated in the workshops that many felt that nurses viewed them as asexual and could not understand or didn't want to recognise that even sick or disabled people had sexual needs and desires.

John thought about his own experiences as a male nurse and midwife and the often difficult and embarrassing moments he had experienced in his career. As a student nurse, he remembered his acute embarrassment at having to assist a young woman of his own age with a shower. She had broken her ankle whilst playing hockey and John had been allocated to her care. Never one to shirk in the face of a challenge, John politely, but shyly, introduced himself and proceeded to help the patient to the shower room. It was clear that they were both uncomfortable as John helped her out of her night-gown, but their embarrassment multiplied as John bent down and struggled to take her underwear off over her injured limb. Humour is an excellent tool in these circumstances and it was the patient that said, "You have my pants off and I didn't even get a meal and a movie."

"And I am not going to give you my number either," said John. Their comments broke the tension and crippled the embarrassment a little. "Now that you are ready, I'll turn on the shower and leave you to wash yourself, if that's alright?" John explained before leaving the shower room. Their banter had eased the tension and when John returned to help dry and dress the young woman they were able to have a 'normal' conversation and establish a suitable therapeutic relationship.

There was nothing in his training as a nurse that had prepared him for dealing with that sort of situation. No one had explained any strategies for maintaining a therapeutic relationship when faced with a naked young woman. Should a female colleague have been called to do this job? Probably, John thought. But for centuries female nurses had been washing and dressing young men. How had they coped with the issues that had, often quite literally, 'arisen'? These issues were never discussed in nurse training school and he was sure his female colleagues were more often in situations where patients' sexuality or their own sexual interest was tested.

As a student midwife, John had been surprised by the attitude of a more experienced midwife when she reacted negatively to a request from a woman, who had given birth only hours before, to allow her husband to spend the night lying next to her on her bed.

The experienced midwife refused the woman's benign request because they thought the couple might, 'do more than cuddle.' One suggested his presence would interfere with their being able to take observations and another that the woman needed to rest and that he would be a hindrance to this. John's impression was that they had just shared in the experience of her first birth and that they were in love and wanted to be together.

John didn't see how the husband's being there to comfort and help his wife would be a hindrance to her resting, or the midwives' ability to do the postnatal observations. However, as a student midwife, John hadn't spoken up. He didn't feel he could. The more senior midwife on the shift made the decision and the husband was told to go home. At coffee break, later that shift, the staff discussed the husband's request and most views supported the decision made by the senior midwife. It was the predominant view that what the couple had requested was somehow disgusting or perverted that worried John the most.

When he spoke up with his thoughts that the request was harmless and innocent and should have been supported, he was met with a barrage of derision and reminded that he was "just a student". John was told "that he had a lot to learn about midwifery" and that men (he wasn't sure if they meant the husband or him as a male midwife) "had no place in a midwifery unit". John reflected that at the time he did indeed have a lot to learn about midwifery, but that it was the midwives who were making unfair assumptions about the couple's intent and potential behaviour. John felt sure something about the events that evening had reflected poorly on the decision making skills of the senior midwife and that, as a result, an opportunity to offer a genuinely wonderful post birth experience had been missed.

Apart from the midwives' comments during the tea room discussion, John's gender had only come up once while he was a student midwife, when a woman's husband had sternly asked that John not be involved in his wife's labour. John had been surprised, but agreed to leave and was replaced by a female midwife. Oddly, the husband said nothing when a male medical officer helped later, as his wife's labour stalled. John was sure the husband was judging John's gender and not his midwifery competence and wondered why the husband had been so insecure with John in attendance at the birth.

