# thehive

#1 AUTUMN 2013

Australian College of **Nursing**

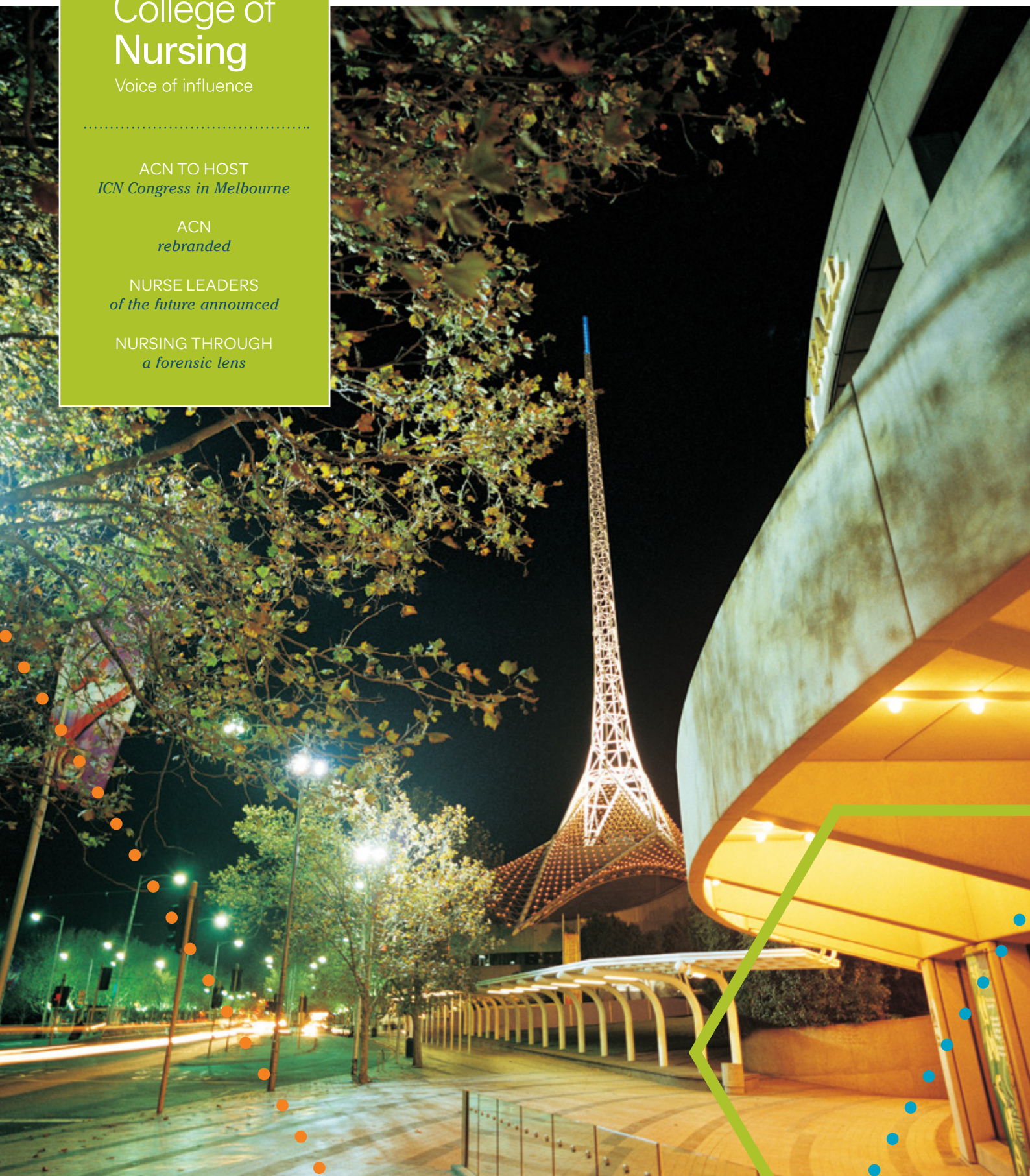
Voice of influence

ACN TO HOST
*ICN Congress in Melbourne*

ACN
*rebranded*

NURSE LEADERS
*of the future announced*

NURSING THROUGH
*a forensic lens*



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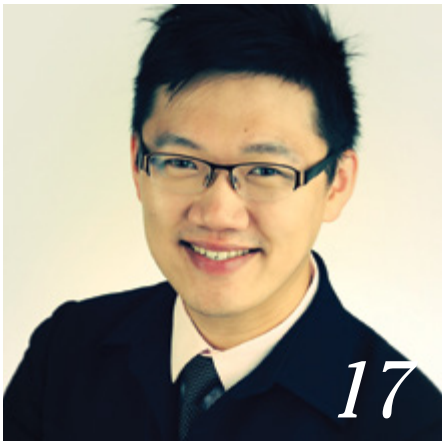





## PUBLISHING DETAILS

Distributed quarterly

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ABN 48 154 924 642

**Printing**
Paragon Printers

**Get published** with the Australian College of Nursing
Send your submissions to publications@rcna.org.au

To view submission guidelines visit www.acn.edu.au

**Advertise** with the Australian College of Nursing. Send your enquiries to advertising@rcna.org.au




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MELBOURNE
AUSTRALIA

## COVER STORY



## REGULAR



## SPECIAL FEATURES



## OPINION



## FEATURES

# WELCOME FROM THE CEO

ADJUNCT PROFESSOR **DEBRA THOMS** FACN (DLF)

*“The Hive presents us with one of the many opportunities unification has brought us; a blank canvas with which we can begin afresh.”*

It’s my great delight to present our new Australian College of Nursing (ACN) quarterly print publication to you, our members. *The Hive* presents us with one of the many opportunities unification has brought us; a blank canvas with which we can begin afresh. This new publication has drawn on many elements of its predecessors (*Connections* and *Nursing.Aust*), but has also taken the opportunity for change and growth. As with many aspects of unification, I sincerely believe that *The Hive* will be greater than the sum of its two parts.

In one of our special features, *ACN rebranded*, I provide you with a snap-shot of how our new ‘look’ came about. This article highlights how the rebranding strategy was much more than ‘just a new logo’; it’s a new direction, a new philosophy, a new beginning for ACN.

An integral part of this ‘new beginning’ is the election of the new ACN Board of Directors. The ACN Transitional Board has done an exceptional job in developing a strong foundation on which ACN can grow, and now is the ideal time for the handover process to begin. Transitional Board members are eligible to stand for election to the new Board if they so choose. Additional detail around the election process will be provided to all members over the coming months.

In this inaugural edition we are also pleased to introduce to you the ACN Emerging Nurse Leaders (ENLs) for 2013. They will participate in a five year program to develop today’s nursing students into the leaders of tomorrow. Following on from the precedent set by our 2012 ENL winners, this year’s candidates are exceptional. I look forward to following their nursing journey over the coming years.

We feature a variety of articles in this edition of *The Hive*. We look at advancements in technology and the changing needs of Australian health care. *Technological change in the workplace: reflecting upon Personally Controlled Electronic Health Records* acknowledges the progressive, technological outlook for the Australian health care landscape. In a contrasting article we follow Jody Bonar as she shares her inspiring story of working in Cambodia with little technology, very limited medical equipment and ‘leaping chickens’. The challenges she faces and her problem solving responses to these challenges foster a sense of pride for the ‘hands-on’ attitude of our profession.

Finally, in our cover story we are also taking a closer look at this year’s 25th Quadrennial International Council of Nurse’s Congress, which is taking place in Melbourne in May. ACN is proud to be the Australian national nurses association to co-host the Congress; a Congress that was last held in Australia over 50 years ago. As you can see this is a ‘once in a career’ opportunity and I would strongly encourage all of our members to register for this event.

I hope you enjoy reading this first issue of *The Hive* and we look forward to drawing upon the expertise and narrative of our members in future editions. ■

## IN MEMORY

It was with great sadness that we learnt of the passing of ACN member, Greg Boddy. We were fortunate to feature an article, *Synchronicity and the nurse practitioner,* by Greg in the September 2012 edition of *Connections*.

In this article Greg spoke of his love of nursing, in particular his role as a nurse practitioner. ACN extends its condolences to Greg’s family, friends and colleagues.

# Grow your career by joining ACN!

*ACN offers a variety of activities that are of value to you, at the different stages of your career.*

- Be supported with your continuing professional development and ongoing education via ACN conferences, events and through our Life Long Learning Program (3LP).
- You will stay up-to-date with critical issues affecting the nursing profession through ACN publications, media releases and member-based communications. A chance to be published and recognised by peers is available too!
- You can gain career advancement and knowledge through our many and varied national networking opportunities.
- Grants and awards accessible to members can support you in undertaking research, projects and professional development.
- As a member you receive discounts on insurance, accommodation, publications and educational courses, these savings alone pay for your membership!

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**QLD Expo**
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**NSW Expo**
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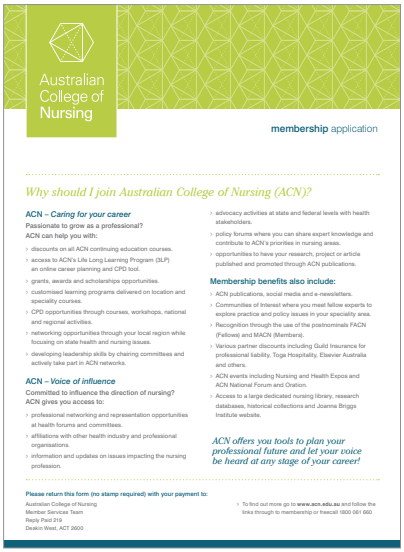


# ACN REBRANDED

BY ADJUNCT PROFESSOR **DEBRA THOMS** FACN (DLF)
CHIEF EXECUTIVE OFFICER, ACN

*Since unification Australian College of Nursing (ACN) has worked tirelessly to combine the positive attributes of The College of Nursing (TCoN) and Royal College of Nursing, Australia (RCNA), to provide our members with a consolidated and strengthened professional nursing organisation. Much of this work has been in effect 'behind the scenes.' A key step in this establishment work has been the development of the ACN branding strategy.*

This strategy takes into account the many aspects of the newly formed organisation and the needs of the nurses ACN represents. I have to say that although the branding process has been challenging on many levels it has also been an exciting and dynamic time for us all, and we've learnt so much. We've learnt that the most important part of our brand is not the logo – it's about reaching out and connecting with our members.

Initial work commenced on the rebranding long before I even joined ACN. The previous CEOs, Tracey Osmond and Debra Cerasa, along with each college's respective board and staff, gathered in-depth feedback from their membership bases to discover what they valued about their college and what they felt could be improved. Over the past eight months the ACN Transitional Board and I, along with staff from both the Canberra and Sydney offices, were able to progress this analysis. We all understood the importance of this exercise, so engaged the services of an external branding agency, Step Change Marketing, who were instrumental in assisting us in establishing our core value propositions to build a new look, direction and focus for ACN.

The first step in rebranding ACN was a qualitative study of the nursing sector's priorities, behaviours, desires and unmet needs. Nursing focus groups from regional and metropolitan areas were asked to provide feedback on what affects their professional life and their choices around organisational memberships.

*“We’ve learnt that the most important part of our brand is not the logo – it’s about reaching out and connecting with our members.”*

Australian College of Nursing

It was encouraging to learn there were many things we do well. Staff members were considered helpful, friendly and timely in their responses to enquiries. The quality of education was highly regarded, senior nurses had a strong appreciation of the representative functions of ACN, and the content of publications was considered informative and of a high quality. Most importantly, we learnt what we can improve on – greater local engagement, wider dispersion of educational opportunities, and a more visible profile.

The insights from this study were not only useful for the branding strategy but will be instrumental over the coming years in creating better products and services, for our members, our students and the nurses we represent.

Next, a group of internal stakeholders across membership, policy and representation, education, marketing and more, met for a full-day strategic workshop to review existing marketing, messaging, products and services. A key outcome from this workshop was the development of two distinct taglines (see breakout box). These were developed with reflection on the needs of our members and the role ACN will play, and continue to play in representing the nursing profession.

