the hive

#17 AUTUMN 2017

CARDIOVASCULAR DISEASE

ETHICAL DILEMMAS
MORAL ISSUES EXPERIENCED BY CARDIAC NURSES

CONGENITAL HEART DISEASE
PULSE OXIMETRY SCREENING FOR HIGH RISK NEONATES

CORONARY ARTERY STENT EVOLUTION
THE IMPACT ON PATIENT SURVIVAL AND QUALITY OF LIFE

+MORE INSIDE

NEWS & VIEWS | FEE HELP NOW AVAILABLE | THE BANKA ISLAND MASSACRE | THE NATIONAL NURSING FORUM 2017

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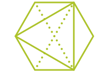
#17 AUTUMN 2017
CARDIOVASCULAR DISEASE



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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.

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Professor Christine Duffield FACN
ACN President

Future directions

2016 was an eventful year for the Australian College of Nursing (ACN) and much was achieved with the launch of many exciting new initiatives.

As the pre-eminent and national leader of the nursing profession, ACN secured a number of key objectives and outcomes for Australian nurses throughout the course of the year. This saw a significant increase in our membership and we expect this growth to continue as ACN strengthens its presence in every state and territory to secure a position of influence now, and into the future.

Engagement with the next generation of nurse leaders is key to ACN moving forward as a powerful presence in the Australian health care system. Last year, the introduction of two new membership options for undergraduate nurses and the relaunch of our Emerging Nurse Leader program were important steps in supporting the future development of our profession.

With a view to expand our reach and extend our professional network, ACN developed a new framework for our Affiliation Program in 2016. Since then, we have formed strong corporate partnerships with 32 high-performing organisations that share our passion for advancing nurse leadership to enhance the health care of all Australians.

As the collective voice of the Australian nursing profession, ACN advocates for the expertise and experiences of nurses to be represented in health and aged care policy reform. Last October, we released a 'Nurses are Essential in Health and Aged Care Reform' white paper to highlight the need for nurses to be heard in strategic policy debates and reform developments. Our white paper was launched by Prime Minister, The Hon Malcolm Turnbull MP, alongside prominent leaders in nursing, health and government. The launch was an enormous success and momentous achievement for our profession.

Keeping in line with ACN's commitment to support the education and professional development of the Australian nursing workforce, we successfully secured FEE-HELP for all of our Graduate Certificate courses late last year. With FEE-HELP now in place, more nurses will be able to access our high-calibre courses in the years ahead.

Since being elected President in December last year, it has been a pleasure to work closely with the CEO and the Board to further drive our engagement and membership within the Australian nursing community. With a view towards the future, ACN will continue to advance nurse leadership through a new strategic direction that will centre on three key areas of focus: *Representation and Engagement, Capacity and Capability Development,* and *Policy and Advocacy*. This new direction will provide us with a framework on which to build upon moving forward as the pre-eminent and national leader of the nursing profession.

Nurses today work in complex environments where scientific knowledge and technological competence are just as important as kindness and compassion. This edition of *The Hive* demonstrates the need for a highly skilled nursing workforce to address the increasing burden of cardiovascular disease in the Australian population. At the forefront of care delivery, nurses are well placed to tackle complex health challenges and drive change to enhance patient outcomes across the country.

Regards, Christine

MEMBERSHIP

ACN has experienced a 9% increase in membership throughout the past year.

EMERGING NURSE LEADERS

At the beginning of 2017, 36 up-and-coming nurse leaders were welcomed into ACN's new Emerging Nurse Leader program.

AFFILIATION

Following the 2016 relaunch of the ACN Affiliation Program, ACN now has 32 Affiliates. ACN Affiliation packages are available across four levels: Platinum, Gold, Silver and Bronze.

COMMUNITIES OF INTEREST

In the past six months, ACN introduced the Cosmetic Nurses, Nurse Informatics and Next Generation Communities of Interest into its suite of special interest groups.

Adjunct Professor Kylie Ward FACN
ACN Chief Executive Officer

Hello!

I am excited to present to you the new look for the Australian College of Nursing's quarterly member magazine, *The Hive*.

After four years, 16 editions and hundreds of articles covering the unique stories of our diverse membership, ACN has completely transformed *The Hive* to reflect our evolution as the pre-eminent and national leader of the nursing profession. While retaining all of our regular features and in-depth analysis of the latest issues facing the Australian nursing community, we have revamped our design to create a more contemporary, vibrant and bold expression of who we are as an organisation.

To accompany our fresh new look, ACN has chosen four themes for the 2017 editions of *The Hive* that will explore the deadliest diseases currently impacting the Australian population: *Cardiovascular Disease, Dementia and Alzheimer's Disease, Respiratory Disease, and Diabetes and Obesity*. Through these themes, we will explore the rising incidence of chronic disease throughout Australia and how the nursing workforce is leading improvements to enhance health outcomes in our communities.

In our Autumn edition of *The Hive*, we will be featuring a number of insightful articles that focus on the widespread impact of cardiovascular disease and the vital role nurses play in reducing the national burden of this critical health issue.

Nurse-led prevention and management programs are an essential step in reducing mortality and morbidity rates for cardiovascular disease. In their highly informative research update, **The ImPress intervention**, **Professor Elizabeth Halcomb FACN** and **Catherine Stephen**, emphasise the need for Australian health services to utilise the skills and expertise of our nursing workforce in chronic disease management.

The evolution of pharmacological, interventional and surgical treatments for cardiovascular disease have facilitated a significant shift in the management of chronic health conditions over time. Reflecting upon her experiences as a cardiovascular nurse, one of our knowledgeable educators **Elizabeth Moran** explains how new technologies have increased patient survival and quality of life in her engaging article, **Coronary artery stent evolution**.

Just as technology has facilitated advanced methods of care, it has also provided nurses with new and improved ways to further their education. In her insightful article, **Clinical workplace education**, Nurse Educator **Elizabeth Matters FACN** provides insights into how we can overcome barriers to quality education in an acute care cardiothoracic ward.

I hope you love our new look and enjoy this fascinating read!

Regards, Kylie

ACN Hobart
Christmas Function

Australian War Memorial
Last Post Ceremony

ACN Canberra
Christmas Function

Australian
Healthcare Week

ACN NEWS & VIEWS

FEE HELP

At the end of 2016, ACN received some wonderful news that FEE-HELP is now available for all of our Graduate Certificate courses.

FEE-HELP is a loan scheme that assists eligible fee paying students pay all or part of their tuition fees. Students are eligible for FEE-HELP if they are studying at an approved provider, meet the citizenship requirements and are enrolled in an eligible unit of study.

With FEE-HELP now available at ACN, more nurses will be able to access our high-calibre Graduate Certificate courses. At ACN, our courses prepare nurses for a rewarding career in the health and community services sector. We offer coursework programs that are academically challenging and professionally relevant in an environment that encourages independent learning and interaction amongst peers.

Our courses provide the knowledge, skills and attitudes directly suited to working in specialist areas of health care and are designed to meet contemporary industry needs.

If you would like to find out more about FEE-HELP or our Graduate Certificates, please visit www.acn.edu.au

75TH ANNIVERSARY OF THE BANKA ISLAND MASSACRE

More than 100 guests, including many ACN members, attended a special event at the Nurses Memorial Centre in Melbourne on Thursday 16 February.

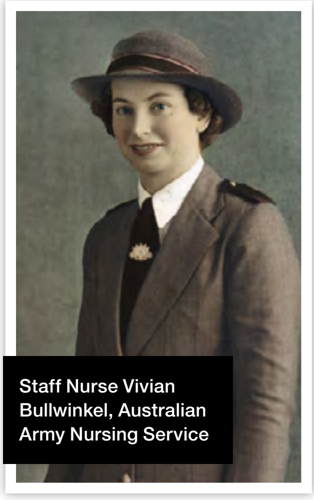
This date was significant, as it was 75 years to the day that 22 Australian Army Nurses were massacred on Radji Beach, Banka Island following the bombing and sinking of the *SS Vyner Brooke*. This special event was held to remember and honour Victorian and other Australian nurses, who lost their lives on that day.

The Nurses Memorial Centre welcomed two special guests who spoke at the event. First, Mr John Bullwinkel, the nephew of Sister Vivian Bullwinkel AO MBE ARRC ED, who was the sole survivor of the massacre, gave an address on the history of the *SS Vyner Brooke* and a personal account of his aunt.

Second, Ms Emily Malone, the grand-niece of Sister Agnes Betty Jeffrey OAM, who wrote about her WWII nursing and prisoner of war experiences that she shared with Vivian Bullwinkel and others, in her book *White Coolies*.

Emily spoke about her 'Aunty Bett' and read a story that was recently discovered in her aunt's archives, *The Girls on the Beach*.

Former President of the International Council of Nurses and Board Director of ACN, Dr Rosemary Bryant AO FACN (DLF), and ACN Board Director, Ms Christine Smith FACN (DLF), represented ACN at this event.



Staff Nurse Vivian Bullwinkel, Australian Army Nursing Service

An informal presentation of floral tributes took place at the Nurses Memorial on St Kilda Road following the event.

Author details:
ACN Board Director, Ms Christine Smith FACN (DLF)

THE NATIONAL NURSING FORUM 2017

Registrations are now open for ACN's annual signature event, the National Nursing Forum (NNF).

Bringing together nurses from across the country and around the world, the upcoming NNF will inform and inspire delegates through exceptional keynote speeches, concurrent sessions and masterclasses.

The theme for the upcoming NNF is ***Make Change Happen.*** This theme is a celebration of nurses who work tirelessly to drive change across the Australian health care system. ***Make Change Happen*** will explore the creative and innovative ways that nurses can make a difference to individuals, communities and social determinates of health at a local, national and global level.

Last year's NNF theme, ***The Power of Now***, was met with excellent thoughts and innovative ideas. In 2017, we will carry these ideas forward and put ***The Power of Now*** into action. Whether you are a student nurse or an experienced professional, each of you have the opportunity to achieve your leadership goals and change the face of health care within Australia by utilising ***The Power of Now*** to ***Make Change Happen***.

This year's NNF will provide a platform for nurses to come together, share insights and form a collective movement to lead the development of solutions to Australia's complex health and aged care challenges.

The NNF is one event you will not want to miss! Please visit our website for more information and to register your attendance. We look forward to celebrating the passion, innovation and energy across all generations of nursing with you at our signature event this year!

PIXABAY

ACN SNAPS

At ACN, we love getting out and about with our members and the wider nursing community! If you are at an ACN function or event, please share your snaps with us through our social media channels!

“...ACN is progressive with all that is on offer to their members and provides a number of platforms for networking opportunities...”

Nancy Arnold MACN

“...ACN is my ‘tribe’ where I belong, am valued, informed and where I can contribute to supporting our profession to flourish...”

Ilze Jaunberzins MACN

“...I am thrilled to become a part of the nursing profession and I am so glad that I became an ACN member...”

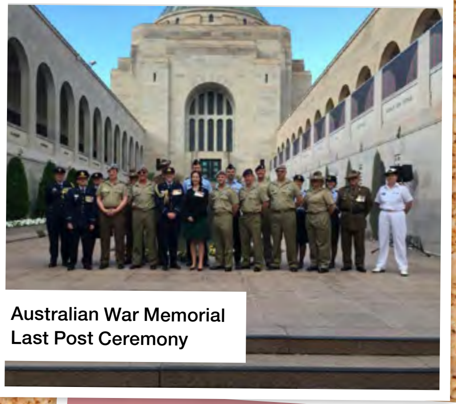
Katie Dickson MACN

Banka Island massacre memorial service, Melbourne

ACN Canberra Office

First EPIQ Class of 2017

ACN Team Building Day



Australian War Memorial Last Post Ceremony

Melbourne Region Function

ALP Health Policy Summit

ACN Brisbane Christmas Function

ACN Melbourne Christmas Function

MAY

7
PNEUMONIA AWARENESS WEEK
This week aims to educate Australians about the seriousness of pneumonia.

12
INTERNATIONAL NURSES DAY
ACN's National Nurses Breakfast is hosted annually to celebrate International Nurses Day.

22
WORLD HEALTH ASSEMBLY
An international gathering of delegates from member states of the World Health Organization.

25
NATIONAL SORRY DAY An annual event to remember and commemorate the mistreatment of the Indigenous population.

27
ICN CONGRESS
An international gathering of nurses in Barcelona that will explore our leading role in the transformation of care.

31
WORLD NO TOBACCO DAY
A campaign that raises awareness of the health risks associated with tobacco use.

JUNE

1
MEDICAL RESEARCH WEEK
A week-long celebration of Australia's contribution to medical research

12
MEN'S HEALTH WEEK
A week-long campaign promoting men's health and wellbeing.

14
WORLD BLOOD DONOR DAY
An initiative that raises awareness of the need for safe blood products and thanks donors.

18
REFUGEE WEEK
An annual week-long celebration of the positive contributions of refugees to Australian society.

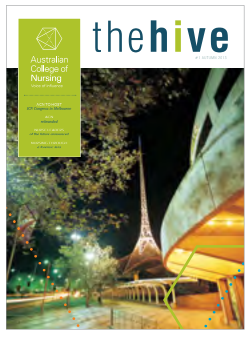
22
VINNIES CEO SLEEPOUT
Our CEO joins community leaders in experiencing homeless life for one night.

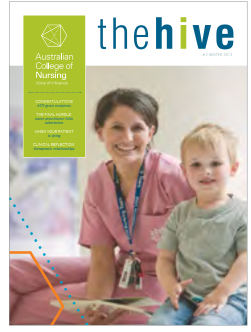
30
RED NOSE DAY
A fundraiser for Red Nose, an organisation dedicated to saving babies' and children's lives.

MORE Visit our website to see more upcoming events in Australia and around the world for the nursing and health professions: **www.acn.edu.au/events**

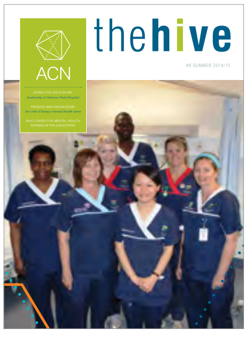
The evolution of *the hive*

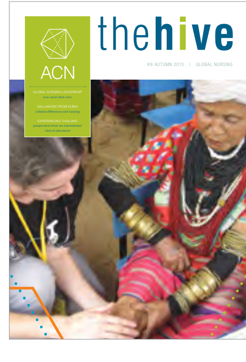
2013–2017

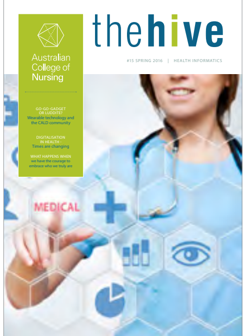




+MANY MORE TO COME!



