thehive

#8 SUMMER 2014/15

ACN

GOING FOR GOLD IN WA:
leadership at Osborne Park Hospital

PASSION AND KNOWLEDGE:
the craft of being a mental health nurse

WHO CARES FOR MENTAL HEALTH NURSES AFTER DISASTERS?

Launching nationally in 2015

NSW Matters, Sydney – 4 March 2015
TAS Matters, Hobart – 12 March 2015
VIC Matters, Melbourne – 16 April 2015
WA Matters, Perth – 30 April 2015
SA Matters, Adelaide – 28 May 2015
QLD Matters, Cairns – 7 July 2015
NT Matters, Darwin – 9 July 2015
ACT Matters, Canberra – 23 July 2015

ACN
2015
State
Matters

ACN

Looking to expand your leadership capacity?

Explore the ACN Leadership Programs and build your leadership capabilities throughout your career:

- Leadership FIRST Series for early and mid-career nurses
- Graduate Certificate in Leadership and Management for early and mid-career nurses
- ASTUTE Management Series for mid-career nurses
- Leadership MASTER Series for nurse executives
- The National Nursing Forum

For more information visit **www.acn.edu.au** or phone **1800 061 660**

thehive

#8 SUMMER 2014/15
(December – February)

PUBLISHING DETAILS

ISSN 2202-8765
Distributed quarterly

Editors
Adjunct Professor Debra Thoms FACN (DLF) and Jackie Poyser

Editorial Committee
Melissa Bloomer FACN
Ruth DeSouza MACN
Debra Kerr MACN
Kate Kunzelmann MACN
Elizabeth Matters FACN

Editorial coordinator
Emily Legge-Wilkinson

Editorial assistant
Phoebe Glover

Design
Tim Spooner

Publisher
Australian College of Nursing
1 Napier Close, Deakin ACT 2600
t 02 6283 3400 | **acn@acn.edu.au**
ABN 48 154 924 642

Printing
Paragon Printers, Canberra

Advertise with ACN
Send your enquiries to
advertising@acn.edu.au

Cover
Osborne Park Hospital nurses and midwives

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

Nursing Review is an external publication provided to ACN members and is produced by APN Educational Media Pty Ltd.

CEO REPORT

ADJUNCT PROFESSOR DEBRA THOMS FACN (DLF)

Debra Thoms FACN (DLF)

Welcome to the final edition of *The Hive* for 2014 – and what an edition it is! We are focussing on the important topic of mental health; the importance of nurses looking after their own mental health as well as profiling the essential work of mental health nurses.

Sally-Anne Wherry and Amy Jones, in their article, *Isolated practice: reflections of a Parkinson's nurse,* pay particular attention to "professional isolation" and how, if not dealt with appropriately, it can lead to unwarranted stress. The theme of mindfulness of our own mental health continues in *Who cares for the mental health of nurses after a disaster?* Kim Usher, Cindy Woods and Caryn West explore the experiences of mental health nurses in the wake of Tropical Cyclone Yasi and focusses on the extreme pressure many were under. One nurse recounted, " …there was no one for me… I found myself in a lot of tears. Just from being overwhelmed." These articles, and many more within this edition, clearly demonstrate that although a fundamental component of our nursing role is to care for others, we must never lose sight of the need to care for our colleagues and ourselves.

Ruth DeSouza's words in *Passion and knowledge: the craft of being a mental health nurse* articulate perfectly the many facets of the mental health nursing role, "... [it is a] philosophy of practice that sees people in the context of their culture, family and society". The article goes on to showcase the varied careers of mental health nurses – those just beginning their journey and those who've been on the journey for many, many years. Elijah Sabondo offers a very personal account of his experiences as a mental health nurse in *Respect and mental health: we can do better.* Elijah offers the poignant reminder that "Nurses can be champions of societal change when it comes to referring to people with a mental health condition."

This edition also offers our regular features including, 'ACN News and Views', 'Regional Roundup', articles from our 'Communities of Interest' and a follow-up story from Elizabeth Matters in the 'Your Say' section.

As this is the final edition of 2014 I'd like to take the opportunity to offer a warm thanks to all our contributors throughout the year. It is our members, with their wisdom and personal insight, that ensure the quality of *The Hive* remains first-class. I would also like to thank the Editorial Committee for their time and influence. Their expertise has added greatly to the value of *The Hive* and we look forward to their continued involvement in 2015.

Finally, on behalf of the ACN Board and staff I would like to wish you all a very happy and peaceful Christmas and New Year. I hope this edition of *The Hive* has inspired you to be mindful of your own mental health wellbeing as we continue to face the challenges of a complex health system into 2015.

PUBLICATION GUIDELINES

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

- Articles should be from 300 – 1,500 words in Microsoft Word format.
- Articles should be original, previously unpublished and not under consideration for any other publication.
- We do not accept submissions of an advertorial nature.
- Pictures/photos are to be in JPEG or TIF format of high resolution 300dpi.
- All references must be supplied in modified Harvard system.
- Complete authorial details including: name, job title, organisation and location.
- Articles are submitted via email to **publications@acn.edu.au.**

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

Autumn 2015 - Global nursing

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

CEO REPORT

OUT AND ABOUT WITH THE CEO

"As we move into the Festive Season I thank you for your engagement with ACN and wish you and your families a safe and enjoyable festive season. I look forward to continuing to meet and work with many members throughout 2015."

OCTOBER

- At the Annual General Meeting I had the honour to be elected as the Chair of the Australian Nursing and Midwifery Accreditation Council (ANMAC). I very much look forward to working with the new CEO, Fiona Stoker MACN, and the Board of ANMAC.
- I had the pleasure of attending a regional function in Armidale. The evening seminar, hosted with the University of New England, featured an excellent presentation by Professor Debra Jackson FACN with active discussion from those in attendance. Thanks to Kim Usher FACN for the invitation to attend. At the function I also took the opportunity to thank Kim for her longstanding contribution to *Collegian* as an Editor. Kim has taken up a role with the *International Journal of Mental Health Nursing* and has relinquished her role as an editor with *Collegian*.
- Along with Helen Goodall (Executive Manager, Business Planning and Development) and Sophia Hartl (Business Development Officer) from the Canberra office, I attended a luncheon at the invitation of HESTA. ACN has recently entered into a corporate partnership with HESTA and we were pleased to be able to meet the CEO, Anne-Marie Corboy, who shared with us some interesting information about HESTA but also superannuation more broadly. Certainly companies such as HESTA are responding to consumer demand for more environmentally friendly options. The history of HESTA and its growth under her leadership was inspiring.
- Later in the month we welcomed Professor Lisa McKenna FACN to the Canberra office for a familiarisation regarding her role as the new Editor in Chief of *Collegian*. Professor John Daly FACN has done a wonderful job in raising the profile and ranking of *Collegian* and I am confident that Lisa will ensure the continued growth and enhancement of *Collegian* as ACN's referred journal.

Carmen Morgan FACN, ACN President, and Debra at the National Nursing Forum

NOVEMBER

- November saw a number of members gather in Adelaide for the National Nursing Forum. It was great to catch up with members and hear some interesting and innovative papers as well as network and share. Pages 24 and 25, in this edition of *The Hive*, provide a comprehensive overview of the Forum.
- I attended a one day workshop at the Australian Commission for Safety and Quality in Health Care regarding mapping the RN Standards for Practice against the National Safety and Quality Health Service Standards. The workshop looked at how well embedded safety and quality are within the standards and, overall, it was pleasing to see that this is incorporated in a variety of ways. There was also considerable discussion on the role that organisational culture plays in supporting nurses in delivering safe and quality care.
- Over this period the ACN Executive Leadership Team, along with Wendy Hooke (Manager, Marketing) and Jackie Poyser (Manager, Communications), have been working on the communications strategy around the new strategic intent and the new *Leadership@ACN* program.

DECEMBER

- A number of meetings, regarding the RN Standards Project and matters related to ANMAC, have been attended. I was also able to participate in a roundtable on the employment challenges being faced by first year registered nurses hosted by the Federal Australian Nursing and Midwifery Federation (ANMF).
- As we move into the Festive Season I thank you for your engagement with ACN and wish you and your families a safe and enjoyable festive season. I look forward to continuing to meet and work with many members throughout 2015.

MEMBER UPDATE

WELCOME TO ACN FELLOWSHIP

Liz Hutchings FACN

Membership of ACN is an integral aspect of my nursing identity. Being made a Fellow is not only a great honour and privilege but a personal confirmation of my commitment to the ideals of the nursing profession, ACN, its goals and its wider membership. It is my intention to continue to work with ACN and expand the influence and voice of nurses across the Australian community.

Elizabeth Matters FACN

ACN plays a key role in giving nurses a professional voice at a national and international level. My membership of ACN has allowed me to mix with inspiring and dedicated colleagues from across the world, all bound by a common mission to further the cause of nursing for the benefit of the ill people who rely on our work. I am very humbled that my own efforts to advance the profession have been deemed worthy of Fellowship, at this stage in my career, and I look forward to many more years of involvement with ACN and our partner associations around the world.

