thehive

#6 WINTER 2014

Australian College of Nursing

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in the 21st Century

THE POTENTIAL OF THE
enrolled nursing workforce

NURSES' ATTITUDES TO WORKING
with older people in acute care

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thehive

#6 WINTER 2014 (June–August)

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Cover
FedUni student's in the simulated learning space

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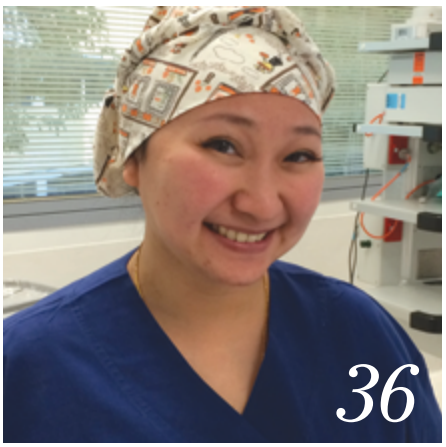

ADJUNCT PROFESSOR DEBRA THOMS FACN (DLF)

In this winter edition of 'The Hive' we're proud to shine the spotlight on the integral role enrolled nurses (ENs) play in the delivery of health care in our country.

Our EN Special Feature showcases an in-depth analysis by our Policy team, *The potential of the enrolled nursing workforce*, focussing on the EN demographics as well as the ongoing evolution of the EN role within the health care structure. June Cox FACN and David Prendergast's article, *An educational initiative to expand the enrolled nurse scope of practice*, discusses an education initiative undertaken in an Adelaide hospital which aimed to enable ENs to work to their full scope of practice. Closing out our Special Feature is a profile of EN and ACN Board Director, Maryanne Craker MACN. Maryanne shares with us her passion for the EN role and how it empowered her to become a nurse leader.

On the topic of leadership we showcase Cheyne Chalmers FACN, in our new regular feature, *Q & A with the CEO*. I hope you enjoy reading about her leadership journey as much as I did.

Sadly, we also bid a fond farewell to three pioneering Australian nurse leaders – Judith Cornell AM FACN, Professor Barbara Hayes FACN (DLF) and Dr Sue Nagy FACN. Their contribution to our profession will be felt for many generations to come.

This edition of *The Hive* is the first with the additional direction and expertise of *The Hive* Editorial Committee – Melissa Bloomer FACN, Ruth DeSouza MACN, Debra Kerr MACN, Kate Kunzelmann MACN and Elizabeth Matters MACN. The Committee, alongside Jackie Poyser, ACN Publications and Communications Manager, and I will:

- participate as reviewers and edit articles related to their area of specialty
- where required, suggest areas for improvement on articles submitted
- provide input on the content direction of the publication
- advise on the selection of articles for publication
- monitor the quality of the publication and propose measures for improvement.

We very much look forward to the Committee's input and have no doubt the depth and variety of their experiences will add great value to *The Hive*.

PUBLICATION GUIDELINES

We love to see member submissions making up a significant proportion of content in *The Hive*. If you're interested in having your submission published in an upcoming edition of *The Hive* please follow our publishing guidelines below.

- Articles should be from 300–1,200 words in Microsoft Word format.
- Articles should be original, previously unpublished and not under consideration for any other publication.
- We do not accept articles of an advertorial nature.
- Pictures/photos are to be in JPEG or TIF format of high resolution 300dpi.
- All references must be supplied in modified Harvard system.
- Complete authorial details including: name, job title, organisation and location.
- Articles are submitted via email to publications@acn.edu.au.

Each edition of *The Hive* has a content theme. Your submissions don't have to correlate with these themes but if you have a research piece, clinical update, personal reflection or profile that relate to either of these themes below we'd be eager to hear from you.

Spring 2014 – *The role of practice standards*

Summer 2014 – *Mental health*

Please remember the ACN editorial team are here to assist you with the process.

OUT AND ABOUT WITH THE CEO

Some of you may wonder what it is that the CEO does in an organisation like the Australian College of Nursing (ACN)… and some may not! From this issue of *The Hive* I thought I would provide a snapshot of some of the activities I have been involved in on behalf of ACN, beyond the work involved in the day-to-day management of the organisation.

So, in the months from March to May here is a brief overview of some of my activities.

ADVOCACY

I met with the Minister for Health, the Hon Peter Dutton, and discussed a range of issues of interest to ACN, and how the nursing profession can contribute to effective and efficient health care delivery and services. We have also scheduled a meeting with the Workforce Advisor in the Aged Care Minister's office.

I met with the Secretary of the Department of Immigration and Border Protection to discuss nursing input and contribution to decisions/advice regarding health care in detention centres for refugees and asylum seekers, following the dissolution of the Immigration Health Advisory Group. I'm pleased to report this was a favourable hearing and our suggestions are under consideration.

Kathleen McLaughlin FACN, Executive Manager Member Relations, and I met with International Health and Medical Services regarding the delivery of health care services in detention centres to asylum seekers and refugees. This proved an informative visit on this difficult issue.

I co-chaired the Australian Commission on Safety and Quality in Health Care (ACSQHC) Clinical Care Standards Advisory Committee. This is important work being undertaken by ACSQHC on developing specific clinical care standards covering acute coronary syndrome, antimicrobial stewardship and stroke at this stage.

I worked with the Australian College of Midwives, Australian Primary Health Care Nurses Association, Australian College of Mental Health Nurses and Australian Nursing and Midwifery Federation on a response to the Nursing and Midwifery Board of Australia (NMBA) regarding issues with the NMBA Social Media Policy that has been recently issued.

MEETINGS

I attended the Nursing and Midwifery Strategic Reference Group chaired by the Australian Government Chief Nurse and Midwifery Officer, Dr Rosemary Bryant FACN. This brings together key nursing and midwifery organisations to discuss issues of mutual interest with the Chief Nurse.

I attended the Cranlana Program in Melbourne. This is an invitation only event and involves a small group of participants in discussion under the title *Medicine and Society*. Previously, this program has predominantly consisted of medical practitioners; however, this year they sought to involve someone from nursing. I attended the two day program with approximately 20 others and we discussed and debated some key readings from philosophers across the ages with respect to health and society. This was a thought provoking and stimulating two days and really makes you think about how we approach not just health care but broader societal and social issues and the role that organisations like ACN can play in those discussions and debates.

John Kemsley-Brown FACN, Executive Manager Education, and I met with the Australian Health Practitioner Regulation Agency (AHPRA) staff to discuss the potential impact of the changes to the NMBA standard on the registration of overseas nurses.

I attended the Chief Nurse and Midwifery Office's (CNMO) meeting in Brisbane to brief the CNMOs from each state about ACN and to discuss how ACN can work with them.

ACN is a member of the Australian Nursing and Midwifery Accreditation Council (ANMAC) Board and meetings are held regularly – I attend in my role as an ANMAC Board member and I also attend associated committees.

Dr Ruth Rae FACN and I met with the local member for Reid (where the ACN Burwood office is located), Mr Craig Laundy MP, to discuss the planned publication of the *First World War Trilogy Box Set* authored by Dr Rae as part of the celebrations for the centenary of Anzac in 2015.

John Kemsley-Brown and I met with the CEO of the Hospital Pharmacists Society of Australia to discuss potential areas to work together.

I met with the QLD CNMO to discuss potential areas to work with the Nursing and Midwifery Office, Queensland.

CONFERENCES

I attended the Queensland Nurses' Union Conference in Brisbane and presented an invited paper titled *Nursing and Midwifery leadership is essential for quality care*.

I attended the Mercy Health Nursing Leaders Conference in Melbourne and delivered an invited address on leadership.

I travelled to Geneva for the International Council of Nurses' meetings – more of that in the next issue of *The Hive*.

MEET ACN'S NEWEST BOARD MEMBERS

Over the coming year 'The Hive' will feature a series of ACN Board updates, covering topics such as the role and responsibilities of the ACN Board as well as the 2015 and beyond ACN Strategic Plan. In this edition we introduce to you ACN's two independent Board Directors.

Chris Drummer

Brian Gatfield

CHRIS DRUMMER GAICD – INDEPENDENT DIRECTOR

Chris is a qualified lawyer with an MBA and a graduate of the Australian Institute of Company Directors. He has broad commercial experience having worked in executive capacities for a diverse range of organisations including top 100 ASX listed entities AMP, Lend Lease and NAB, unlisted corporates and significant experience with NFPs and industry associations. Chris has 10 years' experience working in the health sector as a General Manager with the major Health Fund Bupa and with Australia's largest Radiology Network, I-MED. Chris was appointed to the Board in 2014 for a two year term.

BRIAN GATFIELD – INDEPENDENT DIRECTOR

Brian has had a distinguished 40 year career in investment banking, finance and business management. He has served as Chairman and an Independent Board Director of many companies in the publicly-owned and private sectors, chairing finance, audit and risk committees. He lists his interests as family, history, wine, cricket and physical conditioning. Brian was appointed to the Board in 2014 for a four year term.

In the next edition of *The Hive* we will feature an in-depth analysis of ACN's new strategic direction.

ACN FELLOWSHIP

We are proud to welcome Alison Hutton as a Fellow of ACN.

It is with great honour that I receive the recognition as a Fellow of the Australian College of Nursing.

I have spent the last 20 years advocating for the rights of children and young people. As a nurse and researcher my primary focus is creating supportive environments for young people in health care. I feel that the profession of nursing enables positive changes to peoples' lives and their communities.

PROFESSIONAL DEVELOPMENT: ACN'S LIFE LONG LEARNING PROGRAM

ACN's Life Long Learning Program (3LP) offers free content that can help members with their career planning, continuing professional development hours collection and skills development. E-learning activities include online courses, videos and resources.

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ACN's 3LP

Support your nursing registration through ACN's Life Long Learning Program

Australian College of Nursing (ACN)'s Life Long Learning Plan (3LP) is an online program which allows you to create a learning plan and record your professional development. This member only benefit integrates e-learning activities, quality nursing research materials and publications to support your professional development.

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- Develop and export a CV
- Create a profile
- Write a blog

For more information on 3LP please visit **www.acn.edu.au/life-long-learning-program**. For membership details please see **www.acn.edu.au/membership**, call **1800 061 660** or email **membership@acn.edu.au**

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ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

In-line with ACN's new strategic direction as the national professional association for nurse leaders, both emerging and current, each edition of 'The Hive' will feature a 'Q & A' session with ACN's CEO, Debra Thoms. This series of articles will profile current nurse leaders and provide our members with an insight into their personal journey to a position of influence and leadership.

"Q"

Debra Thoms

Cheyne Chalmers

"A"

We're proud to feature nurse leader **Adjunct Professor Cheyne Chalmers FACN** in the first of this 'Q & A' series. Cheyne is the Executive Director of Nursing, Midwifery & Support Services at Monash Health and has held this position since August 2009. She holds a Masters in Management (Health Service Management). Cheyne is the chair of the Ministerial Advisory Council for Nursing and Midwifery in Victoria, and Deputy Chair of the Public Sector Aged Care Leadership Group. Cheyne has led the development of the Monash Health Nursing and Midwifery Strategy, including the creation of a Nursing and Midwifery Governance framework to oversee Nursing and Midwifery clinical practice. Cheyne has also led innovative activities such as the development of the cleaning innovations project, which includes the implementation of Steam and Microfiber across Monash Health, and the implementation of the Kronos Rostering system organisation wide.

Prior to joining Monash Health, Cheyne's profile included Director of Nursing & Midwifery at the Capital & Coast District Health Board, Wellington, New Zealand where she implemented an organisation wide Nursing and Midwifery Model of Care; Director of Nursing & Midwifery representative on the National Quality Improvement Committee and the Safe Medicines Management Committee; lead Director of Nursing on the National Cardiac Surgery Steering Group that produced a strategy to guide the government's approach to cardiac surgery in New Zealand.