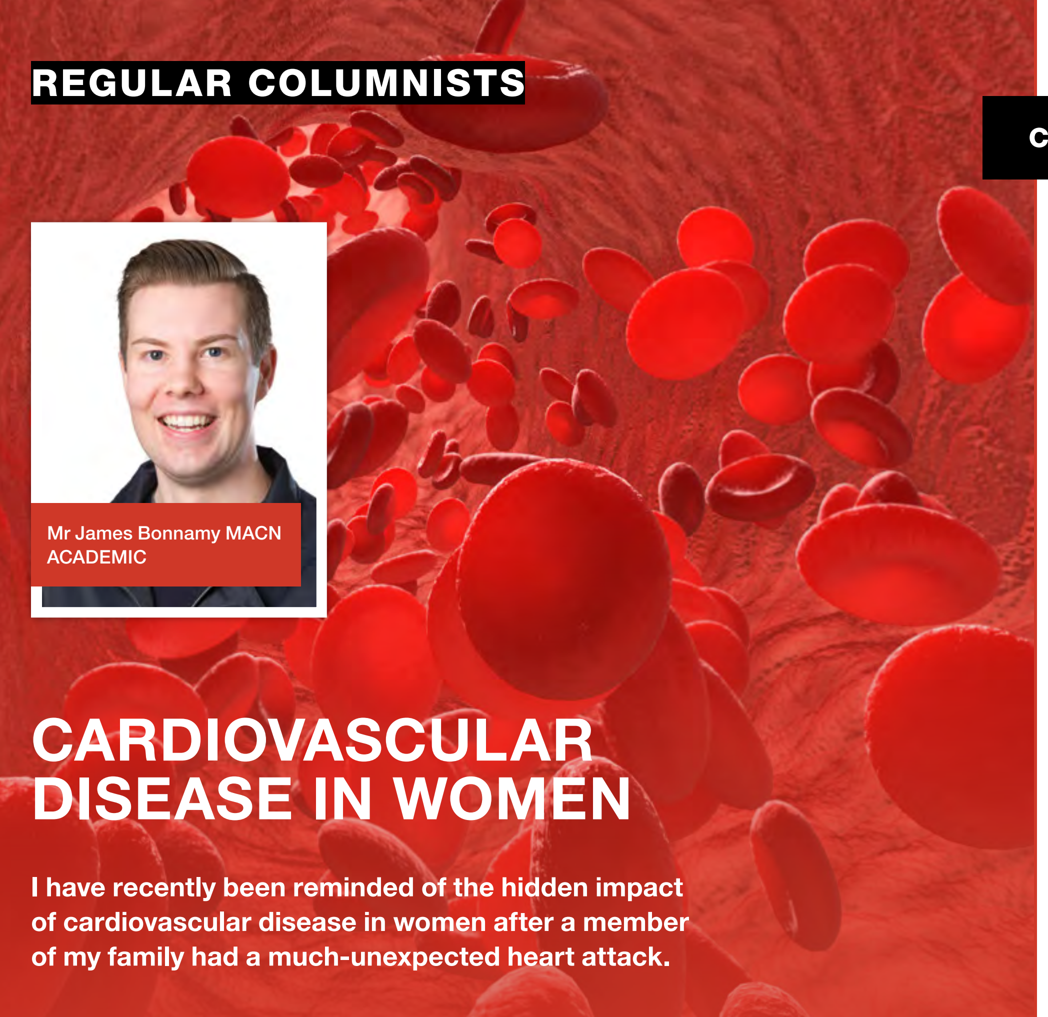




LETTERS TO THE EDITOR

As an organisation committed to continuous quality improvement, we welcome all feedback on the new layout for *The Hive* and encourage you to share your thoughts on the content.

Please contact us at publications@acn.edu.au to let us know your insights and ideas. All contributions will be considered for publication in the next edition of *The Hive.*



Mr James Bonnamy MACN
ACADEMIC

CARDIOVASCULAR DISEASE IN WOMEN

I have recently been reminded of the hidden impact of cardiovascular disease in women after a member of my family had a much-unexpected heart attack.

On a global scale, heart disease is the number one killer of women, causing one in three deaths each year – that is approximately one woman every minute (American Heart Association, 2016). The publicity this hidden epidemic receives is far less than breast and gynaecological cancer, yet it is a significant cause of reduced quality of life.

Cardiovascular disease is often overlooked in women because the disease does not affect women the same as men. For example, women do not experience the typical symptoms of a heart attack like men and may attribute their symptoms to other causes with detrimental consequences. In 2006–2007, diagnostic and therapeutic procedures for cardiovascular disease were less commonly performed for women than men, despite the number of women living with cardiovascular disease and stroke exceeding men (Australian Institute of Health and Welfare, 2010).

There is enormous potential to improve the awareness of the risk of cardiovascular disease in women. Several successful campaigns have been run by both the American and Australian Heart Foundations, which have seen a decrease in the death rate resulting from cardiovascular disease (Mosca, Barrett-Connor, & Kass Wenger, 2011). Much more still needs to be done to reduce the risk profile of Australian women and therefore, reduce the number of women and families affected by cardiovascular disease.

> **“Women are the majority of health care consumers, the majority of health service providers and the majority of carers in Australia.”**

Women are the majority of health care consumers, the majority of health service providers and the majority of carers in Australia (Australian Institute of Health and Welfare, 2010). Improving awareness of cardiovascular disease in women and the wider population will improve the health and wellbeing of the whole of Australia.

Make sure you sign-up for the Go Red for Women campaign this year to raise awareness: **www.goredforwomen.org.**

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American Heart Association 2016, *Facts about heart disease in women*, accessed 2 March 2017, <www.goredforwomen.org/>

Australian Institute of Health and Welfare 2010, *Women and heart disease: Cardiovascular profile of women in Australia*, accessed 2 March 2017, <www.aihw.gov.au>

Mosca L, Barrett-Connor E, & Kass Wenger N 2011, ‘Sex/Gender Differences in Cardiovascular Disease Prevention’, *What a Difference a Decade Makes*, 124(19), 2145-2154

ISTOCK

CARDIOVASCULAR STATS

1 in 5
Australian adults had cardiovascular disease in 2014–15. That is approximately 4.2 million people.

1.1 MILLION
hospitalisations were associated with cardiovascular disease in 2014–15, that is 11% of all hospitalisations in Australia.

29%
Australian deaths had cardiovascular disease as the underlying cause of death – that is 45,000 deaths in 2014.

2X
Aboriginal and Torres Strait Islander peoples are twice as likely to be hospitalised with cardiovascular disease compared with non-Indigenous Australians.

43%
Cardiovascular disease death rates are 43% higher in the lowest socioeconomic group compared with the highest.

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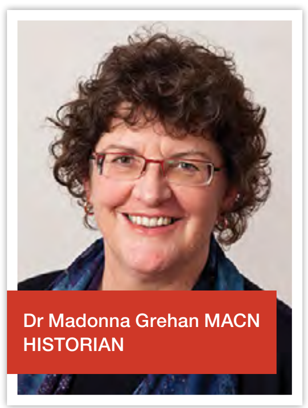
Australian Institute of Health and Welfare 2017, ***What is Cardiovascular disease***, accessed 22 February 2017, <http://www.aihw.gov.au/cardiovascular-disease/what-is-cvd/>

CARDIAC DISEASE – A HISTORICAL APPROACH



Dr Madonna Grehan MACN
HISTORIAN

These days, cardiac disease is inherently treatable either by drugs or surgery to replace valves, clear obstructions, regulate electrical impulses or even replace the organ itself. Changing diet has been argued as making an enormous difference to cardiac status too.

It's a vast gulf from heart disease 150 years ago, which I've been reminded of through my research on women's deaths in colonial Australia. The sources I used were coronial investigations into unexpected deaths (inquests and magisterial inquiries). In most cases, a surgeon gave evidence of findings at post-mortem.

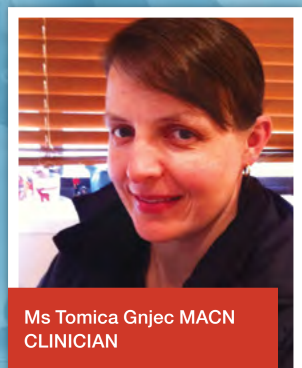
"The determinations of contributors to death were crude compared with our sophisticated understanding of human biology and physiology today."

The women whose deaths I've been looking at were aged less than 50 years old. The determinations of contributors to death were crude compared with our sophisticated understanding of human biology and physiology today.

Even so, I've been surprised at how many reported observations about the heart were made in this population. These observations were along the lines of: the heart was not healthy; the heart was enlarged and the walls of it, thin; she had a damaged valve. Most surprising to me was that fat was observed and expressed as: excessive fat around the heart; fatty matter mixed up in the heart; the heart was affected with fatty degeneration; the heart was loaded with the considerable quantity of fat; the heart's surface was loaded with fat.

A most affecting case, in which heart health was implicated, was that of a young woman whose body was not subjected to post-mortem. A single mother, reportedly, she had fretted severely because her baby was born into a world without a father. It's likely from the evidence that she suffered an embolus. The attending doctor, however, determined she had died of remorse, coupled with syncope of the heart.

CARDIOVASCULAR HEALTH CARE



Ms Tomica Gnjec MACN
CLINICIAN

In recent years I attended a gastroenterology specialist appointment with a family member. I was surprised when the specialist made comment about my relatives' weight and exercise habits, and was not simply focused on the gastrointestinal component of her being!

A holistic health focus is imperative to the attention of, and the most effective method of addressing, any health concern.

Cardiovascular disease is known to be the number one cause of death in Australia today (Department of Health, 2016). Unlike the difficult risk factors of genetic predisposition and advancing age – risk factors involving those of behavioural or lifestyle choices are worthy of concerted investment and focus in the potential for positive change.

From which platform is it then best to promote the importance of cardiovascular health?
I believe it lies at the door of every health facility, consulting room and interaction with all health professionals. Nurses have previously been identified as being in an ideal position for the delivery of health promotion messages and in engaging individuals in self-care and decision making (Chambers & Thompson, 2009).

It has been suggested that health promotion messages can be delivered through opportunistic openings (identification of behavioural factors, such as tobacco smoking) starting conversations (during a health assessment) and empowering the individual with direction and information (referrals, written information) in order to gain ownership and control over their health (Chambers & Thompson, 2009). Therefore, the opportunity potentially lies at any of these interfaces. It is becoming increasingly important that this opportunity is not lost.

It is also important that we collectively move forward and work to change the goals of 'cardiovascular disease care' to 'cardiovascular *health care*'.

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Chambers D & Thompson S 2009, Empowerment and its application in health promotion in acute care settings: nurses' perceptions, *Journal of Advanced Nursing*, 65 (1): 130 – 138

Department of Health 2016, *Conditions and Diseases – Cardiovascular disease*, accessed 1 March 2017 <www.health.gov.au/internet/main/publishing.nsf/content/chronic-cardio>

ISTOCK

CARDIOLOGY: WHERE NURSES MAKE THE DIFFERENCE

Ms Laurie Bickhoff MACN
EARLY CAREER NURSE

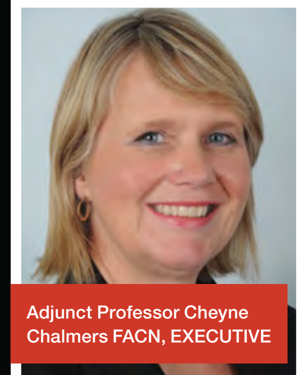
> **“My experience within a busy coronary care unit taught me how critical the nursing voice was to patient care.”**

As an undergraduate, I was determined to work within an emergency department. Luckily, during my graduate program, I rotated through both a cardiology medical and a cardiothoracic surgical ward, and realised cardiology was my true calling.

Of course, each nurse thinks their specialty is the best but for me, cardiology had me hooked. This was where I saw the amazing impact nurses could have, not only on patient outcomes, but also in prevention programs.

Within cardiology, I have seen the difference nurses have made through effectively working and communicating with other departments. Cardiology encompasses many areas, including general cardiac wards, cardiac cath labs, coronary care units, cardiac rehabilitation, heart failure management teams, preventative care, primary health programs, and many more. Each area compliments another and the best patient outcomes rely on them all working together. The units I saw working together cohesively, and keeping the focus on the patient, were units with nurses at the helm.

My experiences within a busy coronary care unit taught me how critical the nursing voice was to patient care. Nurses in this department were expected to speak up, to make their opinion known and essentially ensure the patient was heard. Their knowledge, assessment and critical thinking skills were tested each shift and a true interdisciplinary team approach was utilised. This was the type of nursing I had been looking for and why I will always be a cardiology nurse at heart.



Adjunct Professor Cheyne Chalmers FACN, EXECUTIVE

CHRONIC DISEASE MANAGEMENT

The role of the nurse leader/manager in chronic disease management

No one gets out of here alive, however, it’s about how we live that counts. Living with chronic disease really challenges the concept of being able to live life to the full; however, it doesn’t mean that you can’t still experience joy and those essential elements that make up a good quality life.

I see the role of the nurse working with people living with chronic illness as pivotal. Health systems in all jurisdictions are complex and require a significant amount of patience, skill and literacy to navigate.

Nurses have an essential role, as the health professional most equipped to advocate, navigate and empower people living with a chronic disease. This role is to enable people to do what they need to, for their own health and wellbeing, and take ownership of their quality of life. The nurse is key in shifting the paradigm to help people with chronic disease switch their focus from what’s the matter with them to what matters to them.

The wider role of nurse leaders in the system is to influence policy and legislation, such as prescribing and funding, to ensure that all nurses, but in particular those in advanced nursing roles, can practice to their full scope and really make a difference; not just to individuals living with chronic disease but to whole populations. Advanced nursing roles play a key role in working with people with chronic disease, from preventing hospital admissions to providing a link between the primary practitioners and specialist health care providers, as well as being that expert navigator of the complex Australian health care system.

Do all people living with chronic disease have an advanced care directive or plan? Do they feel they are in control of what they are able to be in control of? Do they truly understand what is required to keep themselves as fit and healthy as they possibly can? Until we can answer yes to these questions the nurse will always have a role in leading the care of people living with chronic disease.

PIXABAY

THE IMPRESS INTERVENTION

A nurse-led hypertension management intervention program in Australian general practice

Hypertension is the most frequently seen condition in Australian general practice (Britt H et al, 2015). Of the 4.6 million Australians living with hypertension, many struggle to maintain adequate blood pressure control and are at an increased risk of cardiovascular disease and premature death (Australian Institute of Health and Welfare 2015, Cadilhac et al, 2012). As such there is a pressing need to identify evidence based strategies to improve the management of hypertension in general practice.

The ImPress intervention sought to test a nurse-led program for hypertension management in general practice. During 2014/2015, 10 general practices in Sydney participated in the study, with 90 consumers who had uncontrolled hypertension taking part. Consumer participants received consultations and/or telephone support by a General Practice Nurse (GPN) for six months. During these consultations, the GPNs provided tailored lifestyle advice, action planning, health monitoring and motivational counselling.

The outcome data is soon to be published in the *Australian Family Physician*.

On completion of the intervention, qualitative evaluation was conducted through semi-structured interviews with six General Practitioners' (GPs), seven GPNs and 12 consumers. This process evaluation formed the data for Ms Catherine Stephen's Bachelor of Nursing (Honours) thesis.

In addition to its positive impact on blood pressure, the ImPress intervention was found to be acceptable and feasible to deliver in Australian general practice. However, the ongoing sustainability of the model rests largely upon overcoming the organisational, educational and professional barriers that constrain the GPNs role. Findings demonstrate great potential for GPNs to significantly contribute to improved health outcomes and play a more active role in chronic disease management. This role could be optimised with the development of motivational interviewing skills, enhanced GP/GPN collaborative practice and increased opportunity for consumer follow up.

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RESEARCH UPDATE BY

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PIXABAY

CORONARY ARTERY STENT EVOLUTION

The impact on patient survival and quality of life

According to the Heart Foundation, in 2013, cardiovascular disease (CVD) was the underlying cause of 43,603 deaths; 30% of all deaths in Australia (2014). Coronary artery disease (CAD) is the biggest contributor to cardiovascular-related mortality and morbidity. In 2013, coronary artery disease accounted for 13% of all deaths.

CVD remains one of the most expensive disease groups in Australia, costing about $7.6 billion in 2008–2009; equating to 12% of all allocated health care expenditure in Australia (Australian Institute of Health and Welfare (AIHW), 2016a).

CVD was first endorsed as a national health priority area at the Australian Health Ministers Conference in 1996 in recognition of the high prevalence of the disease in Australia, its impact on morbidity and mortality, and its potential for health improvements through prevention and treatment programs (AIHW, 2016b).

Earlier diagnosis and improved management means that many more people are living with CVD. The steady decline in CAD related deaths can be attributed, in part, to enhanced survival in patients with an acute myocardial infarction.

Acute coronary syndrome (ACS) is a reduction in blood flow to an area of heart muscle secondary to the narrowing of the vessel lumen due to atheromatous plague formation. ACS can manifest as a range of clinical presentations, including ST elevation myocardial infarction (STEMI), non ST elevation myocardial infarction (NSTEMI) and unstable angina.

In the last 50 years there have been significant advancements in new technologies and new pharmacological, interventional and surgical treatments. Of particular note is the emergence of coronary revascularisation.