Kay Ross FACN

ACN Fellowship demonstrates acknowledgement of my many years as a nurse and educator and my commitment to providing nurses with educational opportunities that challenge them to be the best that they can be. Taking a moment to look at the many outstanding nurses who are also Fellows makes me feel proud to stand beside them, recognising the vast amounts of knowledge and dedication held by this collective group.

LETTER TO THE EDITOR

Many thanks for your excellent article about Lyme disease [*Our battle for treatment of a disease that doesn't exist*] in the Spring 2014 issue of *The Hive!*

I thought it may interest you to know that I have been through a similar journey myself until my diagnosis with Lyme disease some 2.5 years ago. At that time I was severely disabled by my condition and barely functioning. I was tentatively diagnosed with MS, chronic fatigue and chronic regional pain syndrome. I was also losing my vision and was having mild seizures in response to one of my pain medications. I worked from home at the time, but could barely get through a full day's work without taking a lunchtime nap, and I was sleeping approximately 12-14 hours per night. Despite all these symptoms, I had to fight for my diagnosis too, ignoring the advice of some of Sydney's leading neurologists and immunologists and driving seven hours north to see a GP who was willing to order appropriate tests for me. That was the most important trip of my life!

Since my diagnosis, I have been receiving treatment here in Australia, at enormous expense to myself, and considerable risk to my doctor who could face disciplinary action for treating a 'non-existent' disease. Still we press ahead, and the great news is that I'm now almost completely well again! I'm able to work a regular 40 hour week in the ACN office, my vision is perfect, I can walk short distances without fatigue, and I'm rarely in any pain anymore. So there really is light at the end of the tunnel for Lyme sufferers! We just need access to appropriate testing and treatment at an affordable price.

I've been extremely grateful for the last 12 months to be working here at ACN, where the work environment is very supportive. I've never felt I've had to hide my diagnosis, or been made to feel crazy for having this 'non-existent' disease. I've just been treated as one of the team, working hard to support Australian nurses.

– Lois MacCullagh

MEMBER UPDATE

BOARD LEADERSHIP: ESSENTIAL FOR THE ONGOING SUCCESS OF ACN

The ACN Board consists of seven directors elected from and by the membership of ACN and two independent directors appointed by the Board. Current Board Members are from a range of geographical locations in Australia and have a balance of skills and experience.

In 2015, ACN will be holding elections for three new member elected directors, so it's timely to provide our members with an overview of the responsibilities of ACN Board Directors.

Responsibilities

The Board is responsible to ACN members for the overall governance of ACN, including ensuring the long-term viability and enhancing the performance of ACN through strategy formulation and policy making. It's important to note that the Board is not responsible for the day-to-day operational undertakings of ACN.

Key responsibilities include:

- determining the strategic direction of ACN
- establishing the policies by which the organisation will be governed
- monitoring and supervising the organisation's performance and its control and accountability systems
- ensuring accountability of the organisation to members, regulators and other stakeholders
- ensuring key organisational positions are filled with appropriately skilled and qualified individuals
- working with and through the CEO.

ACN encourages all members who are interested in Board governance to consider nominating for one of the three positions when they open in mid-2015. There is a comprehensive induction process for all new Board members which include governance training for those members who have no previous Board experience.

If you would like more detail around the role and responsibilities of an ACN Board Member please email acn@acn.edu.au.

Q&A WITH THE CEO

DR ROSEMARY BRYANT AO FACN

"Q"

Debra Thoms FACN (DLF)

Dr Rosemary Bryant AO FACN

"A"

Debra - How do you think your prior experience has enabled you to become a nurse leader?

Rosemary - I have a broad experience across the health sector in terms of employment - working in hospital, community and policy. I have also had a long engagement with nursing organisations at state, national and international levels. In summary, my experiences were used as stepping stones - sometimes along a crooked pathway - but I draw on all my experiences in my present position.

Debra - How do you maintain a work/life balance?

Rosemary - This is hard as it is for everyone but I have a tight-knit circle of friends and family who keep me based in reality! Looking after oneself is also paramount and a short interlude of downtime, in a busy day, is essential - even if it is just reading the newspaper.

Debra - What have been your career highlights?

Rosemary - Being appointed as Director of Nursing at Royal Adelaide Hospital while I was still under 40 was, at the time, a wonderful opportunity and many highlights flowed from that. The other significant moment was being elected as President of the International Council of Nurses, a privilege which was unparalleled for me.

Debra - What are the key challenges facing today's nurse leaders?

Rosemary - Keeping nursing and midwifery at the forefront of health care delivery and being able to reinvent the way we deliver care is essential. Managing a large professional workforce is also a challenge as nurses and midwives today have very different expectations about their careers and working lives.

Debra - Has mentorship played a role in your success?

Rosemary – Yes, very much so but on no formal basis. I am still in touch with one of my key mentors who was very helpful to me in my early years. The value of mentoring cannot be underestimated.

Debra - How do you identify and develop your top performers?

Rosemary - I have no other nurses working with me in my current position. In the days when I did employ staff, one of my criteria for identifying top performers was their ability and willingness to go the extra mile.

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

Rosemary - My advice is around planning one's career - both in terms of qualifications and experience; making sure that you have options for career advancement rather than having a focus on only one pathway; always communicating with and bringing other members of the profession with you; making sure that you grasp every opportunity to contribute to the profession by engaging in professional organisations and ensuring that you remain grounded in the profession.

Debra - Do you have a leader that you admire?

Rosemary - I cannot think of one specifically. Many leaders have qualities I admire which I have studied and hope to have emulated!

BOOK FEATURE

THE HISTORY OF AUSTRALIAN NURSES IN THE FIRST WORLD WAR: AN ACN CENTENARY COMMEMORATIVE TRILOGY

ACN is proud to partner Dr Ruth Rae FACN in a commemorative publication of *The History of Australian Nurses in the First World War: An ACN Centenary Commemorative Trilogy* (the *Trilogy*).

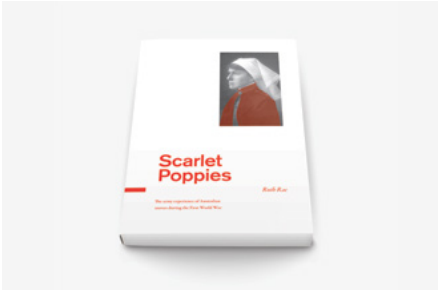
Below is a summary of the three books contained in the *Trilogy*; all books showcase the important contribution of Australian nurses who served in the First World War and highlight the valuable service Australian nurses provided to the ongoing professionalism of civilian and military nursing in this country

Book one: *From Narromine to the Nile*

From Narromine to the Nile: Jessie Tomlins - An Australian Army Nurse in the First World War (2nd ed.) provides the reader with an introduction into the social, nursing, military and political history of the time through the experiences of one nurse, Jessie Tomlins.

Jessie's family history is a quintessential Australian pioneering story with a strong connection to the land and two of her brothers, Fred and Will, became Australian Lighthorsemen. This book follows Jessie's journey through her civilian training program at Sydney Hospital to the wards of the No. 14 Australian General Hospital in Egypt and, after the war, to the rehabilitation wards in England.

Narromine to the Nile incorporates the different experiences of Jessie, Fred and Will Tomlins in the same theatre of the First World War, the present day Middle East, providing a unique snapshot of history. It also details the social changes in the immediate aftermath of the war while Australian nurses and soldiers awaited transport home from England.



Book two: *Scarlet Poppies*

Scarlet Poppies: The army experience of Australian nurses during the First World War (3rd ed.) analyses the impact the military paradigm had upon the challenges faced by the 2,500 civilian trained nurses who joined the Australian Army Nursing Service.

Dr Rae researched, in detail, one such challenge which was the management of the 1918-19 influenza pandemic. The treatment of soldiers and their nurses at the Woodman's Point Quarantine Station near Fremantle (WA) provides an example of a lack of understanding of an essentially civilian medical and nursing emergency. The consequences for one of four nursing reinforcements, Doris Ridgway, who was '… such a dear little girl… ' and had recently completed her nurse training at the Adelaide Hospital was tragic. Doris was an outstanding student who received four first-class passes. Ironically, she never had one day sick leave during her three years of training but, within a week of arriving at the quarantine station from Adelaide, she was dead.

In *Scarlet Poppies,* Dr Rae examines the complex relationship between the male dominated military model and the female dominated Nightingale system of nurse training undertaken by the First World War nurses.

Book three: *Veiled Lives*

Veiled Lives: Threading Australian nursing history into the fabric of the First World War (3rd ed.) considers the family and social lives, civilian nurse training, military nursing experiences and the premature deaths of qualified Australian nurses who endured the horrors of the 1914–18 war. *Veiled Lives* uncovers the impact of their absence on the nurses' families, friends, colleagues and communities.

For instance, the mother of Matron Nellie Miles Walker, Louisa, '…was in close correspondence all those four years with my beloved daughter.' When Nellie died her mother's grief was clear when she wrote to the army that '… the very smallest trifle belonging to my child is most precious to me, and I wish no other hand to touch it first. This may sound sentimental but if you have ever loved anyone deeply you will understand it'.