With all the background work complete we were able to move onto the creative process – the look and feel of our brand. Using the defined strategy from the business growth plan, the agency began the process of creating the

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## VOICE OF INFLUENCE

*ACN is able to provide the nursing expertise and experience required when government departments and key stakeholders are deciding the future of health. We ensure that nurses have a say in how the profession is shaped and its place in the health care system. We provide a platform for nurse experts. ACN is the voice of influence, with our network encompassing the key decision makers and influencers in nursing.*

*Whether it’s our academics, senior nurses, organisational leaders or retired nurses turned mentors, we involve the major players that aren’t represented anywhere else.*

*We have the people that can make change happen, so whether you are looking to be heard or evoke change in the health sector, ACN should be your first point of call.*

## CARING FOR YOUR CAREER

*We believe that each and every nurse in Australia should have the opportunity to grow their career and further our profession. ACN provides nurses with tools to plan their career pathway, educational supports, opportunities to network and participate in professional forums and a range of benefits that stem from being part of a profession that is moving in the right direction.*

*“As nurses, we can achieve further recognition and success in our careers if we understand that we’re part of the greater profession; a profession that needs a strong influential voice – we at ACN believe we are this voice of influence.”*

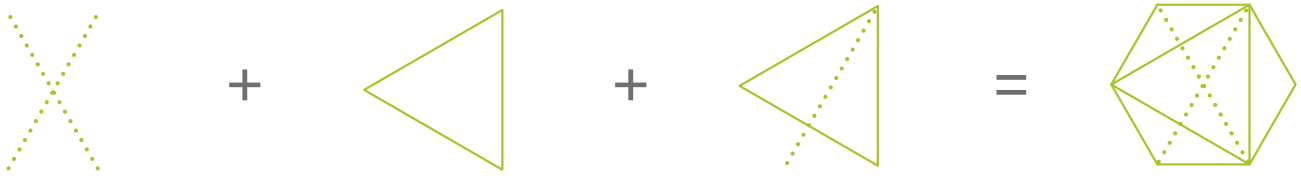
## ACN LOGO DEVELOPMENT

*Intersection point*
MEMBERSHIP

*Amplification of voice*
POLICY

*Support to move forward*
EDUCATION

*Community*
AUSTRALIAN COLLEGE OF NURSING



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ACN visualisation. With input from a Board Director, the Executive Leadership Team, marketing and our graphic designer, the new brand for ACN was born, and on presentation to the full Board approved/endorsed.

As mentioned previously, considerable feedback from our members has been gathered over the past 18 months. With this feedback ACN has taken the opportunity to strengthen many elements of our business.

One of these elements is our member engagement strategy and how we can best harness the contribution of members. The new engagement structure will acknowledge the different levels of interest, varying expectations and involvement of our members. We believe this restructure will lead to greater membership opportunities, especially for those members located outside metropolitan and larger regional areas. As you would be well aware health jurisdictions are facing many challenges, some of these challenges are unique while others are shared. From a policy point of view, this enhanced membership engagement model will better equip us to effectively advocate to governments on the needs and requirements of nurses across the country. Further information about this restructure will be made available to all members over the coming months.

Another development will be the expansion of our education portfolio. Taking on-board member feedback we will be offering our educational courses to a wider audience across the country; through the expansion of our online programs and more access to face-to-face learning.

As was the case under TCoN and RCNA, ACN will continue to thrive upon the contribution and experience of our members. *The Hive* and new-look *NurseClick* (our monthly interactive e-magazine) will offer members regular opportunities to submit articles to share their stories – stories that focus on new research findings, innovations in the nursing profession, updates from our regions, personal profiles and opinion pieces.

As you can see, many elements have led to the creation of not only a new ‘visual’ look and feel for ACN but also a new vision and identity. The branding process has allowed ACN to move forward with a clear direction and improved awareness of how ACN can best serve its members, the wider nurse community and the health care needs of all Australians. As nurses, we can achieve further recognition and success in our careers if we understand that we’re part of the greater profession; a profession that needs a strong influential voice – we at ACN believe we are this voice of influence. ■

# NURSE LEADERS OF THE FUTURE ANNOUNCED

Emerging Nurse Leader top 10 finalists

The Emerging Nurse Leader (ENL) program is a yearly award offered to five outstanding nurse leaders of the future. The program was first launched in 2011 as an initiative of The College of Nursing (TCoN). With the unification of TCoN and Royal College *of* Nursing, *Australia*, ACN has now proudly taken over this initiative.

The vision of the ENL program came from many years of discussion and feedback from senior leaders within the profession. These conversations told us that there are many experienced leaders projected to retire over the next decade. Furthermore, generational experts tell us that there are high numbers of early career nurses leaving the profession. The ENL program looks to address these workforce issues by creating a platform that recognises potential and assists to cultivate future leaders. John Kemsley-Brown, ACN Executive Manager of Education, and one of the architects of the program says, "The ENL initiative allows ACN to develop nurse leaders who have the skill, ability and opportunity to influence and change health care policy through active participation. It is hoped, that in time, this will provide the nursing profession with a generation that will lead us into the next decade and beyond."

In October 2012, the Museum of Sydney provided the perfect backdrop for the announcement of the ACN ENL winners for 2013. ACN was honoured to have the NSW Minister for Health, The Hon. Jillian Skinner, revealed the five successful recipients. Congratulations to Carol Mudford, Natalie Sharp, Renee Callender, Paula Lambert and Georgia Corrie – the 2013 ENL recipients.

The evening also afforded the wonderful opportunity to acknowledge, not only the achievements of the five ENL winners, but those of all 10 finalists. ACN's Chief Executive Officer, Adjunct Professor Debra Thoms was encouraged by the depth of talent and potential displayed by all the shortlisted applicants. "This year's candidates were of a very high standard, and I am thrilled to accept the five successful applicants into the program. I believe I can say, with great confidence, that the future of Australian nursing is looking bright," Professor Thoms said. All finalists demonstrated a range of personal and professional characteristics in-line with the ENL program selection criteria: leadership amongst their peers; commitment to the nursing profession; creativity and innovation; involvement in student and community activities; courage and confidence.

John Kemsley-Brown said, "As leaders we know that to truly be creative, courageous and confident we need to support and encourage those that are to come after us. This is our legacy." ACN is delighted to be a part of this 'legacy' and we look forward to working with and following the careers of our 2013 ENL winners.

*ACN would like to acknowledge and thank HIP, The Co-op Bookshop and CM Health; our ENL program corporate sponsors for their ongoing support.*

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Ken Whitton – Health Industry Plan Business Development Manager
Olivia Ryan – ACN Business Development Manager
Ross Bernays – Health Industry Plan CEO


ACN CEO, Adjunct Professor Debra Thoms

## THE 2013 ENL WINNERS

CAROL MUDFORD
Charles Sturt University (CSU), Victoria

Carol's vision is to see equality in health care delivery across Australia's population.

Carol has been both the beneficiary and deliverer of the services provided by an organisation called Mittagundi, a not-for-profit (NFP) community managed outdoor education centre in the high country of Victoria. Carol became involved with Mittagundi as a seventeen year old student and, having benefitted from the Mittagundi programs, became involved as a volunteer leader, helping other young people to find their way in life.

Currently sitting on the Executive of CSU's Multidisciplinary Albury Rural Health Club, Carol is a driving force in spreading the word about the importance of nursing in rural and remote locations and has set up the group's social media platforms to get the message out faster.

NATALIE SHARP
University of Notre Dame, Western Australia

Natalie's background as a personal carer has provided her with great insight and a love of caring for the elderly. She is now a passionate advocate for improving the quality of aged care in Australia.

Natalie understands the importance of bridging the gap between the generations, both in nursing and in life. Embracing technology in health care practices, whilst not losing sight of the basics is something that Natalie is keen to have an impact on.

As a student mentor, Natalie has thrown herself into university life and has completed a volunteer clinical placement in Vietnam, requiring her to raise thousands of dollars and take on a leadership role in the team she travelled with.

RENEE CALLENDER
University of Wollongong, New South Wales

Renee understands the need for creativity and innovation in our health care system; in a profession where resources are often constrained, and improved standards of care are demanded, creativity and innovation are essential.

Renee also appreciates the sensitive nature of some of the relationships that exist within the spectrum of health care service delivery and is intent on exploring ways to effect change in the level of equitable care delivered to patients, but also equity in the support and opportunities offered to all members of the health care team.

Renee is an active member of St John's Ambulance, involved in organising the University Ball and she has plans to volunteer overseas as a health worker through an NFP.

Laurie Bickhoff (2012 ENL), Renee Callender, Georgia Corrie, Elyse Taylor (2012 ENL), NSW Minister for Health, The Hon. Jillian Skinner, ACN President Carmen Morgan, Adjunct Professor Debra Thoms, Paula Lambert, Carol Mudford, Natalie Sharp and Sherrie Lee (2012 ENL)

PAULA LAMBERT
University of the Sunshine Coast, Queensland

Improving health care and patient contact through the leveraged use of technology is an area which Paula would like to see enhanced, but only after research and due diligence has been undertaken.

Paula is keen to improve the student experience and find ways to improve learning outcomes. Paula is a participant in the university's Peer Note Taking Program, sharing her notes with other students who have difficulties.

As a former leader in St Johns Ambulance Cadets, Paula took on various roles including committee representation, paramedic activities and the running of cadet skill sessions. Paula is now a volunteer for Street Angels, an organisation that provides community assistance for people in need on Friday and Saturday nights in and around night clubs and bars on the Sunshine Coast.

GEORGIA CORRIE
Australian Catholic University, Victoria

Spending nine days with the Anangu people in 2009 started a pre-occupation with improving the health of Indigenous Australians. Georgia believes that the implementation of a core unit across all nursing courses, incorporating Indigenous Australian health, could assist in addressing the health care needs of Indigenous Australians.

Georgia also advocates that the role of nurses in Indigenous Australian communities would be best adapted to incorporate principles that embrace Indigenous culture and beliefs, and in a way that facilitates communication in the language of the community.

Georgia's community involvement includes association with the Australian Catholic University (Melbourne Campus) Nursing Club, St John's Ambulance and Oxfam's *Close The Gap* Campaign.

## ACN CONGRATULATES THE 10 EMERGING NURSE LEADER FINALISTS FOR 2013:

*Carol Mudford of Charles Sturt University, Victoria*

*Natalie Sharp of the University of Notre Dame, Western Australia*

*Renee Callender of the University of Wollongong, New South Wales*

*Paula Lambert of the University of the Sunshine Coast, Queensland*

*Georgie Corrie of the Australian Catholic University, Victoria*

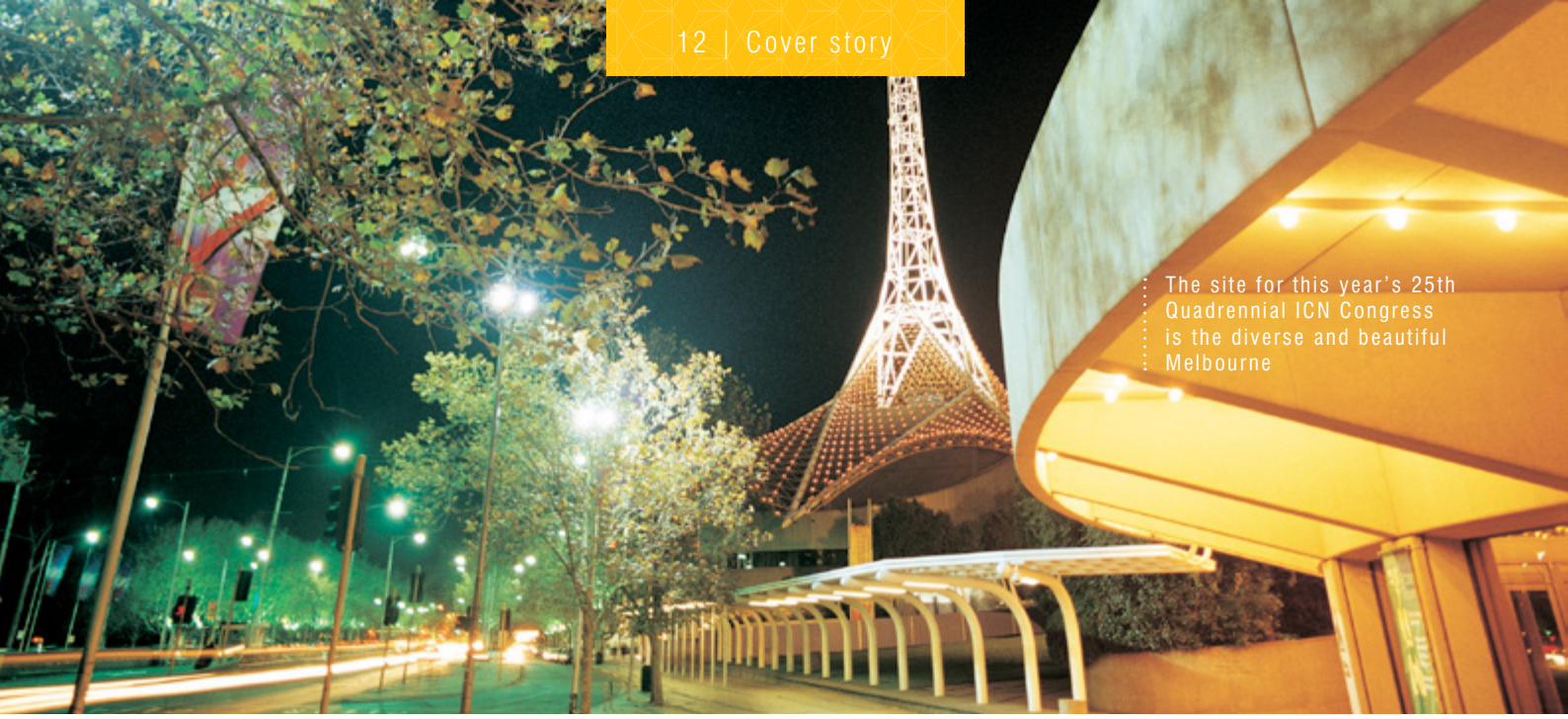
*Melissa Childs of Flinders University, Adelaide*

*Gemma Powell of Curtin University, Western Australia*

*Joanna Yun Kyoung Um of the University of Technology, New South Wales*

*Nezhmi Newmann of the Queensland University of Technology, Queensland*

*Jan Gregor of Charles Darwin University, Northern Territory*



The site for this year's 25th Quadrennial ICN Congress is the diverse and beautiful Melbourne

# ACN TO HOST ICN CONGRESS IN MELBOURNE

Australian College of Nursing (ACN) is hosting the International Council of Nurses (ICN) 25th Quadrennial Congress in Melbourne from 18–23 May 2013. The opportunity to host the Congress was secured following a highly competitive international bidding process conducted by ICN in 2007. As the host organisation, ACN has been working with ICN in promoting the event nationally and internationally and is confident in the strong delegate interest in the Congress, with up to 5000 nurses expected to attend.