Percutaneous coronary intervention (PCI) is a non-surgical procedure formally known as angioplasty and stenting. The aim of PCI is to open the obstructed vessel/s and re-establish blood flow to the myocardium in order to preserve cardiac function. This has been recognised as the gold standard reperfusion strategy for STEMI if performed promptly by an interventional cardiologist (NHFA & CSANZ, 2016).

The procedure is to access either the femoral or brachial artery by inserting a guide wire, under fluoroscopy, around the aortic arch and into the left and right coronary arteries. It is over this wire that the balloon and stent are guided and positioned carefully before being deployed. A coronary stent is a tube shaped metal mesh structure, which is 2–4mm in diameter.

Coronary angioplasty has been performed since the 1960's, however the first stent implanted into a human coronary artery did not occur until 1986 and it was not until 1991 that the first coronary stent was used to treat an acute myocardial infarction.

In 1990, I first entered the specialist field of cardiovascular nursing. In the last 27 years, I have witnessed the evolution of stents from first generation stents (bare metal stents) to second and third generation stents (drug eluting stents) to new generation stents (bioresorbable).

With the bare metal stents there was a significant percentage of restenosis at the site of implantation due to trauma of the vessel wall.

The first drug eluting stent (DES) was not implanted until 1999. Drug eluting stents are coated with a polymer that contains a medication, which releases slowly and locally. This medication, such as rapamycin, has immunosuppressive and antiprolifeative properties, thus preventing restenosis.

Drug eluting stents have revolutionised the treatment of obstructive coronary artery disease by reducing the rate of stent restenosis from 20–40% with bare metal stents to 6–8% with DES (Ernst & Bulum, 2014).

Bioresorbable stents were first implanted in 2011. As the stent scaffold is bioreabsorble, it may potentially eliminate or reduce stent thrombosis by avoiding the presence of a permanent metallic structure left in the coronary artery (Di Mario and Caiazzo, 2015).

Compliance with antiplatelet medication, aspirin and clopidogrel will help prevent thrombus formation at the site of the stent implantation until endothelialisation occurs and the stent becomes part of the vessel wall. Patients are usually on aspirin for life and clopidegrol for at least 12 months, unless contraindicated.

The coronary stents have evolved since their first use in the 1980s and there are on-going studies to refine their design, structure and material. As the quest for the ideal stent continues, ongoing studies will continue to improve the stent platforms, anti-proliferative drugs, new polymers and bioresorbable stents.

It will be very interesting and exciting to see what the next generation of technology will bring. For me, it has been incredible to see the impact on patient survival and quality of life due to this coronary stent evolution.

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CARDIOTHORACIC PNSAS

My role as a cardiothoracic perioperative nurse surgical assistant

Internationally, a nurse working as a surgical assistant is not a new concept. The role of the Registered Nurse First Assistants (RNFA) was established in the United States of America and Canada in the early 1990s, and the role of the Surgical Care Practitioner (SCP) was established in the United Kingdom in the 1980s (Hains et al, 2016a).

In Australia in 2001, Bernadette Brennan, a pioneer in the field of Perioperative Nurse Surgical Assistants (PNSA), suggested that the advanced practice of perioperative nurses in the role of a PNSA could provide a cost-effective and versatile service in the health care sector (Brennan, 2001). This statement coupled with a mandate of the Australian Government in the *Health Workforce Australia Work Plan 2013–14* to boost productivity (within health care) with an emphasis on "supporting national implementation of new workforce roles" (Australian Federal Government, 2013) suggests that the role of the PNSA could be likely to provide cost benefits within the perioperative setting.

A recent survey of PNSAs in Australia yielded 83 respondents with the highest uptake of PNSAs in the orthopaedic surgical specialty. The survey found that the greater part of nurses working in the role of a PNSA had more than 11 years' experience as a registered nurse, worked predominately in metropolitan hospitals and had been a PNSA for eight years or less. 12% of the PNSAs listed one of their specialties as cardiac/vascular/thoracic (Hains et al, 2016b), findings revealed.

My background consists of more than 20 years as a cardiothoracic scrub nurse. So what does my PNSA role involve on a daily basis? I work in an intraoperative capacity with a number of cardiothoracic surgeons. My role for cardiac procedures involves all the tasks a perioperative nurse would usually undertake such as positioning, prepping and draping. In addition to this, my responsibilities include harvesting of the conduit for coronary artery bypass grafts, helping the surgeon place the patient on cardiopulmonary bypass, assisting with vascular anastomosis and haemostasis, discontinuation of cardiopulmonary bypass and closure of the chest. The conduit I harvest is either the long saphenous vein or the radial artery.

Figure 1

The long saphenous vein is usually harvested via an endoscopic technique.

Figure 1: Shows the telescope inserted to access the vein at the level of the patient's knee for vein harvest. A light can be detected in the thigh that signifies the distal part of the telescope.

Figure 2: A view of the long saphenous vein from inside the leg during endoscopic harvest. A tunnel has been created and filled with CO_2 and the vein is held by a component of the vein harvesting kit.

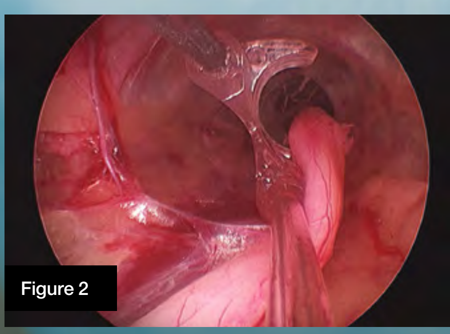

Figure 2

In my role as a cardiothoracic PNSA, I am accredited at six private hospitals. While my actual qualifications are a Master of Clinical Science (Perioperative Nurse Surgeon's Assistant) and Master of Nurse Practitioner Studies, many private health care facilities in Australia do not recognise Nurse Practitioner (NP) credentials, so in the private sector NPs cannot use all of the advanced practice skills they possess and work as PNSAs. Aside from the process of credentialing being problematic, remuneration of the PNSA in the private sector is challenging.

To date, it could be said that the PNSA is a disruptive innovator. This means that while the PNSA provides a service (not as a hospital employee) in the private perioperative setting, there are no mechanisms, such as a means of remuneration from the Medical Benefits Schedule/Private Healthfunds, in place to support this role (Christensen, 2016). In Australia, only doctors can access payment by Medical Benefits Schedule/Private Healthfunds for intraoperative assisting (Victorian Government, 2014). This translates to PNSAs either being employed by a surgeon or surgical practice or charging individual surgeons or patients for their clinical services.

As evidenced by the uptake of PNSAs in Australia (Hains et al, 2016b), this role provides a service for perioperative patients. Although this role has not been fully evaluated from a formal economic evaluation point, the trends to date show it could be potentially cost effective or cost saving (Hains et al, 2017).

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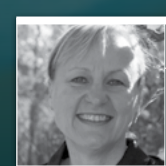

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ETHICAL DILEMMAS

Moral issues experienced by cardiac nurses

Ethics are of special importance to all health professionals. Professions such as nursing have a great responsibility to society to do their job ethically.

This story is centered on an incident proven to be of significance to the performance of a particular cardiac nurse, who will be referred to in this context as, Jull.

The violation of some ethical principles leads to ethical dilemmas. It takes into question whether we should respect a patient's autonomy and compromise standards of care or to ignore a patient's wishes for the sake of their safety.

Respecting confidentiality and anonymity, we can introduce the patient as Ms Brown, an old lady, admitted to a cardiac unit with symptoms of acute cardiac failure, arhythmia and syncope with a fall.

On a night shift, while doing regular observations on the monitor, Jull noticed that telemetry monitoring for Ms Brown had been lost. Checking the old lady, Jull found her out of bed with telemetry leads removed, trying to lift the mattress to look for her car key so that she "could drive to see a friend". After a quick assessment, Jull found that the patient was confused and believed she was still at home.

With some gentle coaxing Ms Brown settled back to bed but flatly refused to have telemetry on. Jull tried several times to replace monitoring but the old lady became agitated, raising her voice wanting to call the police.

The old lady had a serious cardiac problem after a recent fall, hitting her head badly and consequently developing a large intracranial haematoma. As a result, she could be temporarily disoriented and confused. When the old lady settled back to bed, Jull decided to keep a close eye on her and to leave telemetry off for a while, in order to avoid further irritation and distress.

Following this decision, Jull experienced a number of feelings pertaining to the incident. She felt uneasy and began to worry about the situation; not long ago an unmonitored patient went into a life-threatening cardiac arrest. Though that man was successfully resuscitated, that event resulted in the Nurse Unit Manager (NUM) mandating monitoring for all cardiac patients until discharge. The possibility that Ms Brown's heart condition would deteriorate was most worrisome to Jull and she was diligent in maintaining a very close watch on her.

Nurses often deal with ethical dilemmas in the clinical area. The combination of determining right and wrong, and being responsible for our actions creates the standards for ethical behavior. Sadly, knowing what is right and wrong may not always be that simple.

Another concern for Jull, regarding the incident, was whether she would be disciplined by the Nursing Manager. Her fear was eased the following morning at handover as the NUM made a comment that Jull "did the best she could". The end of the shift also brought a feeling of relief for her because Ms Brown had a good rest and made it through the night without any adverse consequences of being unmonitored.

Nonetheless, regardless of these outcomes, the incident had caused Jull enough vexation that a few days later she asked the Unit's Clinical Nurse Consultant (CNC) to talk about the situation and what the result could have been if the patient's condition had worsened. They discussed a number of rationales, interventions and outcomes of the situation.

If a doctor had been informed he would have either given an order that the patient be sedated and put back on the monitor or be kept without telemetry for the night. In this case, Jull could have documented that, and been legally covered in the event that Ms Brown's cardiac condition had worsened.

A well-informed patient with decision-making capacity has an autonomous right to refuse and forego recommended treatments and procedures. Nevertheless, health care professionals need to make certain that the patient's decision is truly autonomous and consciously taken. Even though Jull felt disappointed about making the wrong decision, the talk was beneficial for her future practice as a cardiac nurse.

Nurses are always held accountable for their actions even if they follow the instructions given by a doctor. Conflicting ideas about health and illness, good and bad, and right or wrong become apparent in daily nursing practice. All of these things lead to difficult decisions. Nurses should recognise the complexity of ethical problems and concerns in health care settings before making their

“Primum non nocere / First do no harm.”

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decision (Kopala, B, and Burkhart, L, 2005). Jull's lack of experience in a situation like this played a role in her error of judgment.

Over time, nurses gain knowledge and practical experience that aid their ability to make thoughtful observations and judgments. The individual conscience can be developed by practical experience and will guide a person on what is right or wrong. Appropriate clinical decisions are made by reflecting on previous knowledge and experience, listening to other's views and selecting the best solution for a patient's particular problem (Potter, 2001).

Clinical situations are multifaceted, which is why every clinical case, especially those raising an ethical problem, should be analysed by means of a few relevant points: medical indications, patient preferences, quality of life, and contextual features (defined as the social, economic, legal and administrative context in which the case occurs) (Jecker N et al, 2007).

Ethics are a personal code of behavior and require accountability. An ethical dilemma occurs when a person is confronted with making decisions between two or more actions that she or he can morally justify. (Beauchamp & Childress as cited in Butts & Rich, 2005).

In this perplexing situation, Jull faced the problem of making a choice between keeping Ms Brown's wish or to abide by the policies. Her decision placed the patient in possible danger of an unnoticed cardiac event. This looks like Jull breached an ethical principle.

However, the alternative of somehow forcing the old lady to wear telemetry would have brought her further irritation and distress, which would have been undesirable considering her health condition.

Hendrick (2001) describes that as ‘the duty to do no harm or to minimise harm’. Jull's perception at the time was that by not causing Ms Brown further agitation, she was being non-maleficent. Though the old lady was becoming distressed and agitated, the nurse must question whether in her mental state, she could make that decision.

In this context it is interesting to know that the following shift, when Ms Brown was fully oriented and therefore able to consent and make autonomous decisions about her care, she still refused to wear telemetry.

The ethical dilemma for the nurse becomes more complicated when one tries to ascertain whether in fact telemetry is a life-saving intervention. While the monitoring does not reduce the risk of worsening the patient's condition, it plays a role in the prompt delivery of resuscitation (Goldman, 2001).

Telemetry could be viewed as an observational tool and not a direct life-saving intervention. Jull had witnessed both successful and unsuccessful resuscitations on monitored and unmonitored patients, which added to her confusion. It should be recognised, nevertheless, that a quick phone call to a doctor could have cleared this confusion. This course of action became evident to Jull through the use of reflection – the practice of looking back and going over something that has already occurred. It also provides a method of 'continuous monitoring and improvement of practice' (Usher & Holmes, 2006). Reflection provided Jull with the knowledge for her future decision-making. According to Usher & Holmes (2006) the process of questioning practice is critical thinking.

In conclusion, nurses are faced with many ethical dilemmas during their working career. They need to make ethical decisions daily and it is very important that they to do this functionally, correctly and safely.

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CONGENITAL HEART DISEASE

Pulse oximetry screening for high risk neonates

It is astonishing to acknowledge that by the time a woman realises she is pregnant, her baby has already undergone fundamentally important anatomical growth. During this vulnerable period the developing foetus is impacted by a variety of genetic and environmental factors.

Therefore, determining the multifactorial causes of congenital defects while enhancing screening and detection rates, has the capacity to positively impact on treatment options and outcomes for effected infants and their families.

With specific reference to congenital heart disease (CHD), cost effective measures, such as universal pulse oximetry screening, have been found useful in capturing previously undiagnosed infants, even in well monitored populations (such as babies admitted to neonatal intensive care settings and special care nurseries). Therefore, neonatal nurses and midwives are encouraged to participate in the development and refinement of evidence based screening guidelines to address the requirements of this particular population.

By the time an embryo is three weeks old the capacity for oxygen distribution, waste removal and cellular nutrition have outgrown that provided by simple diffusion, necessitating a rudimentary pump to circulate blood and oxygen around the body (Carlson 2014, p.104). As the embryo takes shape through a complex process of multidirectional folding, cardiogenic cells migrate and collect together (Carlson 2014, p.104). The resulting horse-shoe shaped collection of mesodermal tissue becomes tubular then rapidly folds upon itself forming the heart's basic chambers (Carlson 2014, p.105). Twenty-one days following fertilisation, cardiac muscle cells are sufficiently differentiated to allow the primitive heart to beat (Carlson 2014, p.105).

Not surprisingly, there are many ways in which this crucial developmental phase can be negatively impacted by genetic and environmental factors, leading to structural abnormalities. Congenital heart disease (CHD) affects eight babies per 1,000 births and contributes greatly to infant mortality and morbidity (Kumar 2016, p.36).

Between 30–50% of all deaths from congenital malformations and 6–10% of all infant deaths are attributable to CHD (Kumar 2016, p. 35). Two thousand Australian infants are born with CHD each year and approximately 50% of these defects require surgical correction (Blue et al, 2012, p.155). Increasing prevalence of CHD is attributable to many factors, including advancing maternal age. However, one fifth of all cases remain attributable to either genetic syndromes or maternal exposure to teratogens (Van der Linde, Konings & Slager 2011, cited Kumar 2016, p.36).

Chromosomal anomalies are present in 10% of CHD cases. For instance, approximately half of all babies born with Down Syndrome, also present with a congenital heart defect (Blue et al, 2012, p.156). Familial inheritance leads to high recurrence rates – up to 10% in siblings – and higher still if an infant's mother is effected (Burn et al, 1998, cited Blue et al, 2012, p.157). Additionally, recurrence rates vary for different types of CHD. For example, coarctation of the aorta (a stricture in the aorta leading to impaired circulation to the lower body) has higher recurrence risks than other types of congenital heart defects (Kerstjens-Frderikse et al, 2011, cited Blue et al, 2012, p.158).