Australian College of Nursing

Community & Primary Health Care Nursing Week

The Australian College of Nursing (ACN) **Community and Primary Health Care Nursing Week: *Nurses where you need them*** national campaign will take place from **19–25 September 2016** and its intentions are to:

- Raise awareness of the current and potential contribution of community and primary health care nursing and its impact on the health and wellbeing of individuals and communities;
- Inform the general public in order to increase their health literacy about community based health care options;
- Inform nurses of community and primary health care nursing roles and career opportunities;
- Inform state and territory governments as funders of many community and primary health care services and drivers of state health reform of the capacity of community and primary health care nurses;
- Inform the federal government as a funder of community and primary health care services and general practice based services and as a driver of national health reform of the capacity of community and primary health care nurses; and
- Inform other health professions active in community and primary health care to raise their awareness of community and primary health care nursing services.

WHO ARE COMMUNITY AND PRIMARY HEALTH CARE NURSES?

Community and primary health care nurses are enrolled nurses, registered nurses and nurse practitioners whose work settings may include hospital-affiliated clinics, community health centres, outreach clinics, homes, schools, prisons, maternal and child health centres, Aboriginal medical services, and a range of other health service settings.

Community and primary health care nursing practice includes health promotion, illness prevention, treatment and care of the sick, advocacy and rehabilitation (APHCRI 2009). The provision of community and primary health care nursing supports individuals to more effectively manage their well-being within their communities and improve health outcomes (Keleher 2001).

Nurses lead and provide care in many community-based health services across the country, striving to improve equity of access for the hardest to reach communities and promoting the integration of health care delivered by a range of services.

How to get involved:

SUBMIT YOUR STORY

Share a story that describes a time 'when' your nursing care has impacted on the health and wellbeing of individuals and/or communities in the Community and Primary Health Care: Nurses Where You Need Them 2016 eBook.

WEAR ORANGE

Wear an orange scarf or t-shirt during the week to show your support of Community and Primary Health Care Nurses.

HOLD AN EVENT

Hold an event during the week to get your town or city on the virtual map of supporters across the country and to share readings from the eBook to promote and discuss the important roles in Community and Primary Health Care Nursing. Be sure to register your event with us!

BECOME A SUPPORTER

Nursing organisations can join ACN as a supporter of the week to raise awareness and the profile of Community and Primary Health Care Nurses. Supporters will be acknowledged on the ACN website and in the eBook.

SPREAD THE WORD

Show your support on social media!
#nurseswhereyouneedthem

Visit www.acn.edu.au/CPHCNW

With thanks to the support of our official sponsor

Australian MUSHROOMS

MILITARY AND CIVILIAN NURSES REMEMBERED AT BATHURST SERVICE

By Linda Shields FACN

Nurses serve wherever they are needed in peacetime, in conflict and in war. One hundred and two Australian nurses have died on active service since the South African (Boer) War, while many civilian nurses have given their lives serving others. All nurses serve the people for whom they care.

On 15 May 2016, a commemorative service for nurses who have served others was held at All Saints' Anglican Cathedral, Bathurst.

The service coincided with the anniversary of the sinking of Australian Hospital Ship Centaur, when 11 nurses died at sea, and also celebrated International Nurses Day. We remembered both military and civilian nurses.

The service was co-hosted by the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, All Saints' Anglican Cathedral, Bathurst Hospital, the Centaur Memorial Fund for Nurses and the Australian College of Nursing (ACN).

Many people from Bathurst and the surrounding areas attended. A very moving address was given by Captain Amanda Garlick MACN (Royal Australian Navy), who spoke of her time serving in Afghanistan, and the Vice Chancellor of Charles Sturt University, Professor Andrew Vann, was one of the readers.

ACN was represented by Liza Edwards MACN, military nursing by Major Jane Currie MACN and the Australian Army by Lieutenant Colonel Doug Humphreys. Others involved in the service were the Bathurst Sub-Branch of the RSL, and parishioners and clergy from All Saints' Cathedral and other churches in Bathurst.

Captain Amanda Garlick MACN (Royal Australian Navy) giving the address and The Very Reverent Anne Wenzel, Dean of All Saints' Cathedral.