Veiled Lives brings into sharp historical focus the reality for those who waited at home for more than four long years while these women, whose lives have been hidden from history for far too long, came home or were buried with the war dead.

The *Trilogy* will be available for purchase in April 2015. To express your interest please email publications@acn.edu.au.

MENTAL HEALTH

ACADEMIC

Dr Melissa Bloomer FACN

Compassion fatigue and burnout in nursing

Nursing is about caring. The opportunity we have to bond and build relationships with our patients and families and provide individualised care is what makes our profession stand apart from others. Just as patient satisfaction is significantly correlated with the quality of nursing care, the opportunity to care is likely to be a key aspect of our job that gives meaning and satisfaction, but caring can also come at a cost.

Higher workloads, and the perception that the care the nurse can provide is sometimes less than ideal, can lead to job dissatisfaction, compassion fatigue and burnout (Hooper et al 2010). Compassion fatigue results as a consequence of repeated care of people who are suffering. Similarly, burnout is described as the response to chronic emotional and interpersonal stressors in the course of work (Maslach 2003). Several studies have identified that compassion fatigue and burnout can occur in nurses as a result of repeated involvement in emotionally demanding situations, such as providing prescribed care for a patient that is in conflict with the nurse's personal opinions on how and what care should be provided.

When nurses are affected by compassion fatigue and/or burnout, it can result in decreased job satisfaction, an increase in workplace errors, personality change, a decline in physical health and nurses leaving the profession. Just as health service managers must prioritise nurse recruitment, the risk factors and potential for compassion fatigue and burnout in the existing nursing workforce must be considered, especially if the goal is to support, nurture and retain the nursing workforce.

References

Hooper, C., Craig, J., Janvrin, DR., Wetsel, MA., Reimels, E. 2010, 'Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties', *Journal of Emergency Nursing,* vol. 36, no. 5, pp. 420-427.

Maslach, C. 2003, 'Job burnout: new directions in research and intervention, *Current Directions in Psychological Science,* vol. 12, pp. 189-92.

CLINICIAN

Ms Tomica Gnjec MACN

Dignified care a necessity

Traversing the complexities of the health system is difficult in the best of circumstances - add advanced age and mental health - another layer of challenges exist.

A few years back I found myself in the challenging position of advocating for an older individual for whom I was appointed legal guardian. This individual presented to the local emergency department for a psychiatric admission for symptoms of functional psychosis, on a background of schizophrenia. An ideal scenario would have been a direct admission to an older person's mental health unit but, due to lack of beds, the only option was a temporary admission to the general adult mental health unit. Challenges for this individual included a high level of cognitive distress with their presenting psychiatric symptoms, disorientation within a foreign environment alongside Alzheimer's dementia and a number of other co-morbidities. All of these factors were compounded by the chaotic environment within an acute care facility and made for a challenging journey to optimal psychiatric management and therapy.

This scenario highlighted for me how very different wellbeing or mental health presentations are. They involve far more subjective matter and require a longer-term specialised observation, support and investment in an already overstretched and increasingly time-poor system!

Clinical scenarios concerning mental health often involve society's most vulnerable individuals with a complex interplay of biological, psychological and socio-cultural factors. Therefore, within the confines of our human and physical resources these situations call for us clinicians to be responsive and respectful. And, with the ability to recognise, promote, involve and disseminate information in dealing with individuals and their families, endeavour to provide the best care we can.

ETHICIST

Professor Mary Chiarella FACN

Caring for our colleagues

I want to raise our mandatory/legal responsibilities to our colleagues when we believe they are suffering from a mental illness, and also our collegial/ethical responsibilities. The Health Practitioner Regulation National Law 2009 (Qld) s.141 creates a mandatory obligation to notify about a health practitioner colleague if we have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession. Notifiable conduct is defined (inter alia) as "placing the public at risk of substantial harm because of an impairment (health issue)". This includes mental health issues. The key factors here are "reasonable belief" and "risk of substantial harm".

So that obligation is clear. Less clear is how health professionals support colleagues when they believe they have an impairment, regardless of public risk. A colleague of mine recently took unprecedented and lengthy sick leave due to mental illness (although no question of public risk). The colleague made no secret of the source of the illness. When a nurse has cancer, or even a broken leg, we know how nursing colleagues respond. There are flowers, visits, cards, phone calls, casseroles for the family even – we are good at this stuff. But for my colleague mainly there was silence. This is not an isolated example. Far from using the 'R U OK? example, the majority of nurses and midwives still tend to shy away from mental illness in their colleagues (Ross & Goldner 2009). We have a long way to go.

Reference

Ross, C.A. & Goldner, E.M. 2009, 'Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature', *Journal of Psychiatric and Mental Health Nursing,* 16 (6), pp. 558–567.

MENTAL HEALTH

HISTORIAN

Dr Madonna Grehan MACN

From asylums to mental health

The term 'mental health' is relatively new in Australia's health care lexicon, but the concept of restoring 'health' to those afflicted by conditions known as insanity, madness, derangement, lunacy, hysteria and instability, is not. With the arrival of Europeans in Australia, people who were 'disturbed' were locked up, separated from the rest of society. Historian Lee-Ann Monk has argued, in *Attending Madness: at work in the colonial asylum,* that this attitude changed in the late nineteenth-century when asylums introduced 'moral therapy' as treatment. In moral therapy, attendants modelled behaviours of self-control that inpatients could emulate. Asylums, at that time, were envisaged as curative places where health could be restored to individuals so that they could return to live in the community (Monk 2008).

Inevitably, asylums were custodial and controlling, and moral therapy did not work for most. In the twentieth century, asylums became more like hospitals. Inmates were subject to pharmacological and other experimental treatments which, likewise, were aimed at recovery. Some therapies showed considerable benefits, others had mixed results. Controversial practices, such as water baths and deep-sleep therapy, took years to be exposed as harmful to patients' health or just fallacious. De-institutionalisation in the 1980s and 1990s was a momentous shift in the focus of care of the mentally ill but did not, in itself, produce mental 'health'. We now recognise that achieving and maintaining mental health is a complex process. It requires the same effort as achieving physical health and there are no quick fixes. That means mental health is a work-in-progress for most Australians.

Reference

Lee-Ann Monk 2008, *Attending Madness: at work in the colonial asylum,* Amsterdam, New York: Rodopi.

MANAGER

Adjunct Professor Cheyne Chalmers FACN

Leadership and mental health

As a nurse leader I find myself increasingly concerned about the impact of compassion fatigue. Factors such as providing care to an increasingly complex population, financial security, health and wellbeing of the nurse and their family, increasing violence and drug abuse, all lead to an environment that makes me question the expectations we put on our nurses.

The prevalence of anxiety, depression and general 'unhappiness' is increasing in the general population and, as care givers, nurses are particularly vulnerable to these experiences.

I see the nurse leader's role in this context as very much the provider of the safety net, ensuring we have systems and processes in place to minimise psychological harm in the workplace and to support nurses to maintain their own mental health.

In my experience there is a strong link between staff happiness and patient experience. Recently, I was privileged to attend the APAC Forum where Maureen Bisognano, CEO of Institute for Health Improvement, was the keynote speaker.

She spoke about 'Joy'. She described the impact that happiness or joy has on a health professional's ability to deliver positive care and the impact that this care has on the patient's experience and their healing journey. She said it was possible to improve our individual happiness, and proposed a challenge to those present that we finish our days for two weeks by noting down three good things that happened to us. I was so taken by this I have started to use it, personally and professionally, and have been impressed with the improved perspective that this exercise brings. I have taken on an adjunct title in my role of the Executive Director of Staff Happiness and I invite all nursing leaders to do the same.

NEWLY REGISTERED

Ms Laurie Bickhoff MACN

Mental health: who do you call?

Recently, I cared for a lady with complete heart block. Nothing too unusual, a fairly regular occurrence in a cardiology ward. The difference, she was 40 weeks pregnant, two days past her due date. I'm not ashamed to admit, I was paranoid about the baby making an entrance. In the event of an emergency, I didn't have the right skills or knowledge to care for this patient or her baby, and this left me feeling anxious. Luckily, I had back-up with the delivery suite, obstetrics team and midwives only a call away.

As an early career nurse, I find the same unease and stress when caring for mental health patients. I can competently monitor and treat their physical condition. Yet I can't help but feel unable to give their mental health the same level of care. If their physical condition deteriorates, I know what action to take and have access to immediate help. If their mental health changes, there is little specialised support immediately available.

Patients with mental health conditions are regularly admitted to general wards with acute physical illnesses. We need to recognise the unique skill set mental health nurses have and the difficulties and stress nurses from other specialties may be under when caring for mental health patients. We need more mental health training for all nurses so they may be able to recognise changes, initiate appropriate actions and de-escalate situations if needed. Nurses caring for patients with mental health conditions should have the same level of support as I had for my pregnant patient. Only then can we say we are providing safe, holistic care.

"If their mental health changes, there is little specialised support immediately available."