DEBRA: How do you think your prior experience (both personal and professional) has enabled you to become a nurse leader?

CHEYNE: I always wanted to be a nurse; as a small child I remember articulating this fact. I was one of the children that when asked "What do you want to be when you grow up?" I had no hesitation. My childhood activities supported my preparation; I was a girl-guide, and a ranger, I undertook my 'nursing at home' and first aid training as part of undertaking my Queens Guide program, and I went through my first leadership course at 13.

Interestingly, I applied to nursing school at 17 years and didn't get in. I went and worked in a bank and then kept trying for three years – it wasn't until my third try that I got in. I guess by then I really knew it was something I wanted to do.

When I completed my Diploma in the mid-1980s and became a Registered Comprehensive Nurse (in New Zealand), I went and worked in mental health. This was where I learnt about "my line" – i.e. what was the standard of care I was prepared to accept, (or not). Mental health was about to undergo significant reform at that time and cultural challenges existed, including how we viewed and treated mental health clients. This was where I formed my strong views around advocacy, change, leadership and education.

These experiences stayed with me on my journey as I moved across to general nursing and worked with respiratory patients and palliative care patients. I have learnt resilience and kept my passion and commitment making a difference to the communities we work in.

DEBRA: How do you maintain a work/life balance?

CHEYNE: For a long time I was a single mother, raising a son and working full-time. My son is now 22 and doing well living back home in NZ. My partner and I have a full life outside of work. We have our dog, Bones, who is always wanting us to play. Living in Australia has been a revelation. I'm always planning my next holiday, there is so much to explore here, as well as my trips home to NZ. I am very lucky to have close family and friends. They keep me sane. I also believe in laughing and having fun!

DEBRA: What have been your career highlights?

CHEYNE: Lots, almost too many to say. I have worked with some fantastic nursing and health leaders in New Zealand and Australia. More recently taking up the Chair of Nursing and Midwifery Ministerial Advisory Committee in Victoria, has been a great honour and an opportunity to impact on the future direction of nursing and midwifery in Victoria.

A significant hallmark for my career has been leading significant change in all my roles. An example was in Auckland in 2003. I was the last Director of Nursing of the then Green Lane Hospital, as we moved this iconic service to amalgamate with the new Auckland City Hospital. We moved tertiary cardiac, respiratory and ear, nose, and throat services across, which had been in the one hospital for over 50 years. We transformed every single system and process, including nursing models of care. I was proud to lead a nursing team who managed this significant cultural and environmental transition safely and effectively.

DEBRA: What are the key challenges facing today's nurse leaders?

CHEYNE: The key ones are political, financial, environmental, our ageing population, our ageing workforce, the global economy and generational differences. A lot to consider, I know, and they may become overwhelming when you see them like this, but challenges can become opportunities so it's how you turn these challenges into opportunities.

DEBRA: Has mentorship played a role in your success?

CHEYNE: Absolutely, I have been privileged to have strong nursing leaders work with me and support me at all stages of my career. I also learnt a lot from those not so strong leaders as well. Everyone has something to teach us.

DEBRA: How do you identify and develop your top performers?

CHEYNE: By their spark, their passion and commitment to getting the job done. Their ability to identify issues and problem solve. Positivity is also essential.

DEBRA: What lessons did you learn on your way to becoming a nurse leader and what advice do you have for future nurse leaders?

CHEYNE: "Know thy self" – be brave, know your limits, be humble, consciously put in place the steps to achieve the learnings that are required, seek out wise counsel. Make mistakes and learn from them, learn from other peoples' mistakes as well. Never be afraid to admit you're wrong. Nursing leadership has no place for arrogance and reflection is imperative.

Always ask yourself "How would I feel?" if that care was being provided to me or my loved ones.

Go and see – don't take others' words for things – go and check them out for yourself.

DEBRA: Do you have a 'leader' that you admire?

CHEYNE: There are loads of leaders who have inspired me on my journey but at the moment I like Richard Branson [Virgin founder and CEO] and his vision to change the world and have fun doing it.

DEBRA: Do you have a favourite leadership quote?

CHEYNE: I have many favourite quotes but here are two of my top ones:

Soon is not a timeframe, hope is not a plan.
Culture eats change for lunch.

THE POTENTIAL OF THE ENROLLED NURSING WORKFORCE

BY ROSINA MUIR, ACN RESEARCH ASSISTANT
BY DR MARLENE EGGERT MACN, REGISTERED NURSE AND ACN POLICY MANAGER

"Our EN workforce is highly dynamic and continues to evolve within the changing landscape of Australian health care policy and regulation."

In Australia, enrolled nurses (ENs) are a core component of the health care workforce and make an important contribution to Australia's world-class health outcomes. ENs work in varied settings across the country, from blood services to aged care facilities. Increasingly, ENs are playing an important role in meeting the growing demand for care.

Not all countries have recognised the importance of ENs in the nurse workforce mix. Several European countries, including France, Denmark, Italy and Spain, have only one category of regulated nurse (HWA 2013; Robinson and Griffiths 2007). The United Kingdom (UK) ceased admitting new ENs to the register in the 1980s. The minimum qualification for all UK nurses is now a three-year bachelor's degree. As a result, the UK relies heavily on unregistered health care assistants rather than second-level nurses (UK Department of Health, 2013). Closer to home, New Zealand ceased training ENs in 1993, only to recommence in the 2000s (Meek 2009). New Zealand's experiment is an instructive demonstration of the importance of ENs in the health care workforce, as the demand for nursing care increases.

In Australia, we have remained committed to maintaining the EN role. Rather than relying on unregistered health care workers, Australia has chosen to maintain a large, educated and professional EN workforce. The skilled work of ENs is recognised to be of paramount importance to the delivery of high quality nursing care. Our EN workforce is highly dynamic and continues to evolve within the changing landscape of Australian health care policy and regulation.

ENROLLED NURSE DEMOGRAPHICS

According to the latest national figures, there are 51,624 ENs working in Australia. The great majority of ENs have completed their pre-registration education in Australia; fewer than 5% have been educated overseas (HWA 2013).

The EN workforce has a relatively high average age of 46 years, and forty-five per cent of ENs have celebrated their fiftieth birthdays (AIHW 2013). According to Health Workforce Australia, the ageing EN workforce could lead to a significant shortfall in the supply of ENs if action is not taken to retain the current cohort of ENs and increase the number of people studying to be the ENs of tomorrow (HWA 2012).

Men make up roughly 10% of the EN workforce. While this number is rising gradually, it indicates that there is progress to be made in terms of attracting and retaining males within the profession. Aboriginal and Torres Strait Islander people are also underrepresented in the EN workforce: only around 800 of Australia's ENs identify as Indigenous Australians (AIHW 2013).

Among the most common work settings for ENs are aged care, rehabilitation and disability services. In contrast, ENs make up fewer than 5% of the critical care nursing workforce, and represent only a small proportion of nurses working in education, policy and management (AIHW 2013).

These statistics show that there are both challenges and opportunities for Australia's EN workforce. Efforts to recruit and retain ENs will need to be enhanced, with a particular focus on encouraging men and Aboriginal and Torres Strait Islander people to become ENs. At the same time, roles in a wider range of clinical areas are becoming available to suitably educated and qualified ENs, and there will be more such opportunities in the coming years.

A GROWING ROLE FOR ENs

The evolving role of the EN is reflected in recent changes to educational requirements for ENs. As of 1 July 2014, the Certificate IV in enrolled nursing will cease to be available and the minimum qualification for EN entry to practice will be the Diploma of Nursing. The transition to a Diploma recognises the high level of skill ENs contribute to today's health care teams. A nationally consistent approach to EN education is also likely to enhance the mobility of the EN workforce, by giving employers confidence in the knowledge and skills of ENs educated in other states.

ENs are now undertaking a diverse range of advanced and extended roles. One of the earliest areas of role expansion for ENs was medication endorsement. Before the move to national registration in 2010, ENs in some states were able to obtain an endorsement in medicines administration and become Endorsed Enrolled Nurses by completing

specified education units. This endorsement has now been phased out because from 2008 onwards all newly qualified ENs have completed the required medicines administration education. Instead, the register now identifies ENs who have not completed the required courses (NMBA 2014). This example demonstrates how the EN role has evolved over the years. Whereas once only a relatively small number of ENs were educated to administer medicines, now all new graduates complete medicines administration units as part of their initial nursing education.

The EN role is also expanding in other ways. For example, ENs are taking on a growing role within haemodialysis units (Tranter et al. 2011). The 2008 Australia and New Zealand Dialysis Workforce Survey, conducted by the Renal Society of Australia, found that there were 188 ENs working in dialysis alongside 2,433 registered nurses (RNs). The growing demand for dialysis services and the shortage of dialysis RNs in some areas represents a clear opportunity for ENs. According to a New South Wales study conducted in 2009, the scope of practice of ENs in haemodialysis units may include cannulation (including both native access and buttonhole cannulation), connecting and disconnecting haemodialysis central venous catheters (CVCs), performing CVC dressings, giving iron infusions and administering erythropoietin, anticoagulants and Lignocaine. In addition, ENs may also take on a case management or health promotion role for dialysis patients (Bennett et al. 2009).

ENs are also moving into extended roles in rehabilitation services. A recent study of ENs in an Australian rehabilitation facility found that, in addition to assisting patients with activities of daily living, ENs may take on roles in coaching and supporting patients to reach their individual goals, monitoring the patient's progress and liaising with other members of the multidisciplinary rehabilitation team. The study found that many ENs demonstrate an understanding of the philosophy of rehabilitation nursing, including goal setting and enabling self-care (Pryor and Buzio 2013).

In rural Australia, ENs are taking on a diverse range of roles within the EN scope of practice in order to meet local needs. ENs with specialist skills such as infection control or wound care make a significant contribution to some rural health services, although their extended scope of practice is not always given appropriate recognition by their RN colleagues (Nankervis et al. 2008). Rural health services are increasingly recognising that supporting ENs to take on extended roles and further develop their clinical skills can be a successful model for the delivery of high quality patient care.

RECOGNISING THE EVOLVING EN SCOPE OF PRACTICE

In light of the fact that there have been significant changes to EN education, regulation and scope over the last decade, the NMBA has commissioned Monash University to review the currency of the standards against contemporary enrolled nursing roles. The Monash University project has involved a review of the literature as well as a series of focus groups and surveys to gather insights from both RNs and ENs on the education, scope of practice and supervision of ENs (Monash University 2013). The project is expected to be completed in 2014 (NMBA 2013).

OUR ADVOCACY FOR ENs

ACN's advocacy priorities are explicitly designed to support both registered and enrolled nurses. In 2014, ACN has argued for a range of policies that would have a positive impact on the retention and flexibility of enrolled nurses. For example, ACN has proposed a National Transition Framework to support the flexibility and mobility of both the EN and the RN workforces. The Framework would be accessible to nurses entering the workforce, as well as nurses transitioning from one area of practice to another. For example, it would support an EN wishing to transition from the aged care sector to a hospital-based role.

ACN has also put forward a proposal for a new scholarship program to support newly registered and enrolled nurses to practice in rural services. It is essential that rural health service providers are able to attract appropriately educated staff, including both ENs and RNs, in order to maintain an optimal skill mix. The scholarship scheme will allow rural health services to employ newly registered and enrolled nurses as supernumerary team members, while providing them with a structured clinical learning program.

ACN will continue to provide a voice for ENs in policy discussions, and advocate for the role of ENs in health care delivery.