Teratogens are environmental factors, disease processes or ingested substances that can be impactful if the expectant mother is exposed to them. For example, the presence of maternal gestational diabetes increases the risk of congenital heart defects fivefold. This is because abnormal serum glucose levels disrupt the expression of regulatory genes in the embryo, while oxidative stress and free radical production – arising from metabolic disturbances associated with this condition – have a simultaneous impact (Blue et al, 2012, p.156).

Given all that is known about recurrence rates, mortality and morbidity associated with CHD, the benefits of early diagnosis and treatment cannot be underestimated. Critical congenital heart diseases (CCHD) are defined as those requiring surgical intervention within the first year of life or causing significant mortality and morbidity within the first weeks of life (Frank et al, 2013, cited Manja et al, 2015, p.67).

> **Early detection facilitates timely intervention, psychological preparation, genetic counselling and delivery planning.**

Early detection facilitates timely intervention, psychological preparation, genetic counselling and delivery planning. Therefore, fetal morphology screening during pregnancy aims to detect the following critical conditions: hypoplastic left heart syndrome, pulmonary atresia, tetralogy of fallot, truncus arteriosus, tricuspid atresia, total anomalous venous return and transposition of the great arteries (Suresh 2013, p.586).

Transposition of the great arteries (TGA) is one of the more prevalent, critical cyanotic heart lesions detected through fetal morphology screening (Liske et al, 2006, cited Kumar 2016, p.37). This condition is characterised by the 'transposition' of an infant's aorta and pulmonary artery, leading to life threatening hypoxaemia. Newborn survival relies upon early detection and the maintenance of embryonic ducts (foramen ovale and ductus arteriosus) utilising intravenous prostaglandin infusion and/or balloon septostomy in the hours following birth. These procedures allow the shunting of partially oxygenated blood around the body, supporting the infant until an arterial switch operation can be performed (Royal Children's Hospital, n.d.).

Bonnet et al 1999 (cited Kumar 2016, p.37) compared the outcomes of neonates diagnosed with TGA, pre- and post-delivery. This study concluded that infants diagnosed 'in utero' were admitted to appropriate care facilities very quickly (approximately at three hours of age versus three days of age for the comparison group) and consequently exhibited far better clinical conditions on arrival; absent preoperative mortality (versus 6% in the comparison group), shorter post-operative hospital stay and lowered post-operative mortality than those diagnosed after birth.

However, not all lesions are detected by fetal morphology scanning. In one American study, a retrospective analysis of infants diagnosed with CHD was undertaken, in which it was discovered that only 28% were diagnosed before birth (Friedberg et al, 2009, cited Kumar 2016, p.37). This was attributed to human error, level of experience and the type of lesion. Of particular concern, are estimates that between 30–50% of infants with CHD are discharged from hospital without their condition being diagnosed (Kumar 2016, p.37). Therefore, the need for a cost effective and supplementary screening method was identified.

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> **“So, despite technological advancement and the provision of routine fetal morphology scanning, not all congenital heart defects are diagnosed in utero…”**

One option under development is universal pulse oximetry screening. Pulse oximetry screening is a non-invasive method of measuring the oxygen saturation of arterial haemoglobin in the blood. While guidelines differ slightly and continue to be refined, this procedure aims to measure and compare the pre- and post-ductal oxygen saturations of all newborn infants greater than 24 hours old (or as close as possible to discharge) in order to detect the disparities indicative of CHD.

A reading above 95% on the right hand (pre-ductal) or a difference of less than 3% between the two readings (eg. right hand and right foot) indicates an optimal ‘negative’ finding (Kumar 2016, p.40). Readings of less than 90% on one limb, below 95% on both limbs after three measurements (one hour apart) or differences in pre- and post-ductal saturations of greater than 3%, indicate a ‘positive’ result, warranting further investigation, echocardiogram and the exclusion of conditions, such as haemoglobinopathies (Kumar 2016, p.40).

However, suboptimal timing, erroneous application of sensors or interpretation of protocols can give rise to ‘false negative’ results with serious consequences. Therefore, further research and education is required to refine protocols in general and to direct the screening of infants with preexisting conditions and developmental variables, such as those born prematurely or compromised at birth, necessitating admission to neonatal care facilities (Kumar 2016, p.39).

It is estimated that 15% of all newborn infants are admitted to special care nurseries and neonatal intensive care units in Australia (Australian Institute of Health and Welfare (AIHW) 2016, p.37). In clinical guidelines and care pathways developed by the NSW Pregnancy and Newborn Services Network (PSN) pulse oximetry is recommended as part of routine assessment of newborn wellbeing, adding that ‘screening should occur before discharge, but no later than 48 hours of life, to optimise the window of opportunity for early intervention’ (PSN 2017, p.3). Within these guidelines it is acknowledged that early screening (between 4–24 hours of age) may generate high ‘false positive’ rates but that this risk can be justified by the need to rapidly identify infants with critical cardiac conditions requiring urgent medical intervention (PSN, 2017).

Screening infants in newborn care facilities who have been exposed to continuous oxygen saturation monitoring, extensive examination, regular echocardiography and serial radiography may seem superfluous. Yet, cases of infants being discharged from neonatal units with a CCHD have been reported, lending weight to universal pulse oximetry screening, even for this extensively monitored population (Manja et al, 2015, p.70; Suresh 2016, p.588).

Having conducted an integrative review of literature pertaining to neonatal nursing care of infants with congenital heart disease, Magalhaes, Queiroz and Chaves (2016) concurred stating that pulse oximetry screening is warranted, as a painless, cost-effective and non-invasive technique but that further education is required to provide consistent, evidence based care.

So, despite technological advancements and the provision of routine fetal morphology scanning, not all congenital heart defects are diagnosed in utero, impacting on the ability of care providers to deliver safe, timely and supportive care to effected infants and their families. Moreover, discharging a newborn infant from care with an undiagnosed cardiac lesion has serious consequences. Therefore, additional, cost effective, screening methods are required to minimise this risk.

Pulse oximetry screening has the capacity to provide an additional level of scrutiny to the assessment process even for highly monitored infants, such as those admitted to neonatal intensive care units and special care nurseries. Neonatal nurses and midwives have the capacity to lead the development and refinement of guidelines that address the specific developmental and screening requirements of compromised term and premature infants, so that evidence based care is provided to this cohort and missed opportunities to treat are avoided.

Editor’s note:
Trish is responsible for the coordination of our Graduate Certificate in Neonatal Care. If you are interested in finding out more about this course, please visit our website: www.acn.edu.au/neonatal-care

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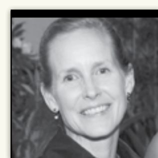

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LIGHTHOUSE HOSPITAL PROJECT

Better cardiac care for Aboriginal and Torres Strait Islander peoples

Lighthouse is a project that is jointly sponsored by the Heart Foundation and the Australian Healthcare and Hospitals Association (AHHA). Its aim is to drive change in the acute care setting to improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease (CHD), the leading cause of death among this population.

Aboriginal and Torres Strait Islander peoples are more likely to be admitted to hospital for Acute Coronary Syndrome (ACS) episodes – heart attack or angina – and are more likely to die in hospital or leave against medical advice. While in hospital, they are also less likely than non-Indigenous Australians to undergo coronary tests and procedures.

Hospitals and their nursing staff have a critical role to play in improving access to evidence based care and addressing disparities in care for Aboriginal and Torres Strait Islander peoples. Further, reducing the self-discharge rate to that of non-Indigenous patients would result in significant savings to hospitals and the health care system.

LIGHTHOUSE PROJECT PHASES I AND II

The first two phases of the project ran from 2012 to June 2016, with pilot testing in eight hospitals during Phase II. Four domains were identified as key to establishing best practice care for Aboriginal and Torres Strait Islander peoples experiencing ACS. These included appropriate governance, cultural competence, use of clinical care pathways, and having a skilled workforce.

The project used a quality improvement (QI) methodology to plan, test and evaluate practice changes. Participating hospitals were supported with a toolkit, *Improving health outcomes for Aboriginal and Torres Strait Islander people with acute coronary syndrome*, which was also evaluated through the project. The toolkit has since been updated to reflect feedback on usability and functionality, as well as inclusion of real-life case studies from Phase II.

Some key outcomes from the project included:

- Better identification of Indigenous patients
- Improved relationships with Aboriginal and Torres Strait Islander patients and communities
- Recognition of the importance and value of Aboriginal Liaison Officers
- Improved confidence of hospital staff in delivering culturally appropriate care
- Greater commitment to follow-up after discharge
- Reduction in discharge against medical advice

Participating hospitals have been enthusiastic supporters of the project, appreciating the systemic improvements to culture and practice that have been achieved. They have also recognised the broader application of the Lighthouse approach to other illnesses, including other heart-related conditions, diabetes and cancer.

LIGHTHOUSE PROJECT PHASE III

On Friday 10 February the Minister for Indigenous Health, The Hon. Ken Wyatt AM MP, announced the expansion of the Lighthouse project into its third phase.

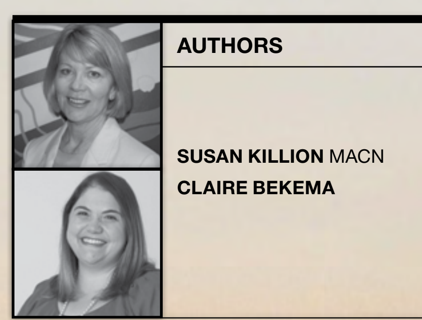
The Heart Foundation and AHHA are currently recruiting 18 hospitals from all states and territories across Australia, except the ACT and Tasmania. Recruitment is targeted to capture nearly one-half of all Aboriginal and Torres Strait Islander CHD separations by inviting hospitals with the highest numbers of such separations to participate. This is to ensure the project has sufficient reach and critical mass to create systemic change.

The project also aims to enhance relationships and coordination of care between hospitals, local Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs), and community and primary health networks. Ongoing inclusion of local communities and leaders in the design, delivery, monitoring and revision of quality improvement activities, will ensure individual hospital projects are responding to identified needs of the community and will create locally based solutions.

Results from the evaluation of Phase II showed that a critical element to implementing the project successfully was the network of support facilitated by the external project team. Phase III project teams will be provided with education and training in the principles of quality improvement, project management and implementation of the toolkit. A project coordinator will be allocated to each site and ongoing quality improvement support will be available to assist in implementing system change.

To help facilitate their participation in the project, hospitals will receive funding support for a project officer and for their quality improvement activity. An added benefit of the Lighthouse Hospital Project is that participation will assist in delivering accreditaton and meeting ACQSHC standards.

Editor's note: ACN is committed to supporting Indigenous health equality. We proudly administer the Puggy Hunter Memorial Scholarships Scheme on behalf of the Commonwealth Department of Health. ACN also delivers a range of rural and remote health scholarships.



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CLAIRE BEKEMA

CHUCK OUT THE OBS

Embracing holistic nursing assessment

Patient safety, specifically failure to recognise and rescue deteriorating patients (Clarke and Aiken, 2003, Kendall-Gallagher et al, 2011), has emerged as an important issue in health care internationally (De Jong et al, 2016). Timely recognition and response to patient deterioration is primarily a nurse's responsibility.

Nurses typically have relied on patient observations, 'the obs', to guide them in recognising and responding to patient deterioration. However, recognition of, and response to, patient deterioration is often suboptimal (Massey et al, 2016, Odell et al, 2009, Quirke et al, 2011), and the reasons for this are not fully understood.

Lack of understanding about pathophysiological processes underlying the signs and symptoms of patient deterioration by nurses appears to be a significant factor (Cooper et al, 2011, Massey et al, 2016, Odell et al, 2009, Steen, 2010). Therefore, nurses may be missing critical opportunities for early intervention and escalation of care for deteriorating patients. This may jeopardise patient safety, lead to adverse events and limit effective utilisation of health care resources.

In this paper, we present a reflective account of recognising and responding to patient deterioration using a holistic patient assessment framework. Rolfe's framework for reflective practice (Rolfe et al, 2001) will be used to structure this reflection. Rolfe's framework involves three stages.

1. **What:** the descriptive level of reflection
2. **So what:** the theory and knowledge level of reflection
3. **Now what:** the action-orientated level of reflection

WHAT?

A 55-year-old man was admitted to a coronary care unit following a large, anterior infarct. He was four day's post infarct and appeared to be making a good recovery. At handover no issues were documented; he sat in a chair, was relatively independent and making a good recovery. His observations were recorded as:

- HR 92 BPM, normal sinus rhythm
- B/P 110/60 mmHg
- Temperature 36.4°C
- Respiratory rate 14 BPM
- Oxygen saturation 98% on room air

Once the nursing handover was completed, and the assessment of the patient's airway and bedside emergency equipment was finished, a holistic patient assessment was performed. This revealed the following information:

- HR 98bpm
- B/P 115/58mmHg
- Temperature 36°C
- Respiratory rate 28 BPM
- Oxygen saturations 96% on room air
- Bilateral pitting oedema in both ankles
- Jugular vein pressure (JVP) 6cms
- Fine inspiratory crackles auscultated bilaterally in both lung bases
- Cold clammy skin
- No urine output for more than six hours

SO, WHAT?

Clearly the patient was deteriorating physiologically and escalation of his care needed to be considered. The most sensitive indicator of patient deterioration is the respiratory rate (Kyriacos et al, 2011), and yet as indicated above, it is also the most poorly performed, and the most commonly unreported (Cretikos et al, 2008).

The presence of other clinical indicators – bilateral pitting oedema, raised JVP, fine bilateral basal inspiratory crackles, diminished urine output and cold clammy skin – also indicated acute deterioration that required urgent escalation and intervention but do not form part of the typically recorded 'obs'.

The holistic assessment framework used in this clinical example demonstrates how a complete clinical assessment 'picture' enables effective referral to a rapid response/medical team. In this case, the patient was rapidly reviewed by the medical staff and 80mg of frusemide was prescribed with good effect.

In this clinical example, we clearly illustrate that reliance on 'the obs' is clinically substandard and unsafe. Use of an holistic patient assessment framework when assessing this person enabled identification of patient deterioration, and timely and appropriate escalation of his care (Douglas et al, 2016).

ISTOCK

NOW WHAT?

We argue that nurses need to 'chuck out the obs' as a task-oriented process and begin utilising a holistic patient assessment framework to maintain their contribution to patient safety in a clinical environment populated with more and more clinically unwell patients (Massey et al, 2009). While assessment and documentation of patient vital signs or 'patient obs' remains an important part of nursing assessment, and of recognising patient deterioration (Douglas et al, 2016), assessment and documentation is often inaccurate and understood as a 'task' in and of itself, rather than a tool to guide further assessment (Mok et al, 2015).

Nurses are taught extensive patient assessment theory and skills, yet appear reluctant to use these skills in clinical practice (Douglas, 2014). Indeed, a recent study by Douglas et al (2016) highlighted that nursing students are under-confident and doubt the impact of using a patient assessment framework in their clinical practice.

Douglas and colleagues argue that patient assessment is in danger of being marginalised from our scope of practice because its relevance and importance are not valued by nurses or health care organisations. This is evidenced by the delegation of patient assessment or 'the obs' to health care assistants (James et al, 2010) or even to automated systems (Shaw et al, 2015, Smith et al, 2015).

As media coverage of nurses' failure to rescue patients from deterioration continues to create negative perceptions of nurses' skills and ability to recognise and respond to patient deterioration, patient surveillance technology is gaining momentum (HCCC, 2016, Smith et al, 2015).

We believe this is a concerning and potentially unsafe trend, which has the potential to dilute and fragment the scope of the nurse's role and practice. Therefore, nurses need to reclaim patient assessment as a fundamental nursing role and ensure its importance in the care continuum is recognised and acknowledged by health care organisations, professional bodies, educational providers and patients.

There have also been calls to reduce the amount of patient assessment content taught in the nursing curriculum (Birks et al, 2013, Giddens, 2007, Giddens and Eddy, 2009) because it is argued that nurses do not use these skills in clinical practice. This rationale is particularly challenging in the context of recent evidence from European data, supporting older North American data, suggesting that clinical surveillance by RNs, rather than less qualified health professionals, decreases patient mortality (Aiken et al, 2014, Aiken et al, 2003).