PASSION AND KNOWLEDGE: THE CRAFT OF BEING A MENTAL HEALTH NURSE

FOREWORD

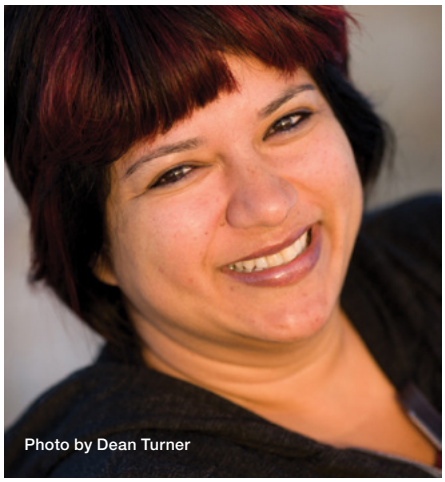


Photo by Dean Turner

Ruth DeSouza MACN

Mental health nursing has a colourful and somewhat contentious history. Attendants, coercion, abuse, stigma and asylum are words associated with the field of psychiatric nursing. The re-branding to mental health nursing and focus on recovery provides opportunities to respond more creatively and therapeutically to the person experiencing mental ill health. Philip and Poppy Barker advocate for a "craft of caring", where the mental health practitioner integrates both the aesthetics and knowledge of nursing to meet the needs and expectations of clients and their own aesthetic and technical desires (Barker & Barkin 2011). The Barkers suggest that caring takes diligence, time and effort combined with creativity and resourcefulness.

This brings me to the stories of the nurses that are contained in this article.

Nurses need these stories for several reasons. Many nurses feel anxious and unprepared for working effectively with people experiencing mental health issues. This gap, combined with stigmatising and hostile views, impact on the quality of care provided. This is concerning given the high prevalence of mental health issues in the general population and the disempowerment that often accompanies a change in health status. However, mental health nursing is a marginal career choice for students entering a Bachelor of Nursing degree. Frequently, they are dissuaded from choosing it as a career option with classmates, faculty and family members not viewing it as 'real' nursing and many students are afraid of people experiencing mental illness (Happell et al. 2013). This is why I was so heartened to read Meg's story. Meg has just completed her final year of her Bachelor of Nursing and is about to embark on a career as a mental health nurse. Her enthusiasm and passion offer great hope that we are already reversing these barriers. I hope that more early career nurses, like Meg, choose the career path so many of us mental health nurses have embraced, through engaging with high quality theory and having positive clinical experiences.

Karen's passion for mental health nursing is evident in her belief that "… it is crucial that mental health nursing education remains clearly identified within undergraduate curricula in stand-alone units and is delivered by academics that are specialists within this field". Here is where future mental health nurses have their seeds of interest sown, nurtured and grown, then reinforced through clinical practice.

Although nurses are implicated in psychiatric care, treatment and processes that valorize vigilance and surveillance to minimise risk, nurses like Christopher deftly work within psychiatry's reductive gaze while attending to the unique lived experience of the person who is experiencing "problems of living" (Barker). Christopher carefully manages the ethical dilemmas of care and control, by remaining client focussed, using the family as a model of care, he tries to create a more equitable world despite nursing in a context of community fear.

This attempt to cultivate an ethical disposition and maintain hope and trust in themselves and in their clients requires that mental health nurses address their own psychological wellbeing amidst an environment of "moral distress" (Barker 2011, Barkin 2011). Barbara's story shows how, in order to promote good mental health, her relationship with colleagues is fundamental for support but equally her relationship with herself also requires nurturing in the form of self-care. What's important about these stories is that they show how central passionate people are to entry to the profession. Edy began her career in orthopedics but became inspired by passionate educators when undertaking further study. She found herself in an environment where she saw mental health nursing being valued and came to consider it as a career option. "Being fascinated" provided the spark for her to take up mental health nursing which has resulted in her being versatile, enjoying herself and learning to deal with what is.

The rewards of crafting are evident in Brett's story, both in being inspired to take up an apprenticeship in mental health nursing and being inspired by highly skilled practitioners, and in the ways he pits his skills against levels of acuity and risk. The lifetime apprenticeship is also evident in Barbara's story; her work with people at various parts of the lifespan, in

different contexts and settings brings richness to her craft. Entrepreneurship and new paths are evident in both Barbara and Christopher's stories, offering further autonomy and creativity. Whether the passion for mental health nursing starts in the blood like it did for some or appears later in their career for others, what is a resounding theme in these stories is the desire to help others to get the most out of life using innovation and creativity.

The caring part is important too; although caring is a human activity, what makes the care that mental health nurses give different is that it happens in the context of competing demands, with people who might have been forsaken by others or difficult to care for (Barker 2008). Importantly, caring must occur by learning about yourself, countering stigma, being a leader and a role model, recognising that mental distress impacts on all aspects of life.

These stories have a common vision of mental health nursing practice as both art and science. Moving beyond a medically dominated view of mental health, these exemplary nurses articulate a philosophy of practice that sees people in the context of their culture, family and society. Motivated by a philosophy and practice of compassion and advocacy in the context of complexity, their narratives reveal mental health nursing to be a craft that is challenging, rewarding and innovative.

Dr Ruth DeSouza is Co-ordinator Bachelor of Nursing, Director of Community Engagement, Faculty of Medicine, Nursing and Health Sciences, Monash University

References

Barker 2008, *Psychiatric and Mental Health Nursing: The craft of caring,* CRC Press, Boca Raton, FL.

Barker & Barkin 2011, 'Promoting critical perspectives in mental health nursing education', *Journal of psychiatric and mental health nursing,* vol. 21, no. 2, pp. 128-137.

Happell, B., & Gaskin, C. J. 2013, 'The attitudes of under-graduate nursing students towards mental health nursing: a systematic review', *Journal of Clinical Nursing,* vol. 22, no. 1, pp. 148-158.

Meg Bransgrove MACN

Mental health nursing is unequivocally a passion for me. It has been my passion from the moment my pen started scribbling on the application form for the Bachelor of Nursing and remains so, as I complete my final year of my degree and head into my first year of practice as a registered nurse.

I've been travelling toward it like a ship to a lighthouse; the winds of industry have buffeted me in many directions and there were days I wondered if I would ever even reach the shore. But, I've had amazing experiences that confirmed I was travelling on the right path and helped me reflect on the nurse I want to become.

Mental health still makes people uneasy, they don't quite know what to think, say or do. Conflicting messages in society further confound the situation: violence, benevolence, aggression and compassion. There are amazing organisations breaking down the barriers and stamping out stigma, but the media can still be merciless. My family keep asking if I really want to be a mental health nurse after watching the latest news bulletin, checking that I've made a good decision, because they heard about this, this and this, so am I sure?

I always say "Without a doubt!"

What I learned on my amazing mental health placement is that this is about people. Health is the mental and physical wellness of people. We all need to care for our minds and bodies every day. They have been separated by history and we are still trying to tell everyone they go together. Mental health nursing is recognising the often-invisible pain and caring for people under immense mental pressure. Yet, so many fellow students and nurses have said to me "I just don't get mental health." The fact is it's not a secret, it's not unfamiliar, if you have a brain you have mental health, it's when your mind is under unbearable pressure that you have an illness. A mental health nurse recently said to me that "1 in 4 people have mental health issues and 3 in 4 people are in denial."

This sense of unfamiliarity still prevails in nursing; many lecturers, mentors and peers have actively tried to dissuade me from mental health. At the 40th Australian College of Mental Health Nurses Conference students came together and spoke about the sense of alienation they felt for wanting to specialise. Among the nursing and medical professions mental health nurses and psychiatrists feel stigmatised by colleagues, yet mental illness is recognised as one of the biggest health problems of our time. So, why are the people trying to help being isolated?

Mental health is exciting, creative, interesting and provides a sense of meaningful connection with consumers that very few specialties achieve. There are so many incredible clinicians and academics that are passionate about what they do and are an inspiration in the nursing profession.

Meg Bransgrove is a Registered Nurse

"Mental health still makes people uneasy, they don't quite know what to think, say or do. Conflicting messages in society further confound the situation: violence, benevolence, aggression and compassion."

Brett McKinnon

My mental health journey started in 1992 when I trained as a mental health nurse. I commenced full-time work in 1996 and have been working in mental health nursing ever since.

Dealing with patients with mental illness can pose enormous challenges for mental health professionals. However, the satisfaction that comes from progressing with patients and achieving desired outcomes makes overcoming these challenges very worthwhile.

A professional challenge of mental health nursing is the lack of recognition received by mental health nurses under the Medicare Benefits Scheme. Allowing mental health nurses to achieve something similar to allied health professionals would go a long way in progressing our clinical discipline.

A major highlight of working in mental health nursing has been working with, and witnessing, highly skilled practitioners apply their craft to deliver meaningful patient outcomes. Working in such close proximity to my colleagues develops a great friendship bond and allows us to work together to provide worthwhile care to our patients.

Mental health nursing allows me to pit my skills against high levels of acuity and risks. I assist in saving and recalibrating lives every day and that sense of achievement is very rewarding.

Brett McKinnon is a Mental Health Services Manager

Christopher Veal MACN

I have been a mental health nurse since 2001. I began working in prisons and completed my Honours Thesis, *How nurses care for prisoners in jail,* before going on to complete my Master's degree in Mental Health Nursing at the University of Southern Queensland in Toowoomba.