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AN EDUCATIONAL INITIATIVE TO EXPAND THE ENROLLED NURSE SCOPE OF PRACTICE

Sean Prendergast and June Cox

BY JUNE COX FACN, REGISTERED NURSE, ADVANCED EDUCATION FACILITATOR, MANAGER, CENTRE FOR NURSING EDUCATION, REPATRIATION GENERAL HOSPITAL, SA

BY SEAN PRENDERGAST, REGISTERED NURSE, CLINICAL EDUCATION FACILITATOR, CENTRE FOR NURSING EDUCATION, REPATRIATION GENERAL HOSPITAL, SA

The Repatriation General Hospital (RGH) in Adelaide has implemented and evaluated an education initiative designed to assist enrolled and registered nurses and nursing leaders to better understand the contemporary enrolled nurse (EN) scope of practice, and to confidently apply this knowledge to their practice.

In the current health climate, with an ageing population, increasingly complex health demands and funding challenges, there is a renewed interest in the important role of the enrolled nurse in acute care.

Nursing is unique in that it has two distinct levels of qualification. The difference between the registered nurse (RN)/midwife and the EN is related to the level of accountability and decision making and not competence, (Willis, 2011). The EN is an associate to the RN and works under direction and supervision of the RN. At all times the EN retains responsibility for their actions and is accountable for the delegated nursing care that she provides. The EN is required to function only within the limits of their competence and education (Repatriation General Hospital 2009, p.1). However, there is consensus in the literature that EN practice continues to remain both blurred and misunderstood (Heartfield & Gibson 2005, Kenny & Duckett 2005, McErlean 2003) and this confusion, coupled with perceived historical and cultural factors influencing EN practice at the RGH, led to the hospital's Nursing Support Services, partnered with Flinders University, School of Nursing and Midwifery, Adelaide to research the cultural attitudes and system practices that were thought to act as barriers to the full utilisation of the practice role of the EN at the RGH. (Repatriation General Hospital & Flinders University 2010.)

This research, led by Professor Jan Paterson, utilised action research methodology, action cycles utilising focus groups and thematic analysis. The research outcomes identified considerable confusion and sometimes entrenched attitudes about the scope of the EN role in acute care at the RGH.

A range of recommendations were made, including the development of the following educational resources and initiatives:

- A comprehensive education program, including distribution of a position statement, pocket prompter and poster to all wards and nurses, providing advice on determining the EN scope of practice.
- Up-skilling programs for ENs, enabling them to confidently take on new clinical opportunities such as medication administration, venepuncture and their own patient case load.
- Education through interactive problem solving about commonly encountered scope of practice and delegation/supervision dilemmas.

In-keeping with these recommendations, a comprehensive education program was implemented to assist nurses to understand and apply scope of practice and delegation/supervision skills to their practice. In addition, the program facilitated clarification around scope of practice issues and also served to alleviate concerns about the perceived erosion of the RN role by diploma prepared ENs.

“…the program facilitated clarification around scope of practice issues and also served to alleviate concerns about the perceived erosion of the RN role by diploma prepared ENs.”

The educational initiative included:

- 24 interactive two-hour workshops for all nursing staff, conducted over a 12 week period at different times to ensure maximum attendance. The sessions incorporated scenario based learning designed to cover common scope of practice dilemmas.
- The development of an interactive online education program with its emphasis on the principles of delegation, supervision and accountability for practice. Both the online program and education sessions were contributed to and facilitated by a nursing policy consultant (Willis 2011).
- Wide distribution of laminated ‘pocket prompters’ which can attach to a name badge and offer a quick reference for scope of practice decision making.

Challenges

The workshops were fruitful but, at times, challenging. A small number of ENs and RNs found the program confronting, even anxiety producing. There was a tendency to reduce all discussions to a task focus with role demarcation causing some conflict between ENs and RNs.

A small number of RNs disagreed with the expanding EN scope of practice and a minority made disparaging comments, sparking some conflict in the sessions. Some concern was expressed about EN role expansion jeopardising RN jobs and role satisfaction. Conversely, a small number of ENs expressed grief and anger regarding their perceived lower role and status in the clinical team. This interaction required careful and skilled facilitation.

Workshop evaluation

The evaluation confirmed that the majority of nursing staff surveyed experienced a change in practice regarding the RNs confidence in delegation, and indicated that the program gave them the tools for this.

ENs surveyed also felt more encouraged, fulfilled, and positive about their expanded role. The majority of nurses surveyed overwhelmingly believed that ENs were now working to their full scope (within hospital policy).

Follow-up evaluation

A follow-up evaluation four months after the last workshop consolidated the positive benefits of the education initiative. These included:

- Significantly increased RN confidence in delegation and supervision with a resulting change of practice.
- 90% of RNs’ responses and 77% of ENs’ responses indicated they thought ENs are now working to their full scope. The discrepancy in the responses related to the individual ward environment, i.e. some acute care areas, or ENs who were happy with their work role prior to the initiative.
- Nursing managers reported that team work had improved, as had the ability of RNs to confidently delegate and supervise
- Most ENs reported increased job satisfaction with the positive role changes being their ability to now undertake medication administration, veni-puncture and being allocated their own patient load.

All respondents stated that ENs were coping well with their increased role responsibility.

Future challenges – the way forward

Despite excellent outcomes following the education initiative, there are still a number of challenges ahead. They are:

- Lack of consistency from RN staff regarding EN supervision and delegation.
- Continued poor understanding of ENs scope of practice amongst relieving, casual and agency staff.
- Continuing self-esteem and job satisfaction issues for some ENs who still feel unable to work to their full scope. This is related to their individual practice area.
- There is also a need to change hospital policies which remain ambiguous and inconsistent with the recent expansion of the EN scope of practice.
- Importantly, the most difficult and ongoing challenge is to encourage all nursing staff to consider EN scope of practice in the broader framework of knowledge, education, competence and authorisation and not depend on the security of check lists and exacting policy or directives to instruct them in scope of practice issues.

Since the completion of the education initiative, the hospital has employed ENs in departments that have previously been staffed solely by RNs, for example procedural areas such as Radiology and the Investigational Procedures Unit, with opportunity for ENs to expand their practice roles. In addition, a number of general clinical procedure guidelines have been updated to reflect the EN full scope of practice. These changes are practical examples, in a suite of changes, that have occurred in our hospital to enable ENs to deliver patient care (in accordance with hospital policy) utilising their full scope of practice. The hospital continues to maintain, as a priority, education on the EN scope of practice and related accountability, delegation and supervision frameworks.

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ENROLLED NURSE LEADING THE WAY

Profile: Maryanne Craker MACN, Enrolled Nurse and ACN Board Director

"I truly believe we ENs, as professionals, make a positive contribution to those in our community needing care. However, this doesn't mean we can just sit back on our laurels. We must participate in the ongoing advancement of our sector in the nursing profession."

I come from a long line of nurses. My grandfather, father and mother were psychiatric nurses. Most of my father's sisters also joined the nursing fraternity. Having younger siblings (there are 11 of us) meant I played a big part in caring and nurturing them. I suppose these factors would have all gone towards influencing my decision to become a nurse.

Caratis Christi Hospice in Kew, Victoria was where my nursing education began as I commenced training to become a nursing aide. I have to say the content of the course at that time was worlds away from how the role and function for the enrolled nurse (EN) of the 21st century looks like today. Part-way through my course I wasn't sure if this was what I really wanted to do so I left and perused alternative career pathways. During this time I met my husband and life partner, Ronnie, and we were blessed with three children. To-date they have given us four wonderful grandchildren and we look forward to many more.

However, in one form or another, I kept gravitating back to caring for people. With my family's support I returned to complete my nursing education. As luck would have it, I had the opportunity to return to Caratis Christi Hospice to complete my qualification.

At Caratis I found it both a privilege and an inspiration to be allowed to assist people as

they prepared to depart this world of ours. During my time there I was privileged to work with some remarkable people and, even though we are scattered across Australia, many of us are still close friends today. Over the years I have nursed across a multitude of health disciplines and the underpinning education, compassion and knowledge I gained at Caratis has given me a solid basis to develop as an EN.

I truly believe we ENs, as professionals, make a positive contribution to those in our community needing care. However, this doesn't mean we can just sit back on our laurels. We must participate in the ongoing advancement of our sector in the nursing profession. To do this we need to attend forums and conferences, engage in the discussions that take place and participate in the direction of our educational standards and scope of practice in the current health environment.

If you haven't already guessed I'm a passionate EN and strongly believe in the ongoing advancement of all aspects of enrolled nursing. I always find it rather interesting when people say, "Maryanne, you are quite knowledgeable about many aspects of nursing why don't you become a registered nurse?" I find this a very interesting comment when we have our own career pathways through the Enrolled Nurse Advanced Diploma streams.

Currently, I have the honour of being the EN on the ACN Board of Directors and I am keen to present the views of ENs. What do you think needs to be addressed? How should our education be funded? What opportunities should there be for advancement as an EN? As an important part of the profession what direction should enrolled nursing take? Where do you see enrolled nursing in the years to come?

I would welcome and value your input and can be contacted at Maryanne.Craker@vu.edu.au. Together, we can lead the way with the advancement of the enrolled nursing role.

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A LEADER IN THE AREA OF DISASTER HEALTH

Profile: Jamie Ranse FACN

ASSISTANT PROFESSOR, FACULTY OF HEALTH, UNIVERSITY OF CANBERRA, ACT
ACN KEY CONTACT, DISASTER HEALTH COMMUNITY OF INTEREST

Nursing background

I am currently employed as an Assistant Professor in Nursing at the University of Canberra. Prior to this, I was a Clinical Manager in the Emergency Department at Calvary Health Care ACT, where I am still employed as a casual registered nurse. My nursing career has included various roles in emergency and intensive care including research, education, management and leadership. I have volunteered with St John Ambulance Australia for over 20 years; previously holding the high-level national strategic position of Chief Nurse. I am actively engaged with a number of professional nursing associations, including the Australian College of Nursing.

What led to your interest in joining the Disaster Health Community of Interest (COI)?

I have been researching issues relating to disaster nursing in Australia for a number of years. Increasingly, during this time nurses have been writing to me asking about issues relating to disaster health, such as: what courses are available for nurses, how can nurses assist, and what needs research attention? I joined the Disaster Health COI with a vision to provide a consensus view to answering these types of questions.

What are your hopes for the Disaster Health COI?

Over the coming years, I hope to see the Disaster Health COI grow in membership. Chiefly, members who wish to make a contribution to networking with other like-minded members. In particular, I see the COI being a vehicle for sharing ideas and experiences of assisting in a disaster. By doing this, the COI will become a central knowledge point for Australian disaster nursing related topics. Ultimately, I see the COI providing an opportunity to progress the nursing profession to develop a better understanding of the experience of nurses in disasters, which may inform policy, education/training programs, research and practice in disaster health.

Highlight the importance of the nurses' role in disasters.

The role of nurses in disaster health is diverse. It includes aspects of disaster risk reduction, preparedness, response and recovery. Commonly, nurses who have assisted in a disaster describe using their 'everyday' nursing skills and knowledge, and applying these within a different context – a disaster. The nurses' role may include clinical care, being a psychosocial supporter, leader, educator, coordinator of care and problem solver. Nurses care for people in disaster-affected communities and relief workers working in these communities. In a disaster, nurses need to be willing to let go of their expectations, able to improvise, realise that resources are strained and have a sense of humour.

What are some of the current issues and challenges facing disaster nursing?

Disasters are non-discriminatory and may affect any community. As such, it is important for nurses to understand that any nurse may be needed to assist in a disaster, not only those who deploy with professional organisations and associations. As such, all nurses should have some awareness of nursing in a disaster. This awareness doesn't necessarily need to focus on the everyday nurses or clinical activities. It should focus on the realities of nursing in a disaster – such as working with limited or no resources. Can you care for your patients with no electricity or water supply?

What are some of the challenges you've witnessed during a natural disaster throughout your career?