For many nurses in Australia the Congress is a once in a life time opportunity to attend an international nursing event that attracts a wide range of international speakers and delegates. Many nurses draw great inspiration from attending an ICN Congress. It has been over 50 years since Australia last hosted the Congress, so this year's event presents Australian nurses with a wonderful and rare opportunity; the chance to network, learn, debate, inspire, and be inspired by nurses from around the globe.

Australian nurses have played significant roles within ICN since its inception in 1899. Miss Susan McGahey, once the Matron of the Royal Prince Alfred Hospital, Sydney NSW, became the president of ICN in 1904 after she worked to co-found the Australasian Trained Nurses Association; now the Australian Nursing Federation. Olive Anstey, from WA, served as ICN President from 1977–81 and was a member of the Florence Nightingale Committee, which was committed to raising funds to support scholarships for nurses to undertake post basic education. We are honoured to have Dr Rosemary Bryant FACN, Chief Nurse and Midwifery Officer, Department of Health and Ageing and the current ICN President, preside over this year's Congress.

The Congress is a part of ICN's role to advance the profession of nursing and health through the development of policies, partnerships, advocacy, leadership, networks and special projects. As many as 75 countries have contributed to the program and 35 countries will be represented at this year's conference through over 55 speakers.

The Congress will run over five days and a myriad of events will be presented throughout this period: entertaining opening and closing ceremonies, where attending countries will parade in traditional dress; professional site visits for international delegates offering the opportunity to learn about Australian nursing practice and health care systems; the announcement of the prestigious Florence Nightingale International Foundation Achievement Award and Christiane Reimann Prize recipients; a Student Assembly Forum; presentations and workshops from a range of international perspectives; and the chance for Australian nurses to showcase our nursing profession to an international audience.

Whilst the Congress program provides a great enticement for both Australian and international nurses to seriously consider their attendance the Congress location of Melbourne, a culturally rich and dynamic city, offers visitors a range of social activities and is the ideal backdrop for ICN's Congress.

ACN is providing a range of opportunities for nurses in Australia to participate in the Congress. Nurses across Australia have been encouraged to submit abstracts for presentation throughout the Congress and 200 Australian nurses have also accepted the invitation to be abstract reviewers for the scientific program. There has also been the opportunity for a range of health services to showcase their nursing services through a professional visits program available to visitors attending the Congress. ACN will also offer the chance for nurses to work at the Congress as volunteers and student nurses will be able to participate in an international student assembly held at the Congress.

It will be many years before the Congress is held again in Australia so ACN is very pleased to have secured the Congress and looks forward to many nurses across Australia joining their international colleagues to profile, discuss and further nursing initiatives, services and policy development. ■


ICN 25th Quadrennial Congress

**18–23 MAY 2013** | MELBOURNE AUSTRALIA

***Equity and Access to Health Care***

# DON'T FORGET TO REGISTER

The International Council of Nurses 25th Quadrennial Congress **– the largest international nursing event is coming to Australia in May 2013**

For further information about the Congress or to register please visit **www.icn2013.ch**

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AUSTRALIA

# TECHNOLOGICAL CHANGE IN THE WORKPLACE:

## Reflecting upon Personally Controlled Electronic Health Records

BY DAVID MACKLYN MACN, NURSE UNIT MANAGER, MATER HEALTH SERVICES, QLD

My working life started in 1978 when I took a job in a bank in Central Queensland. A year after I started, our branch received the latest in technology – a machine that printed entries onto passbooks. It seems primitive now but it was cutting edge at the time and made significant improvements to work processes; remember, this was long before ATMs, PCs, internet banking and mobile phones. I sometimes stop to reflect on the changes I have experienced and try to apply that extent of technological change to the health care world. As change is definitely on the way, just what will change with the introduction of Personally Controlled Electronic Health Records (PCEHRs)?

My own nursing job is already changing. My hospital introduced Wave 1 PCEHR for maternity patients and new born babies in 2012 (NEHTA, 2012). The project allows private specialists, GPs, and private and public hospitals to access an electronic record. The nurses and midwives have access to the online record too, meaning there is less paper in the 'chart' and more readily available information on the computer. Although not yet a complete online medical record, the plan is for that to be a reality in the near future. When giving clinical handover we use information from both the chart and the PCEHR. Clinical alerts and admission details are in the PCEHR.

With the advent of PCEHR, if a patient were to present to a doctor's office anywhere in Australia, that doctor will soon have access to the patient's complete medical history including their personal GP's notes, previous test results, immunisations, allergies, medical reports, X-rays and access to all information from any medical specialist the patient may have seen in the past (Stokes, 2010; Donovan, 2010). Of course, these can be seen as benefits for both the patient and the clinician as it can give an accurate and more complete picture to the clinician (O'Brien, 2000). It should be noted that it is the consumer who has control over the information in their record and who is allowed access to that information.

Another benefit for the clinician is that the information is presented legibly and in a logical manner. Discipline-specific information can be found easily, clinical notes can be added to the record and the multiple collection, duplication and recording of information would no longer occur (O'Brien, 2000). PCEHRs can reduce medical errors, costs, increase accuracy, reliability and integrity in the health care system and this is why there is currently such effort being put into their development (Gupta & Murtaza, 2009). When it comes to reducing medical errors a PCEHR could have built-in decision support modules, provide links to internet-based information and have automatic warning systems to stop a clinician from ordering inappropriate drug doses or drugs that are incompatible with a patient's current medications. Records no longer need to be transported across hospitals or copied and sent to other locations. More than one clinician can be reading and adding data to the record at any one time (Tan, 2005).

PCEHRs enable access to financial information. The system could store billing information, automatically charge the patient and insurer, or access any government rebate scheme so that the clinician receives full and immediate payment for services. Abuse of government payment systems could also be negated. Private health insurance payments and refunds could be processed quickly and transparently (Tan, 2005).

As information systems and PCEHRs become truly entrenched into a national system benefits will be realised for the community as a whole. Vast amounts of data, existing in a standardised electronic format, can be mined for research purposes and whole communities and populations can be studied easily. Electronically stored and coded data can be divided up and massaged in numerous ways allowing researchers to look at the information in

*“Discipline-specific information can be found easily, clinical notes can be added to the record easily and the multiple collection, duplication and recording of information would no longer occur.”*

David Macklyn

innovative ways (Tan, 2005). This can result in the development of public health initiatives that can lead to significant improvements in health delivery and better ways of measuring the outcomes, quality and efficiency of any new health system programs (Tan, 2005; O’Brien, 2000).

Donovan (2010) says that the consumer would have access to their entire health record, at any time, and in one place, as all health providers would be adding their notes to one centralised record. The system would also provide a list of all medications, tests and procedures previously administered. Another ancillary benefit would be the internet infrastructure that would have to be in place for the PCEHRs to be readily available to all citizens across Australia. The high-speed internet access created for the PCEHR would also have flow-on effects for all rural and remote communities that did not have that access before the existence of the PCEHRs. Communities, individuals and businesses would have better access to all manner of information, not just health information and this would lead to better community outcomes (Donovan, 2010). Expanding broadband services will increase health outcomes by giving access to emergency services, enabling remote consultations (allowing more accurate and timely diagnoses) and even perhaps greater ability to monitor the elderly and unwell population (Telemedicine, 2011).

Every Australian that is enrolled with Medicare or holds a Department of Veterans Affairs Treatment Card has already been allocated an Individual Health Identifier number. In the 2010/11 Federal Budget, $466.7 million was allocated to developing Australia’s PCEHRs (NEHTA, 2012). In 2012 a further $233.7 million was committed to the PCEHR system (Plibersek, 2012) and Wave 1 of that program is already in place across many test-sites around Australia (NEHTA, 2012).

The PCEHR is no longer something for the future: the future is now. Already my workplace has changed and we are only into the first stage of PCEHR implementation. What will things look like in, say, ten years? Will we be holding hand-held devices with access to the entire patient record by the bedside including pathology results and medication records? Will the GP and specialist notes all be there? Will our discharge summaries be instantly available to the patient, GP, health insurers and hospital administrators? My experience of technological change in a different industry tells me that the health care world will be a very different place and I find that an exciting prospect. ■


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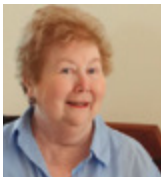
Article acknowledgement: Mark Smith FACN, Chair, Community and Primary Health Care Faculty Advisory Committee

# I LIVE IN A COMMUNITY, NOT IN A HOSPITAL

BY CATHERINE WILKIN FACN, COMMUNITY AND PRIMARY HEALTH CARE FACULTY ADVISORY COMMITTEE MEMBER, NURSE ACADEMIC, MONASH UNIVERSITY, VIC

*"Personal responsibility for care is a caveat of primary health care, but if the client is shut out of the system, through control of information, this limits appropriate personal actions."*



Recently, I have had bouts of acute illness which required that I be admitted to rural and metropolitan hospitals in Victoria. I was extremely grateful for the care I received but gladly left the acute facility to continue my recovery at home. However, a feature of my care was the 'silo' effect of relevant health care services who were helping me deal with my problems (some of which were iatrogenic). This meant there was little communication between the various facilities. As a result, I was left to make the links as and when I could. My diary of my many appointments, and my handbag have become a mobile medical resource, which I share with the various facilities as I access them, since often requests for opinions by referring physicians focus on physical problems but do not acknowledge other referrals or the outcomes. The focus of care is almost entirely on my physical health with little emphasis on my social needs and none related to my psychological needs.

This experience has been made more difficult because I was cared for in a number of acute care facilities and then referred on to my local GP, who did not know me. I was newly arrived in the community and had little knowledge of services or the people attached to those services. Community health services, that could have provided me with support, were not notified that I was at home. Friends and family visited to help when and where they could. By far the most helpful, constant and supportive person was a new neighbour whom I had met only twice previously.

My experience involved a complex number of symptoms, each of which was addressed in isolation by the many physicians to whom I was referred. The referring physician was the person who received the report and occasionally a copy was also given to me but only if I requested it; it's my belief that this should change. This information relates to me and so belongs to me. I am the expert on my condition and how it is evolving and a copy should automatically be given to the client (me) – I should not have to ask for it. Personal responsibility for care is a caveat of primary health care, but if the client is shut out of the system, through control of information, this limits appropriate personal actions. It should be noted that some clients may be distressed by the results of such assessments and they should be afforded the option to 'opt-out' of such sharing of information.

In my role as an academic, a concurrent (and ongoing) discussion has revolved around proposed changes to undergraduate nursing curriculums to better reflect the government's health care reform agenda and the change in government policy to primary health care, away from a medical model of care. This will, it is hoped, reflect stronger horizontal system wide links between services and in-turn better patient care. The reality is that since medical surgical care must, by its nature, be limited to a linear model and is still usually classified as primary care, it does not make a systematic difference. This needs to change, and some primary carers are trying to make what they do more systematic in approach. In my experience, current acute care services are not supportive of this and so it is up to individuals, or individual hospitals to make the links away from this silo effect.

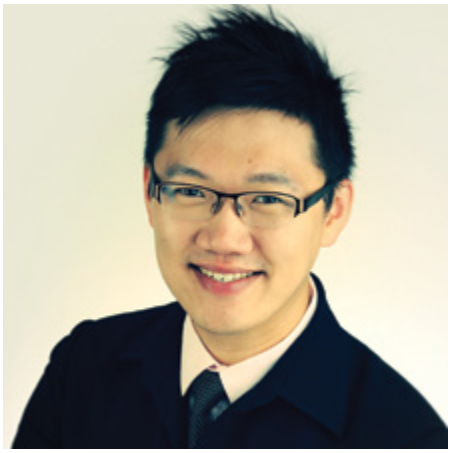
Since nurses are by far the largest group of health care professionals the proposed changes in evolving undergraduate nursing curricula should see a trickle-down effect to other people employed in the public health system. Primary health care is taught in other medical and paramedical courses but this is seen too often as a context based mode of care. It is acknowledged that we cannot afford a wasted opportunity to make changes in behaviour or usage patterns in health. Educating health care consumers as well as health care students should be the role of all nurses. Educating nurses to value and use a non-medical surgical, non-acute model of care is going to be a challenge, given the current funding pressures. Unless it starts from day one in their education and has a focus on valuing the process, what happened to me as a patient will continue to happen, but to people within the community with less knowledge of how the system works and what expectations the consumer should have. ■

Article acknowledgement: Mark Smith FACN, Chair, Community and Primary Health Care Faculty Advisory Committee

# THE PATIENT'S VOICE DRIVING NURSING RESEARCH:

## A double-blind randomised controlled trial of MooGoo Udder Cream® versus aqueous cream for managing radiation dermatitis in cancer patients

BY RAYMOND JAVAN CHAN FACN, NURSE RESEARCHER
JENNIFER MANN, REGISTERED NURSE
ROYAL BRISBANE AND WOMEN'S HOSPITAL, QLD



*"Patients with radiation dermatitis can experience skin dryness, itching, discomfort, pain, warmth and burning."*

Radiation dermatitis is a very common side effect experienced by cancer patients undergoing radiotherapy. Patients with radiation dermatitis can experience skin dryness, itching, discomfort, pain, warmth and burning. Unfortunately, evidence for management strategies is lacking, with the majority of research studies being low quality and reporting negative results (Chan et al. 2012a).