I started out in the Neo-Natal Intensive Care Unit at the Royal Hobart Hospital but quickly realised neo-natal nursing wasn't for me. I then moved on to a nursing job at a prison as I had experience working in a prison environment previously. It was in the prison environment I saw the need for people with mental illness to be provided excellent care, and I enjoyed looking after them.

The main highlight of my career has been buying my business. After years of working in the government I saw deficiencies in the care being offered and I decided that I wanted to extend on the basic care provided and improve the quality of life for people with mental illnesses.

"I find that the biggest challenge is finding the balance in providing quality of life and integrating people into society in a safe and secure manner and managing community expectations and complaints."

I've been able to reflect my philosophy in my care model. I believe that people with a mental illness should still have the same opportunities as people in societies and my business ensures that our residents have those opportunities.

I find that the biggest challenge is finding the balance in providing quality of life and integrating people into society in a safe and secure manner and managing community expectations and complaints. The negative responses and complaints from local businesses and people in the community are costly and time consuming to investigate, if we were able to utilise this time and money better we would be able to take on another part-time employee or develop more activities to provide better care for the residents.

Mental health nursing allows me to develop a nurturing, family environment where everyone feels at home, running my businesses allows me to treat everyone as I would my own family members and provide to them the care they need.

Christopher Veal is a Managing Director of Brynhild Pty Ltd and Grimhild Pty Ltd

Jane Bonfield

I graduated from the University of Newcastle in 1996 and worked in emergency medicine and infectious diseases before completing my Masters in Health Science.

In 2010 I began work for the Newcastle Assertive Outreach Service 'Reaching Home'. During my four years at Reaching Home I have worked as a primary care nurse, working with client's complex needs.

My role gives me the opportunity to build and demonstrate my advanced clinical skills by managing complex client needs. I assist in managing clients from the initial assessment stage, triage and prioritisation of client needs, to care planning, direct nursing care and coordination of supports and services to adequately meet the needs to the client.

Working in a mental health nursing capacity has given me the opportunity to further enhance my leadership and management skills. It has also required me to develop high level of communication skills as it is crucial that I liaise effectively with other staff and services so we were able to provide a coordinated and affective approach to client care.

Through my work with Reaching Homes I have been able to provide a service and access to vulnerable people who deserve the very best of care and I want to continue to do this.

Jane Bonfield is a Registered Nurse

Barbara Pentecost

I have been a mental health nurse for about 30 years. I trained in Portsmouth in England at a big hospital which, at that time, was one of the leading hospitals in mental health.

I enjoyed my training and afterwards moved to Cornwall where I worked on the wards for two years and gained promotion to Charge Nurse of a female long stay ward. It was interesting times as they were trying to place people back in the community. Some people had been in the hospital for over 50 years.

In 1997 I emigrated to WA and worked in a large mental health hospital in Perth and took on a number of roles over the years including the coordinator in a day therapy service for people over 65.

I then moved to Albany and worked as a community Mental Health Nurse. I found working in a rural setting very different from anything I have ever done before and, due to the large caseload, very stressful.

I now work as the Intake Coordinator with *headspace*, National Youth Mental Health Foundation. This is one of the best jobs I have ever had; working with young adults aged 12 to 25.

This job allows me to do what I'm passionate about; promote positive mental health, counselling, case management and working together with fellow services to provide the best care possible for each individual. I am fortunate to work with a motivated team that cares for each other and supports each other, which is much needed as some of the stories we hear are heart breaking. Importantly, I have learnt over the years that our mental health suffers when not supported in a job or if we don't practice good mental health strategies ourselves.

Barbara Pentecost is a Mental Health Nurse

Edy Saint deWinter

I began my nursing in the most northern hospital in New Zealand seven months after I had turned 15, in those days you were interviewed by the matron for your suitability to become a nurse.

I came to Australia in 1976. From 1976 to 2005 I worked mainly in orthopaedics and loved it so much I thought I would be doing orthopaedics until the day I died.

It was whilst working on the orthopaedic ward that my interest in mental health nursing first arose. I attended a study hour which was held by a mental health nurse who was a lecturer at The Adelaide University. He made mental health sound fascinating and he inspired a girlfriend and me, we came away thinking "we can do this" and that day I enrolled to do a postgraduate in Mental Health Nursing – the same year I turned 50.

My postgraduate degree was the best year of my university life, I had amazing lecturers, facilitators and preceptors and the placements were amazing.

I catch myself saying "this is the most fascinating time of my nursing life, I love mental health" and I surprise myself because, like a lot of nurses, I had mixed reactions to patients in surgical/medical nursing that had mental health issues.

All through my nursing life I prided myself on my nursing values of being respectful, compassionate, gentle and caring but I regret that, during my earlier nursing life, I could have done so much more with patients that had mental illness if I had had a better understanding of mental health and addressed my fears.

Edy Saint deWinter is a Mental Health Nurse

Karen Harder

I am a registered mental health nurse with twenty plus years' experience spanning both public and private mental health services, including management, education and clinical roles.

Mental health nursing has offered me a career opportunity to work with marginalised and vulnerable people at a time in their life when they need support, guidance and strategy based interventions to facilitate recovery from their illness. While a career in mental health nursing has been personally and professionally challenging, it has provided a diversity of clinical experiences with a dynamic and constantly evolving environment. The strength of the clients who have experienced torment and hardship, whether this be due to personal choice or due to circumstances beyond their own control, needs to be admired and by joining them via the therapeutic relationship and using our specialist knowledge and skills we join with them on their journey of recovery.

It is crucial that mental health nursing education remains clearly identified within undergraduate curricula in stand-alone units and is delivered by academics that are specialists within this field.

Stigma against clients and their families with mental illness, unfortunately, remains prevalent in the community and can be perpetuated from health care staff; however, with improved education, increased media scrutiny and increased community mental health literacy, this has seen key government officials and media personalities publically acknowledging their own personal struggle with mental illness, and is offering hope and inspiration to others who suffer in silence while striving to achieve increased community acceptance.

Karen Harder is a Lecturer in Mental Health Nursing

"...I regret that, during my earlier nursing life, I could have done so much more with patients that had mental illness if I had had a better understanding of mental health and addressed my fears."

IMPROVING MENTAL HEALTH OUTCOMES THROUGH NURSE CARE COORDINATORS

By ACN Policy Unit

Almost half (45%) of all Australians aged 16-85 years will experience a common mental health condition at some time in their life, such as depression, anxiety, or a substance use disorder. One in five (20%) will experience this in any given 12-month period (ABS 2008). Furthermore, approximately 64,000 Australians are living with a psychotic illness and are in contact with public specialised mental health services each year (Australian Department of Health 2011).

Mental illness significantly impacts on the lives of those who suffer the condition, in addition to profoundly affecting their family, friends and the broader community. Poverty, unemployment, homelessness, isolation, discrimination, and stigma are all problems commonly associated with mental health disorders (AIHW 2014). Its direct financial impact is also substantial with more than $7 billion being spent on mental health-related services each year, including on residential, community and hospital-based care (AIHW 2014).

Contributing to the high prevalence of mental health disorders and their associated costs is Australia's siloed and fragmented health system, driven by poor service integration and coordination. Service fragmentation occurs at multiple levels of the health system and can be categorised crudely into 'vertical' and 'horizontal' distinctions. Vertical fragmentation refers to a lack of coordination between different hierarchical levels of the health system, such as between primary, secondary and tertiary care services. Horizontal fragmentation refers to a lack of coordination between multidisciplinary providers working at the same level (e.g. primary). In a narrow sense, this can occur between services within a particular sector, such as primary health care, where there may be a disconnect between a general practitioner, primary health care nurse, community pharmacist and psychologist. In its broader form, horizontal fragmentation also occurs between different sectors, especially health and social care, where, for example, a lack of coordination between a general practice, drug and alcohol counselling, housing, employment, and education services takes place.

Fragmentation across each of these areas is highly problematic for people who suffer from a mental health condition (as well as their carers) as they must often traverse across all of them to meet their needs adequately. When they are unable to do this effectively, due to an inability to identify and engage with the correct services for example, they are at much greater risk of experiencing sub-optimal care, poorer health outcomes and low levels of service satisfaction (Powell Davies et al. 2006).

The role of nurses in coordinating multidisciplinary mental health care

Nurses play a significant role in addressing service fragmentation by coordinating and integrating much of the multidisciplinary care that people with mental illness require. The role and function of nurse care coordinators* may differ widely across the health system, depending on the setting, patient needs and professional competencies. In general, the task often involves some level of assessment, development of a service/treatment plan, brokerage, service implementation and coordination, advocacy, mentoring and monitoring and evaluation (Browne et al. 2012).

Nurses are able to perform this role effectively as they possess a broad range of skills and knowledge which allows them to work comfortably across a wide range of disciplines and sectors, including in collaboration with medical specialists, GPs, allied health professionals, community pharmacists and social service providers. In addition to their technical ability, nurses excel in these roles because they have a tendency to approach care holistically, identifying and meeting the cultural, spiritual and emotional needs of patients, in addition to their clinical needs. This approach involves working collaboratively with the patient's carer, family and other relevant social supports.