Out of good will, some nurses may self-deploy to a disaster. This should be avoided as this places stresses on an already chaotic and complex situation. Instead, nurses wishing to deploy to disasters should do so with an organisation which has been invited to assist. Whilst the initial response to a disaster is commonly the focus from a media perspective, the recovery of a community continues for many years, if not decades in some circumstances. From a population perspective, there is an overwhelming psychosocial support need of the disaster affected community during and following a disaster. Additionally, the psychosocial wellbeing of nurses who assist in disaster health activities need to be considered.

Have there been some positive developments in this area you'd like to highlight?

Historically, the deployment of health personnel and resources in disaster assistance has been haphazard. However, as disaster health assistance is evolving there have been a number of improvements to avoid this haphazard approach. The establishment of the Australian Medical Assistant Teams is an example of this, as too is the introduction of specialised training and education for those wishing to assist in these teams. However, getting the right person to the disaster within the right timeframe with the right resources remains a challenge, as each disaster is complex and requires a different approach.

IT'S NEVER TOO EARLY TO BECOME A LEADER

Profile: Renee Callender MACN

REGISTERED NURSE, WOLLONGONG, NSW
ACN KEY CONTACT, SYDNEY SOUTH/ILLAWARRA REGION

"The general misconception that irks me isn't so much a misconception, more a statement I've heard multiple times – "Why didn't you become a doctor? Why are you just a nurse?"

How did you become involved in nursing?
I started volunteering from age 14 with St John Ambulance Australia in my hometown of Moruya, NSW. I loved everything about it – loved the joy of helping others and I was so intrigued to learn how to respond effectively in emergencies and show true compassion to others. I was also fortunate to have had some very down-to-earth and inspiring mentors who encouraged my interest in nursing and after graduation from high school I undertook the University of Wollongong's Bachelor of Nursing degree.

I started my first paid nursing related employment in my third year of the degree at a local hospital. I have now graduated and am working as a registered nurse (RN) in a local aged care facility; learning the ins and outs of multiple comorbidities, patient-centred care and compassionate palliative and end-of-life care.

What is your nursing specialty?
As I still consider myself as a 'newbie' RN I haven't really discovered a specialty yet, though I have interests in aged care, mental health, cardiology and nursing research. So, I guess I am intrigued to be involved in one or all of these areas at some point in my career, but I am open to any interesting opportunities that may come my way.

What do you love most about nursing?
This is truly the job that never has a dull day! Each day is different and I feel privileged to be so trusted with the lives of my patients and residents in their moments of hardship and need. Along with my love of the workings of the human body, the evidence-base behind nursing care and continuous educational opportunities, I love the 'team' focus of nursing, especially when the patient is at the centre of decision making and everything goes to plan.

What is your least favourite part of nursing?
When everything doesn't go to plan.

What brought you to this area of Australia?
I'm originally from NSW South, but I moved to Wollongong for University and have stuck around for the area, the people and to continue to work and study here.

What are some of the nursing and health issues that are specific to the Sydney South/Illawarra Region?
Two big issues come to mind. Firstly, many newly graduated RNs within our region have been unable to find employment. Secondly, local nurses struggle to find the time within their working hours to keep up to date with advances in education.

What do you see as the biggest challenge currently facing the nursing profession, and how do you think the profession is placed to respond to these challenges?
I believe possible health funding cuts and workforce shortages, that in-turn affect our ability to provide adequate and safe patient care, are two significant challenges facing our profession. There are recently graduated RNs who remain jobless yet there are local health districts crying out for nurses but only those with 'experience', with undergraduate nursing experience ignored. Looking into alternative transition programs is key to overcoming this challenge.

What's the biggest misconception about your career choice?
I have met some amazingly talented and intelligent nurses in a variety of roles, who all make a great difference in the lives of their patients, or indirectly through organisations or research. The general misconception that irks me isn't so much a misconception, more a statement I've heard multiple times – "Why didn't you become a doctor? Why are you just a nurse?" I did not become a nurse because I didn't have the marks to be a doctor, and by the time I finish university again with a Research Masters I would have physically been enrolled in university for the same length of time;

I became a nurse because I found a passion for this role, and spending time with people inspires me.

Nursing is a holistic role that encompasses so much. We are health professionals, role models, educators, support systems and innovators; we understand intimately, the fragility of life and the human relationships that bring it meaning.

THE CONTINUED USE OF ANTI-PSYCHOTIC MEDICINES IN RESIDENTIAL AGED CARE

BY DR RODNEY JILEK MACN, REGISTERED NURSE, AGED CARE CLINICAL ADVISER, NSW

Despite both longstanding and contemporary literature and clinical research all raising significant issues with the ongoing use of anti-psychotic medicines in the elderly (Ballard et al. 2009, Kales et al. 2011, Kales et al. 2007), we continue to see these medicines used as the front-line tool to manage behavioural disturbance in residents presenting with dementia in residential aged care services.

The main behavioural and psychological symptoms of dementia (BPSD) requiring intervention by residential aged care providers is agitation. Agitation includes wandering, calling out, abusive vocalisations, and assaultive behaviour and these behaviours are demonstrated by up to 70% of people with dementia (DBMAS 2014).

Anti-psychotic medicines, or in simple language, medicines that have a direct effect on mental activity, perception and behaviour, have long been used in the mental health field to manage and treat a wide range of acute and chronic major mental health disorders such as Schizophrenia and Bipolar Affective Disorder – a use that is widely accepted, licensed and approved across the world. This class of drugs are also known as major tranquilisers, reflecting their significant sedative effects.

HALOPERIDOL, OLANZAPINE AND QUETIAPINE

What is not so widely known or understood in the aged care setting is that many of these medicines, including the commonly prescribed Haloperidol (Serenace), Olanzapine (Zyprexa) and Quetiapine (Seroquel) are not approved for the treatment of behaviour problems in older adults with dementia in their countries of manufacture and are the target of strict warnings on their use in this vulnerable population in the United States, Canada and the United Kingdom. Studies have shown that older adults with dementia who take anti-psychotics such as Haloperidol, Olanzapine and Quetiapine have an increased chance of death during treatment (Medline Plus 2014).

A Cochrane Collaboration systematic review highlighted that in clinical trials Haloperidol, in particular, appeared to provide no improvement of agitation in patients with dementia when compared to placebo, while adverse side effects were common (Lonergan et al. 2012). The supporting research conducted by Vida et al (2012) and Kales et al (2011), included as part of the systematic review, concluded that medicines such as Haloperidol were ineffective in managing agitation in dementia and, therefore, should not be used for this purpose – except in cases where extreme physical aggression was present.

RISPERIDONE

Even Risperidone (Risperdal), which is more widely approved for use in the aged population, comes with strict guidelines and specific indications for use:

for behavioural disturbances characterised by psychotic symptoms and aggression in patients with dementia where non-pharmacological methods have been unsuccessful.
(National Prescribing Service, 2005a)

Drug therapy is second-line treatment for behavioural disturbances in dementia. Managing underlying causes and non-drug strategies should be tried first. Risperidone produces modest improvements in problem behaviours characterised by psychosis and aggression; there is no conclusive evidence that it is any more effective than other drugs but it is the only atypical antipsychotic that is both TGA approved and PBS listed for this indication.
(National Prescribing Service, 2005b)

SIDE EFFECTS

According to Medline Plus (2014), anti-psychotic medicines are known to cause a wide range of unpleasant/negative side effects in up to 50% of users including:

- Sedation
- Headaches
- Dizziness
- Diarrhoea
- Anxiety
- Extrapyramidal side effects, which includes:
  - Akathisia
  - Dystonia
  - Parkinsonism
  - Tremor
- Hyperprolactinaemia, which can cause:
  - Galactorrhoea – unusual secretion of breast milk.
  - Gynaecomastia
  - Sexual dysfunction (in both sexes)
  - Osteoporosis
- Orthostatic hypotension
- Weight gain
- Anticholinergic side-effects such as:
  - Amnesia
  - Blurred vision
  - Constipation
  - Dry mouth (although hypersalivation may also occur)
- Tardive dyskinesia appears to be more frequent in those on high-potency

first-generation anti-psychotics such as haloperidol (Serenace) and tends to appear after chronic and not acute treatment. It is characterised by slow (hence the *tardive*) repetitive, involuntary and purposeless movements, most often of the face, lips, legs, or torso, which tend to resist treatment and are frequently irreversible.

A less common, but far more extreme consequence, is increased mortality due to cardiovascular complications, particularly in elderly patients (Medline Plus 2014).

CONSENT

Consent is another major issue in this area. If the resident has dementia and has lost capacity to make decisions and provide informed consent, who consents to this course of treatment?

Many nurses and medical practitioners appear to falsely believe that because the medicine is being prescribed to treat an identified illness (dementia and BPSD) then consent is not required. Others also falsely believe that this form of treatment does not constitute chemical restraint as outlined in the national guidelines published by the former Department of Health and Ageing (2012). Others argue that the national guidelines are merely that, 'guidelines', and therefore are not enforceable or mandatory. As the majority of these medications are not recognised or approved as appropriate treatments for dementia, many of these arguments become invalid.

Nurses may argue that gaining consent is a medical issue – but on many occasions, these medicines are first prescribed on the advice of nursing staff, over the telephone, without the resident even being seen. Consent is also required for the act of medication administration. I contend that all health professionals, regardless of discipline, have a duty to ensure appropriate informed consent is gained prior to the intervention being commenced.

SO WHY, DESPITE ALL THAT IS KNOWN ABOUT THESE MEDICINES, DO WE STILL SO READILY REACH FOR ANTI-PSYCHOTICS IN RESIDENTIAL AGED CARE?

There are a multitude of reasons:

Many nurses believe that because it is prescribed by the medical practitioner, they are simply following a legal order. Others falsely believe that these drugs are accepted as 'drugs of choice'.

Medical practitioners often believe there are no other viable alternatives and at times prescribe these medicines at the behest of exasperated nursing staff that are not appropriately equipped to manage behaviour.

Many staff do not understand that the use of these medicines constitutes a chemical restraint and appropriate preparation, discussion, consultation and consent are required.

SO, WHAT IS THE ANSWER?

Given the lack of viable, evidence-based pharmacological alternatives it is clear that, in some cases, especially where extreme physical aggression is a presenting feature, these medicines will need to be used.

The appropriate approach has to be that these medications are used sparingly, as an intervention of last resort, at the lowest possible doses and for the shortest possible time period, with regular assessment, review and monitoring and consent (Watson-Wolfe et al. 2014). Nursing and medical staff should ensure that these processes are well documented.

Nursing and medical staff need to acknowledge that the use of these medications does, in-fact, constitute a chemical restraint and as a result they should follow the guidelines provided by the Commonwealth (Department of Health & Ageing 2012).

Non-pharmacological interventions must be explored and exhaustively trialled before pharmacological interventions are contemplated.

Nursing staff and medical practitioners should also be encouraged to actively seek assistance and guidance from external bodies such as the Dementia Behaviour Management Advisory Service (DBMAS) or local mental health practitioners and specialists. DBMAS, in particular, offers a free 24 hour telephone advice service Australia wide on 1800 699 799 (DBMAS 2014).

Be proactive, consult widely and employ as many non-pharmacological interventions as possible before reaching for the sedation.

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CHILD AND FAMILY HEALTH NURSING:

the challenges of working in a Home Visiting Early Intervention program

BY ANNE-LYSE DE GUIO MACN, REGISTERED NURSE, TRESILLIAN EDUCATION UNIT, SYDNEY, NSW

BY JACQUI WALKER, CHILD AND FAMILY HEALTH NURSE, HOME VISITING EARLY INTERVENTION TEAM, TRESILLIAN FAMILY CARE CENTRES, SYDNEY, NSW

BY JULIE MADDOX, CLINICAL NURSE CONSULTANT, PROGRAM MANAGER, TRESILLIAN FAMILY CARE CENTRES, SYDNEY, NSW

Pictured left to right: Anne-Lyse De Guio, Jacqui Walker and Julie Maddox

Tresillian Family Care Centres is a state-wide parenting organisation which provides specialist interventions when sleep, settling, feeding and maternal emotional issues seem insurmountable.