A number of patients receiving radiation treatment at the Royal Brisbane and Women's Hospital have been reporting the benefits of using the MooGoo Udder Cream® to their doctors and nurses. The MooGoo Udder Cream® is a natural product that was first founded by an Australian who adapted a cream used in dairy farms to help a family member with a skin problem. The dairy version of 'udder cream' was designed to heal cows' udders and keep them in good condition for milking. Many patients are now purchasing the cream for this condition. However, there is not yet any evidence supporting this practice.

With the anecdotal evidence, the researchers at Cancer Care Services, Royal Brisbane and Women's Hospital are now conducting a double-blind randomised controlled trial to evaluate this cream against aqueous cream, which is the current standard of practice (Chan et al. 2012b). It is expected that this trial will recruit 172 patients undergoing radiotherapy for breast, lung and head and neck cancer. This study will provide new information for the management of this distressing problem. ■

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Pictured above Raymond Chan

# CHICKENS IN THE TREES AND OTHER THINGS I LEARNT IN SOUTH EAST ASIA

BY JODY BONAR MACN, NURSE UNIT MANAGER, BRISBANE PRIVATE HOSPITAL, QLD

Jody Bonar with her patient

Who knew that chickens in Cambodia liked to spend equal amounts of time in the trees as they do scavenging amongst the dirt and rubbish? I certainly had no idea until, while staying with the family of a friend in Battambang, I saw for myself a chicken leap up into the tree and apparently take an afternoon nap.

The chicken is just one of the many things that I've seen while living in Siem Reap, Cambodia. I moved to Cambodia in January 2012, initially for a year, to run a free health clinic for a non-government organisation called New Hope Cambodia. In 2000 I had worked in the mountains of Lebanon and I had wanted to do something similar as the experience, although incredibly challenging, without a doubt made me a better, more resilient nurse and human.

My background is largely in surgical nursing. I currently work for Brisbane Private Hospital as the Nurse Unit Manager of their general surgical and paediatric ward. My Director of Nursing and General Manager could not have been more supportive and graciously allowed me the time off. The staff I work with are brilliant clinicians and helped make the decision easier, as I knew the ward would continue its great service provision without me.

The New Hope clinic is situated in the middle of one of the poorest villages in Siem Reap, and consequently the access to health care for these people is also poor. The clinic is staffed by a Khmer army medic, a Khmer student nurse, a Filipino trained graduate nurse, drivers to take people to the hospital, a counsellor, a phlebotomist, translators and yours truly. A newly graduated Khmer doctor also joined the team and there are plans to employ a trained pharmacist. The team is growing and I'm happy to say, so are the skills of all the staff.

Typically our day starts at 8.00 am and, depending on the rain and if we have a volunteer doctor, we see up to 50 patients until we break for lunch at 11.00 am. In Cambodia everyone enjoys a protracted lunch during the hottest part of the day, so the clinic is closed until two in the afternoon. In the morning session we also do a round at the hospital and visit any of our clinic patients who required admission. During our visit we check on their condition to ensure they are improving, we give them a small amount of money with which to buy food and we also provide them with essentials like sleeping mats, mosquito nets, towels and sarongs as required.

I tend to schedule our home visits in the afternoons when it is generally quieter in the clinic. We see patients that are too sick or frail to come into the clinic. Mostly it is a family member who asks us to make a home visit but on occasion the Outreach staff (the social work arm of New Hope) tell us about a person or family in the village or the jungle area that needs to be seen. We arrange to visit them and take care of them, as best we can, with limited resources. I've lost count of the number of wounds I've dressed while people lay on unimaginably uncomfortable bamboo slat beds in their little crumbling organic matter houses.

As people don't have the income to pay for health care and the fact that the local hospital is poorly funded and incredibly busy, we see conditions like burns and rashes that have been allowed to fester for unacceptably long periods of time. Poor sanitation, using the river that runs through the village as the toilet, bath and also the kitchen sink, lead to outbreaks of typhoid and other gut bugs. Dengue fever, malaria, chikungunya, tuberculosis (TB), hepatitis, HIV and diabetes are also very common amongst

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*Jody has returned to Siem Reap, Cambodia and continues to work with New Hope.*

*New Hope provides free health care, education and training to families as well as assisting with social issues like domestic violence and basic housing and access to clean water. To find out more, please visit the New Hope Cambodia website.*

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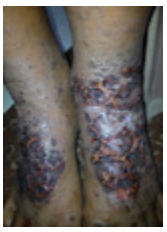
the people we care for. At one stage we were dealing with an outbreak of Ebola Virus 71 that had reportedly killed over 70 children throughout the country.

Each day in the clinic I've learnt something new and stretched my poor brain and heart to, what feels like, beyond their capacity. I struggled when a volunteer doctor asked me to arrange a brain CT ($150 worth) for an 88 year old lady with headache, dizziness, blurry vision and a history of TB. He's thinking that maybe she has some TB scarring in her brain and I'm thinking that she is an elderly lady who works planting rice, has a prominent kyphosis and probably doesn't drink enough water during the 38 degree days. I suggested some rehydration solutions, some simple analgesia for the headache and a review in a week with a view to an eye test if no improvement. I don't really know if the doctor's request would be considered reasonable in a western clinical setting and this is where my heart and brain battle.

I also struggle with the fact that we cannot access treatments that back in Brisbane we take for granted. There is nowhere in the entire province of Siem Reap where you can obtain an ultrasound guided drainage of an abscess. Not even the international hospital can perform this procedure; they recommend either making the six hour bus journey to Phnom Penh or popping over to Bangkok. I can't change the health care system in Siem Reap but our small clinic is effecting change for many people and that makes my heart and brain happy.

Probably the most significant thing that I've learnt while being in Cambodia is that there are a lot of people in my life who love to talk about being supportive, and then there are the people who don't talk, they just get on and show their support. Without this latter group of people there is no-way I would have been able to achieve all I have throughout my now, continuing time in Siem Reap. My colleagues from my ward in Brisbane are incredible and the donations they've sent truly saved some lives; both the patients and I are exceptionally grateful. ■

## CASE STUDY ONE



An 11 year old girl with a similar condition

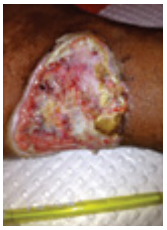
*An elderly man came to the clinic one day with what can only be described as tree bark all over the tops of his feet. Between his toes the bark was so thick that you couldn't move his toes individually; he almost had webbed feet. He'd had this condition for more than five years and had seen doctors previously but his feet just continued to get worse.*

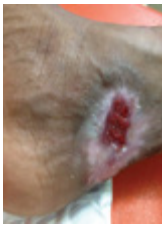
*When I first saw his feet I had to have a little sit down so I could try and come up with a treatment plan – this wasn't a straight-forward surgical wound I was dealing with. I decided that there was no point in using the topical antifungal cream until you could actually see some skin that might start to absorb the cream. So I spent almost two hours soaking his feet and then chipping away the 'bark' to reveal some nice pink skin. This lovely man and I had a standing date each day where I would soak, chip, moisturise and then medicate his feet. He loved it.*

*One particular day I was still out doing our hospital rounds when he arrived. One of our fabulous volunteers decided to offer him some coffee while he waited and proceeded to buy him a latte from our training restaurant. Obviously he was delighted with this kindness and on subsequent visits while having his feet bathed he would ask if he could have a coffee.*

*After only a couple of weeks his feet were virtually unrecognisable. He had this lovely pink, soft skin with only the smallest of patches of infection. Our hard work and his diligence in attending clinic and maintaining our regime on the weekends, as well as a new pair of thongs gave this man his feet back. After just his second treatment with me, he told me that for the first time in many years he was able to get a full night's sleep without burning pain in his feet repeatedly waking him up.*

## CASE STUDY TWO





The healing process

*I don't have a great deal of experience with burns, so when a very sick looking 17 year old boy was brought in with a burn that was already 20 days old, I was completely out of my depth. My first instinct was to send him immediately to hospital for surgical debridement, skin graft and IV antibiotics but on mentioning this to both the patient and his father, the fear in their faces grew exponentially. Apparently when the burn first happened, courtesy of a motorbike, he went to the local hospital where it was bandaged and he was sent home. By the time he could get to our clinic after the Khmer New Year holiday, he had a terribly swollen, cellulitic foot and was clinically very unwell, but the worst was still yet to be revealed. When I took the bandage off to see the burn, it made me feel as sick as the poor kid. He had a burn that was around 14 cm in diameter on the inner aspect of his right ankle. The burn was covered in a thick leathery scab of sorts, which was just floating on top of a pool of offensive fluid.*

*After the first week of treating this burn, we were finally able to see the base and found that he had exposed tendon and still some necrotic tissue. I am happy to say that at the time of writing this article, we had been treating him for seven weeks and the wound had granulated up and was less than 5 cm in diameter. Needless to say we were all elated at the progress.*

# NEUROSURGERY IN PARKINSON'S

BY MARY JONES MACN, MOVEMENT DISORDERS AND PARKINSON'S NURSE CONSULTANT, VIC

Functional neurosurgery in movement disorders is becoming, increasingly, a management strategy for people with Parkinson's disease. Often drug treatments, which may have been successful for a considerable time, become more unreliable with fluctuations in Parkinson's symptoms that isolate a person and impact on their ability to work and participate in life. The impact on partners and families is also significant.

## HISTORY

Surgical intervention for Parkinson's was first performed in the 1940s using lesioning of the thalamus. For several years it was widely performed as the only really useful management tool for Parkinson's; at that time there was no medical treatment available. In 1968 Dr. Cotzias introduced a clinically practical form of levodopa to replace the declining supply of dopamine in the patient's brain and the apparent need for Parkinson's surgery declined.

Interest was revived in the 1990s for people experiencing side effects of levodopa therapy and again lesioning was used. With better imaging techniques more targeted choices were available, depending on the symptoms seen in patients. Early in the development of stereotactic lesioning surgery it was noted the neurostimulation used to pinpoint the target reduced Parkinsonian tremor. From these observations stimulation devices were developed and used as an alternative to ablation of a targeted area of the brain.

In 1993 Dr Alim Benabid in France placed the first permanent subthalamic nucleus stimulator in a patient with Parkinson's.

Today deep brain stimulation (DBS) is the most frequently used treatment for surgical management of Parkinson's. It is considered relatively safe, does not destroy an area of the brain, it can be reversed and is adjustable as the Parkinson's progresses.

As Parkinson's patients have complex needs, and are considering a procedure which is daunting and will require long term specialist care, the level of support required is considerable. It was this need that led to the role of a specialist nurse experienced in the management of DBS; both pre and post operation.

It is estimated that 5–10% of people with Parkinson's will benefit from surgery. However, in young onset patients it may be as high as 50–60%. Unfortunately many patients, who would benefit from surgery, are not referred to a specialist for assessment of their suitability or they are referred too late. The role of DBS is still seen by many as a last stage treatment when, in fact, it should be performed before irreversible symptoms such as poor balance, falls, freezing or cognitive changes develop (Colosimo & Stacy, 2012).

## THE SPECIALIST DEEP BRAIN STIMULATION NURSE IN AUSTRALIA

In Australia the role of the DBS nurse has only recently been addressed and there are now five nurses working in private practices with neurologists. Their main role is to assist with the identification of suitable people for the surgery, to educate and support the patient and family through the procedure, and to assist with the long-term management and programming of the device. The benefit to the patient is access to a clinician with expertise and time to perform the complex programming and a support that they can access readily to receive help and advice.

For the neurologist it assists with managing the intense programming that occurs in the early stages of the procedure immediately post operation and with the less intensive but necessary regular reviews for the rest of the patient's life.

Placing the leads in the precise position in the brain is critical and the clinician programmer has to decide which of four electrodes on each lead requires activation in a monopolar or bipolar configuration, how many amps are required and at what rate and speed. The process is complex and requires time to work. It may take several programming sessions to adjust the settings initially and as the Parkinson's progresses, further changes will be made over time. Research shows that, "the mean total time spent programming the stimulator and assessing these patients ranged from 18.0–36.2 hours per patient" in the first year (Hunka, et al. 2005). For a neurologist seeing 40 or more new DBS patients a year this would amount to 720–1440 hours in a year or 18–36 weeks a year, seeing new patients only.