The breadth and depth of these skills can be appreciated by examining what Stewart et al. (2012) identify as necessary attributes for mental health care coordinators:

- A proactive, collaborative and inclusive approach.
- Strong communication and people skills.
- Strong negotiation and mediation skills.

- The ability to manage interactions with and between staff, especially senior staff.
- Skills at working effectively with family systems and managing group dynamics.
- Familiarity with the working environment.
- Familiarity with other mental health settings and broader community resources.

Importantly, the authors point out that these skills are not exogenous, but are developed and refined over time, meaning that any nurse is capable of developing them to become effective care coordinators across a number of diverse settings.

Benefits of nurse care coordination

When mandated and supported to perform a care coordination role, nurses can have a significant impact on patient clinical outcomes, health service experience (including that of carers) and on team morale. In the acute clinical setting, evidence demonstrates that nurse care coordinators are key drivers in improving inpatient service delivery, clinical outcomes, and patient and carer satisfaction (Stewart et al. 2012). Through a controlled study, Stewart et al. find that when a nurse care coordinator is involved in coordinating mental health patients' care, there is more consistent discharge planning, faster follow-up by community mental health professionals following discharge and a greater number and variety of health and welfare service providers involved in the patient's assessment and treatment. They also find that the improved service provision attributable to the nurse care coordinator leads to a 50% reduction (462 bed days per year) in the time spent in the intensive care unit for mental health patients.

Moreover, the patients and their significant others report higher overall levels of satisfaction with the care they receive, especially with regard to how the service users' physical, emotional and spiritual safety was protected during their admission. Complementing this is the fact that liaison with family and community resources, including their active involvement in the assessment, planning and treatment processes was greatly improved under the care coordinator model (Stewart et al. 2012).

The positive effect of nurse care coordinators can also be observed in the broader inter-sectoral setting. In studying a number of child mental health care coordination programs, Browne et al. (2012) identify the pivotal role that nurses play in providing holistic care to the child and their family. In these cases the nurse primarily acts as a focal point for the coordination, monitoring, and assessment of the child's health and social services, which includes frequent liaison and collaboration between the nurse, the child's family, school, and other community service providers. In the models investigated by Browne et al., they find greater parent satisfaction with the services, and improved behavioural and mental health outcomes for the child; especially when all necessary services are identified and provided, such as counselling, other talking therapies and general supports.

Barriers to effective mental health care coordination

Health and social service fragmentation is a significant problem in Australia, where service gaps, duplication, inefficiency and waste characterise the system. Part of the problem lies in the siloed funding model that Australia employs to fund its health and social care sectors; involving funding from two (and often three) tiers of government with little regard for intergovernmental collaboration, coordination, or communication. As a result, service objectives, scope, responsibilities, and accountabilities can be incoherent, making it difficult for health care providers, like nurses, to meet the needs of their patients holistically; especially when they are constrained by unnecessary and inconsistent regulatory and reporting burdens imposed by multiple funders.

The lack of eHealth infrastructure and related support is another factor driving system fragmentation. A shared electronic health record and secure messaging are two critical tools for helping multidisciplinary providers share information and communicate with each other; in addition to promoting greater consumer participation. Yet the roll-out of these programs in Australia has been patchy, slow and relatively unsuccessful, to-date. One reason for this is the lack of engagement and support provided to health professionals beyond the medical profession, especially nurses and allied health providers who play crucial roles in the care of people with mental illness – and others with complex and chronic conditions.

Adding further to the issue of fragmentation is the lack of knowledge that many providers have about the skills and scope of other health and social care professionals. General practitioners, as 'gate keepers'

“High among its priorities was the need to acknowledge the critical role that nurses already play in coordinating comprehensive care for people with mental illness. More importantly was explaining how nurses can play a much greater role in this area if given the correct supports and incentives to do so.”

to the secondary and tertiary care sectors, for example, may not be fully aware of all the services that are available to their patients, such as those that can be provided by mental health nurses, psychologists, counsellors and social workers. This can lead to a reluctance by the GP to refer the patient on to secondary care options, meaning the patient may miss out on valuable services and receive inefficient and sub-optimal care.

Advocating for change

While the barriers identified above are significant in their ability to impact on service delivery, and therefore on the outcomes of people suffering from mental illness, they are by no means intractable. Funding siloes can be fixed, eHealth technology can be enhanced and health care provider knowledge can be improved and maintained. What is needed is sufficient government will, achieved through strong and sustained community support. Key to this is the role of relevant professional bodies in advocating for change and offering practical evidence-based solutions on behalf of their members. That is why, in its recent joint submission[1] to the Senate Select Committee *Inquiry into Health Policy, Expenditure, and Administration,* ACN proposed and advocated for a suite of policy changes that would help address Australia’s service fragmentation issue.

High among its priorities was the need to acknowledge the critical role that nurses already play in coordinating comprehensive care for people with mental illness. More importantly was explaining how nurses can play a much greater role in this area if given the correct supports and incentives to do so. One such support would be a reformed health care financing model which recognises and adequately remunerates nurses for the leadership roles they play in joining up multidisciplinary services. This would include ensuring that they are supported to work across their full scope of practice, and that nurse practitioners and other specialist nurses are given the autonomy and support necessary to practice without the need for medical supervision or affiliation, where this is appropriate.

Also among the priorities was the need for government to continue funding and supporting the roll-out of eHealth technology, but to also extend this support to nurses and other health professionals who are critical in creating a coordinated and integrated health care system for those who need it most.

Finally, but not least, was the need to address the knowledge gaps that many providers have regarding the skills and scope of other health professionals, which is currently leading to service gaps and sub-optimal care for patients. To help achieve this, ACN is advocating for improved education and training programs, from the undergraduate level right through to continuing professional development programs. Better professional education, a reformed health financing model and an improvement and extension of Australia’s eHealth infrastructure, would all support better mental health care coordination by promoting knowledge sharing, respect and collaboration amongst relevant professionals and stakeholders. These issues, amongst others, are what ACN is advocating for on behalf of its members and the Australian community more broadly, with the goal being better connected health and social care systems that comprehensively meet the needs of people affected by mental health conditions.

*The term ‘nurse care coordinator’ is used loosely in this article to refer to both the formal ‘nurse care coordinator’ position and to the general coordinating role that many nurses play irrespective of whether that is their official title or principal role.

1. The joint submission was made by ACN in conjunction with Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Australian Primary Health Care Nurses Association, CRANAplus, Australian College of Mental Health Nurses and Australian College of Midwives.

Author acknowledgement

Acknowledgement to Scott Brown, PhD Candidate, University of Melbourne, in the preparation of this article.

References

Australian Bureau of Statistics. 2008, *National Survey of Mental Health and Wellbeing*, 2007.

Australian Department of Health. 2011, *People Living with Psychotic Illness, 2010.*

Australian Institute of Health and Welfare. 2014, Mental health services in Australia. Accessed 14 October 2014, available at: http://mhsa.aihw.gov.au/home/.

Browne, G., Cashin, A. & Graham, I. 2012, Models of case management for working with young children: Implications for mental health nurses, *International Journal of Mental Health Nursing,* 2012, vol. 21; pp123-130.

Powell Davies, G., Harris, M., Perkins, D., Roland, M., Williams, A., Larsen, K. & McDonald, J. 2006, *Coordination of care within primary health care and with other sectors: A systematic review.* Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW 2006.

Stewart, M. W., Wilson, M., Bergquist, K. & Thorburn, J. 2012, Care coordinators: A controlled evaluation of an inpatient mental health service innovation, *International Journal of Mental Health Nursing 2012,* vol. 21; pp82-91.

RESPECT AND MENTAL HEALTH: WE CAN DO BETTER

By Elijah Sabondo

It was during one of my shifts covering in the emergency department (ED) as the Mental Health Clinical Nurse Consultant that I heard one of the ED staff nurses shouting 'mental health, mental health'. I turned to see what was going on and realised she was actually talking to me! I told her I preferred being called by my actual name. Though she jokingly said 'mental health' in reference to me, it reminded me of the stigma surrounding mental illness and how both mental health patients and the staff who care for them are often looked down upon. Why is the stigma present and how can we, as nurses, change the situation?

It is common knowledge that one in five Australians will grapple with a mental illness at some point in their life. Those stigmatised with mental illness can often be treated by society in such a way that their life chances and prospects of realising their own potential are significantly diminished (Hinshaw 2007). Sadly, such attitudes also exist amongst nurses, including those employed in mental health.

Research has shown that there are many prejudices and negative attitudes towards people with a mental illness in the wider community. Many people find social interaction with people with a mental illness uncomfortable, and regard the behaviour of the individuals as potentially dangerous and violent (Lauber 2008). These prejudices can impact on sufferers across all facets of their life. According to Pope (2011) common discrimination towards those with mental illnesses results in disparities in education, housing, job opportunities, income, health care and other facets of life. Employers are less likely to hire people who disclose they suffer from a mental illness; research has shown that employers assume that people with a mental illness are more likely to be absent from work, dangerous, or unpredictable (Green et al. 2003). Page (1995) noted that landlords responded in the same way as employers. Few landlords were willing to lease apartments to someone who identified as having a mental illness.