Established through Commonwealth funding in 2008, the *Tresillian Home Visiting Early Intervention program* assists high risk families with complex needs. For example, some mothers struggle with long term mental health, substance misuse, child protection issues, history of childhood trauma and other adversities that can impact negatively on parenting. Families are identified through routine psychosocial screening during their antenatal care and presented at a fortnightly antenatal multidisciplinary meeting attended by the Tresillian Early Intervention Nurses or postnatally by referral from community child and family health nurses or GPs and non-government agencies supporting mothers with complex needs. Three registered nurses with child and family health nursing qualifications practise under the guidance of the Tresillian Clinical Nurse Consultant to provide home-based long term interventions.

ANNE-LYSE: I met with Jacqui Walker, Child and Family Health Nurse, to discuss what it is like being a registered nurse in the Tresillian Home Visiting Early Intervention Team, working with families with complex needs.

ANNE-LYSE: What were your first impressions of the role of a Tresillian Home Visiting Early Intervention Nurse?

JACQUI: From the moment I joined the team I thoroughly enjoyed my new role. Previously, I had worked in the hospital day-stay unit, where mothers spent the day making changes to their babies existing daily pattern (routine) and increased their understanding of their children. This was the first time in my career that I needed to make home visits and working in a community setting certainly proved a challenge. Not only did the job require finding my way around Sydney's inner-west but also reverse parking in all situations – I would often arrive at the client's house with nervous sweat on my top lip! I also discovered it's more difficult to challenge clients to reach their goals and meet their infant needs outside of the power provided by the hospital environment. I realised that I would quickly

“Now that I reflect on my experience, I can see it usually takes a team practising collaboratively to help the families that are referred to us. I always knew that theory-based evidence supported collaborative practice and now I see the evidence in my own clinical practice.”

need to improve my communication and family partnership skills, to make these home visits as effective as possible.

ANNE-LYSE: What is the framework employed by the Tresillian Home program?
JACQUI: The program uses a primary health care framework, so I had to ensure that my approach was community focussed and that I was able to work in close partnership with non-government organisations. Most families referred to the program will require further community support to reach their potential. This means that we will often participate in joint home visits with other support agencies in order to reach success. I have found that most other services are keen to learn and share their knowledge.

ANNE-LYSE: What do you enjoy about a multidisciplinary approach to service provision?
JACQUI: I am particularly fond of Tresillian's working relationship with an inner city, abstinence-based rehabilitation program for homeless mothers and their children called Kathleen York House (KYH). Mothers and children, from pregnancy to 10 years of age, live in the facility and participate in a dense framework of rehabilitation activities. I now feel safe working within the established structure of KYH. The immediate support of drug and alcohol workers, psychologists and attending the multidisciplinary client review meetings adds knowledge and interest. Most importantly, I have learnt to place how to help mothers 'learn their baby', in the context of their recovery from active addiction.

Initially, I found it intimidating to speak with community mental health services, psychiatrists and psychologists regarding a plan of care for our mutually shared clients. I almost apologised for taking their time and didn't always follow up on non-returned phone calls as soon as I should have. Now that I reflect on my experience, I can see it usually takes a team practising collaboratively to help the families that are referred to us. I always knew that theory-based evidence supported collaborative practice and now I see the evidence in my own clinical practice.

ANNE-LYSE: How has working in this program changed you as a nurse?
JACQUI: Although I've been in the role for three years I still find myself challenged by situations that I never anticipated. For example, the local area Community Health Centre was seeking the help of a nurse to develop and facilitate a simple computer and Internet class on parenting for women from culturally and linguistically diverse background. The opportunity was a good-fit within our primary health care framework and it was also an area of skills that I wanted to develop. So, although my children thought that their mum teaching others about computers and the Internet was the funniest thing on earth, I took on this new challenge.

Although there have been challenges along the way there is no-doubt that I have developed professionally. I have learnt to transfer theory into practise with more complex families and unusual situations. I have learnt to be spontaneous and creative but still base my practice on evidence. The good news for me is that the learning curve will not flatten because I love a challenge and learning. There is much to understand about families facing adversity, identifying their resilience and working towards their goals whilst allowing them to grow.

The specialist nurses working in the team are registered nurses with a wealth of knowledge and skills in child and family health nursing as well as highly developed communication skills. These skills not only support effective engagement with parents (often known as the hard to reach families) but also help to form productive partnerships with community agencies involved in the families care, to ensure that support is coordinated and continues once the program is completed.

Tresillian acknowledges the changing needs of the community and is open to the development of new nursing practices and models of care. Tresillian is an organisation that embraces partnerships and collaboration with government and non-government agencies in order to provide the best long term care for vulnerable families. By sharing expertise, knowledge and resources, this collaboration has enabled the development of high level knowledge and skills in child and family health nursing, in order to work with highly vulnerable families.

CONTACT

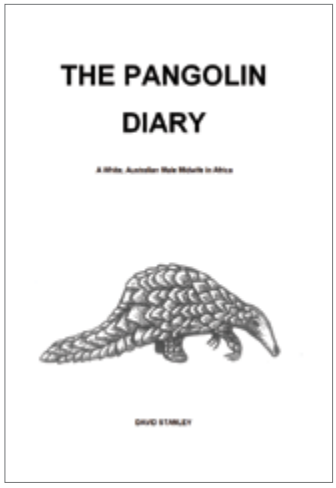
For further information about the program you can contact Julie Maddox at **julie.maddox@sswahs.nsw.gov.au**.

For further information about the services Tresillian provides or to gain resources you can access the Tresillian website **www.tresillian.net**

THE PANGOLIN DIARY:

An Australian Male Midwife in Africa

BY DAVID STANLEY MACN, REGISTERED NURSE AND MIDWIFE, ASSOCIATE PROFESSOR, UNIVERSITY OF WESTERN AUSTRALIA, WA



Photos: David Stanley; Twins in a postnatal ward incubator; The postnatal ward, Murambinda

The Pangolin Dairy: An Australian Male Midwife in Africa offers the reflections and insights into my role as an Australian male midwife in rural and remote Murambinda, Zimbabwe in the early 1990s.

It's an autobiographical account of my first year working at a Catholic mission hospital as a midwifery tutor and midwife, as I set-up a midwifery programme and transitioned to life in a remote community. It was a time when AIDS and tuberculosis were beginning to spread their dark shadows across the continent, impacting on the lives of everyone; no matter how remote they were from the cities, how rich or poor they were, or what their faith or beliefs were.

The story is set at Murambinda Mission Hospital where I was placed by the Australian Government's Australian Volunteer Abroad service. The book explores a range of issues including the development of friendships, and the medical and social issues faced by Zimbabwean women as they grapple with the impact of HIV/AIDS and other medical/midwifery conditions.

I share how relationship building became the key to my surviving and, indeed, growing in the challenging and lonely environment. The book recounts how I dealt with meeting new people, how I developed and built new relationships and how I coped with the fear and dangers of working in a medically confronting, resource poor and overburdened health service hit by the HIV/AIDS epidemic.

The Pangolin Diary also focusses on my personal journey as I tried to adjust and cope with the language difficulties, the challenges of living alone and far from home, and how I coped with the grief of losing my closest friend to a sudden illness.

My book offers personal insights into the sometimes poignant and often tragic events all too common at this time in rural and remote Zimbabwe. I share stories from the women's perspective; their experiences of birth or pregnancy.

The Pangolin Diary depicts my life as a midwife in rural Zimbabwe and also relays the experiences of local people as they cope, and sometimes suffer, in a country struggling to manage the onset of the HIV/AIDS epidemic.

An extract from The Pangolin Diary

She lay back on the bed and closed her eyes. Beads of sweat formed on her brow and she reached down to her groin in an attempt to hold in the burning pain. The evening was hot and humid and she lay on the bed completely naked. The nurse came back in and said that she had tried to contact the hospital, but the storm had brought down the telephone lines somewhere between the clinic and the

> *"The book recounts how I dealt with meeting new people, how I developed and built new relationships and how I coped with the fear and dangers of working in a medically confronting, resource poor and overburdened health service hit by the HIV/AIDS epidemic."*

hospital. They would just have to make do as best they could.

Mrs Chikwekwete had been in labour all day and most of the day before. It was now late evening. As the sky blazed orange and golden with the last rays of the sun breaking free beneath the heavy black clouds, she felt her strength setting too. "How much longer," she pleaded with the nurse.

The sun had set and she was alone. The clinic had no electricity and the room had only a dim, paraffin light, which the nurse had placed on the floor near the door. Ishwa (flying ants) crawled under the door or flew in the open window to swarm in a fatal dance around the light. Seduced by the light's false promise, dead and dying ants collected in a pile at the base of the lamp. In the dim half-light of the labour room, Mrs Chikwekwete felt completely isolated, afraid and alone.

The nurse came over and looked between Mrs Chikwekwete's legs. The light was poor so she went over to the door and brushing Ishwa away, picked up the paraffin lamp. She held it up in the air with one hand and again opened Mrs Chikwekwete's legs. This time she could clearly see the baby's head crowning.

"It's time," the nurse said.

(Chapter 26, pp 241–242)

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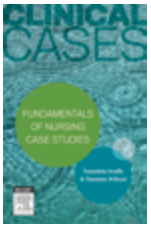

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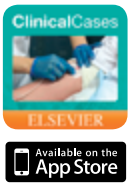

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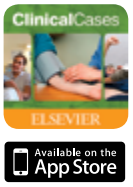

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NURSES' ATTITUDES TO WORKING WITH OLDER PEOPLE IN ACUTE CARE

BY DR ANNE-MARIE MAHONEY MACN, LECTURER, LA TROBE UNIVERSITY, ALBURY/WODONGA CAMPUS, VIC
BY ASSOCIATE PROFESSOR DAVID BECKETT, DEPUTY DEAN, GRADUATE SCHOOL OF EDUCATION, UNIVERSITY OF MELBOURNE, VIC


Anne-Marie Mahoney


David Beckett

Is there a problem with nurses' attitudes to the group they are increasingly meeting in wards and units, namely, the older Australian? This was the question posed in our study which was undertaken at a tertiary teaching hospital in Melbourne. For many nurses, working with older people is stressful, not how they envisioned their nursing practice to be, and accordingly, is often described negatively (Courtney, Tong and Walsh 2000; Higgins et al. 2007; Poole 2009).

The aim of this study was to focus on immersion in practice and the impact of immersion on nurses' attitudes to working with older people. This paper provides a brief overview of the study and an impression of the data.

Method

This was an interview-based study, utilising an ethnographic approach and gathered data though the use of semi-structured interviews (Denzin and Lincoln 1993). Fifteen nurses participated in this study. Participants responded to a call for expressions of interest in the organisation's internal newsletter. Written consent was obtained prior to conducting the interviews during work hours. The interviews ranged from 30 minutes to an hour. Two of the participants were in administrative roles and the remainder were employed as clinical nurses, practicing between six months and 30 years.

There were three main research questions:

- What are the attitudes of nurses toward caring for older persons within an acute care setting?
- Can an understanding of the impact of immersion in practice on attitude inform an education model focused on improving care of older persons in acute care?
- Does immersion in practice impact attitudes to working with older people?

Through the interview process and verbal exchange, a shared meaning of experiences and understandings of the research foci were possible. Data obtained from the interviews was coded (pattern coded) and subjected to thematic content analysis (Miles and Huberman 1994; Fereday and Muir-Cochrane 2006). Pattern codes are explanatory or inferential codes that identify emergent themes (Miles and Huberman 1994). Analysis continued until no new themes emerged and saturation was achieved (Lincoln and Guba 1985).