At present there is no formal DBS specific training for nurses. However, excellent knowledge of Parkinson's symptoms, awareness of the potential of DBS and education and support from the neurologist and the companies who market the products, enables the nurses to manipulate very good outcomes. "Programming is 30% physical science, 30% listening and observing, 30% clinical movement disorders training, and 10% creative thinking (Greenberg)."

For patients the outcomes from DBS are life changing. Melissa* describes some of the emotions experienced...

*“It is estimated that 5–10% of people with Parkinson’s will benefit from surgery however, in young onset patients it may be as high as 50–60%.”*

*They turned on the electrodes on the operating table. The feeling was like a wave breaking on the beach. My whole body just relaxed and it felt wonderful.*

*I realised that this neuro-stimulator had an immediate effect, unlike drugs, which take time to get into the bloodstream.*

*In the following couple of weeks, I reduced the drugs from 27 tablets a day to four! I had no continuous injection of apo-morphine! And ... I am ‘on’ all the time!*

*Suffice to say that this is an absolute miracle and I feel my body clock has gone back at least 10 years! I would recommend the operation thoroughly!*

For the nurse specialist the rewards from seeing a previously semi-dependant person whose quality of life is seriously compromised are priceless. This surgery is described as life changing for the patient and it truly is. They still have a progressive condition but they have wound the clock back. Who wouldn’t like to do that when confronted with a progressive neurological condition. ■

Article acknowledgement: Karen O’Maley MACN, Member, Movement Disorders and Parkinson’s Nurses Faculty Advisory Committee

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**Name has been changed to maintain privacy.*

# BURN PAIN, PSYCHOSOCIAL DISTURBANCES AND DELIRIUM:

## The challenges of burns nursing

BY JAMES BONNAMY MACN, REGISTERED NURSE, ALFRED HEALTH, VIC

*"Burns care requires a multidisciplinary team of clinicians to meet the patient's needs, and help enable the burn injured patient to recover to their greatest potential."*

Caring for a burns patient is immensely challenging. Recent advances in treatments and therapies have resulted in greater survival rates, however, burn injuries still evoke strong emotional responses in both lay persons and health professionals who are confronted by the "spectre of pain, deformity, and potential death" associated with a severe burn injury (Herndon, 2007, 9). This article highlights some of the unique challenges nurses face, in particular, managing burn pain, psychosocial disturbances and delirium associated with a severe burn injury.

As a burns nurse, the challenge is to provide expert clinical care for the physical injuries while also supporting the psychosocial needs of the patient and their family. Burns care requires a multidisciplinary team of clinicians to meet the patient's needs, and help enable the burn injured patient to recover to their greatest potential. The recovery from a severe burn injury is relatively slow, may be intensely painful and complicated by psychosocial disturbances. Nurses, who represent the largest clinician group and provide 24 hour patient care, are central to the coordination and provision of care and are ideally placed to holistically care for the physical and psychological needs of burn injured patients (Herndon, 2007).

A burn injured patient not only experiences one of the most intense and prolonged forms of pain (Summer et al. 2007), but they also face the constant threat of sepsis, a prolonged hospitalisation and their survival can be encumbered by disfigurement and disability. The management of burn pain is a never ending challenge for burns nurses owing to the 'day-to-day' and 'hour-to-hour' task of managing background, procedural and breakthrough pain (Choiniere et al. 1989). Patients with burn pain not only withstand background pain associated with the initial injury but also endure pain associated with routine burn care. If poorly managed it can reduce compliance with dressing change regimes, result in reluctance to participate in rehabilitation activities and is thought to contribute to long-term sensory complications including chronic pain states (Richardson & Mustard, 2009).

Burns nurses must assess and quantify pain effectively and utilise a range of both pharmacological and non-pharmacological approaches to ameliorate burn pain. Understanding and advocating for multi-modal and individualised analgesic regimes is integral. Improvements in therapeutic management have resulted in use of adjuvant analgesic agents to complement existing therapies including antidepressants, methadone and nerve stabilisers. Although effective analgesia is vital to burn pain management, non-pharmacological means of attenuating pain are also engaged. Instead of dry removal of wound dressings that may have adhered to the wound bed, a specialised bath is available that enables dressings to be soaked from the patient, thus reducing the pain associated with re-dressing burn wounds. The use of music may also be employed during the bath

James Bonnamy

to decrease anxiety and maximise patient comfort.

An equally challenging aspect of burns nursing is managing a patient's psychosocial well-being and potential delirium. Pre-existing psychological disorders, illicit substance use, alcohol intoxication and risk-taking behaviour are often linked to the aetiology of the burn injury and may continue to pose care challenges, with the burns patient experiencing feelings of guilt or regret over the event (Grobmyer et al. 1996). The burns nurse role, therefore, involves an element of counselling as they help the patient address the issues surrounding their injury.

Acute delirium can also result following a burn injury, the causes of which are multifactorial and include altered sleep states, post-traumatic stress symptoms, electrolyte imbalances and sepsis. Pre-existing psychological illness, illicit substance use and alcohol abuse can also put the burns patient at increased risk of developing delirium (Herndon, 2007). It is not uncommon for burn injured patients to develop an altered conscious state, misinterpret their surroundings, misidentify people and experience auditory and visual hallucinations. The impact of alterations in conscious state, perception and cognition can be so frightening that some burns patients attempt traumatic removal of wound dressings and may harm freshly harvested and grafted skin. For the family, the behaviours exhibited by burn patients with delirium are understandably distressing, and they also require ongoing education and support from the nurse and other members of the clinical team.

Burns nursing is a unique nursing specialty which presents an abundance of challenges for nurses and the multidisciplinary team. Managing the pain caused by a burn injury is significant and a constant challenge.

Equally, rapid detection and response to symptoms of altered psychosocial function and cognition is paramount to the well-being of the burns patient. Despite the myriad of challenges that nurses in a burns unit face, it is an extremely rewarding and satisfying high-acuity specialty dedicated to restoring patient form and function following a severe burn injury. ■

Article acknowledgement: Melissa Bloomer FACN, Network Editor, Acute Care National Network

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# CORRECT WOUND MANAGEMENT IN CAESAREAN SECTIONS

BY SHERRIE LEE MACN, ACN EMERGING NURSE LEADER, GRADUATE NURSE, QLD

Sherrie Lee

> *“…it is very important that an accurate nursing assessment is carried out prior to delivery, to ensure correct wound management, and to decrease the risk of infection.”*

*As a part of a bachelor of nursing program, and on clinical placement in a women’s unit at a local private hospital, it became apparent to Sherrie Lee that many women are choosing to have a caesarean section over a vaginal birth. Sherrie is one of ACN’s Emerging Nurse Leaders and in 2013 commenced her graduate year. Sherrie looks at the issues surrounding the caesarean procedure.*

A caesarean is a simple surgical procedure, where an incision is made in the lower abdomen to deliver a baby. The surgeon is required to cut seven layers: the skin, fatty layer, fascia, muscle separation, smooth surface, bladder flap and then the uterus (Edwards, 2009). Once the caesarean section is complete and the baby successfully delivered a minimum of three layers need to be closed (Edwards 2009). Many different incisions can be made for a caesarean section. The transverse incision, also known as the horizontal incision, is the most common and the one that produces less scarring (Gould, 2007). The type chosen is very important information to provide post-procedure, to allow accurate midwifery care. It is important that the woman knows although the outer wound may be healed, the many layers inside may take months to heal (Gould 2007). In addition, the RN/RM needs to educate the woman on discharge of signs of infection.

It is explained by Edozien (2007) that there has been a rise in the number of caesareans being conducted. Identified by Vejnovic et al. (2011) is that in Australia 23.3 per cent of births are delivered through caesarean sections. Delbaere et al. (2012), notes that the World Health Organization recommends that the rate of caesareans should be 15 per cent; however, the above statistics far exceed this recommendation.

## WOUND MANAGEMENT

Research has shown there are more disadvantages to caesarean sections than advantages, however, can be beneficial when they are required (Niina, 2011). Having a caesarean can be a disadvantage if a woman decides to have a normal vaginal delivery in following births. The abdominal muscles that have previously been weakened where the incision was made, may have a tendency to ‘give way,’ (Edozien, 2007). On the other hand, Edozien (2007) explains that this disadvantage should not stop a woman having a vaginal delivery if she wishes to do so. Antenatal education should be given and precautionary measures put in place. In following pregnancies, many women do choose to have a vaginal delivery. This is supported by Islam et al. (2011), explaining that 60–80% of women can achieve a vaginal delivery after a caesarean section.

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## INFECTION CONTROL

Infection control is a major issue in any hospital. Correct techniques are taught to minimise and prevent adverse patient outcomes. Incorrect wound management and non-aseptic technique can have a detrimental effect on patients. In the case of an infection, re-admission to hospital may be required, which, during the time of bonding with their baby, is not ideal (Gregson, 2011). The risk factors causing infection include; age, weight, dressing type and also whether the caesarean was an emergency. Identified by Lavery (2010), is that maintaining infection control is a crucial part of patient care, and also knowing the chain of infection. Some infections are quite debilitating, causing pain and disability.

Obesity can also cause issues with wound healing. There are four contributing factors that obese women can have that increase risk of infection: increased adipose tissue, decreased mobility, poorer nutrition and comorbidities such as diabetes (Nobbs & Crazier, 2011). Jacobsen (cited in Fitzsimmons et al. 2008) says an obese woman can be at further risk of postpartum haemorrhage, which can lead to infection (Fitzsimons et al. 2009). In caesarean sections, a postpartum haemorrhage is blood loss greater than 1000mLs (Yiadom 2012). Any pregnant woman can have a postpartum haemorrhage; however, certain factors put some women at higher risk, such as obesity. Thus, it is very important that an accurate midwifery assessment is carried out prior to delivery, to ensure correct wound management, and to decrease the risk of infection.

## CONCLUSION

It is important to identify the risk factors involved prior to a patient's admission for a caesarean. Infection causes inconvenience in a patient's life, delayed wound healing and a longer stay in hospital. Wound assessment forms are useful and should be available. Midwives should offer antenatal and postnatal education for all women, as well as use correct dressings and provide the best possible care. Correct wound management and infection control regarding caesareans will prevent serious infection and further health issues. ■


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# YOUTH MENTAL HEALTH

## What does a parental cancer diagnosis mean for young people?

BY DR PANDORA PATTERSON, GENERAL MANAGER, RESEARCH, EVALUATION & SOCIAL POLICY
ERIN GRIFFITHS, RESEARCH EVALUATION OFFICER
CANTEEN, NSW

CanTeen participants

*For more information on CanTeen and the services CanTeen provides or to make a referral go to canteen.org.au or call 1800 226 833.*

*Please note GP referral letters are not necessary – the counsellors are happy to hear directly from young people or their families.*

Discovering a parent has cancer is a very daunting and distressing experience for adolescents and young adults; particularly as they are at the peak age for risk of mental health problems. It is estimated that every year, over 15,000 young people (12–24 years of age) in Australia have a parent diagnosed with cancer (AIHW, 2011a). Such a diagnosis presents as a unique stressor in a young person's life; threat of loss is implicit in the initial diagnosis, and even when prognosis is good, the young person still faces the threat of the temporary absence of a parent due to symptoms or treatment side-effects and/or a disruption to roles and routines (Compas et al. 1994).

Research led by CanTeen identified alarmingly high rates of psychological distress among these young people (Patterson et al. 2011; Patterson et al. 2012a; Patterson et al. 2012b). Latest findings showed 61% of 248 young people who had been impacted by parental cancer reported clinically elevated levels of distress (Patterson et al. 2012a; Patterson et al. 2012b) in comparison with just 9% of young people in the general population (AIHW, 2011b). Significant unmet needs were also identified in the following areas (Patterson et al. 2012b):

- information about their parent's cancer
- 'time out' and recreation
- support from their friends
- support from other young people in a similar situation
- help dealing with their feelings
- family issues
- practical assistance.

In particular, high levels of unmet needs were reported in relation to expressing and coping with feelings of guilt, anger, sadness and anxiety, and young people reported the need to have access to professional counselling services.

The diagnosis of a parent challenges young people's development of coping skills and can have a prolonged influence on a young person's life (Osborn, 2007). Even if the parent goes into remission, the young person still has to face the changes that the cancer brought, such as changes in family relationships, the threat of recurrence of their parent's cancer and the possibility that the parent will no longer be able to act as carer (Osborn, 2007). The majority of research indicates that parental cancer is associated with social and mental health problems for young people, as well as increased family conflict and reduced cohesion (Compas et al. 1994; Osborn, 2007; Visser et al. 2004). These difficulties often result in long-term problems in functioning.