This dichotomy is illustrated by the relative emphasis on education levels between nurses, and then between nurses and medical practitioners, and their relative

pragmatic contribution to patient examination and care. A paradigm shift is needed to move ‘the obs’ from being a component of the daily ‘tasks’ (that anyone can perform and document) back into the repertoire of the registered nurse’s expert capacity to assess patients holistically to inform their clinical decision-making.

Assessment of vital signs, as a small part of directing and creating a holistic patient assessment, empowers nurses to support patients and to act/advocate on their behalf. Not just ‘doing the obs’ but rather, creating a patient-centred, clinically relevant physiological picture of each individual that emboldens nurses’ contributions to patient care and enhances the nurse’s role in the multidisciplinary clinical arena. It ensures that nurses remain key to safety and quality care provision in health care. So, we urge all nurses to ‘chuck out the obs’ and embrace a holistic patient assessment framework.

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iSTOCK

NURSING HISTORY

From the first moon landing to coronary care units

“The first coronary care unit concept in Australia was established at Sydney Hospital in a research ward in the early 1960s.”

Have you ever thought how long ago something new was introduced and how close you were, in time, to the innovation? All history is not ancient and many of you will have been on the cusp of, or involved in, the implementation of a new nursing practice or medical invention.

As with the 50th anniversary of the moon landing only a couple of years away, I am sure there will be another round of conversations amongst you that start with “do you remember where you were when …?” – the same can happen in nursing.

Yes, I remember the moon landing linked to my nursing career; I was on my first ward after my introductory block – women’s surgical. But what was happening then in nursing practice? What platform did this provide to how we practice now?

Let’s think about the technology you use today in your everyday practice. Where were you when the first tablet and smartphones were introduced as tools for your practice? What were they used for? What impact did they have on nursing practice? How did they change practice? What about the technology in the ICU? When did all this start? What changes occurred in the nursing management of people with myocardial infarctions and what impact did it have on patient outcomes?

The first coronary care unit concept in Australia was established at Sydney Hospital in a research ward in the early 1960s. The unit involved routine monitoring of patients who had suffered acute myocardial infarctions (Julian 1962, pp. 621-624). Pioneering work on defibrillation, resuscitation, and coronary care had already been taking place in the United States prior to this.

However, with the additional development of specialised coronary care units, it soon became apparent that resident doctors were not interested in continuous observation, which of course, led to the establishment of specialised nurses as the key carers (Julian 1962, pp. 621-624). And the rest is nursing history – a history that is full of twists and turns as new knowledge and technologies significantly build on these early developments.

History is for every nurse. It is more than fascinating – it can make the everyday make a whole lot of sense and challenge our thinking.

Share your stories and history, or your review of a book or film, or your visit to a place of nursing history interest, through the ACN History Community of Interest (COI).

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Dr Julian was involved in the establishment of the ward at Sydney Hospital in 1962.

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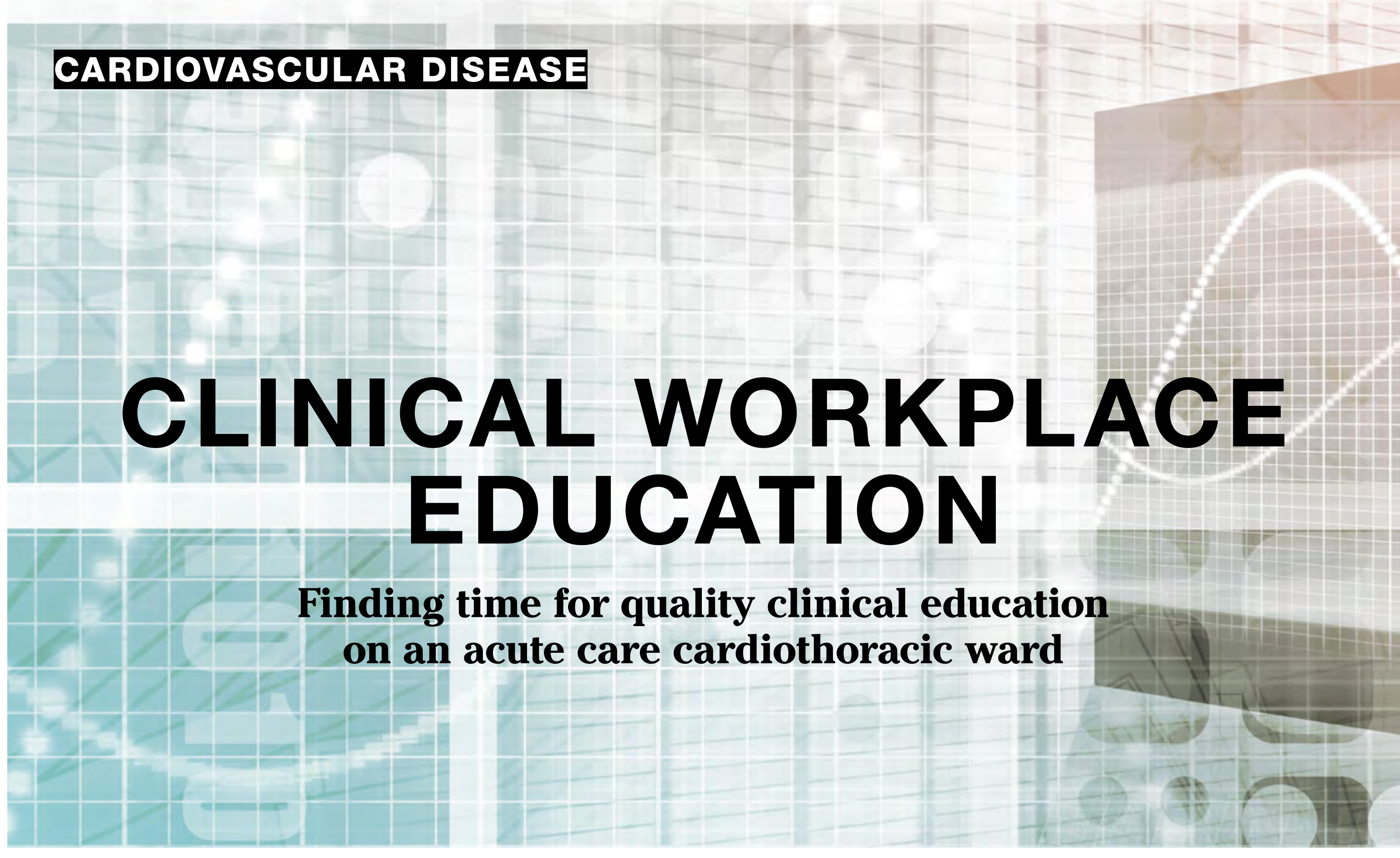
PIXABAY



CLINICAL WORKPLACE EDUCATION

Finding time for quality clinical education on an acute care cardiothoracic ward

Ongoing continuous professional development (CPD) activities for clinical nursing staff are widely regarded as an essential component of quality assurance and risk mitigation, and are a mandated part of the annual requirements to maintain professional registration as a registered or enrolled nurse (Nursing and Midwifery Board of Australia, 2010). CPD is acknowledged in the literature as a key tool in ensuring successful clinical outcomes for patients and positive workplace cultural growth for nursing staff and health care organisations on a number of levels.

On a personal level, nurses who engage in CPD activities exhibit increased job satisfaction, efficacy, confidence and accountability as practitioners, and are less likely to experience burnout resulting in a departure from the profession (Pool, Poell & Cate, 2013; McCormack & Slater 2006; Nsemo et al, 2013).

On an organisational level, CPD programs have been shown to establish and maintain high care standards, promote positive behavioural change and assure safety of clinical care (McCormack & Slater, 2006; Katsikitis et al, 2013; Clarke, Kelleher & Fairbrother, 2010). Furthermore, a well administered CPD program can contribute to the successful attraction and retention of high quality nursing staff and can ultimately add to the financial viability of the organisation (Johnson et al, 2011).

Despite these advantages, the challenge of finding time in the acute care clinical setting for educational activities remains difficult to combat. Many nurses work under considerable time, financial and workload pressures, and will not engage in educational activities in addition to their patient responsibilities unless they are provided with ongoing support to do so (Katsikitis et al, 2013).

Therefore, it is essential that CPD opportunities are provided in an organisational environment that is conducive to learning and development, and which offers educational opportunities in a series of diverse formats (McCormack & Slater, 2006; Katsikitis et al, 2013). In addition, the educational offerings must be tailored to the interests of the target audience (Katsikitis et al, 2013).

As a new clinical nurse educator, trying to establish a program which would engage a group of motivated but very busy cardiac nurses, I found that there were few places to turn for practical ideas on how to bring education into an acute care ward where there was very little time to spare. The result was that we developed our program from scratch in a way which made educational activities a relevant and significant part of our daily working lives while still allowing us to deliver high quality patient care.

It is my hope that by sharing our experiences, other nurse educators looking for ideas will be able to bring some new educational initiatives into their own workplace and see the benefits for themselves.

THE PROGRAM

The chief aim of our program was to reinvigorate staff enthusiasm for education and to emphasise that engagement with quality assurance and professional development has a direct effect on the success of the unit and their own job satisfaction. The program was commenced with a focus on the individual learning needs and career aspirations of the staff. In pursuit of a fresh approach to educational engagement, we launched a range of new initiatives.

- **Professional Development Planning Sessions.** These sessions were held in January with each staff member in order to review their professional development progress and set personal goals for the next 12 months. Where possible, these goals were formulated to tie in with the unit's quality assurance objectives. *Personalised Professional Development Plans* were constructed following the sessions and distributed to each nurse so they could chart their own progress throughout the year. Copies of the plans were also given to the Nursing Unit Manager so that they could be integrated into each staff member's performance appraisal.

> **" When staff feel that their participation and involvement in professional development is a source of pride and an important aspect of their working life, they will seek out opportunities to involve themselves in learning despite the other demands on their time and energy. "**

- **Implementation of a mix of group and private learning sessions.** The frequency of group learning (in-service) sessions was increased to five per week (once daily on weekdays during the shift overlap between the morning and afternoon shifts) with the same topics repeated several times so that more staff could attend and benefit from the knowledge. Two educational themes were allocated to each month and the learning sessions were planned to link in with these themes. In addition, the educator worked with each staff member individually to achieve their learning goals in the course of their work by acting opportunistically to provide short informal teaching sessions.
- **Increased focus on involving staff in positive role modelling.** Senior staff were asked to act as advocates for various elements of clinical care. Representatives of the team attended hospital wide meetings on their area of special interest and reported back to the rest of the department.
- **Provision of written resources.** An education folder was developed for those staff who worked weekends or night duty. The folder contained handouts pertaining to all the topics covered in the in-service sessions for those who could not attend in order to emphasise that education was accessible to all staff members regardless of shift patterns.
- **Creation of a departmental education newsletter.** The monthly newsletter contained a description of the educational goals for the following month, the previous month's audit results and details of upcoming educational study days. It also included a column in which pertinent nursing updates and care standards were articulated. This newsletter was sent to each staff member via email.
- **Set up of a permanent education display.** The education display, located in the tea room, included the previous month's audit results with strategies for improvement, the education calendar, copies of the current newsletter, nursing care updates and descriptions of the educational content of each of the upcoming group learning sessions. The display also included the departmental 'skills bank' in which nurses who possessed a particular skill or clinical background were acknowledged. The skills bank acted as both a public statement of an individual nurse's expertise and also as a resource for nurses who were seeking advice or support from their colleagues in a particular area.
- **Establishment of a quality roundtable.** This monthly forum gave staff the opportunity to bring issues or problems which they were encountering in the provision of clinical care to a democratic discussion in which solutions were developed as a team. Various topics were discussed throughout the year including reports on new findings from conferences and clinical issues which needed attention.
- **Promotion of a 'Skill of the Week'.** Each week, a small practical skill (injection technique, IDC insertion etc.) was highlighted for attention in order to ensure that staff remained confident and competent in their full skill set. The skill was chosen to complement the learning themes for the month. The 'Skill of the Week' was identified each week on the education board and staff who were unfamiliar with the skill were able to request an individual learning session with the educator during their shift.
- **Establishment of reflection sessions.** An open forum was held at the conclusion of the year to allow staff to give their feedback on the program and to make suggestions for the following year. These sessions allowed the staff to express personal interests and goals which were taken into consideration when educational planning took place.
- **Acknowledgment of achievement.** Each staff member received a Certificate and Record of Participation summarising their participation in CPD activities throughout the year, as well as a list of all the competencies which they had achieved.

RESULTS

Like all new ideas, it took a while for the staff to integrate the new educational offerings into their workday routine but, once they did, they came to appreciate the benefits. An average of 90% of the participating staff completed their CPD registration requirements directly through engagement with the program and did not have to use their personal time to fulfil these obligations. Attendance at education sessions rose dramatically and it became popular to attend on a regular basis.

An increase in participation itself had a positive effect on the quality of the education offerings. Thanks to the guarantee of regular ward in-service times and satisfactory attendance, we were able to offer education on a wide range of topics taught by medical, nursing and allied health internal and external guest speakers.

Each year, we delivered education on an average of 64 distinct medical and nursing topics. Each nurse attended, on average, 26 sessions a year. The reputation of the program grew within the hospital with many staff from other departments attending education sessions on the unit.

Our staff showed appreciation for the range of professional development opportunities available to them in the workplace and also took up educational offerings outside the hospital with the financial support of the organisation. They believed that the morale on the ward had improved and volunteered that they felt positive and supported. In short, they felt that there was a promising and exciting future for them in this facility which would support their career aspirations and professional goals.

CONCLUSIONS

While the project proved extremely successful in creating a workplace culture where learning and education was valued by management and bedside staff alike, it involved a lot of effort and personal commitment on the part of the educator. We found that it took time, creativity and tenacity to create the initial buy-in to make such a program successful and, at times, it was easy to feel that the task was too big to be achieved.

I believe in retrospect that, when staff feel that their participation and involvement in professional development is a source of pride and an important aspect of their working life, they will seek out opportunities to involve themselves in learning despite the other demands on their time and energy.

In the future, it is my hope that clinical workplace education can be given more prominence and support across the nursing spectrum and that the clinical educators of Australia can find more opportunities to share their ideas and innovations with each other. There is so much potential just waiting to be explored and developed!

Acknowledgments: With thanks to the staff on Level One and the executives at North Shore Private Hospital for supporting this initiative.

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PIXABAY

MY RESEARCH INTERNSHIP

Exploring factors that contribute to ideal cardiovascular health

I have a confession for you. Coming to nursing as a mature-aged student, I enrolled in the fast-track Bachelor of Nursing at the University of Tasmania (UTas) not because I had a burning desire to be a nurse but because I thought it would be a challenging job that would provide a solid foundation for postgraduate studies. I'd been an editor for 20+ years and a nutritionist for more than 10, and I wanted to transition to health care as my career but I wasn't sure quite where I'd end up.

Fast forward a couple of years and I'm delighted to be a novice nurse participating in the ACN Emerging Nurse Leader (ENL) program and about to begin my transition to practice graduate year. Just as it became clear during my studies that I wanted to practise as an oncology nurse, I realised I also wanted to be involved in research. So, with trepidation, towards the end of my undergraduate degree, I applied for a research internship at the Menzies Institute for Medical Research via the Undergraduate Research Opportunities Program (UROP).

The UROP is a program for UTas undergraduates who work under a mentor researcher for six weeks on a project that forms part of a research program at the Menzies Institute (and similar programs are available in other states). I applied so I could gain insight into biomedical research work and experience what it involves day-to-day, to find out if research suits me, and more importantly, if I suit it! The onus was on me to secure a researcher-mentor and I was immediately drawn to two epidemiological research projects led by one researcher who agreed to take me on. And so I find myself in week four of six, drafting an article about our research project for submission to a peer-reviewed journal.