Professor Linda Shields FACN laying a wreath for the Centaur Memorial Fund for Nurses.

Liza Edwards MACN laying the ACN wreath.

Professor Catherine Hungerford, Head, School of Nursing, Midwifery and Indigenous Health CSU with nursing students.

ACN NATIONAL NURSES BREAKFAST

We would like to sincerely thank all our members who got involved in the 2016 ACN National Nurses Breakfast. We hope you enjoyed spending International Nurses Day with your colleagues and friends and celebrating the invaluable contribution nurses make to the health of our society.

240 breakfasts were held across the country with over 9,000 individuals taking part. It was wonderful to see so many groups involved and sharing their celebrations on social media.

Visit storify.com/ACN to see all the #ACNBreakfast posts from breakfast hosts and supporters across Australia.

With thanks to the support of

HESTA
An Industry SuperFund

Esperance Hospital staff celebrated with a barbecue breakfast.

Complimentary educational seminars offered expo attendees valuable career advice.

Expo visitors sought information and services from more than 110 exhibitors.

ACN NURSING & HEALTH EXPOS

More than 6000 eager visitors attended the ACN Nursing & Health Expos in Melbourne and Perth this year. The crowd was buzzing with energy as undergraduate students and aspiring or current nurses connected with exhibitors who were on hand to offer valuable advice and provide information about upcoming graduate programs, as well as education and employment opportunities.

Visitors also attended complimentary seminars that were held throughout the day, covering topics such as CV and interview skills, leadership in nursing and graduate opportunities. The seminars provided attendees with practical up-to-date information to assist them in furthering their career.

ACN would like to thank our Members and Fellows who volunteered their time to assist onsite at the expos, your support and expertise helped us make the day a success.

With thanks to the support of

VICTORIA State Government

Government of Western Australia
Department of Health
Nursing and Midwifery Office

Australian College of Nursing

CPD short courses @ACN 2016

ENQUIRIES: 1800 265 534 | events@acn.edu.au | Visit www.acn.edu.au/cpd-short-courses to secure your place

30–31 AUGUST
Wound management
RN/EN | 2 days | 14 CPD hours | **Perth**

8–9 SEPTEMBER
Rehabilitation nursing
RN/EN | 2 days | 14 CPD hours | **Perth**

27–28 SEPTEMBER
Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Geraldton**

3–4 NOVEMBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Perth**

9–10 NOVEMBER
The deteriorating patient: clinical decision making
RN/EN | 2 days | 14 CPD hours | **Perth**

15–16 NOVEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Albany**

1–2 DECEMBER
Infection prevention and control
RN/EN | 2 days | 14 CPD hours | **Perth**

17 AUGUST
Infection prevention and control in residential care
RN/EN | 1 day | 7 CPD hours | **Adelaide**

22–23 SEPTEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Adelaide**

20–21 OCTOBER
Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Adelaide**

17–18 NOVEMBER
Managing acute mental health-related presentations
RN/EN | 2 days | 14 CPD hours | **Mount Gambier**

25 NOVEMBER
PACU nurses: overcoming challenges
RN/EN | 1 day | 7 CPD hours | **Adelaide**

12 AUGUST
Building resilience: self-care strategies for nurses
RN/EN | 1 day | 7 CPD hours | **Melbourne**

8–9 SEPTEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Ballarat**

13–14 OCTOBER
Managing acute mental health-related presentations
RN/EN | 2 days | 14 CPD hours | **Melbourne**