FINDINGS

POINT OF CARE – CLINICAL NURSES' INSIGHTS

Images of older people

There are many stereotypical images of older people within society generally, as well as within the nursing population. The participants were invited to describe their visualisation of an older person and this included physical appearance, degree of function and state of health.

This participant's image showed an overall negativity – one of bodily decline:

Frail and in poor health. That would be my interpretation of old. So not necessarily old in number but old in body, worn out, organ failure, unwell perhaps. A005

I see a physical and psychological element to it. Some people age psychologically faster than others. There's a bit in there about whether people are independent or dependent. There's a bit in there about agility and physical cope-ability. A011

These images were found to have a profound influence on how nurses perceive working with older people and they appear to set up

the relationship that exists between the nurse and the older person.

This participant's image included physical characteristics as well as functionality:

Don't walk so fast, may need a little bit of help. They've got a walking aid, grey whitish hair, no longer the colour that we associate with younger people... wrinkles and wears glasses, needs glasses to see and lives in a nursing home. A002

Following an exploration of images, the concept of interest in working with older people was explored.

Interest in older people

There were common elements to the responses on 'interest', namely the issue of complexity.

Note this participant's comment about complexity:

…it's taken me 30 years to feel confident. Older patients are much more complex than younger patients; you tend to focus on the high functional demands of these patients. A003

The nurses' recognised an interest, through expectations of themselves, that they had a role to play in caring for older people over time. Participants described increasing confidence that also emerged over time. Interest was strongly linked to an ethical stance, where some described a respect for older persons' needs and a requirement to ensure that the dignity of older persons was maintained. Participants spoke of the achievements of older people and of the older person's life experiences.

I have a lot of respect for them [older people] *...what they have achieved and when they get to a stage in life when they are slowly becoming dependent on other people – I don't feel sorry for them...I respect them.* D003

When asked about their confidence working with older people, all of the participants provided animated responses. One spoke about her early career in a nursing home.

I worked in a nursing home from aged fourteen...I love it. Giving the time, being compassionate in terms of caring for the elderly. B002

Role-modelling

Participants spoke about the influence of others on their practice; in particular being influenced by nurses who they described as having a positive influence on their practice. The power and influence of role-modelling was woven into many participants' stories. One participant, a very experienced nurse, discussed role-modelling through a clinical teacher.

I still remember my first clinical teacher… who was very passionate about assisting older people. She had a very positive attitude towards older people and it rubbed off. I would say that a lot of my focus has been shaped by experts in the field that influenced me when I was a new nurse. A011

Other participants spoke about the impact of role models on them, as student nurses and the impression that has assisted in shaping their attitudes to practice.

So much of this (attitudes to older persons) is dependent on the clinical experience and the clinical exposure and people they're working with. It does get back to role models and the people we've worked with. I recall working in a nursing home before I did nursing and I had some lovely people, they were sisters that I worked with, who loved their work and older people. So I enjoyed it too. I found it hard, physically hard but I can still remember the names of some of those people...this goes back to 1970, I remembered what I learned. A011

EMERGENT THEMES

The themes are presented here in-brief. Detailed exploration of the themes is beyond the scope of this article.

Dependence

The theme of dependence was seen as both a positive and a negative for the participants in this study. For example, a negative aspect of dependence was related to the sense of frailty which could lead to a decline in functionality.

Relationality

The notion of relationality is manifest in the reciprocity of benefit to both the patient and the nurse. Nurses expressed a need to have what we would call a relational component to their practice. The majority of the participants experienced a personal reward from the relationship that developed with older people and experienced satisfaction through appreciation of their effort.

Role-modelling

The value of role-modelling and opportunity for reflection was a strong theme. Reflection in this sense, as a social construction rather, than an individual activity. Correlations were determined with the value of mentorship and workplace learning through observation in practice and reflection on practice.

NEXT STEPS

The themes of relationality, role-modelling and dependence have informed the development of a professional development program for nurses at the site of this research project – *Achieving Relational Reflection – Improving care of older people*. Implementation of a professional development program, together with a deeper understanding of the impact of experience on nurses' attitudes to working with older people, provides a way forward for nurses in acute care.

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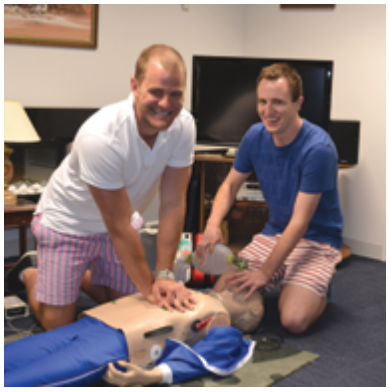
SIMULATED LEARNING IN THE 21ST CENTURY

BY PROFESSOR SALLY WELLARD, PROFESSOR OF NURSING,
SCHOOL OF HEALTH SCIENCES, FACULTY OF HEALTH, FEDERATION UNIVERSITY AUSTRALIA, VIC



Federation University Australia (FedUni) has developed the unique Simulated Home Environment Learning Space (SHELS) for health science students, to simulate a range of real-life conditions that health professionals might encounter in their practice outside of health care institutions. The centre is located at FedUni's School of Health Sciences, at the Mount Helen campus in Victoria.

Usually programs leading to registration for nurses and midwives use skill laboratories that resemble contemporary acute care health settings. This is largely influenced by current curricula that specify a range of required clinical skills students need to gain that can be rehearsed in these spaces.

In today's current health care climate, more and more often nursing, midwifery and allied health students need to learn and think about how to work with and support people's health needs outside of the traditional hospital learning spaces. The delivery of health services is increasingly occurring in the community and presents new challenges for health professionals when working in clients' homes.

These challenges include operating in an environment where you are a guest, negotiating and customising care to meet the specific needs of people in their unique situation. The SHELS provides simulation for these types of challenges.

The SHELS teaching space has a 50 seat auditorium with a direct view into a one bedroom unit. The unit has a glass wall to the audience who can view the ways people use and interact in the space. The unit has a kitchen, bathroom and toilet, bedroom and living room.

The lab shines the spotlight on care of people in their home. Students in the audience can view demonstrations or they can view peers figuring out how to work with people and how to understand how people live, rather than just thinking of giving them care and support in hospital but what actually happens when people leave the predicable environment of the hospital. Stereotypical perceptions of how people might live can be challenged.

The SHELS provides an engaging learning environment where students can, over the three years of their program, be incrementally challenged to work with increasing complexity as their knowledge and practical skills expand. For example, in their first year students will explore their assessment skills by assessing a person, their support systems and the environment. More senior students will build on this assessment and develop customised interventions that meet the specific situation. This requires sophisticated communication skills as well as technical knowledge. Senior students are provided with a rehearsal space for their transition to practice.

The facility also features an ambulance and a sedan in an adjoining room, enabling simulation for manual handling for paramedic and nursing students. Video feed and recording assists in engaging the audience in analysis of scenarios and opportunity to critique and suggest other ways to respond to situations.

There is a wide array of ways people live, but students (and others) often make assumptions about how others live. We aim to disrupt the assumptions students have and assist them in being respectful of the differences they may encounter.

Health professionals need to learn how to navigate and negotiate with people in their homes, but there is very limited access to this type of experience in the field. Therefore, this type of space is a valuable adjunct to the other learning and teaching strategies used in undergraduate health professionals education.

Funding of $950,000 for the laboratory was provided by the Federal Government's Education Investment Fund's Teaching and Learning Capital Fund.

Photos:
Sally Wellard
FedUni student's in the simulated learning space
Simulated learning space

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"POVBESITY":

the relationship between obesity, low socio-economic status and inequity of access to bariatric surgery

BY CASEY LOWDEN-CROOK MACN, REGISTERED NURSE,
ASEPS/HEALTHCARE AUSTRALIA AND ECT COORDINATOR, THE MARIAN CENTRE, PERTH, WA

Casey Lowden-Crook

"During 2012–2013 I conducted a qualitative study to determine if Australian registered nurses had ethical concerns in providing care for patients undergoing bariatric surgery."

Obesity has become a global health issue. Defined as "An excess of body fat that occurs when energy intake exceeds energy expenditure" (McAlpine et al. 2010, p. 305), changes to lifestyle and socioeconomic factors known as 'obesogenic' environments have been identified as contributing factors. Obesogenic describes the influence of the environment and surroundings, opportunities or conditions which can promote obesity in individuals or populations (Swinburn, Egger & Raza 1999). These influences include the availability of fast foods (calorific but nutritionally desolate), limited supermarket access, sedentary lifestyles, long working hours, poor nutrition and a deficit in food preparation education.

As the prevalence of obesity increases globally, so too does the demand for bariatric surgery. The primary intent of bariatric surgery is for the person to lose weight. To achieve this, the structure of the stomach and intestinal tract (malabsorptive procedures) is altered which results in the reduction of the size of the stomach for food intake (restrictive procedures) and absorption of food from the intestinal tract (malabsorptive procedures). The bariatric procedure performed generally reflects the surgeon's preference, health care rebates, body mass index and patient's personal choice. Many physicians promote bariatric surgery as a safe procedure which can result in significant weight loss, thereby reducing obesity co-morbidities and the possibility of premature death. However, there are an array of surgical and anaesthetic complications associated with bariatric surgery which are directly attributable to the fact the patient is obese.

During 2012–2013 I conducted a qualitative study to determine if Australian registered nurses had ethical concerns in providing care for patients undergoing bariatric surgery. The motivation for this study was threefold; the alarming rates of obesity and overweight in Australia, current and predicted (Organisation for Economic Co-operation & Development [OECD] 2010), the increasing prevalence of bariatric surgery (Australian Institute for Health & Welfare [AIHW] 2010) and evidence of ethical concern demonstrated by health professionals involved in bariatric surgery in the US and Europe (AIHW 2003; Camden 2009a, Camden 2009b, Camden 2010; Saarni et al. 2011).

Previous studies which explored the ethical concerns related to bariatric surgery exposed issues such as: the benefit versus burden debate (Camden 2010), the relationship between poverty and obesity (Delpeuch, Maire & Monnier 2009; World Health Organization [WHO] 2011), 'obesogenic' environments (Swinburn, Egger & Raza 1999), medicalisation of obesity (Saarni et al. 2011), education deficits amongst nurses involved in the care of bariatric surgery patients (Ide, Farber & Lautz 2008) and inequity of access (AIHW 2003; Carbonell et al. 2005; Delpeuch, Maire & Monnier 2009).

Ten anaesthetic nurses were recruited to participate in individual interviews. Results from the study showed that the participants did have ethical concerns in relation to the

“Results from the study showed that the participants did have ethical concerns in relation to the access to bariatric surgery. This access was not based on fairness or equity but rather on the patient’s ability to afford private health insurance.”

access to bariatric surgery. This access was not based on fairness or equity but rather on the patient’s ability to afford private health insurance. Thus, those patients had priority over those without private health insurance or the ability to pay for the procedure, who may also have been in desperate need for surgery but with little chance of receiving it.

In Australia between 2000 and 2004, 91.4% of bariatric surgeries were performed in private hospitals (Smith et al. 2008). Despite this inequity of access, the WHO (2011) described obesity as a commonplace condition of the poor and low socio-economic status. The inextricable link between obesity and poverty supports the notion of ‘too poor to be thin’, which refers to obesity as an illness of deprivation. In essence, poor households are stocking up on sugar, starch, oil and other processed foods to provide high energy, low cost meals (Delpeuch Maire & Monnier 2009).

Inequity of access refers to a breach in the ethical principle of justice, which is about the fair distribution of resources (Berglund 2012). Other ethical concerns amongst nurses may include moral indifference, moral uncertainty and moral distress. Moral uncertainty occurs when nurses perceive something as not quite right or when they feel uncomfortable about a situation but cannot establish the root of the problem (Burkhardt & Nathaniel 2008). Internal and external constraints contribute to moral distress, for example when a health professional is perceived to be fully responsible but then constrained from acting in a morally appropriate manner (Freegard 2007). Occurrences of moral concern are common in high stress areas of nursing care (emergency departments, intensive care units and operating theatres) and may result in nurse burnout and attrition and a negative impact on patient care.