Our epidemiology project aims to assess how healthy Australians are and what makes them so. We are using Australian Bureau of Statistics data from the National Health Survey to measure the health of Australian adults against the American Heart Association's *Life's Simple 7* health metrics. *Life's Simple 7* sets out seven health behaviours and factors that contribute to ideal cardiovascular health and is increasingly used as an international benchmark in population-health research. I feel very fortunate to be working on a project that combines my interests in nutrition, healthy living and public health.

Because I'd never studied statistics and was more familiar with qualitative than quantitative methods, I began my internship by reading an epidemiology textbook. I needed a glossary of the language of quantitative research at hand. Along the way I've compared Australian health guidelines against *Life's Simple 7's* recommendations, conducted a literature review, defined the search parameters for our statistical inquiries and reviewed a first pass of our findings. At the same time, I've been drafting the method and limitations sections of my article, which I will continue to work on after my six weeks comes to an end.

The hands-on research and writing experience has been enlightening, challenging and interesting, and I am now determined to forge a career in research alongside my career in nursing. However, the UROP's invaluable benefit has been meeting regularly with my researcher who has not only shared her considerable expertise to encourage me through the process, but also acted as a career mentor. It can be difficult for student nurses to make the leap into research and even four weeks in, I feel better informed to tackle research Honours in the short term.

I've no doubt that the UROP is my first step towards a research career and I'd encourage nursing undergraduates who are interested in finding out what research is about to apply to similar programs. Don't think: 'Oh that's just for biomedicine and medical students!' (as I did). As nurses, we bring a unique combination of skills and knowledge to research and just as there are diverse nursing roles, there are many research avenues to pursue. I was already excited about what this year, my first as a nurse, would bring. And now that I'm considering what I can bring to research as a nurse, my future seems even brighter.

Editor's note: ACN's ENL Program is designed to develop skills, build confidence and provide opportunities for nurses to represent our profession as leaders. Visit our website to find out more about our ENL program.

AUTHOR

MELANIE ESLICK MACN
REGISTERED NURSE AT THE ROYAL HOBART HOSPITAL IN TASMANIA.
PARTICIPANT IN THE ACN EMERGING NURSE LEADER PROGRAM STAGE 2.

CROWN STREET WOMEN'S HOSPITAL: A HISTORY 1893–1983

Author: Judith Godden FACN (Hon)
Publisher: Allen & Unwin
Published: 2017
Reviewer: ACN History COI Key Contact Marilyn Gendek FACN

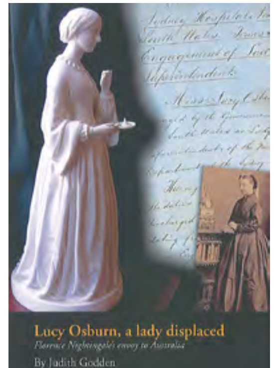
This illustrated history of Sydney's pioneering maternity hospital recounts 90 years of medical and social innovation. It features previously unpublished and revealing photographs, and draws on private records and over 150 interviews of staff and patients.

Crown Street Women's Hospital was the largest women's hospital in NSW. Located in the heart of Surry Hills, it was a referral hospital for women throughout the state and a leading teaching centre for obstetricians and midwives. Affectionately known as 'Crown Street', an essential part of its role was caring for the poorest and most marginalised women in Sydney.

It became internationally famous after its success with treating eclampsia, a major cause of maternal death. It was the centre of the thalidomide scandal and renowned for its care of newborn babies. From its first years, it sheltered homeless pregnant women and cared for those who had undergone botched illegal abortions; the hospital was later involved in the distress of forced adoptions. In its final years, its birth centre revolutionised birth practices in Australia. Among the many individual stories is that of May Yarrowick, who in 1907 became the first formally trained Aboriginal midwife, and that of Edna Shaw, Sydney's most popular matron.

Judith Godden is an internationally recognised expert in the history of medicine and nursing. She is a former academic at the University of Sydney and an Honorary Associate in its Department of History. Judith is the author of many books including *Australia's Controversial Matron: Gwen Burbidge and Nursing Reform*.

Website: www.judithgodden.com.au



LUCY OSBURN, A LADY DISPLACED

Author: Judith Godden FACN (Hon)
Publisher: Sydney University Press
Date of Publication: 2016
Reviewer: ACN Publications Lead Sally Coen

Beautifully written and refreshingly honest, Judith's Godden's new biography of Lucy Osburn builds an intriguing picture of an independent middle-class woman who would one day become the founder of modern nursing in Australia.

Delving into Osburn's unconventional relationship with Florence Nightingale, Godden gives readers unique insights into the discourse between these two powerful nurse leaders. Far from the nineteenth century stereotypical silent and submissive angel-in-waiting, Osburn is portrayed as an ambitious, energetic and intellect young woman who reshaped the face of the Australian nursing profession.

Throughout the novel, Godden cleverly describes the complex web of power and authority in colonial Australia. Highlighting Osburn's determined navigation of class tensions and gender imbalances during this time, Godden really highlights the battles women overcame to secure the freedoms we enjoy today.

Lucy Osburn, a lady displaced: Florence Nightingale's envoy to Australia is an enthralling and enlightening read that I would highly recommend to anyone interested in Australian nursing history.

Website: www.shop.acn.edu.au

CARING CORRUPTED: THE KILLING NURSES OF THE THIRD REICH

Authors and Directors: Linda Shields FACN, Susan Benedict, Patricia Starck
Reviewer: ACN History COI Key Contact Marilyn Gendek FACN

"Susan Benedict is the world's top scholar in the role of nurses in the Nazi era and this film was her initiative and idea. She is the Professor of Nursing, Director of Global Health, and Co-Director of the Campus-Wide Ethics Program at the University of Texas. It took a lot of persistence on her part to get it going. Patricia Starck was Head of the School of Nursing at Texas Medical Center and was the driving force behind making the film happen." – Linda Shields Professor of Rural Health, Charles Sturt University.

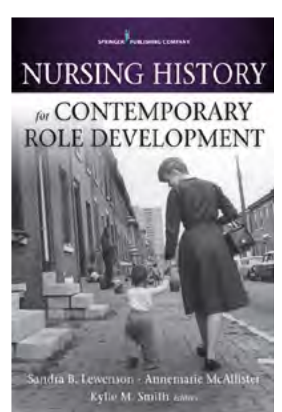
Susan Benedict and Linda Shields are co-authors of the book *Nurses and Midwives in Nazi Germany: The "Euthanasia Programs"*.

Video: www.youtube.com

PIXABAY

A COLLECTION OF NURSING BOOK AND FILM REVIEWS

If you would like to submit a nursing book or film review for publication in an upcoming edition of *The Hive*, please email us at publications@acn.edu.au



NURSING HISTORY FOR CONTEMPORARY ROLE DEVELOPMENT

Editors: Sandra B. Lewenson, Annemarie McAllister, Kylie Smith
Publisher: Springer Publishing Company (Kindle version available)
Date of Publication: 2016 – 1st Edition
Reviewer: ACN History COI Key Contact Marilyn Gendek FACN

Designed primarily for students, this book delves into the intricacies of nursing history and its impact on contemporary nursing practice, education and research. An accompanying instructor's manual features guidelines for bringing historical elements into nursing curriculum.

Chapters examine key issues in contemporary nursing today, such as the care of diverse populations, rural health care, mental health care, neonatal health care, the nurse educator role, entry into practice issues, and more. The text contextualises their evolution, showing what remains tried and true, what has been disproven, and what remains to be examined. It illustrates how nursing history fits into the broader context of culture and society from the late 19th century to the present.

Sandra B. Lewenson is co-editor of *Capturing Nursing History: A Guide to Historical Methods in Nursing*, and a Professor of Nursing at Pace University. Annemarie McAllister is Dean of the Cochran School of Nursing at St. John's Riverside. Kylie M. Smith, previously from the University of Wollongong, joined the Nell Hodgson Woodruff School of Nursing at Emory University as the school's first Andrew W. Mellon Faculty Fellow in Nursing and the Humanities in 2015.

THE HISTORY OF AUSTRALIAN NURSES IN THE FIRST WORLD WAR

Author: Ruth Rae
Publisher: Australian College of Nursing
Date of Publication: 2015
Reviewer: ACN Publications Lead Sally Coen

Nurses have a proud, selfless and heroic history of military service. Both in times of conflict and peace.

The History of Australian Nurses in the First World War: An ACN Centenary Commemorative Trilogy is a beautiful tribute to the many nurses who served in honour of our profession. Threading Australian nursing history into the fabric of the First World War, the Trilogy highlights the valuable service Australian nurses provided, to not only the servicemen, but to the ongoing professionalism of civilian and military nursing in this country. The Trilogy features three separate books and a nominal roll, that comes together to paint a picture of the shared experiences of Australian army nurses during this time.

Through personal accounts interwoven with valuable historical insights, the Trilogy brings into sharp focus the harsh realities of war and honours the sacrifice of those who gave their lives for our freedom.

Website: www.shop.acn.edu.au

FIGHTING FIT: THE WARTIME BATTLE FOR BRITAIN'S HEALTH

Author: Laura Dawes
Publisher: Weidenfeld and Nicholson (Kindle and Audible versions available)
Published: 2016
Reviewer: ACN History COI Key Contact Marilyn Gendek FACN

In the theme of cardiovascular nursing, what risk did the humble deck chair in a bomb shelter on a night of bombing raids have in common with a flight from Melbourne to Los Angeles? Yes – that's right – deep vein thrombosis!

Extensively researched and jauntily written, *Fighting Fit* shows how meticulous planning for medical services drew on the skills and expertise of so many different people; from boy scouts to the London expert on body lice. Homefront public health efforts showed that a well-fed population with good medical care was capable of economic and military marvels.

Wartime experience became the foundation for the modern National Health Service. This book tells the surprising stories of efforts to keep Britain fighting fit, and how these efforts won the quietest victory of all. At the end of six years of war, Britannia was in better health than she had ever been. Never, indeed, had so much been owed by so many to so many.

Laura Dawes is based in Australia. She is a freelance writer and historian of medicine. Laura holds a PhD from Harvard University and is the author of *Childhood Obesity in America: Biography of an Epidemic*.

Website: www.lauradawes.org

Nursing moments

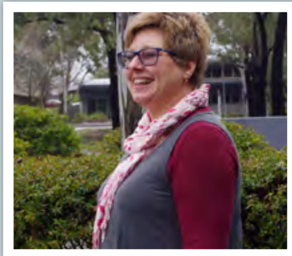
Moments *when* community and primary health care nursing is provided...

Community and Primary Health Care Nursing Week is an annual campaign that aims to raise awareness of the current and potential contribution of community and primary health care (CPHC) nurses.

As part of the celebrations, ACN publishes a **Community and Primary Health Care Nursing Week eBook** each year. The eBook is a collection of stories by CPHC nurses, organisations and academics. Last year, the eBook featured stories about moments *when* CPHC nursing is needed.

Following publication of the 2016 eBook, readers had the opportunity to vote on their favourite submissions. The following stories are in the top three submissions as voted by our readers.

MENTAL HEALTH NURSING: WALKING ALONGSIDE YOUR CLIENT THROUGH THEIR JOURNEY



LISA HAWKE
MENTAL HEALTH CLINICAL MANAGER, CAPITAL HEALTH NETWORK

Lisa believes her empathy and ability to communicate well have been crucial in her role as a credentialed mental health nurse. She feels that the key to mental health nursing is actually walking alongside your client through their journey. This is how she approaches her role, which she loves.

Lisa commenced her career in the UK as a registered mental nurse and came to Australia in 2006, where she became a credentialed mental health nurse. She has worked in a variety of settings. Her first job in Canberra was in the Acute Mental Health Unit at The Canberra Hospital. She then worked within the Queanbeyan community mental health area before returning to the tertiary sector, this time to the Calvary Hospital Acute Mental Health Unit. Lisa also taught at the Australian Catholic University and supervised nursing students on the hospital ward.

In her current role with Capital Health Network (CHN), ACT's primary health network, Lisa is the Mental Health Clinical Manager. She triages clients into CHN's suite of mental health programs, from clients with severe and persistent mental health issues, to those who need to see a psychologist but face financial barriers, to those living with mild-moderate anxiety or depression. Lisa undertakes supervision of CHN's NewAccess coaches and PIR Facilitators.

The new national mental health reforms have opened up new opportunities. CHN has been funded by the Commonwealth Department of Health to commission regionally appropriate primary mental health care services as part of the reform. CHN has also been funded as a Lead Primary Heath Network Site to trial innovative approaches to services for youth who are at risk of or who are experiencing severe mental health issues.

Prior to CHN, Lisa was working with general practices to encourage them to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders and register with the Mental Health Nurse Incentive Program (MHNIP).

Lisa's face lights up when she recalls a teenager that she helped and saw grow through this program. The teenager had been diagnosed with bipolar and Lisa had assisted with symptom identification, medication education and lifestyle factors. However, Lisa felt there was still something missing in the teenager's recovery.

She identified the need for a medication review by a psychiatrist but the teenager faced financial barriers. Following psychotic symptoms, Lisa advocated and liaised with the local mental health team and was able to help the client get into a public psychiatrist and receive a medication review. As a result, the client's emotional regulation improved and so did her relationships with her parents and partner. Lisa smiles when she says the teenager is now working and studying interstate with her partner.

Lisa believes that effective mental health nursing is equal parts skill, personality and intuition.

WHEN MOMENTS COUNT

MANDY CLEAVER MACN
ACTING CLINICAL NURSE IN COMMUNITY PALLIATIVE CARE

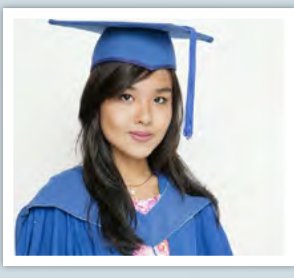
As a first time mum, I had immediate trust in my midwives. How could these women be so humble, when they were so confident and amazing at what they did! The thought that these people, who literally help deliver life itself, could be the same people you might pass in the supermarket doing things that ordinary people do, astounded me. I think, as nurses, we can become blasé to what we actually do and the extent our care can impact someone's life (for better or worse). That is a privilege as much as it is a responsibility.

I remember walking out of the maternity ward, holding my precious and healthy first baby girl and thinking – um, what if there's a problem? What if I can't get her on the breast correctly again? And then remembered the relief of knowing a community midwife was coming to my house daily for a few days, to check in on me and bub. Her visits provided me with encouragement, education, reassurance and support *when* I really needed it.

However, there is also many a time *when* nurses are there to promote the healing – emotionally, psychologically, spiritually or physically. I remember being in the home of a patient recently discharged from hospital with a dressing covering her removed implantable device site. She was scared. This was a time when she was unsure of what to do and how to do it. I had the privilege of being there with her as the community specialist wound care nurse arrived. His manner, knowledge, competence and approach reduced her anxiety, reassured her she was not alone and his expertise in wound care physically assisted with the healing process.

"I think, as nurses, we can become blasé to what we actually do and the extent our care can impact someone's life."

MY BACHELOR OF NURSING (HONOURS) JOURNEY



KAARA RAY B. CALMA MACN
BN RN, BN (HONOURS) CANDIDATE, SCHOOL OF NURSING, UNIVERSITY OF WOLLONGONG

I completed my Bachelor of Nursing in 2015 and am currently enrolled in a Bachelor of Nursing (Honours) Degree at the University of Wollongong. Since the very beginning and throughout the course of my undergraduate nursing course, I have always been passionate and enthusiastic about the field of research. To me, research in health is an integral part of continuous learning and development of knowledge and new innovations, and consequently has great capacity to make significant implications on practice.

For my project, I am currently working with a team of researchers to investigate the health planning and health needs of Australian nomads. My qualitative study is a small part of a larger national survey of Australian nomads. Using semi-structured interviews, my study explores the impacts of chronic conditions on our participants' health, the barriers to health care (which they have experienced whilst being on the road) issues with self-management and how travelling has impacted their general wellbeing.

Our study is paramount to the wellbeing of older Australian travellers living with chronic conditions as we explore the challenges that impact on them. In doing so, we aim to better understand these challenges and propose strategies to facilitate better health care to assist Australian nomads in their travels, health and lives.