What should be of most concern to all nurses, not just those specialising in mental health, are the barriers faced by people experiencing a mental health condition in obtaining and accessing treatment services. They are often perceived as unable to pay for the services provided to them. They are on the receiving end of negative attitudes from some health professionals. Just entering into treatment can also be a huge barrier. For instance, 40% of people with schizophrenia who attempted to obtain treatment failed (Corrigan 2004). Even once treatment is received the effects of stigma have shown to influence the efficacy of their treatment and, worryingly the culmination of these negative interactions can lead to the person visualising themselves in a negative way. People diagnosed with a mental illness often find that their self-image and confidence is eroded away, not just by the experience of their illness, but by the way others treated them (Cleary, Deacon, Jackson et al. 2012).

Three themes around attitudes are worth mentioning here – language, love and life. Both patients and health professionals have noted issues of language. Health practitioners can refer to patients as 'cases' instead of people. Such language is founded in a history of oppressing and dehumanising people with mental illness. The second theme is around the lack of love. People experiencing a mental health condition referred to feelings of loneliness and lack of acceptance. They reported simply wanting love in their lives but that it was missing (Overton & Medina 2008). The third theme is that people with a mental health condition felt like they lacked a life of their own. They felt that others were making choices and setting goals for them.

Nurses can be champions of societal change when it comes to referring to people with a mental health condition. We can act as role models in our professional, social and family circles and exhibit inclusive attitudes towards those with mental illness. Goffman (1963), as far as four decades ago, argued that nurses are in an ideal position to have a sophisticated level of insight and empathy, and to work against stigmatising negative attitudes towards a person experiencing a mental health condition. By 'speaking out' nurses can help mitigate the stigma. Next time you hear a person experiencing a mental health condition referred to as a 'case' or you witness discrimination, even if unintentional, why don't you speak up and advocate for respectful and dignified care?

Remember, mental illness is not selective and it does not discriminate – your brother, friend, mother or child could develop a mental illness. You have the power to influence how they are nurtured and supported and provide the acceptance and autonomy in their life that will support recovery.

Author details

Elijah Sabondo is a Mental Health Nurse and Tertiary Nurse Educator at ACN, NSW.

References

Cleary, M., Deacon, M., Jackson, D., Andrew, S. & Chan, S.W. 2012, 'Stigma in mental illness: A continuing concern', *Contemporary Nurse : a Journal for the Australian Nursing Profession,* vol. 41, no. 1, pp. 48-50.

Corrigan, P.W. 2004, 'How stigma interferes with mental health care', *American Psychologist,* vol. 59, pp. 614-625.

Green, G., Hayes, C., Dickinson, D., Whittaker, A. & Gilheany, B. 2003, 'A mental health services users' perspective to stigmatization', *Journal of Mental Health,* vol. 12, pp. 223-234.

Goffman, E. 1963, 'Stigma: Notes on the management of spoiled identity', Englewood Cliffs, NJ, Prentice Hall.

Hinshaw, S.P. 2007, *The mark of shame: Stigma of mental illness and an agenda for change,* Oxford University Press, New York, 2007.

Lauber, C. 2008, 'Stigma and discrimination against people with mental illness: A critical appraisal', *Epidemiologia e Psichiatria Sociale,* vol. 17, no. 1, pp. 10-13.

Overton, S.L. & Medina, S.L. 2008, 'The Stigma of Mental Illness', *Journal of Counselling and Development: JCD,* 2008, vol.86, pp. 2.

Page, S. 1995, 'Effects of the mental illness label in 1993: Acceptance and rejection in the community', *Journal of Health and Social Policy,* vol. 7, pp. 61-68.

Pope, W.S. 2011, 'Another face of health care disparity', *Journal of Psychosocial Nursing and Mental Health Services,* vol. 49, no. 9, pp. 27-31.

ISOLATED PRACTICE: REFLECTIONS OF A PARKINSON'S NURSE


Sally-Anne Wherry MACN


Amy Jones

By Sally-Anne Wherry MACN and Amy Jones

Parkinson's nurses are specialist practitioners, with skills in leadership, case management, education and evaluation of care. They manage patients from the point of diagnosis, throughout the disease progression, into palliative care. They provide support for families and carers, combining their knowledge of the disease with compassion and caring. They provide nursing support in a range of locations, including care homes, hospitals and people's own homes (Parkinson's Australia n.d.) and, in many instances, this care is delivered in isolated practice.

Below is a reflective piece, based on Rolfe's reflective model, addressing these questions - *What?, So what?* and *Now what?* (Rolfe 2001). These reflections highlight how isolated practice and working in repeated stressful situations can impact negatively on a nurses' mental health.

What?

Amy: The Queensland Parkinson's nurse is embedded in tertiary care. Patients are seen in a hierarchy of critical/complicated to non-urgent. We investigate the problems that pertain to their movement disorder, adjust medical treatment and give advice accordingly. Due to time constraints we don't always talk about the broader determinants of their health such as their social supports, their future with Parkinson's disease (PD) and we don't usually provide an action plan to help patients meet their overall health goals. It is generally a prescriptive consultation with limited collaboration with the patient and their other health providers. This isn't by choice; there simply isn't the infrastructure, resources, collaboration, culture and there is little incentive to change. To shift to a chronic care model would be a mammoth task and a political and cultural nightmare. However, the evidence clearly shows that people need to manage their chronic conditions better in order to reduce disability, prevent premature death, have better quality of life and reduce burden on health care systems. I do think providing patient care in the context of a chronic care framework would be a much better use of our time and resources if the change was thoroughly supported.

Sally-Anne: Duquette et al.'s (1994) paper identifies three groups of factors that link to stress, or burnout, for nurses:

- Organisational - the demands of the job.
- Buffering - the demands of our own coping techniques.
- Demographics - age and experience.

Lack of control over our work and a lack of workplace support are positively correlated with higher stress (Xie et al. 2011). The frustration at the limitations and lack of control of Amy's role speak loudly from her words which, in themselves, act as an identifier for the organisational stressor – service limitations, high workloads and inadequate resources.

Amy: As a Parkinson's Disease nurse in Queensland, I believe my experience is consistent with many specialist nurses around Australia. As a novice in this position I struggled to understand how the politics, bureaucracy, funding restrictions, hospital culture and lack of nursing peers (in my field) were impacting on my practice and why we do things the way we do.

I felt like I was in this bubble, when I asked questions about clinical practice or processes, often peers didn't know or didn't have the time to help and I would spend a considerable amount of time trying to find the solutions myself. The lack of transparency and roadmap on how to negotiate the challenges I faced, to say the least, were frustrating and isolating. I found myself playing the role of the worker ant and following orders.

Sally-Anne: Parkinson's nurses frequently manage a large caseload of patients with palliative, emotional and mental health needs without team members or colleagues to support them. This problem is particularly acute in areas where the numbers of this specialty are limited, such as Australia. Distance from colleagues and health services were shown to be stressors by Wilkes and Beale (2001) in their study on rural nurses in home-based palliative care.

Of course, these stressors are not only relevant to PD nurses. Nurses, in general, have high levels of stress (Smith et al. 2000), having a large impact on the staff and their lives, sometimes to a devastating degree. Stress at work is an important cause of job dissatisfaction and is strongly linked with nurses' decisions to stay or leave the job, or profession (Flanagan and Flanagan 2002).

So what?

Amy: Playing the role of a worker ant did have a few benefits. I started figuring out who my mentors, champions and adversaries were and I started making a road map of my own. This helped me negotiate

“Networking, attendance of educational experiences and a mentor have been invaluable for my professional development, overcoming challenges and reducing my professional isolation.”

new challenges such as introducing new infusion therapies, ordering better equipment, admitting patients sooner or avoiding unnecessary workplace political confrontations.

It has been by chance, rather than determination, that I have slowly met other peers working with patients with PD. The consultant I work with probably understood the predicament I was facing better than I did. He put me in contact with pharmaceutical representatives who helped me attend national conferences. He also discussed the finer points of patient treatment, diagnosis, physiology and workplace politics. Networking, attendance of educational experiences and a mentor have been invaluable for my professional development, overcoming challenges and reducing my professional isolation. They have helped me better understand the conditions I treat, realise the challenges I face are not unique and have helped me be critical about how bigger factors are preventing us from providing optimal care for our patients.

Sally-Anne: Feeling supported is a vital mediator of stress and can minimise the impact of the stressful situations (Healy and McKay 2000; Peters et al. 2012). Understanding your professional role helps the nurse reduce the conflict between the nursing role and the wider team, alongside the understanding of the best practice in PD care (Peters et al. 2012). The informal networks of support, such as the Australasian Parkinson’s Nurse Network and the ACN Movement Disorder Community of Interest, ensure that standards are maintained, practice and knowledge shared and support is gained through mentorship (Healy and McKay 2000).