Those young people who become bereaved through the death of their parent experienced additional loss and grief as they face a future without their parent. The death of a parent is considered one of the most stressful life events that a young person can experience (Haine et al. 2008) primarily because nothing, up to that point, has prepared them for the feelings of anger, sadness, loneliness, disbelief and guilt that may accompany such a loss. Recent population-based research reported one-fifth of cancer-bereaved youth, from a sample of 622, had engaged in self-injury behaviour, representing twice the odds for self-injury in their 451 non-bereaved peers (Grenklo et al. 2012). The researchers concluded that raised awareness in health care and allied disciplines would enable identification and support provision to this vulnerable group.

Given the significant impact a cancer diagnosis can have on a family, linking families and young

*“The death of a parent is considered one of the most stressful life events that a young person can experience primarily because nothing, up to that point, has prepared them for the feelings of anger, sadness, loneliness, disbelief and guilt that may accompany such a loss.”*

## A GLANCE AT JAMES’ STORY, WHO IS A CANTEEN BEREAVED OFFSPRING MEMBER

*I remember walking in the front door after school and seeing my dad crying. I was completely shocked, as I had never seen him cry before. He then sat me down and explained to me that he had a number of brain tumors. At first this didn’t mean much to me as I was too young to understand the extent of his illness, but as time went on I slowly began to understand.*

*As time passed dad became quite sick, and was soon transferred to a hospice, dad passed away after putting up a strong fight for just over 6 months. It took me a while to come to terms with dad’s death; however the support given to me from my friends and family, along with CanTeen, helped me tremendously.*

James goes on to tell us that time passed and his mum remarried, however shortly after and just when he thought life was getting “back to normal” his step-dad was diagnosed with cancer and passed away.

*My step-dad was diagnosed with an advanced form of prostate cancer, which had spread through into his bones. Over 15 months, I watched a perfectly healthy man go through extreme amounts of suffering. The pain that he endured was so intense that he would often be screaming.*

James’ journey is a devastating one and there are many more like it. Due to the support that CanTeen has provided he has managed to find a way to live a “close to” normal life.

*It’s because of CanTeen that I am able to share my story. CanTeen has helped me realise that sharing my story is a great way of helping myself as it gets any grief off my chest, whilst at the same time helping others as they realise they are not alone. CanTeen has helped me tremendously, and continues to do so in so many ways; it has enabled me to live a ‘close to’ normal life, whilst forming a number of strong friendships, which will no doubt last a lifetime. (CanTeen, 2012, “Member stories – James’ Story”)*

people in with appropriate support services becomes a vital means of providing holistic care. Nurses, due to their first-hand role with patients, often see the long-term and wider life impacts of illness on both the individual and their family. Nurses can play a crucial role in identifying these needs, and facilitating connections between families and appropriate support services.

In response to our research, CanTeen recognised a gap in service provision for young people aged 12–24 impacted by parental cancer, including parentally cancer-bereaved youth, and started a counselling service specifically designed for them. The counsellors are qualified and experienced in working with young people, and in grief support. Counselling is offered free of charge (through funding provided by the nib foundation) and is delivered face-to-face, online and via telephone, and is available individually and in groups. ■

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# INSIGHT INTO THE TREATMENT OF OBESE PATIENTS IN AUSTRALIAN HOSPITALS

BY JANET HOPE MACN, REGISTERED NURSE, VIC

*"New technology is entering the market at a fast pace to meet the growing demands and we are seeing more options for safe patient handling than ever before."*

I am a bariatric nurse consultant with 13 years' experience in the physical management of the obese. I have worked in nursing education as well as clinical nutrition and metabolism for the past 20 years. In this time I've cared for numerous underweight, overweight and obese patients and have learnt the challenges that arise for both staff and patients as a result of these conditions.

Obesity continues to be a public health issue in Australia and it comes with high risk factors of other conditions such as diabetes, heart disease, musculoskeletal disorders and cancer. Health care providers are struggling to meet the physical and mental needs of this patient group and I feel that the health system is failing health professionals and our obese population, by not being prepared to safely manage their size. Equity of access is not an option; it is a mandatory health requirement.

The definition of a bariatric patient is a point of contention as many Australian facilities have developed their own definition. Australia must unite and come to a decision on a universal definition. One definition of bariatric patients is: "Patients whose weight far exceeds recommended guidelines, and where body size restricts their mobility, health, or access to available services" (NSW Department of Health, 2005). Others have been as simple as bariatric patient = weight > 150kg or Body Mass Index (BMI)> 35.

BMI can provide a guide to defining obesity, although BMI is not totally independent of height; it tends to overestimate obesity among the shortest people and underestimate it among the tallest. Therefore, BMI should not be used alone to define the bariatric status as a guide for adults who are very short (less than 150cm) or very tall (more than 190cm).

Discrimination is taboo in most areas of our lives, but not however, when it comes to obesity. Patients say they often feel unwelcome in medical settings, where they encounter negative attitudes, discriminatory behaviour and a challenging physical environment. These negative experiences are often the reason why bariatric patients are more likely to delay seeking clinical examinations. Health professionals are not in a position to discriminate when it comes to health care; we treat people regardless of their circumstances, including prisoners, alcoholics and drug addicts so why are we finding it such a challenge with bariatric patients?

Many bariatric patients have suffered unnecessarily through the use of inefficient, unsuitable and 'makeshift' transport and lifting equipment. In many cases, there has been no equipment to fit their size at all. One patient I spoke to, who weighs over 200kg, said he fears each trip to hospital, not knowing what treatments he might be denied due to his size. Some patients are over 300kg and can't access emergency care, or they take much longer to recover from procedures because they constantly have to wait while a hospital finds adequate equipment and staff to cater for them.

Associate Professor James Harrison of Flinders University says that injured patients who are obese have a longer length of stay in hospital, than those patients who are not obese. "They may also have greater requirements for respiratory support, and are more likely to suffer certain complications of


care, such as pneumonia, renal failure and sepsis, during their time in hospital," said Mr Harrison (Norton et al. 2011).

The physical management of bariatric patients not only includes safe patient handling but everything from the logistics of moving the patient through their medical/surgical journey (and having the knowledge of what is available), to accessing the most suitable medical equipment for their treatment and keeping abreast of the latest innovations and knowledge in bariatric care.

Another area of concern is that general bariatric education is lacking in Australia. In the USA there is a Certificate in Bariatric Nursing which is only open to American registered nurses. The standard of nursing care of the bariatric patient will be mixed until this area of expertise has a defined and standard form of assessment. An increased level of competency in bariatric nursing can only improve the bariatric patient's standard of care therefore improving outcomes and reducing their length of stay in hospital.

New technology is entering the market at a fast pace to meet the growing demands and we are seeing more options for safe patient handling than ever before. The coordination of bariatric patients throughout our health care system calls for well-developed policies and guidelines. Although many facilities are developing their own guidelines of varying standards there is a dearth of literature in Australia on bariatric patient presentations to health care and subsequently we have, in many cases, insufficient data to demonstrate the true numbers of obese and super obese patient presentations. I would encourage facilities to improve the data collection on this group and collect bariatric case studies to share with other facilities. From here we can begin to determine best practices in bariatric nursing care.

Although many hospitals are making some changes to accommodate the obese, there is not enough being done to make it effective. Hospitals urgently need to do the following to ensure they can deal with bariatric patients:

- eliminate discrimination and improve communication
- have suitable bariatric equipment ready
- increase staff education on the physical management of obesity
- have bariatric guidelines in place
- ensure access is suitable in ALL areas.

It may seem costly initially, but dollars will be saved by a patient's shorter length of stay and reduction in staff and patient injuries. ■

Article acknowledgement: Dr Evdokia Kalaitzidis MACN, Network Editor, Ethics National Network

*Janet Hope is the Director of AusBIG. Membership is free and by joining you become a member of a community of professionals dedicated to improving the management and care of the overweight, obese and morbidly obese population.*

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# NURSING THROUGH A FORENSIC LENS

BY ASSOCIATE PROFESSOR LINDA STARR FACN, REGISTERED NURSE,
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Most nurses recognise that their scope of practice will expand as developments in science and technology continue to grow. However, there is one field that is generally unrecognised; that is the requirement of nurses to develop skills in the application of forensic science in their practice.

Although not commonly referred to, the role of a forensic nurse is well established across the globe and is openly recognised in North America and Canada. The term 'forensic' is derived from the word 'forum,' referring to the place where lawyers once met to debate and today is known as the court room (Ranson, 1996, 1). Generally, people associate the word forensic with dead bodies and the investigation of death as a sequel to criminal activity or fatal accidents. In this context the word is readily associated with the role of the pathologist in the scientific investigation of death and perhaps the coroner in their inquiry into the cause of death.

However, this sub-specialty of clinical forensic medicine rapidly developed a focus on the forensic needs of the living, where the practices and principles used by the forensic pathologist are applied to living patients in clinical settings. This area of practice is extremely important for the identification and collection of evidence during the examination and treatment of clients, which can be overlooked and destroyed by those with an untrained forensic eye.

Nurses have been involved in the practice of clinical forensics since 1987 when Harry McNamara, the Chief Medical Examiner for Ulster County, New York saw the value of bringing the field of forensic medicine to the discipline of clinical nursing. This enabled them to properly process forensic evidence for patients with liability related injuries (Lynch, 1991). Forensic nursing as a specialty area, has continued to pioneer its way forward. Today there are a number of well established roles including:

- clinical forensic nursing
- correctional nursing
- forensic psychiatric nursing
- sexual assault nurse examiners.

In Australia the role of the forensic psychiatric and correctional nurse has been established for some time. Since 1992, nurses have also provided a forensic nursing service (assessment, referral and primary health care) in police watch houses, where they attend those who have been arrested and charged but not yet convicted. More recently there has been a growing number of nurses working as sexual assault nurse examiners. These nurses have advanced skills in forensic health and meet the immediate needs of the sexual assault victim, including: physical assessment; forensic examination; collection of evidence; STI testing; supportive counselling; preparing a legal report; and where necessary testifying in court.

Possibly the widest potential for the development of forensic nursing practice is that of the clinical forensic nurse role which has been defined by Lynch as 'the application of clinical nursing practice to trauma survivors or to those whose death is pronounced in the clinical environs, involving the identification of unrecognized, unidentified injuries and the proper processing of forensic evidence (Lynch, 1997).'

It is here that it can be argued that every nurse is a forensic nurse at some time. Whilst a nurse's priority duty is the care of their patient, it is possible to meet the patient's immediate health needs and approach the case with an index of suspicion, recognising evidence where it exists and correctly, collecting and processing this for use in any subsequent forensic investigation.

Nurses working in the emergency department are in a prime position to influence the identification, collection, preservation and documentation of evidence, ensuring the chain of custody is maintained which can make a significant difference to the medico legal outcomes of a case. However, so too are those responsible for the mandatory reporting of abuse. Clearly those in the paediatric units will be familiar with this role. But today with mandatory reporting of elder abuse, it is abundantly clear that nurses and personal carers working in aged care should also be skilled in this field. Unfortunately the majority of older Australian victims of abuse are in no position to corroborate claims of abuse due to some level of mental or physical incapacity. Hence it is critical to the police to have independent evidence to support allegations of abuse. Understanding what is a patterned or pattern of injury may serve to raise awareness and suspicion when a given history proves to be inconsistent with the presenting injury. This may then prompt the nurse to undertake a more thorough investigation and assessment of their client, which could lead to interventions that will assist in the prosecution of the offender and help make the community a safer place to live in. ■

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# SPACED EDUCATION:

## A novel continuing professional development delivery method

BY PROFESSOR JANE L. PHILLIPS MACN, REGISTERD NURSE, PROFESSOR PALLIATIVE NURSING
NICOLE HENEKA, SPACED EDUCATION PROJECT OFFICER
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*If you are interested in finding out more about Spaced Education please contact Ms Nicole Heneka (nheneka@stvincents.com.au) or Professor Jane Phillips (jane.phillips@nd.edu.au).*

Spaced Education offers the potential to engage busy nurses in clinically relevant learning content delivered via regular email. This novel approach to continuing professional development (CPD) was originally developed at Harvard Medical School and is based on two core psychology research findings – the *spacing effect* and the *testing effect*. These findings show that information which is presented and repeated over spaced intervals is learned and retained more effectively compared to traditional methods of education, for example bolus (binge-and-purge) methods (Kerfoot et al. 2009).

The Spaced Education methodology, in itself, is content neutral and can be tailored to deliver specialised clinical content in any number of settings. To date, over a dozen randomised controlled trials have demonstrated that Spaced Education increases health professionals' clinical knowledge and competencies, promotes active learning and retention in specialist areas, impacts on clinical practice and changes clinicians' behaviour (Qstream Inc, 2012; Kerfoot & Brotschi, 2009).

### APPLYING SPACED EDUCATION TO THE SPECIALIST PALLIATIVE CARE NURSING SETTING

In late 2011, a pilot study undertaken within a specialist palliative care inpatient unit in NSW tested the acceptability, feasibility and impact of a tailored Spaced Education module on specialist palliative care nurses' pain assessment practices. An expert panel, composed of palliative care medical and nursing specialists, was convened to develop the 11 case based pain assessment learning scenarios, which formed the basis of the Spaced Education on-line learning module.