The University of Wollongong is currently building a strong research theme around primary health care nursing. I wanted to take the opportunity to work with this group of outstanding, senior researchers because I am a firm believer that primary health care is at the forefront of effective patient care.

Primary health care has always been an interest of mine, as I believe that its specialised focus on individuals in the community allow surveillance for early detection of issues that otherwise can escalate dramatically and lead to hospitalisation and poorer health outcomes. I feel that advocating for this structure of health provision, as well as making individuals more aware that health care is just outside one's door and can in fact be provided in the comfort of one's home, empowers people to see health care as a place that is approachable and worthwhile.

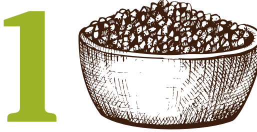
TOP 10

Easy ways to make sure you eat breakfast every morning

ACN NATIONAL NURSES BREAKFAST

The ACN National Nurses Breakfast is an annual celebration of the invaluable contribution nurses make to the health of our society. It is an ACN initiative that provides an opportunity for friends and colleagues to come together to celebrate International Nurses Day.

The theme for International Nurses Day this year is Nurses: *A Voice to Lead, Achieving the Sustainable Development Goals.* As the pre-eminent and national leader of the nursing profession, ACN provides a voice for Australian nurses and advocates on behalf of our membership at a local, national and international level. Therefore, we are excited to embrace this theme and celebrate International Nurses Day with you all this May!

1 

PREPARE THE NIGHT BEFORE

Before you hit the sack, ensure your breakfast food is ready to go. Make your oatmeal ahead of time and put it with your keys, so you don't forget it. This way, you won't feel as rushed in the morning and are less likely to forget to eat!

2

AVOID LATE NIGHT CRAVINGS

As shift workers, many of us would understand the temptation of a late night snack. However, if you need to get up and going the next day, try to starve off those midnight cravings, so you won't be too full to eat breakfast.

6

DRINK YOUR BREAKFAST

Fresh fruit juices and smoothies are a great breakfast option because they are healthy, take very little time to prepare and can be taken with you. The perfect on-the-go option, they are a fantastic choice for those of us who are always running late.

7

MAKE BREAKFAST TIME 'YOUR TIME'

It's all about perspective! Instead of seeing breakfast as a chore and an obstacle to getting those extra few minutes of shut-eye, find a way to make it an enjoyable part of your day. Read a book while you munch on a croissant or eat your cereal outside and enjoy the fresh air.

As nurses, we live busy lives and are often too occupied caring for others to look after ourselves. A good breakfast is a simple way that you can ensure that you are looking after your health and prepared to face the busy day ahead. Here are 10 easy ways to remember to eat a healthy breakfast every morning.

3

IGNORE THOSE COFFEE CRAVINGS

While it may be hard to resist those early morning caffeine cravings, drinking coffee when your stomach is empty can keep you from feeling hungry at breakfast time. So try to hold off your caffeine hit until after you've eaten – the point is to eat a healthy breakfast, not skip it!

4

THINK OUTSIDE OF THE (CEREAL) BOX

We don't eat the same food for dinner every night, so why do it for breakfast? Don't limit yourself to traditional breakfast foods, change things up, make breakfast a meal you look forward!

5

TURN BREAKFAST INTO A SOCIAL EXPERIENCE

While this is not always an option during the busy working week, it's a great idea to make breakfast a social occasion. Go out for pancakes with friends or sit down for breakfast with your family to make sure you remember to eat.

8

EAT AT WORK

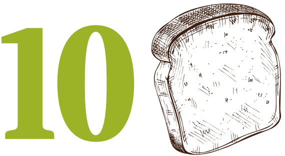
If the last-minute morning rush in your household often leaves you with no time for breakfast, it's a great idea to keep some muesli bars or fruit in your staff room as a back-up option to eat once you've arrived at work.

9

KEEP YOUR PANTRY STOCKED

Running out of your go-to breakfast foods is a surefire way to miss it! Prevent this from happening by making sure your pantry is always fully stocked with all the essential ingredients to make your favourite breakfast smoothie!

10



EAT FIRST, GET READY SECOND

Make breakfast a priority in the morning and eat it before you get ready. That way you will have finished your toast before the last-minute morning rush takes over and you forget to eat.

IEVGENIIA LYTVYNOVYCH

Council of Deans

Meet some of the leaders who make up the Council of Deans of Nursing and Midwifery

The Deans and Heads of Schools of Nursing and Midwifery in universities across the country make a significant contribution to the future of our profession. They play a key role in the education of the nursing workforce and building the next generation of nurse leaders. We will feature these nursing leaders in all of our publications this year.

PROFESSOR WENDY CROSS FACN

Professor Wendy Cross was a mental health nurse for many years and works clinically in crisis teams in the emergency department. She joined Monash University in 2007 as the Associate Professor of Mental Health Nursing in the School of Nursing and Midwifery. In 2009, she was appointed as the Professor and Head of the School of Nursing and Midwifery. In January 2016, she commenced in the role of Associate Dean of Nursing and Allied Health.

Prior to commencing her work at Monash, Professor Cross held senior executive and academic appointments in nursing at Monash Health, Deakin University and the University of Western Sydney.

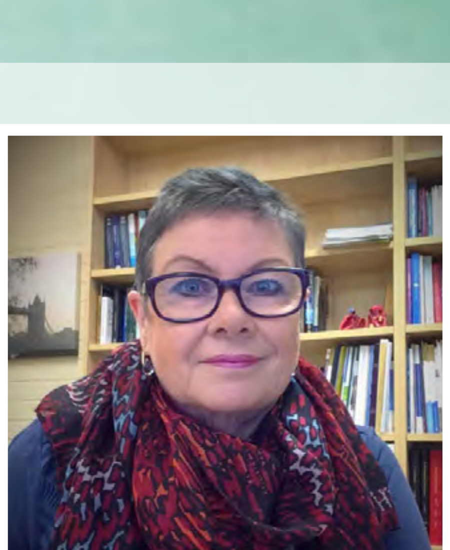
Professor Cross holds a number of leadership positions in mental health nursing and education. Currently, she is the National President of the Australian College of Mental Health Nurses, a Fellow of ACN and a member of the Australian Institute of Company Directors. She chairs the Council of Deans of Nursing and Midwifery (Australia and New Zealand) and is a Board Director for the Australian Nursing and Midwifery Accreditation Council (ANMAC) and the Nursing and Midwifery Health Program (Vic). She was previously (until 2014) a ministerial appointment to the Chisholm Institute of TAFE Board.

Professor Cross contributes to a number of state and national committees including as a: member of Universities Australia, Health Professional Education Standards Group (HPESG); member of the Chief Nursing and Midwifery Officer of Australia, Strategic Reference Group; and Chair of the School of Nursing and Midwifery, Western Sydney University External Advisory Committee.

> **“Both Professor Paliadelis and Professor Cross share ACN’s passion for advancing nurse leadership.”**

Professor Cross has been sought for international advice and is a member of the International Practice Development Collaboration. She sits on a number of editorial boards and regularly reviews manuscripts. Professor Cross has been an external grant reviewer for the National Health and Medical Research Council (NHMRC) and the National Health Service (NHS).

Professor Cross has received competitive research and teaching funding of more than AUD$6 million and supervises many higher degrees by research students (Honours, Masters and PhD). She has published widely, with over 100 publications across all domains.



PROFESSOR PENNY PALIADELIS MACN

Professor Penny Paliadelis MACN is currently the Acting Deputy Vice-Chancellor (Academic) at Federation University Australia, which has four campuses located across the state of Victoria.

Professor Paliadelis' usual role is Executive Dean, Faculty of Health and her discipline background is nursing. She has worked in aged care, coronary and intensive care settings, as well as in generalist rural hospitals before moving into an academic role in the 1990s. She has led the development of high quality, innovative, accredited health curricula across a number of health disciplines, many offered by flexible delivery using engaging online pedagogies.

Professor Paliadelis' research focus is primarily on leadership roles in health and particularly in the nursing profession, and she has engaged in a number of funded projects to create collaborative inter-professional health education using digital story-telling approaches, always with a focus on workforce capacity-building.

Another area of research interest is self-management support for those with chronic conditions. Professor Paliadelis has successfully collaborated internationally with colleagues from Northumbria University in the UK to compare how health professionals in the UK and Australia support patients to manage their chronic conditions.

Professor Paliadelis is a successful PhD supervisor and examiner, and is passionate about encouraging, supporting and mentoring those who aspire to leadership positions in nursing, health and higher education settings. Professor Paliadelis has developed a reputation for encouraging and supporting scholarly and research collaborations within and across health disciplines. She leads a 'women in leadership' initiative at Federation University that inspires and supports academic women who are beginning to aspire to leadership positions.

NOTORIOUSLY POOR COOKS

Invalid cooking as an examinable subject in nursing curriculum

Many nurses who did their general nurse training in hospitals in the early to middle decades of the twentieth century would remember attending invalid cooking classes. Indeed, the official nursing organisation in this period, the Australasian Trained Nurses Association (ATNA), recommended that a series of lectures on invalid cookery be given to nurses who were training in ATNA accredited hospital training schools.

While housekeeping as a subject was deleted from the schedule in 1908, invalid cookery as an examinable subject remained, together with general, medical and surgical nursing (ATNA Register 1908-1909, p. 23). The curriculum for invalid cookery consisted of six practical lessons in the preparation of 'invalid drinks, the cooking of beef tea, broths, poultry, fish, meats, eggs, light puddings, jellies, vegetables, and fruits' (ATNA Register 1908–1909, p.31).

In January 1956, a new syllabus introduced by the New South Wales Nurses' Registration Board (NRB) increased the number of hours of instruction from 78 to 242. However, invalid cookery remained a mandatory subject.

It was only with the introduction of an interim syllabus in 1969 that invalid cookery was no longer required to be taught and examined in schools of nursing (Russell, 1990, p.67; NRB, 1969). This interim syllabus grouped subjects under three headings: biological and physical sciences, social sciences and medical sciences (Russell, 1990, p.144).

Because invalid cookery continued to be taught as an examinable subject until 1969, many cookery books for nurses were written and published by earnest cookery teachers. One such book was Ms Margaret P. Shepherd's, *Mainly for Nurses and Bachelor Girls*, which ran to at least 10 editions. It was first published in the late 1920s.

The foreword to the book remained the same in all editions and perhaps is of most interest. Written under the pseudonym *Macquarie Street*, the author of this foreword (perhaps he a medical man?) suggested that the book had been written for all those incompetent cooks who had no imagination and he asked why the average nurse was such a notoriously poor cook?

He also recognised that this little recipe book would be useful for all categories of women. So it was not only for the average nurse but the single woman or bachelor girl who could not be bothered cooking; the young bride and the older housewife whose 'kitchen style was cramped and whose ideas were stereotyped and stodgy' (Shepherd, n/d).

I am sure if I had been Ms Shepherd, I would not have delighted in such a misogynist and derisive foreword to my recipe book, although the writer does fashion an argument that there was a need for such a book for nurses and others.

Enid Ariel (nee Clark) a 1942 graduate from the Western Suburbs Hospital in Croydon, New South Wales, remembers Ms Shepherd as a tall, middle aged lady who was very patient but who didn't hold back with her criticism of nurses' cooking.

She also did not economise with the ingredients, even though rationing was in place during the war years. To this nurse, she seemed intuitively to know who could cook and who could not. Enid recalls vividly her practical cooking examination when her task was to cook lamb's fry and bacon. Her comment, to me, was how could you make that look attractive?

Ms Shepherd taught from approximately the mid-1920s to at least the mid-1950s – a period of roughly 30 years. The fourth edition of her book, *Mainly for Nurses and Bachelor Girls*, makes mention of her teaching invalid cooking to nurses in no less than 34 hospitals in New South Wales. Her career thus involved many hours travelling as a teacher of cookery to nurses in both city and country hospitals.

The famous Mrs Isabella Beeton wrote the prototype for all English cookbooks, *The Book of Household Management*. Isabella in 1856 married Samuel Beeton, a book and magazine publisher, giving her easy access to a publisher for her articles and books. *The Book of Household Management* was first published in 1861 when Isabella was 23 years old and quickly became the definitive recipe book.

The Prince Henry Hospital
Little Bay, N.S.W.

Cooking Certificate

This is to Certify that Nurse Lynette May WATTS has attended a Course of Instruction in Invalid Cooking, and has passed the prescribed Examination.

Dietitian

Date 5th August 1958

Matron

General Medical Superintendent and Chief Executive Officer.

Enid Clark

Nurse Lynette M. Watts' Cooking Certificate, 1958, Prince Henry Hospital

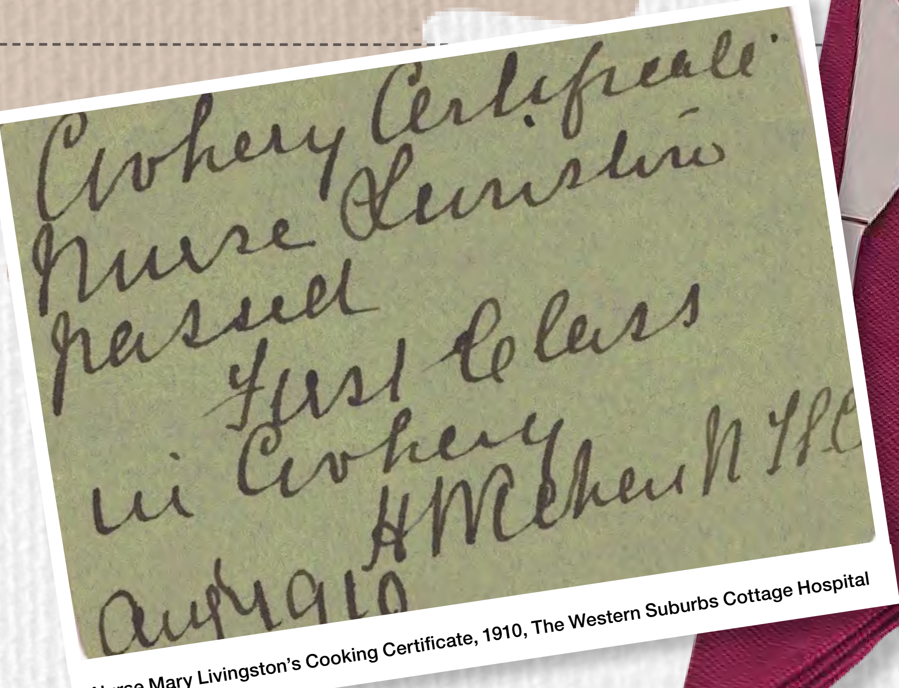
The 4th edition of Margaret P. Shepherd's cook book [ACN Archives]

It was written to provide information and advice not only for the mistress of the house but all women who were concerned with the running of a Victorian household, which could include a nurse, a wet nurse and a sick nurse. This book became so popular because it was essentially an encyclopaedic reference book containing information on many topics such as sanitary, medical and legal matters.

The book became known as *Mrs Beeton's Cookbook* because it contained a large number of recipes. Although many of Mrs Beeton's recipes were from other sources – there was no such thing as copyright in those days – she had two innovative ideas. The first, placing a list of ingredients at the beginning of her recipes and the second, stating the length of time each dish should be cooked for – ideas that are still followed today (HubPages, 2014). Mrs Beeton set something of a standard in the writing of cookbooks for those who would follow in her footsteps.

One such book is *The Schauer Invalid Cookery Book* first published in 1908 in Brisbane and intended for trainee nurses in hospital nursing schools, for those working in private practice and for others who cared for the invalid. Sisters Amy and Minnie Schauer, wrote this slim volume.

Amy Schauer was a qualified domestic science teacher (Ryan, 1988). The aim of this book was to teach amateur and professional nurses in co-operation with medical men how to provide the correct diets for their patients. Following the injunctions of Florence Nightingale, the introduction of the Schauer cookbook specified that nursing care involved nurturing patients so that they might have enough strength to overcome disease. To this end, the greatest aids for the nurse were cleanliness, fresh air, warmth and proper nourishment.