14 OCTOBER
Pressure injury prevention and management
RN/EN | 1 day | 7 CPD hours | **Mildura**

14–15 OCTOBER
Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Bendigo**

22 OCTOBER
Perioperative anaesthetic nursing
RN | 1 day | 7 CPD hours | **Mildura**

4 NOVEMBER
Assessing and managing vascular access devices
RN/EN | 1 day | 7 CPD hours | **Gippsland**

11–12 AUGUST
Wound management
RN/EN | 2 days | 14 CPD hours | **Launceston**

18–19 AUGUST
Wound management
RN/EN | 2 days | 14 CPD hours | **Hobart**

6–7 SEPTEMBER
Leadership First
RN | 2 days | 12 CPD hours | **Launceston**

29–30 NOVEMBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Hobart**

19 JULY
Immunisation update
RN | 1 day | 7 CPD hours | **Brisbane**

29 JULY
Perioperative anaesthetic nursing
RN | 1 day | 7 CPD hours | **Brisbane**

9–10 AUGUST
Wound management
RN/EN | 2 days | 14 CPD hours | **Toowoomba**

6–7 SEPTEMBER
Managing acute mental health-related presentations
RN/EN | 2 days | 14 CPD hours | **Brisbane**

6–7 SEPTEMBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Rockhampton**

3–4 NOVEMBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Gold Coast**

22–23 NOVEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Bundaberg**

6–7 DECEMBER
Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Cairns**

15–16 SEPTEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Darwin**

MORE COURSES TO BE ANNOUNCED SOON, VISIT OUR WEBSITE FOR DETAILS.

Australian College of Nursing

CPD short courses @ACN 2016

ENQUIRIES: 1800 265 534 | events@acn.edu.au | Visit www.acn.edu.au/cpd-short-courses to secure your place

ACT

28 JULY
Immunisation update
RN | 1 day | 7 CPD hours | **Canberra**

1–2 SEPTEMBER
Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Canberra**

17–18 NOVEMBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Canberra**

NSW

11–12 AUGUST
Diabetes management and current guidelines
RN/EN | 2 days | 14 CPD hours | **Goulburn**

12 AUGUST
ECG: introduction
RN/EN | 1 day | 7 CPD hours | **Coffs Harbour**

18–19 AUGUST
Orthopaedic update
RN/EN | 2 days | 14 CPD hours | **Newcastle**

19 AUGUST
Building resilience: self-care strategies for nurses
RN/EN | 1 day | 7 CPD hours | **Parramatta**

23–24 AUGUST
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Wollongong**

26 AUGUST
Assessing and managing vascular access devices
RN/EN | 1 day | 7 CPD hours | **Orange**

14–15 SEPTEMBER
Introduction to the fundamentals of cardiovascular care
RN/EN | 2 days | 14 CPD hours | **Parramatta**

16 SEPTEMBER
Clinical assessment of the older person
RN/EN | 1 day | 7 CPD hours | **Albury**

18 OCTOBER
Continence update
RN/EN | 1 day | 7 CPD hours | **Newcastle**

20–21 OCTOBER
Managing acute mental health-related presentations
RN/EN | 2 days | 14 CPD hours | **Bathurst**

20–21 OCTOBER
Team dynamics and clinical leadership
RN/EN | 2 days | 14 CPD hours | **Wagga Wagga**

2–3 NOVEMBER
Nursing patients with intellectual disability
RN/EN | 2 days | 14 CPD hours | **Parramatta**

15 NOVEMBER
Understanding dementia
RN/EN | 1 day | 7 CPD hours | **Newcastle**

17–18 NOVEMBER
Orthopaedic update
RN/EN | 2 days | 14 CPD hours | **Tweed Heads**

25 NOVEMBER
Improving the clinical handover
RN/EN | 1 day | 7 CPD hours | **Wagga Wagga**

1–2 DECEMBER
Advanced concepts in ECG interpretation
RN | 2 days | 14 CPD hours | **Coffs Harbour**

6–7 DECEMBER
Wound management
RN/EN | 2 days | 14 CPD hours | **Parramatta**

GPCE 2016 BRISBANE

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26–28 AUGUST
Brisbane Convention
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- Management of the Emergency Patient in a General Practice & Remote Setting
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Australian College of Nursing

Community & Primary Health Care Nursing Week

For more information visit:

www.acn.edu.au/community-and-primary-health-care-nursing-week