The nurses involved in this pilot study received two short case-based questions every two days via email. An example of the email question format is provided in Figure 1. On answering the question the nurses were provided with immediate feedback, as illustrated in Figure 2. This feedback also included a take home message, consequences and links to relevant journal articles, websites and/or practice guidelines. Once a question had been correctly answered twice it was 'retired' and was not presented to the participant again.

### DATA COLLECTION

Nurses involved in this pilot study completed the Pain Assessment – Knowledge and Attitudes Survey at four time points: baseline (T1), immediately after the Spaced Education module (T2), eight weeks (T3) and 16 weeks (T4) after the Spaced Education module. In addition to measuring changes in their pain assessment knowledge, chart audits were also conducted at each time point to appraise the quality of pain assessment and reassessment documentation throughout a patients' admission.

#### Preliminary data

Thirty-three nurses consented to participate in the pilot study and provided baseline (T1) data, with 19 nurses completing the Spaced Education module. Thirteen participants completed the survey at (T2) and eight participants completed the survey at all time points.

#### Participant feedback

Of the nurses who completed the Spaced Education module (n=13), 85% felt the module improved their knowledge and confidence of pain assessment and management practices and that they would like to undertake other Spaced Education modules. The majority (93%) felt the module was effective as a method to learn/reinforce key aspects of palliative care pain management.

## PARTICIPANT FEEDBACK

*Great course, specifically relevant to our PCU. I re-read the comments and learnt so much more even if I got the question right. Obviously the team behind this has been doing an immense amount of work but WOW what a great learning tool. I have spoken to other units and they envy this tool. (RN)*

*Fun...challenging at times...stimulated great discussion with palliative care nursing colleagues...well done guys! (CNE)*

*I liked it, it saves time, we can have an eight hour study day, but don't use eight hours; separating (the content) into small pieces is more efficient. (RN)*

### Next steps

Despite the low completion rates, a positive trend in improved pain assessment and documentation practices was observed in the pilot. This trend has supported an extension of the pilot to include two NSW community palliative care teams and an additional specialist palliative care inpatient unit. Based on this preliminary data the project team has secured the Cancer Challenge of the Year 2012 grant from the South Eastern Sydney Translational Cancer Research Network. This funding is supporting the tailoring and testing of the Spaced Education Pain Assessment Module with cancer care nurses across the South Eastern Sydney Cancer Network, and Albury Wodonga region in NSW.

### SUMMARY

If Spaced Education is found to be effective in increasing nurses' pain assessment knowledge and practice then this CPD format is likely to have widespread applicability to a range of other clinical content areas and to clinicians in diverse practice settings. ■

The pilot study was funded by the Curran Foundation and a St Vincent's Clinic Multi-disciplinary Research Grant. Phase 2 has been funded by the Translational Cancer Research.

The study is being led by Professor Jane Phillips, Chair of Palliative Nursing at the University of Notre Dame Australia and Associate Professor Tim Shaw, Director of Program Development in the Workforce Education and Development Group at The University of Sydney.

Article acknowledgement: Jason Mills MACN, Sub-editor, Palliative Care National Network

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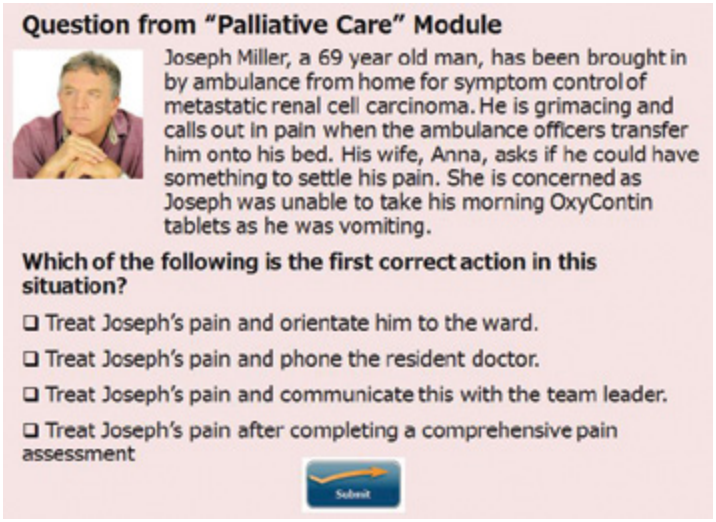


Figure 1: Sample Spaced Education question

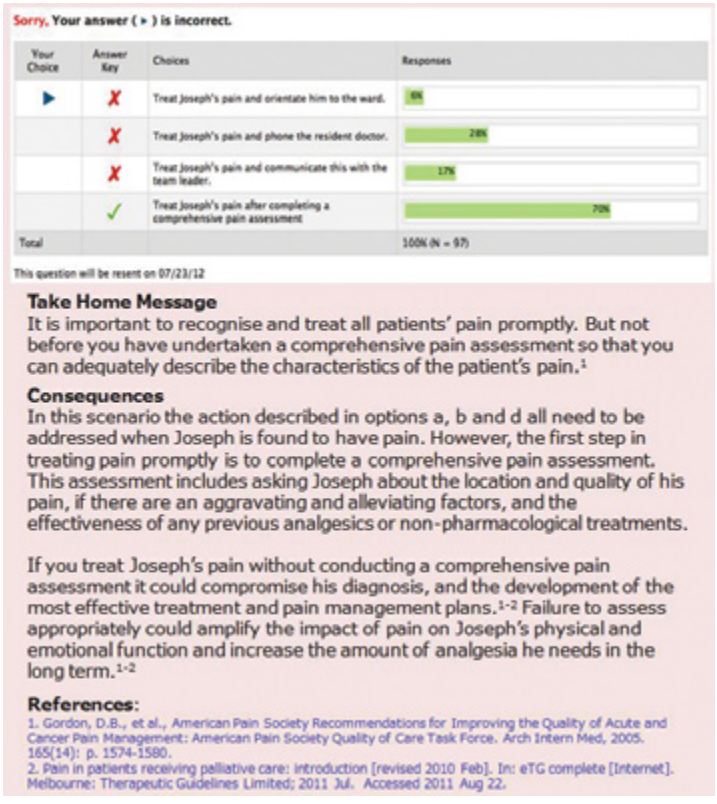


Figure 2: Sample Spaced Education feedback and link to resources

# CLOSING THE DENTAL GAP IN VICTORIA

BY NINA CHRISTOFI MACN, MANAGER, DENTAL ASSISTANTS AT
THE ROYAL DENTAL HOSPITAL MELBOURNE, VIC

*"It is so important that we start at the local level and work our way up to overall better health outcomes for Indigenous communities. Every single person we can help counts!"*

Nina Christofi

The health of Indigenous Australian communities is in a poor state. People of Aboriginal or Torres Strait Islander descent often experience a lower quality of life compared to other Australians, and due to this ill health tend to suffer from lifestyle choices that harm their well-being. They face more challenges when accessing health services, suffer more mental illness and are hospitalised more often than the wider community (Australian Indigenous Health, 2012).

According to the Australian Institute of Health and Welfare (AIHW), Aboriginal and Torres Strait Islander children have consistently higher levels of dental disease than non-Aboriginal and Torres Strait Islander people (especially those in socially disadvantaged groups and those living in remote areas) and those levels are rising. Indigenous adults also have more than double the level of tooth decay, suffer from gum disease and lose all of their teeth more often, and at an earlier age than non-Indigenous adults (Slade et al. 2007).

Dental Health Services Victoria (DHSV) is helping to 'close the gap' between the health outcomes of Aboriginal and non-Aboriginal people by supporting the recruitment of Indigenous staff and encouraging more Indigenous patients to seek dental care.

DHSV has recently created the Indigenous Trainee Program to help find new staff for roles at The Royal Dental Hospital of Melbourne (RDHM). Through the program, DHSV has already recruited two trainee dental assistants who now work with dental professionals. Their role is to treat and educate patients, provide administrative support and help maintain and clean the dental equipment. With more Aboriginal and Torres Strait Islander people on the team, DHSV is able to better communicate and associate with Indigenous patients at

RDHM. Clients feel more comfortable in a culturally appropriate hospital environment.

Melissa and Wazana are the newest dental assistant trainees at RDHM and both love their new positions.

“I get to meet new people every day and I am learning so much. The staff are fantastic and so helpful. They really care about improving the health and wellbeing of the Aboriginal community,” said Melissa. “I get to see Aboriginal and Torres Strait Islander patients from all over Victoria and help them to get the care that they need. Typically their health is far worse than that of non-Aboriginal people and I want to help fix that.”

The dental assistant traineeships run for 18 months and are primarily based at RDHM in Carlton. The program provides trainees with a dedicated mentor, support from the DHSV Aboriginal Community Development Worker, paid study days, monthly days off for personal use, learning and development opportunities and access to a wide range of dental technology and resources. Wazana says her traineeship is a great way to get involved in improving local Indigenous health outcomes.

“Working in partnership with Aboriginal people is the key to achieving health equality. After I achieve my Certificate III Dental Assisting, I will be well on track to help treat people from my community and the surrounding ones too, and contribute to improving the dental health of the people in these groups who are most in need of care,” she said.

DHSV is committed to hiring at least six Indigenous dental assistants before July 2013.

“It is so important that we start at the local level and work our way up to overall better health outcomes for Indigenous communities,” Wazana said. “Every single person we can help counts!”

DHSV’s Aboriginal Community Development Worker and Aboriginal Liaison Officer also offer support for patients through their journey at RDHM. The Aboriginal and Torres Strait Islander Guide to the Royal Dental Hospital of Melbourne is available for patient reference. ■

For more information about any of these services please visit www.dhsv.org.au/aboriginal-services/

Australian Indigenous Health Info Net (2012). *Summary of Australian Indigenous health*. Retrieved from http://www.healthinfonet.ecu.edu.au/health-facts/summary

Slade, G. D., Spencer A. J., & Roberts-Thomson, K. F. (2007). *Australia’s dental generations: the national survey of adult oral health 2004-06*. Canberra: Australian Institute of Health and Welfare

Pictured above: Wazana and Melissa

# NATIONAL RURAL HEALTH ALLIANCE COUNCILFEST 2012

## COUNCILFEST'S EIGHT-POINT AGENDA FOR RURAL HEALTH

1. *Preventing chronic disease with smoking as a sentinel issue – prioritised work to reduce the rate of smoking in rural and remote areas.*
2. *Oral health – promotion of new programs.*
3. *Broadband – allow access to high-speed and affordable broadband through the development of household infrastructure.*
4. *Medicare Locals and healthy community reports – to utilise reports by Medicare Locals to assess how needs are being met in rural communities.*
5. *Workforce – to offer HECS reimbursements for allied health and nursing graduates.*
6. *Mental health – to facilitate new approaches to rural and remote mental health.*
7. *Aged care – to facilitate new approaches to rural and remote aged care.*
8. *Quad bike safety – supporting the Mt Isa Statement on Quad Bike Safety, with its call for the Federal Government to mandate an Australian crush protection device design standard for roll over protection on all quad bikes, and for manufacturers to comply with safety design specifications.*

Photo courtesy of Penny Bradfield, NRHA

2012 CouncilFest delegates at Parliament House

The National Rural Health Alliance (NRHA) held their annual CouncilFest event in Canberra in September 2012. ACN Rural Nursing and Midwifery Faculty Advisory Committee members, Professor Karen Francis FACN and Associate Professor Marg McLeod FACN, represented ACN at this five day event.

CouncilFest provides an annual forum for the 34 member bodies of the NRHA to promote a national commitment to the development of rural health services, as well as work alongside the government to produce better outcomes for the whole Australian community. There are significant gaps in the quality of health care between rural and metropolitan areas and 2012's CouncilFest was an opportunity to identify areas within the rural and remote health community, where reform, funding and action are required.

A critical outcome from 2012's CouncilFest was the confirmation of an eight-point agenda, which the NRHA would work toward over 12 months.

*Nurses and midwives are key personnel in dealing with ageing populations and issues of mental health; and the access to broadband will allow for the enhancement of health care provision and continuing professional development of nurses through online education. Rural nurses and midwives are undoubtedly key players in all these areas, and ACN has the capacity, through the Rural Nursing and Midwifery FAC and through its broader membership, to lobby for improvements in these eight areas.*

– Associate Professor Marg McLeod

*The two days I attended were informative and provided a fantastic opportunity to network with other health professionals and workshop issues impacting on the rural and remote health workforce.*

– Professor Karen Francis

National Rural Health Alliance Inc. (2012). *CouncilFest 2012 confirms eight-point agenda for rural health*, 19 September 2012. Retrieved from http://nrha.ruralhealth.org.au/cms/uploads/mediareleases/mr_190912_final.pdf

# OUR EVOLUTION

## Queensland Nurse Leaders

BY SUE MCKEE MACN, IMMEDIATE PAST PRESIDENT, ASSOCIATION OF QUEENSLAND NURSE LEADERS, QLD

*“ The Association continues to partner with key leadership and nursing bodies including ACN. ”*

### OUR BEGINNINGS, GROWTH AND JOURNEY FORWARD

The first Matron’s Association was formed in Queensland in 1950, with its inaugural meeting taking place in April 1951. The Matron’s Association was formed with the objective of enabling senior nurses to ‘hold yearly conferences to discuss mutual problems and to keep abreast of modern methods.’ The Association was open to matrons of both public and private hospitals. At these meetings the matrons discussed issues similar to those facing our nursing leaders of today such as: staffing; new technologies and techniques; innovations; and changes in patient care. One meeting dedicated a significant amount of time discussing the quality of toilet paper. Although the topic may be different, many nurse leaders spend significant amounts of time discussing the quality or lack there of, of products supplied to their organisations, so not much has changed.