Given the current trends in obesity and the trajectory of bariatric surgery, educators need to include bariatric surgery into the nursing curriculum and staff development programs. Furthermore, ethical issues such as equity of access, informed consent and resource distribution need to be discussed in consideration of this relatively new surgery.

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ACN GRANTS AND AWARDS ARE NOW OPEN

2013 ACN Grants and Awards winners at last year's National Nursing Forum

MARGARET Y WINNING SCHOLARSHIP

Two scholarships are available for study in 2015. Each scholarship valued at $10,000 is available for postgraduate nursing students at Queensland University of Technology.

Applicants must be a Fellow or Member of ACN.

THE SUL STUART-FRASER SCHOLARSHIP

Two scholarships are available for registered nurses wishing to undertake ACN's Graduate Certificate in Perioperative Nursing. The scholarship is a legacy of Matron Harriet 'Sul' Stuart Fraser who had a long and distinguished nursing career in New South Wales.

Applicants must be a Fellow or Member of ACN.

LAURA SAUNDERSON AGED CARE NURSING FUND SCHOLARSHIPS

Funding is available for nurses working in aged care within Western Australia to undertake continuing education activities. Multiple scholarships are available; funding amount is related to the activity. The fund was established to honour the person and accomplishments of the late Laura Saunderson, a pioneer of aged care nursing in Western Australia. Applicants must be nursing in aged care in Western Australia.

It is not necessary to be a Member of ACN to apply.

EMERGING NURSE LEADER PROGRAM

The Emerging Nurse Leader (ENL) Program is a three-year initiative that provides participating students and nurses with a unique opportunity to develop leadership skills that can be applied throughout their nursing careers. Each year this award is offered to five outstanding nurse leaders of the future.

The ENL Program identifies pre-registration nursing students who have demonstrated a commitment to leadership in nursing through their involvement in student activities, community activities, student representation and/or other involvement in the advancement of the nursing profession.

It is not necessary to be a Member of ACN to apply.

As a member of ACN you can have a positive impact on the future of nursing by participating – or supporting a colleague – through the ACN's ENL Program. The Program offers a unique opportunity to develop leadership skills that can be applied throughout your nursing career.

Maryanne Craker MACN, ACN Board Director

FOR MORE INFORMATION

Visit: **www.acn.edu.au/enl** (ENL Program) or **www.acn.edu.au/grants_and_awards** (all other grants)

or email **ACNgrants@acn.edu.au** to learn more.

Applications close 29 June 2014.

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Over the past few months we have farewelled several key nurse leaders and members. Judith Cornell, Barbara Hayes and Sue Nagy all contributed significantly to shaping and influencing the Australian nursing profession. All three were visionary leaders and their legacies will live on for many generations to come.

JUDITH CORNELL AM FACN

Judith Cornell undertook her general nursing at St George Hospital and her midwifery at Brisbane Women's Hospital. Judith travelled with Rosemary Cohen to the USA and Canada where Judith wasn't able to get work in the intensive care unit so she took on a role in the operating room. A decision we are all very grateful for as Judith then went on to devote her nursing life to Operating Room Nursing at Prince of Wales, St George, Sydney, Westmead and Prince Henry/Prince of Wales Group Hospitals – Judith also played an integral role with the NSW Operating Theatre Association (OTA).

Judith took up the position as Executive Director of the then NSW College of Nursing from 1986 to 1996; a memorable time. Judith was feared by her staff at times but she always had their best interests at heart and those of their students and NSW health patients.

Highlights of her operating room days include:

- her days at her precious Westmead Hospital including walking around in the building phase in a 'hard hat' terrorising everyone into doing everything she wanted for her operating suite
- involvement in the establishment of what is now the Australian College of Operating Room Nurses
- first chairperson of the Australian Confederation of Operating Room Nurses
- bringing surgeons, anaesthetists and others to heel very quickly, especially in cahoots with a mate of hers Professor Ross Holland
- annual OTA conferences and trade displays with all our nursing and trade colleagues
- her editorship of the OTA *Forceps* journal
- her terms on the OTA Council including a number as President; Judith was awarded life membership in 1987.

Judith was highly regarded by health politicians from both sides of parliament – even though she served it up to them whenever necessary. I vividly remember one such occasion when I was the President of the NSW College of Nursing and the then Minister wanted a forward copy of a major research report that was to be released by the College. The College Council, on Judith's recommendation, regretfully declined the request. At a Council meeting the agenda had to be suspended four times while I had to explain to the Minister's Chief of Staff why the Council had taken this decision. In the end I had to adjourn the meeting so Judith could march herself off to Parliament House to talk through the issues; needless to say it was a very stimulating meeting!

Even after Judith's so called 'retirement' in 1996 she continued with her work and established, with Ross Holland, and some other passionate personalities, the Society for the Preservation of Artefacts of Surgery and Medicine or SPASM as it is so aptly called. Judith also led the consolidation and further development of the most remarkable archival collection at The College of Nursing and, most recently, the Australian College of Nursing. Judith was very protective of the archives and was fortunate in that all successive Chief Executives allowed her the freedom to preserve nursings' heritage.

While she had a lifelong commitment to the NSW College of Nursing her commitment to the profession transcended that. I know that Judith was thrilled when The College of Nursing and Royal College *of* Nursing, *Australia* (RCNA) finally unified in 2012.

Judith was recognised for her contribution to nursing practice and education with an award in the General Division of the Order of Australia in 1995 – well deserved and applauded by all.

Throughout her career her husband, Tony, was right beside her. Nothing was too much trouble for him to do for her and he was very supportive of all her activities. Judith had a wonderful sense of loyalty to her family and friends. She could say whatever she liked about them, but just let anyone else try. She was particularly close to her nephews and nieces and followed their development with great interest and pride.

In closing, a very appropriate quote from Albert Pike that Debra Thoms included in the ACN Vale.

What we have done for ourselves alone dies with us; what we have done for others and the world remains and is immortal.

Rest in peace and goodbye my very special friend.

Extract from Judith's Eulogy delivered by Judith Meppem PSM FACN, 22 April 2014

On a personal note, I would like to say that I will deeply miss the counsel and wisdom of Judith – a long-time colleague and friend of mine. The depth of her influence on the nursing profession was evidenced by those in attendance at her funeral in April. Along with Judith's family, friends and colleagues we were joined by the Hon. Dr Andrew Refshauge (Former NSW Deputy Premier and Minister for Health and Aboriginal Affairs), Dr Rosemary Bryant (Commonwealth Chief Nurse and Midwifery Officer), Karen Crawshaw (PSM Deputy Director-General NSW Health) and Susan Pearce MACN (Chief Nursing and Midwifery Officer, NSW Health).

Debra Thoms FACN (DLF), ACN CEO

PROFESSOR BARBARA HAYES FACN (DLF)

Professor Barbara Hayes, Emeritus Professor of Nursing, James Cook University and ACN Distinguished Life Fellow, demonstrated an outstanding commitment to the nursing profession.

Barbara's early career was firmly grounded in the practice disciplines of general nursing, midwifery and psychiatric nursing. Barbara's interest in mental health was later combined with a passionate concern for the health of women and children, particularly among the Indigenous populations of Queensland.

Barbara's nursing ability was recognised early when she received the Gold Medal for Nursing Excellence each year of her undergraduate program at St. Vincent's Hospital, Sydney from 1960 to 1964. Thus began a lifelong commitment to excellence in all aspects of her nursing and a pursuit of personal development and she set about preparing herself for the full and fruitful career that followed.

Barbara was one of a few nurses selected to receive the W.K. Kellogg Australian Nursing Fellowship that enabled her study in the United States of America. She also won a grant from the Nurses Memorial Centre, Melbourne and a scholarship from the Centaur War Nurses Memorial Fund which supported her to complete her studies.

In October 1989 Barbara was appointed the foundation Professor of Nursing at the James Cook University, School of Nursing Sciences. As Professor of Nursing she shaped education for nurses that focussed on Indigenous, rural and remote health issues in the context of life in the tropics. Under her guidance the School of Nursing developed special interest areas in mental health, women's health, especially of Indigenous women and children, ethics, evidence for practice, knowledge transfer and development of nursing theory. In particular, the development of culturally sensitive Aboriginal nursing was a special interest and also the study of barriers, cultural and otherwise, to the provision of health care for Indigenous women and their children. Barbara was appointed Emeritus Professor of Nursing at James Cook University in 2007.

Barbara's research interests were reflected in her many and varied publications and presentations, especially as Orator for the Inaugural Sister Elizabeth Kenny Oration in 1991 and RCNA Patricia Chomley Oration in 1997.

Barbara was held in high esteem by her colleagues, in academic circles and the broader nursing community. Barbara's scholarship, wisdom, wit and boundless enthusiasm will be remembered by many.

ACN would like to acknowledge Barbara's distinguished career, and her lifelong commitment to nursing excellence in practice, teaching and research.

RCNA Distinguished Life Fellow citation, 2008

DR SUE NAGY FACN

Dr Sue Nagy was a Life Member of the Council of Children's Nurses as well as a Fellow of ACN. Sue was a leading paediatric nurse academic, and the foundation Chair in Paediatric Nursing at the Children's Hospital Westmead and the University of Western Sydney (1995–2005), and prior to this, an academic at the University of Technology, Sydney. Sue was also a member of the RCNA *Collegian* Editorial Board from 1997 to July 2001.

Sue made an outstanding contribution to paediatric and child health nursing research and scholarship, through all facets of academic and professional life, including research, supervision, mentorship, teaching and publication.

The Council of Children's Nurses (CCN), CCN newsletter, 12 February 2014

INTRODUCING ACN'S 2014 ORATOR

Professor Roianne West

ACN is pleased to announce our 2014 Orator – Professor Roianne West. Professor West has been invited to be this year's Orator due to her outstanding contributions to the nursing profession.

Professor West will deliver her Oration at a special ceremony which will also include the Investiture of Fellows, on 2 November. The annual ACN Oration provides the profession with the opportunity to recognise exceptional contributors to the profession, such as Professor West, and have the opportunity to be both challenged and inspired.

Born and raised in Kalkadoon on her mother's country in North-West Queensland, Professor West has over 20 years of experience in Indigenous health. Her PhD explored factors that impact on successful completions in higher education by Indigenous Australians.

Professor West was Nursing Director for Indigenous Health, and her team won a statewide equity award for delivering outstanding health services and enriching diversity throughout the workplace for their work on an Indigenous Bachelor of Midwifery program. She recently commenced a new role as the first Professor of Indigenous Health and Workforce Development – a joint position between Townsville Hospital and Health Service and Griffith University, School of Nursing and Midwifery.

Professor West's expertise in nursing and midwifery workforce development including recruitment, education and training of Indigenous nurses and midwives and building the cultural capability of non-Indigenous nurses and midwives means her Oration will address national nursing priorities.

THE NATIONAL NURSING FORUM

Meet our keynotes

AN INVITATION

ACN invites our members and the wider nursing community to the heart of Adelaide city to participate in the National Nursing Forum at the Adelaide Convention Centre from 2–4 November 2014. Our theme, ***Staying ahead of the game***, focusses on how to, individually and as a profession, adapt and thrive in a complex, changing and often challenging health environment.

Program highlights:

- Thought provoking keynote and invited speakers.
- Informative concurrent sessions.
- New workshop sessions providing nurses with the tools to implement key concepts in the workplace.
- A members' only day offering the opportunity to network with other members and identify key priorities for ACN over the next twelve months.
- A 'Fashions on the Field' inspired dinner.
- High tea in celebration of the Melbourne Cup.