Cookery Certificate
Nurse Livingstone
passed
First Class
in Cookery
Aug 1910

Nurse Mary Livingston's Cooking Certificate, 1910, The Western Suburbs Cottage Hospital

It is of note that the character of the nurse was the all-important and essential ingredient if she was to be successful in her nursing care when it came to cooking for invalids. It was essential that she be conscientious, punctual and hygienic.

So was the average nurse such a notoriously poor cook as the writer of the foreword to Ms Shepherd's Cookery Book maintained? Perhaps to rectify this perception but certainly to equip the trainee nurse for her duties in the realm of understanding and providing the correct diet and nourishment for their patients, hospital training schools did incorporate theoretical instruction in invalid cooking and a practical examination in the curriculum of nurse training schools until the late 1960s.

If the nurse was successful in the examination she received a *Certificate in Invalid Cooking*. Over time, these certificates gained greater status and their presentation became more professional.

It was important and necessary to teach invalid cookery to nurses in the early decades of the twentieth century, as not all registered nurses were employed in hospitals. Many graduate nurses were employed as private nurses attending a patient or patients in their home. In this capacity, they were responsible for either cooking the meals for their patient or supervising the preparation and serving of such meals.

Registered nurses therefore needed to be skilled in the art of invalid cooking and as a consequence, a number of small cook/recipe books were produced. Their purpose was to both aid the teaching of invalid cookery to hospital trainee nurses and to assist the graduate nurse working in a domestic environment.

In this period, it was an important belief that nourishing food was necessary for the recovery of the patient from illness. The incorporation of courses on invalid cooking into nurse training curriculum indicates that the preparation, cooking and serving of food was deemed an important part of the nurses' care of their patients.

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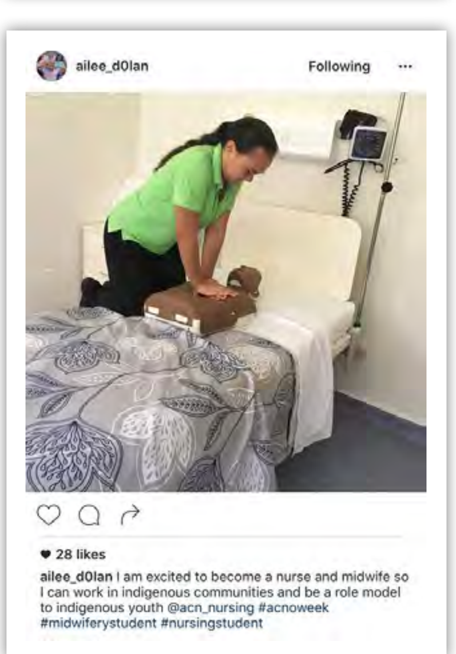
THE WINNING ENTRIES FROM OUR ACN O-WEEK COMPETITION

We asked undergraduate nursing students to tell us why they are excited to become nurses and received some fabulous responses! To see the other entries check out **#acnoweek** on Instagram.



#CONNECT WITHUS

At ACN, we love connecting with our Members, Fellows and the wider nursing community through our social media channels. Engage with us and keep up to date with all things ACN by following us on Facebook, Twitter, LinkedIn and Instagram!

> “Wonderful organisation that is full of amazing people. The ACN is focused on the advancement of the nursing profession and making sure that all within the profession are supported and encouraged in their journey.”
>
> Julia Goolia

Beverley Christine Armstrong

1947 – 2015

“At the forefront of Bev’s mind was the importance of nursing to best practice palliative care in the home setting.”

Beverley (Bev) Christine Armstrong RN RM BHA DipCHN IWC was born in Sunshine, Melbourne, in 1947. She completed her General Nursing Certificate in 1969 at the Alfred Hospital and her Midwifery Certificate at the Royal Women’s Hospital in 1971. Her interest and love of community nursing was sparked at this time after spending a day visiting new mothers and babies at home. In 1971, Bev joined the Royal District Nursing Service (RDNS) where she spent 27 years in various roles and locations.

Bev seized the opportunities that RDNS offered. In 1972 she completed the RDNS Post Basic Course in Community Nursing. Then in 1975 she completed a Diploma in Community Health Nursing and an Infant Welfare Certificate at the College of Nursing, Australia. Later in 1989 she completed a Bachelor of Health Administration (University of NSW).

Her administrative ability was recognised with a promotion to Assistant Supervisor at Heidelberg and Supervisor at Camberwell Centre. From 1975–1984, Bev was Regional Supervisor of the RDNS Southern Region and in 1988, on her return to RDNS after a two-year break, she was appointed Manager at the RDNS Box Hill Centre. There followed appointments as Deputy Director of Nursing, Director of Nursing (DON) and later, DON/Deputy CEO of RDNS.

Beverley’s professional career encompassed major roles in many national and state ministerial advisory committees and reference groups relating to the development of community nursing. These included: the National Community Home Nursing Casemix Project Steering Committee, the Review and Maintenance of Community Nursing Minimum Data Set Project Steering Committee, and the Commonwealth Department of Human Services and Health Review of Respite Care Reference Group.

Within RDNS she supported: a project involving hand-held radio-linked computers, to provide each nurse with a computer that was more than just a data collection tool, but a mobile office; the establishment of the Helen McPherson Smith Institute of Community Health in the late 1990’s, which progressed the merging of clinical research into improved nursing practice; and piloting of RDNS’ now successful district nursing graduate year program.

As a committed member of the Australian Council of Community Nursing Services (ACCNS) Bev was elected to the Management Committee in 1990, serving as the Hon. Secretary from 1991–1994 and President from 1994–1999. As President in 1998, Bev convened the Ninth National ACCNS Congress, *Navigating Cyberspace*, which was an overwhelming success. She was later awarded Life Membership of ACCNS.

Following a structural review of RDNS in late 1998, Bev resigned and set up BECHAR Consulting, through which she could undertake consultancies and special projects related to community nursing for ACCNS, the Australian Council on Healthcare Standards (ACHS) and other organisations. In 1998, Bev was appointed part-time administrator of ACCNS. As a surveyor for ACHS, Bev completed more than 30 audits of community nursing organisations and prepared a Resource Tool for Community Services for ACHS in 2000. She also completed the Australian Aged Care External Assessors Training Course in 2000.

Throughout her career, Bev promoted the principles of palliative and hospice care, and was instrumental in establishing and developing community palliative care services in Victoria. Many difficult conversations and transitions were managed during this period. At the forefront of Bev’s mind was the importance of nursing to best practice palliative care in the home setting. In 2001, she accepted the position of Executive Officer at the Peninsula Hospice Service (PHS), now known as the Peninsula Home Hospice. A role she held until her retirement in 2008.

In this role, Bev contributed significantly to the further development of services in Frankston and the Mornington Peninsula, actively participating in the broader palliative care sector through: membership of the Southern Metropolitan Region Palliative Care Consortium; as a Director of Palliative Care Victoria from 2004–2007; and as a member of the Palliative Care Australia Standards and Quality Committee.

In April 2003, while CEO of PHS, Bev’s work in palliative care culminated in the launch of the Vivian Bullwinkel Chair of Palliative Care Nursing. The Chair was a partnership between Monash University, PHS, Peninsula Health and RDNS, with the aim of enhancing palliative care services, research and partnerships into the future.

On 8 October 2015, after a long illness, Bev died aged 67 years.

Central to Bev’s working ethos was the question: “What will this contribute to improving the care and outcomes for patients and their family/carers?”

Her career demonstrates not only her commitment to the community but also the remarkable successes she achieved answering this question.

Beverley Christine Armstrong – rest easy, Bev!

Author details:

ACN Board Director and Nurse Consultant Ms Christine Smith RN MS FACN (DLF) FAAN

Past RDNS Staff Member and Current RDNS Former Staff Association President Sue Carroll RN

RDNS Policy Operations Coordinator of the Quality and Risk Department Sharon McNeil RN

REFERENCE

Royal District Nursing Service (RDNS) 2016, Former Staff Association Newsletter

Regis McKenzie AM FACN

1938 – 2017

Regis McKenzie AM FACN was a much-loved, highly influential nurse leader who had a resounding impact on the Australian nursing and health care community throughout her forty-year career and continuing into her retirement. Regis was a registered nurse and midwife who was a trailblazer in community nursing at both a state and federal level.

Throughout the course of her distinguished career, Regis was a very active member within the professional nursing community and held several senior nurse leadership positions. This included seven years working as the Assistant Nursing Officer and Acting Chief Nursing Officer for ACT Health. Following this appointment, she went on to be the Nurse Advisor and Assistant Director of Nursing of the Commonwealth Department of Health.

For almost half of her professional life, Regis was the Director of Nursing at the Sydney Home Nursing Service. Here, she had an enormous impact on countless community nurses across the state.

Regis' commitment to nursing was also largely defined by her membership and contribution to a number of professional nursing bodies. She joined the Institute of Nursing Administrators of NSW and ACT, and held the presidency between 1983–1985. Regis was also an active surveyor with the Australian Council on Healthcare Standards, and a member of the NSW Nurses Association and the Australian Nursing Federation from 1967. She was the President of the Australian Council of Community Nursing Services for some years.

Upon retirement, Regis moved to Coffs Harbour, where she continued her tireless efforts to lead our profession forward through her membership on the Mid North Coast Area Health Service Board. This tireless commitment to improving the health of our communities was honoured in 1984, when Regis was made a Member of the Order of Australia.

Regis was a valued Fellow of ACN and a distinguished nurse leader who made a difference to both our organisation and profession. She served three years as Treasurer of the College of Nursing from 1977–1979 and was the first Fellow of the Royal College of Nursing. Through her continued contributions before and after unification, Regis played an integral role in establishing ACN as the national and pre-eminent leader of the nursing profession.

Karen Anne Parish

1958 – 2017

Karen Parish passed away following a long brave battle with cancer on Sunday 19 March 2017 at Daw House Hospice, South Australia.

Karen had a distinguished nursing career and was highly regarded by her colleagues and friends. She held senior leadership positions in Adelaide, including the Director of Nursing at the Repatriation General Hospital, Executive Director of Nursing and Midwifery for Southern Adelaide Local Health Network, Executive Director of Nursing and Midwifery for the Adelaide Health Service, Chief Operating Officer at RSL Care and more recently, as the Operational Services Executive for Eldercare.

Interstate, her previous roles included Director of Nursing at Calvary Public Hospital in the Australian Capital Territory, and Chief Nurse and Midwifery Officer for the Northern Territory.

Karen completed her Bachelor of Nursing at Flinders University in 1989 and completed her Master of Nursing Studies in 1996. Karen was also selected to complete the Governors Leadership Program in 2006 in South Australia.

Karen was passionate about her profession and was a strong advocate for her patients and their families. She had a particular focus on quality and safety, and worked tirelessly throughout her career to improve the lives and outcomes for patients in all settings. This was also evident in her research interest in the quality of end of life care in the acute hospital setting and the care trajectory of elderly patients in the acute hospital setting.

Karen left a lasting impression on many, in both her professional and personal lives, and she will be sadly missed.

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CONTRIBUTORS

SHARE YOUR STORY WITH US

Thank you to all of our wonderful Members and Fellows who contributed to the 2017 Autumn edition of *The Hive*.

The themes for the next few editions of *The Hive* are:

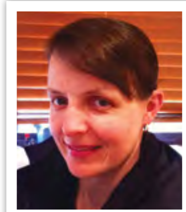
- ***Dementia and Alzheimer's Disease***
- ***Respiratory Disease***
- ***Diabetes and Obesity***

If you have a research piece, clinical update, profile piece or personal story to share that addresses these themes, please contact us at publications@acn.edu.au.

Thank you to all of our authors!

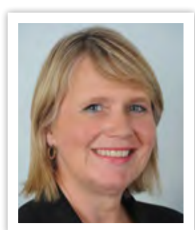
JAMES BONNAMY MACN
Cardiovascular disease in women

MADONNA GREHAN MACN
Cardiac disease – a historical approach



TOMICA GNJEC MACN
Cardiovascular health care

LAURIE BICKHOFF MACN
Cardiology – where nurses make the difference



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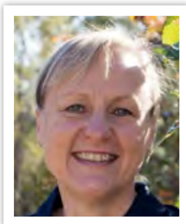
CATHERINE STEPHEN
The Impress Intervention

PROFESSOR ELISABETH HALCOMB FACN
The Impress Intervention

ELIZABETH MORAN
Coronary artery stent evolution



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Cardiothoracic PNSA's

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Ethical dilemmas

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Congenital heart disease

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Lighthouse Hospital Project

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Chuck out the obs

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Chuck out the obs

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Chuck out the obs

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Nursing history and Novel thoughts

ELIZABETH MATTERS FACN
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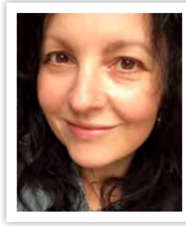
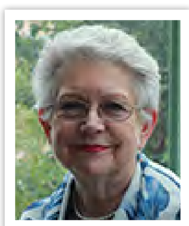


MELANIE ESLICK MACN
My research internship

LESLEY POTTER MACN
Notoriously poor cooks



CHRISTINE SMITH FACN (DLF)
75th anniversary of the Banka Island massacre

ACN would also like to thank Sue Carroll, Sharon McNeil, Christine Smith FACN (DLF) and Adjunct Associate Professor Lydia Dennett MACN who wrote touching tributes for our *In Memory* articles. Furthermore, we would like to thank Lisa Hawke, Mandy Cleaver MACN and Kaara Calma MACN for their intriguing articles from our 2016 Community and Primary Health Care eBook, which where featured in this edition of *The Hive*.

March 8 was International Women's Day and while we've come a long way since the 1980s when just 25% of women had super – there's still a way to go to reach an even playing field.

The vast majority of our 820,000 members are women working in health and community services, where the gender pay gap is 27.7%, according to figures from the Workplace Gender Equality Agency. We're determined to make the super system fairer for women.

Women typically move in and out of the workforce to care for family and have a greater tendency to work part time. They face wage discrimination and live around five years longer than men, leaving a stark gender gap in retirement incomes.

WHAT WE'RE CALLING FOR:

The government to remove the $450 monthly super threshold. Administrative reforms now mean employers can pay their super in one easy upload. So everyone should be eligible for super – including those who work several shifts with different employers, falling below the monthly threshold with some or all of them.

Valuing unpaid caring roles. We think Australia should adopt a model similar to many European and South American countries where unpaid caring roles are recognised and remunerated. Many have systems that ensure women receive a pension voucher or benefit for time taken off work to raise children or care for the elderly.

WHAT WE'RE DOING:

Tackling financial exclusion. Last year, we were the first industry super fund to launch a Financial Inclusion Action Plan (FIAP). Through our FIAP, we're committed to building financial resilience in Australia, including providing support and assistance to our members experiencing financial exclusion.

Using our influence. As an investor in some of Australia's biggest companies we can use our influence to push for greater diversity among their boards and senior management. We want to see at least 30% of board positions go to women and we're putting this view strongly to companies. We know, as an owner of these companies, that boards with balanced opinions at the table make better decisions and perform better over the long term. So we're acting to protect and enhance the long-term value of our members' investments.

Walking the talk. HESTA was recently named an Employer of Choice for Gender Equality by the Workplace Gender Equality Agency. This accreditation, along with the fact that our CEO is a Pay Equity Ambassador, reinforces our commitment to living our values.

For more information, visit **hesta.com.au/mindthegap.**

With almost 30 years of experience and $37 billion in assets, more people in health and community services choose HESTA for their super.

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your future, divided

On average, Australian women have just over half the super of men.*

Maybe it's time to change that?

*According to Australian Bureau of Statistics (ABS) Retirement and Retirement Intentions, Australia, July 2012 to June 2013, women in Australia retire with 47% less in their super than men. abs.gov.au/ausstats/abs@.nsf/mf/6238.0

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