Over the years, the Matron’s Association was instrumental in achieving changes in government policy in relation to the recognition of nurse leaders and their roles in the management and delivery of health care services. In 1975, the Association changed its name to the Nursing Superintendents Association in recognition of the changes that were occurring, particularly in relation to gender mix, of senior nurse leaders.

To this point, the Association had a strong affinity with the Queensland Department of Health and was seen as a departmental instrument under the control and direction of its policy. In 1991, a shift in attitude occurred when the Association, concerned by the direction for health proposed by the government of the day, staged a march on Parliament House and this affirmed the need for the Association to stand as an independent professional body for nurse leaders in Queensland. In 1993, the Association became formally incorporated and independent as the Directors of Nursing Association, Queensland (Incorporated) (DoNA).

As an independent association, DoNA was able to represent Queensland nurse leaders on a variety of panels and advisory bodies. The 1990s saw considerable change in nurse leadership with younger, tertiary educated nurses challenging the ideas, traditions and hierarchies of nursing succession. The focus for the Association returned to its original intent discussing mutual challenges and exploring contemporary solutions.

In 2003, the Association recognised the need to evolve once more. In recognition of the diverse and changing nature of nursing leadership

and to support the development of future nurse leaders, the Association extended membership to registered nurses at the nurse unit manager level and above, across the public, private, education and non-government sectors. The Association also felt compelled to reflect this new direction with a change of name, and became the Association of Queensland Nurse Leaders (Incorporated) (AQNL).

Today, the AQNL is a vibrant diverse Association able to independently represent nurse leaders from multiple industries; it is ever-evolving and looking at ways it can best serve nursing leaders. Recent changes to membership have enabled nurse leaders from other states and different levels to join as associate members. The Association continues to partner with key leadership and nursing bodies including ACN. In 2010, a partnership between AQNL and the then, Queensland Office of the Chief Nursing Officer, enabled the development of a mentoring framework which has been published and used widely throughout the state.

Our annual conference returns us to the original intent of the Association by providing nurse leaders a forum to 'discuss mutual problems and stay abreast of modern methods,' which is as relevant today as it was at the inception of the Association. The conference offers a platform for our nursing awards. The AQNL Emerging Nurse Leader (ENL) Award was established in 2007 and provides financial support to a member to continue their professional development. The AQNL ENL Award recognises the commitment of a leader through a research project, innovative program or the introduction of a significant change. The Outstanding Nurse Leader Award recognises the outstanding achievement made by nurse leaders within their profession. The award acknowledges the significant commitment of an individual to nursing leadership as judged by their peers. The Best Paper Award provides members the opportunity to showcase the work they have been doing by presenting a paper during the conference. These papers are judged by the conference delegates

The participation of members and the commitment of the Executive Committee enable the Association to continue in the proud tradition of the nurse leaders who have gone before, providing networking opportunities, education activities and support. ■

Pictured left page:
AQNL conference delegates enjoying the 2012 themed awards dinner

Pictured above:
Front row L–R: Jeff Potter (President), Nicola Young (Vice President), Amanda Scanlon and Sandy Munro

Back row L–R: Judy March, Louisa Dufty, Wendy Fennah, Carolyn Bourke, Shelley Nowlan, Sue McKee, Kate Field, Sue Freiberg

# NURSING AGENCIES MUST PUT PATIENTS FIRST:

## A call for regulation and accreditation of workforce solutions providers in the Australian health care industry

BY MICHAEL PAGE, REGISTERED NURSE, HEALTHCARE AUSTRALIA, SA

While I was a student nurse over 20 years ago a clinical facilitator drummed into me that, "If you always put your patient first everything else takes care of itself."

This simple but self-evident phrase stayed with me throughout my clinical career and proved to be a valuable philosophy. I hope to have succeeded in being an advocate for the patients I have cared for over the years. Patient-centred care is, one would suspect, a goal all nurses would strive for. Interestingly this philosophy resonates with me even more so in my management career within a leading workforce solutions provider, or nursing agency.

In the past, in terms of education and training within the agency sector, it seems that if quality patient care was provided at all it was delivered at minimal required levels and usually only if demanded by the client. Agencies, by and large, were reactive not proactive and did not see education and training as core activities in their business. There seemed to be no incentive to meet the continuing professional development (CPD) needs of their own staff and, generally, nursing agencies left the education and training to the clients, which created understandable resentment.

Fortunately, not all agencies are alike and more recently there has been an additional incentive to achieve compliance with mandatory and occupational health and safety training as a result of the establishment of the Australian Health Practitioner Regulatory Agency (AHPRA) and of course the *2012 Work, Health and Safety Act* which puts the onus on employers to do all that is reasonably practical to ensure the safety for its employees and those they look after. Note the emphasis on 'those they look after' which has always been problematic for nursing agencies who have no jurisdiction over the physical working environment of their staff. Healthcare Australia (HCA) has embraced a safety culture and insists on 100% compliance with a wide range of annual mandatory competencies and is embarking on a drive to provide at least 20 hours free CPD for nurses in each specialty.

While it is generally accepted that there is a need for regulation and accreditation of aged care facilities and hospitals, the suppliers of staff to these clients i.e. the agencies, have to date remained outside this system. As profit-motivated businesses separated from the 'coal face' of patient care it is perhaps unsurprising, therefore, that some agencies ignore the need for quality. While there is good and bad in any sector of our industry it is encouraging to note that although there is a paucity of research focussing on agency nursing, the available studies present a positive picture overall (Bae et al. 2010; Aiken et al. 2007).

In the modern era it seems that rogue agencies are fewer, but they still exist, and perhaps always will without regulation. After all, without a code of practice and regular audits with punitive powers, what prevents them operating in whatever way they choose?

Whether self-regulation as a goal is embraced or not, all organisations, including agencies, must address the requirements of the *Australian Commission for Safety and Quality in Health Care: National Safety and Quality Health Service Standards*. To achieve this will require significant investment in high quality education and training that is benchmarked to nationally agreed standards and which meets the needs of stakeholders. This way we'll meet with resistance from some quarters. However, as an industry, in order to dispel the myths and negative images of the past we surely need to police ourselves before there becomes a need to force a response.

Michael Page

*“If you always put your patient first everything else takes care of itself.”*

We all need to focus on the patient, as well as our agency staff and the needs of the clients who provide our revenues. Just as my clinical facilitator pointed out, if we as an industry put the patient first then everything else will surely take care of itself.

While some are already adopting a culture of safety and quality supported by nationally respected training (HCA is an Approved Provider of Endorsed Courses under Australian College of Nursing’s APEC system), it would seem unlikely there will be a sudden rush to follow unless the industry polices itself in some way. The first step in this governance process would require a national debate regarding the setting of standards for the industry. It is a process all in the sector should welcome, and all who utilise agency staff should demand. ■

Article acknowledgement: Greg Rickard OAM MACN, Healthcare Australia

Aiken L. H., Xue Y., Clarke S. P., & Sloane D. M. (2007). Supplemental nurse staffing in hospitals and quality of care. *Journal of Nursing Administration (JONA); 37*(7/8), 335-342

Bae S. H., Mark B., & Fried M. (2010). Use of temporary nurses and nurse and patient safety outcomes in acute hospital units. *Health Care Management Review; 35*(3); 334-344

# MARCH – JUNE 2013

## Continuing professional development calendar

## March 2013

**4** Aged care legal issues
RN/EN | One day | 7 CPD hours | Adelaide SA

**7–8** Palliative care
RN/EN | Two days | 14 CPD hours | Dubbo NSW

**11–12** Pain management
RN/EN | Two days | 14 CPD hours | Bendigo VIC

**13** X-ray interpretation
RN | One day | 7 CPD hours | Burwood NSW

**13–15** Clinical assessment: Models of assessment and care
RN/EN | Three days | 21 CPD hours | Burwood NSW

**18–19** Organ & tissue donation awareness
RN | Two days | 14 CPD hours | Burwood NSW

**19** Day surgery nursing
RN/EN | One day | 7 CPD hours | Burwood NSW

**21–22** Wound management
RN/EN | Two days | 14 CPD hours | Geraldton WA

**21–22** Diabetes update
RN/EN | Two days | 14 CPD hours | Albury NSW

**21–22** The deteriorating patient: Clinical decision making
RN/EN | Two days | 14 CPD hours | Brisbane QLD

**22** Pharmacology update
RN/EN | One day | 7 CPD hours | Burwood NSW

## April 2013

**2–3** Wound management
RN/EN | Two days | 14 CPD hours | Alstonville NSW

**3–5** Understanding mental health
RN/EN | Three days | 21 CPD hours | Burwood NSW

**4–5** Understanding team nursing and leadership
RN | Two days | 14 CPD hours | Lismore NSW

**5** Immunisation update
RN | Half-day | 4 CPD hours | Burwood NSW

**9–10** Urological nursing
RN | Two days | 14 CPD hours | Burwood NSW

**11–12** Orthopaedic update
RN/EN | Two days | 14 CPD hours | Grafton NSW

**11–12** Infection prevention update
RN/EN | Two days | 14 CPD hours | Burwood NSW

**12** Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Adelaide SA

**18–19** Diabetes update
RN/EN | Two days | 14 CPD hours | Brisbane QLD

**19** CPD portfolio and competencies workshop
RN/EN | One day | 7 CPD hours | Burwood NSW

**25–26** Wound management
RN/EN | Two days | 14 CPD hours | Hobart TAS

**29–30** Rehabilitation nursing
RN/EN | Two days | 14 CPD hours | Burwood NSW

## May 2013

**2–3** Pain management
RN/EN | Two days | 14 CPD hours | Burwood NSW

**10** ECG – introduction
RN/EN | One day | 7 CPD hours | Burwood NSW

**16–17** Diabetes update
RN/EN | Two days | 14 CPD hours | Kalgoorlie WA

**16–17** The deteriorating patient: Clinical decision making
RN/EN | Two days | 14 CPD hours | Wagga Wagga NSW

**16–17** Palliative care
RN/EN | Two days | 14 CPD hours | Nowra NSW

**21** Presentation skills workshop
RN/EN | One day | 7 CPD hours | Burwood NSW

**22–23** Wound management
RN/EN | Two days | 14 CPD hours | Brisbane QLD

**23** Legal issues for registered nurses
RN | One day | 7 CPD hours | Burwood NSW

**23–24** Diabetes update
RN/EN | Two days | 14 CPD hours | Burwood NSW

**23–24** Chronic and complex disease self-management
RN | Two days | 14 CPD hours | Burwood NSW

**23–24** Organ and tissue donation awareness
RN | Two days | 14 CPD hours | Brisbane QLD

**29–30** Diabetes update
RN/EN | Two days | 14 CPD hours | Melbourne VIC

**30–31** Mental health case management skills
RN | Two days | 14 CPD hours | Burwood NSW

**31** Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Burwood NSW

## June 2013

**12–14** Teaching techniques for nurses
RN/CNS/CNE/CNC | Three days | 21 CPD Hours | Burwood NSW

**13–14** Rehabilitation nursing
RN/EN | Two days | 14 CPD hours | Orange NSW

**14** Breastfeeding update
RN/RM/EN | One day | 7 CPD hours | Burwood NSW

**18–20** Clinical assessment: Models of assessment and care
RN/EN | Three days | 21 CPD Hours | Shellharbour NSW

**20–21** Understanding team nursing and leadership
RN | Two days | 14 CPD hours | Burwood NSW

**20–21** Wound management
RN/EN | Two days | 14 CPD hours | Broken Hill NSW

**21** Aged care legal issues
RN/EN | One day | 7 CPD hours | Brisbane QLD

**21** Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Tweed Heads NSW

**25** Immunisation catch-up schedule workshop
RN | Half-day | 4 CPD hours | Burwood NSW

**25–26** Pain management
RN/EN | Two days | 14 CPD hours | Dubbo NSW

**26** ECG – introduction
RN/EN | One day | 7 CPD hours | Bunbury WA

**27–28** Medical imaging
RN/EN | Two days | 14 CPD hours | Burwood NSW

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> Perioperative anaesthetic nursing 12 April | **Adelaide SA**
RN only | 7 CPD hours

> Wound management 23 – 24 April | **Hobart TAS** | RN, EN
14 CPD hours

> Diabetes update 29 – 30 May | **Melbourne VIC** | RN, EN
14 CPD hours

> Organ and tissue donation awareness 23 – 24 May
**Brisbane QLD** | RN, EN | 14 CPD hours

> Understanding team nursing and leadership 20 – 21 June
**Burwood NSW** | RN only | 14 CPD hours

> ECG introduction 26 June | **Bunbury WA** | RN, EN
7 CPD hours

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