Early bird registration closes **7 July 2014**: register today at **www.acnevents.edu.au/Forum**

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KEYNOTE PRESENTER **DR KEITH SUTER**

Dr Keith Suter is a global futurist, thought leader, author and media personality, recognised and highly respected in the areas of social policy and foreign affairs. He holds three doctorates and can frequently be heard discussing politics and international affairs on radio and television.

Keith is a regular on Seven's *Sunrise* program and is often asked for comment on the ABC, Sky News and Macquarie Live News. One of the world's great thinkers and exemplary communicators Keith has extensive experience in speaking, lecturing and teaching.

He has also been a member of the prestigious Club of Rome since 1993. The Club is "an informal association of independent leading personalities from politics, business and science, men and women who are long-term thinkers interested in contributing in a systemic interdisciplinary and holistic manner to a better world. The Club of Rome members share a common concern for the future of humanity and the planet." The club has only 100 members, with Mikhail Gorbachev amongst them.

Keith will present on Tuesday at the National Nursing Forum on the topic *What are the drivers of change and how can we respond?*

KEYNOTE PRESENTER **FIONA O'LOUGHLIN**

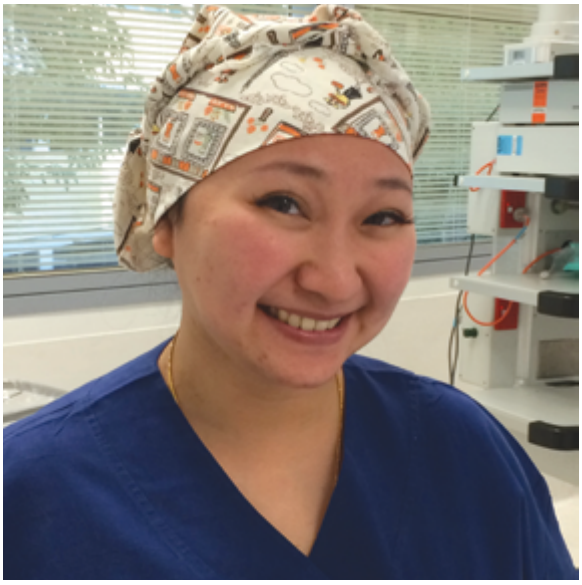
Fiona O'Loughlin is one of the most successful and popular Australian comedians working today; in addition to her stellar comedy career she is also a mother to five children. In 2009 Fiona's contribution to the Australian cultural landscape was recognised when she was awarded the Northern Territory's Australian of the Year honour.

Hailing from Alice Springs, the growth of her career is even more impressive when you take into account the geographic isolation of her home town. To have risen to become one of the most sought after stand-up comedians in the world is truly an incredible feat, and an indisputable testament to her tenacity and talent.

Fiona's moving and often hilarious presentation will motivate you – through her recounting the story of fighting back against nay-sayers and adversity, setting realistic goals, understanding disappointment and taking nothing for granted. Fiona will present on Tuesday at the National Nursing Forum on the topic *Beating the odds to stay ahead of the game*.

BRIDGING THE GAP

Profile: Luciana Lo MACN, Clinical Nurse Specialist, Macquarie University Hospital, NSW



In January 2012, Luciana Lo MACN became a student at the ACN. An overseas registered nurse (RN) from Malaysia, she was keen to move into the Australian nursing workforce and undertook the Assessment of Competence (AOC) course. Having successfully completed the course, Luciana gained nurse registration with the NMBA. She then obtained a position as an RN at Macquarie University Hospital. Eager to continue her studies and progress her career, less than a year later she returned to ACN and successfully completed a Graduate Certificate in Perioperative Nursing. Luciana talked to us about her experiences of studying and working in Australia.

Tell us a bit about your nursing background.

I started my nursing career with a scholarship for a Diploma in Nursing in Malaysia. Those three years of undergraduate hospital training saw the start of my RN career. I worked for two years in Malaysia in theatres and also had a rotation for six months to the wards. At the end of the two years, I was accepted to the University of Technology Sydney and completed my Masters in Nursing in one and a half years. After which, I underwent a conversion program with ACN to obtain my registration in Australia. After working for a year at a private hospital in Sydney, I was awarded the Sul Stuart-Fraser scholarship from ACN and completed my Graduate Certificate in Perioperative Nursing last year.

What inspired you to choose nursing?

All I knew when I went into nursing was that I wanted to use scientific knowledge to care for my patients; I initially thought it was a doctor's job. After my first placement in the wards I realised that everything I ever imagined myself doing could be fulfilled by a career in nursing. This included understanding the disease process and applying that knowledge when caring for the sick patient in hospital. I also had a great passion for the human body and how it miraculously works.

Have you faced any challenges transitioning to nursing in Australia?

I would say the major challenge coming from overseas would be my understanding of the Australian health system. Although, once you have a grasp of the differences between the state and national funding and the private and public system, you are well on your way to be able to provide holistic and high quality patient care. The fundamentals of nursing never change wherever you go in the world. All we nurses need is a heart that cares.

What have been the major differences in nursing overseas and nursing here?

The major difference is the opportunity

for further learning. That was probably my biggest motivation to move to Sydney. In Malaysia, there is a lack of access to journals and current research papers. I feel that with the availability of these journals in Australia there is so much more room for learning and improvement. I often find myself reading other papers on topics that interest me while searching for information for an assignment.

What do you love most about nursing?

The ability to bridge the gap between science and the patient's needs. I also love nursing because of the satisfaction of saving lives and making a difference in someone's life. Not many people can say they assist in saving lives daily.

How long have you worked in perioperative nursing? What has your experience been?

I have been in perioperative nursing since I graduated in 2007. Four clinical years in total because I took some time off to pursue my postgraduate studies. I continually love my job with each passing day and each exciting surgery. I am still in awe of the human body and how advancement in technology and our understanding of the human body enables us to assist the body to heal itself and restore normal function.

I especially love that multidisciplinary teamwork is crucial for the success of a surgical procedure. In surgery, there is that level of communication amongst the surgeons, scrub and scout nurse, anaesthetists and operating assistants that I have not found in other areas of nursing. I think in 10 years' time I will still see myself in the perioperative environment, in one way or another.

What are some of the highlights?

I think my most recent memorable procedure that I had the privilege to be a part of would be a liver resection plus cholecystectomy plus ultra-low anterior resection. I had to accommodate two very different surgeons, combine upper and lower GI knowledge and provide high quality care to the patient. It required a lot more planning than a straight-forward procedure would. Maintaining the sterility was especially challenging in this procedure because of the positioning of the patient and the placement of the various machines used for the procedure.

My highlight is always being able to see the human anatomy in real-life 3D and 2D images. I remind myself that not every nurse gets to have a live anatomy class every day. I am truly privileged.

What are some unique nursing challenges in your specialty area?

Surgery requires the coordination of various parties. A simple surgical procedure requires not only the team members in the room but also other departments to ensure the surgical procedure is successful. These include the sterilising unit where precision is paramount in ensuring that the patient is operated on with sterile instruments. The success of a surgical procedure is dependent on many parties.

Another unique challenge is the growing population of experienced nurses retiring and fewer younger nurses replacing them. The availability of skilled younger nurses is low in all areas of nursing but I think more so in the perioperative environment. The perioperative environment requires specific skills and further understanding of technology and machines that are often not taught in undergraduate programs. Time is needed to train the younger nurses to learn how to scrub for cases and understand how to operate the machines used in surgeries. There is a lack of passing on of knowledge to the next generation of nurses, therefore impeding training. I remember reading an article that said "the perioperative environment is an environment where they eat their young".

Another factor is that the younger nurses are not exposed to the perioperative environment. The perioperative environment is often closed and not widely advertised; therefore, it is not able to spark interests in younger nurses to come onboard the perioperative field.

What was your overall impression of the ACN AOC course?

The AOC assisted me and other overseas nurses in adapting to the health environment of Australia. It provides very practical, up-to-date information on what the right processes are. I am now able to provide knowledge to Australian nurses in my workplace on the changes that NSW Health has implemented as a result of the program. The four weeks in-class and four weeks practical provides a balanced input of both knowledge and hands on experience. I am still reaping the benefits of the program today.

How have you found the difference between studying face-to-face and studying online?

I have not found a huge difference between these two study modes. It was the part-time and full-time dynamics that had an impact on me. In AOC, I was in classes for four weeks doing face-to-face. My body and brain was prepared for that and digested the information well. When I did my Graduate Certificate with ACN, I was working full-time as well as studying part-time. Having to switch my brain from work to studying in a matter of hours was definitely a challenge. Having said that, the age of technology is upon us and I am more inclined towards online learning because I am able to complete my studies in the comfort of my own home without having to travel.

What advice would you give anyone who was considering postgraduate study?

Just go for it! No matter what your age or circumstance, it's always worth the hard work. I have met many married nurses, parents, grandparents, working full-time or working part-time, managers or RNs in all of my postgraduate studies and they all get through it and benefit from it. There is never an expiration date for knowledge.

Why do you think it's important to belong to a national professional organisation like ACN?

I believe that knowledge and information should be shared. Professional organisations encourage the sharing of information therefore are able to advance nursing as a profession. Professional organisations also allow discussions of current issues and provide support to all nurses. It fosters knowledge sharing and unity amongst nurses.

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July 2014

NSW

16 – 18 Clinical assessment: models of assessment NSW Health
RN/EN | Three days | 21 CPD hours | Tamworth

18 Understanding dementia NSW Health
RN/EN | One day | 7 CPD hours | Burwood

22 Day surgery nursing
RN/EN | One day | 7 CPD hours | Burwood

24 – 25 Wound management NSW Health
RN/EN | Two days | 14 CPD hours | Burwood

31 Clinical assessment of the older person
RN/EN | One day | 7 CPD hours | Burwood

TAS

19 Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Launceston

SA

24 – 25 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Port Augusta

QLD

31 X-ray interpretation
RN | One day | 7 CPD hours | Brisbane

August 2014

NSW

14 – 15 Wound management
RN/EN | Two days | 14 CPD hours | Nowra

21 – 22 Rehabilitation nursing NSW Health
RN/EN | Two days | 14 CPD hours | Goulburn

22 Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Burwood

27 – 29 Clinical assessment: models of assessment NSW Health
RN/EN | Three days | 21 CPD hours | Burwood

28 – 29 Diabetes management and current guidelines
RN/EN | Two days | 14 CPD hours | Burwood

29 Immunisation update
RN | One day | 7 CPD hours | Burwood

SA

21 – 22 Diabetes management and current guidelines
RN/EN | Two days | 14 CPD hours | Adelaide

WA

28 – 29 Wound management
RN/EN | Two days | 14 CPD hours | Perth

QLD

28 – 29 Wound management
RN/EN | Two days | 14 CPD hours | Brisbane

September 2014

NSW

3 – 5 Education techniques for nurses NSW Health
RN/CNS/CNE/CNC | Three days | 21 CPD hours | Burwood

4 – 5 Wound management
RN/EN | Two days | 14 CPD hours | Burwood

10 – 12 Understanding mental health NSW Health
RN/EN | Three days | 21 CPD hours | Wagga Wagga

11 – 12 The deteriorating patient: clinical decision making NSW Health
RN/EN | Two days | 14 CPD hours | Burwood

18 – 19 Wound management NSW Health
RN/EN | Two days | 14 CPD hours | Griffith

19 Introduction to clinical facilitation
RN | One day | 7 CPD hours | Burwood

QLD

12 Immunisation update
RN | One day | 7 CPD hours | Brisbane

18 – 19 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Bundaberg

VIC

12 Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Ballarat

WA

17 – 18 Pain management
RN/EN | Two days | 14 CPD hours | Perth

ACT

25 – 26 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Canberra

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