Amy: The best thing I ever did was return to university. I feel better equipped to negotiate the challenges I face and more confident to argue for change because I can now put forth evidence-supported arguments that are more likely to be listened to. The poor responses to questions and deferring tactics that I encounter are smaller barriers now. I realise that my peers in other isolated specialties have valuable insights and skills that I can translate and use to structure my own practice, and that they probably face the same challenges that I face. By collaborating with them I’ve realised that we have the power to improve our processes and patient outcomes.

Sally-Anne: Nurses use emotional intelligence to reduce the stress levels of their roles, monitoring their and others’ feelings, discriminating between them and using that information to guide their own thought processes and actions (Guleryuz et al. 2008). The situation has not changed but the practitioner has, evolving to develop more knowledge and more confidence in managing their own role within the job. This increase in confidence allows job satisfaction to increase, a known benefit of the use of emotional intelligence in nursing (Guleryuz et al. 2008).

Now what?

Amy: I feel there could be better investments made for our state’s future health. Policies don’t always reflect evidence-based practice, or utilise compelling research evidence in practice; both of which could improve public health and save our state money in the long term.

I would like to see a shift from primarily tertiary care to a chronic care model in our practice. Change doesn’t happen overnight, and one of the flaws of my generation and the world that we live in is that we expect results now. I try to be the change that I want to see. When I’ve been burnt out, my passion for nursing, my self-confidence, education and stubbornness have helped me stick out the tough times and believe in the ideals that I stand for. I believe in the power of erosion. Having the patience to accept the things I cannot yet change and courage to change those which I can.

Sally-Anne: There is a danger in this isolation within the health system, reducing the ability of ourselves and others to check and monitor our performance and wellbeing, when those around us may not understand the decisions we must make on a daily basis. The move to a chronic care model, or a community based model, has been proven to reduce long term health costs by using education and early support of patients with issues to reduce admissions to hospital.

It is clear that nurses, newly appointed to specialist roles without other specialist nurses, frequently experience stress at the cost of their own wellbeing. They use extraordinary abilities to monitor and manage their thought processes and actions, developing coping mechanisms and confidence on the way to becoming a fully competent and confident practitioner. These new specialist nurses seek out support, knowledge and competency, despite the system.

Author details

Sally-Anne Wherry is a Parkinson’s Nurse, ACT.

Amy Jones is a Movement Disorders Clinical Nurse, QLD.

References

ACT Health. 2014, Chronic Care Program Parkinson’s Disease Service: Evaluation Report, ACT Health. [Accessed Sept 2014 http://www.health.act.gov.au/health-services/chronic-disease-management/chronic-disease-services/pd-service/].

Flanagan, NA. & Flanagan TJ. 2002, An analysis of the relationship between job satisfaction and job stress in correctional nurses. *Res Nurs Health* 25(4): 282–94.

Guleryuz, G., Guney, S., Aydin, E.M. & Asan, O. 2008, The mediating effect of job satisfaction between emotional intelligence and organisational commitment of nurses: A questionnaire survey, *International Journal of Nursing Studies* 45(2008) 1625-1635.

Healy, CM. & McKay, MF. 2000, Nursing stress: the effects of coping strategies and job satisfaction in a sample of Australian nurses. *J Adv Nurs* 31(3): 681–8.

Parkinson’s Australia. n.d., Help for today, Hope for tomorrow, National Health and Hospitals Reform Commission submission.

Rolfe, G., Freshwater, D. & Jasper, M. 2001, (eds.) Critical Reflection for Nursing and the Helping Professions. Basingstoke, U.K: Palgrave. ISBN 0-333-77795-6. pp. 26 et seq., p. 35.

Smith, A., Brice, C., Collins, A., Matthews, V. & McNamara, R. 2000, The scale of occupational stress: a further analysis of the impact of demographic factors and type of job. HSE Books, Crown copyright.

WORKING TOWARDS CHANGE: MENTAL HEALTH NURSING IN VICTORIA


Tracy Beaton FACN


Mark Davies

By Tracy Beaton FACN and Mark Davies

The role of the Office of the Chief Mental Health Nurse (OCMHN) is to provide mental health nursing leadership and advice to government, the public and private health sector and the education sector. The goal of the office is to improve the experience of consumers, their family and carers by supporting quality improvement and encouraging the uptake of best practice approaches to care. Currently, the OCMHN is involved in four key activities:

Gender sensitivity and safety

In order to address challenges arising from mixed sex environments, limited physical space within facilities and typically higher populations of males than females, the *Building Gender Sensitive and Safe Practice Training Resource* (2013) was developed to support the safety of women in mental health services. A two day training program has been delivered in adult inpatient services, with over 75 mental health practice leaders participating. Participating services have since developed implementation plans outlining how gender sensitivity and safety training will be delivered within services, policy and procedure review and what actions will be taken to improve the physical environment in-line with the principles of gender sensitivity.

Recovery

The notion of recovery, which emerged from and was conceptualised by the consumer movement, has become the dominant paradigm informing policy, service and practice development in Australia. Recovery-oriented service delivery is predicated on the principle that people should be supported to build and maintain a self-defined and self-determined satisfying life and personal identity, irrespective of the presence or not of ongoing symptoms of mental illness (Shepherd, Boardman & Slade 2008).

The Victorian *Framework for Recovery-Oriented Practice* (2011) formalised the expectation that Victoria's mental health services would embed recovery approaches in service delivery. Although much work has been underway in services to facilitate the required culture change for adopting recovery principles, the OCMHN determined that more could be done to assist services. The Centre for Psychiatric Nursing has been commissioned to develop the *Tools for change: A recovery library* website, drawing on nursing, consumer and academic expertise in the design, development and implementation. The website, due to come online in 2015, will be an online repository of recovery-oriented resources intended to support the implementation of the recovery framework in policies, procedures and practice.

Whilst the awareness and understanding of nurses about recovery-based approaches to care is growing, providing recovery-oriented care in acute settings can be complex and challenging. A project, Recovery, Nursing and Advancing Practice (RNAP), was established to address some of these challenges, looking at whether a partnership approach to service improvement with nurses, other health staff, consumers and carers can lead to a more recovery-oriented experience of care in mental health inpatient settings. RNAP brings nurses, other health staff, consumers and carers from an inpatient unit together, as equal partners, to identify aspects of service delivery that impact positively and negatively on people's recovery. By seeking to strengthen the recovery orientation of nursing care it is intended that the quality of consumers' and their significant others' experience of nurse care in realising recovery goals will be improved.

The process is underway in several inpatient units. Early outcome data identified actions to enhance communication at admission and with family and carers, resulting in process change and policy redevelopment.

Reducing Restrictive Interventions

The OCMHN were keen to support Victorian mental health services to reduce and, where possible, eliminate the use of restrictive practices. As a result, a state-wide initiative known as Reducing Restrictive Interventions (RRI) was initiated with the intention of reducing restrictive practices in-line with the Victorian *Mental Health Act 2014*. The RRI initiative included the development of a framework and supporting services to establish local action plans (LAPs) for reducing restrictive interventions. A state-wide RRI team was available to support services during the LAP development process.

Every Victorian mental health service participated in the initiative, with LAPs covering a range of strategies including workforce development, enhanced consumer and carer participation, strengthened clinical governance, innovative therapeutic interventions and sensory modulation. Several services opted to explore the reduction of restrictive practices in partnership with emergency departments. The state-wide

team, in addition to supporting services, also developed and delivered training programs on sensory modulation and trauma-informed care, attended by practitioners from every area mental health service.

The value in undertaking a large scale initiative, such as this, is the opportunity it provides for the development of a broad range of local responses to addressing the use of restrictive interventions and the potential for the sharing of information across the state.

Safewards

A secondary outcome from the RRI project was the implementation of 'Safewards'. Originating in the UK, the objective of the Safewards model is to reduce conflict within mental health services by addressing behaviours in staff and consumers that may result in harm, such as violence, self-harm or absconding and reduce the likelihood of this occurring. The Safewards model describes how inherent features of mental health services create potential 'flashpoints', situations where conflict could arise. Focussing on how staff can act to prevent flashpoints and manage conflict, Safewards is a package of interventions shown to reduce conflict and violence in mental health care areas.

The Department of Health is overseeing a trial of Safewards at seven services, with funding of $1 million available to support the trial. The trial, which commenced in October this year, will implement the Safewards model and seek to determine the appropriateness of the Safewards model in the Victorian context. It is anticipated that Safewards will lead to a reduction in restrictive practices such as seclusion and restraint. The outcomes of the trial will be used to inform any future implementation of Safewards in Victoria.

The work of the OCMHN plays a key role in translating the priorities of government into mental health service policy and delivery, working at both the state-wide policy development level and in partnership with services to support policy implementation. Impetus for the work comes from the sector, from consumers and carers, and from government policy and legislation. Whilst all of the work of the OCMHN seeks to be inclusive of consumer and carer perspectives, the work around recovery have been driven by the influence of the consumer-led recovery movement and is intended to help services create environments that support people's recovery efforts.

Author details

Tracy Beaton is the Chief Mental Health Nurse, VIC.

Mark Davies is the Senior Project Officer, Office of the Chief Mental Health Nurse, VIC.

References

Shepherd, G., Boardman, J, & Slade, M. 2008, *Making recovery a reality: Policy Paper,* Sainsbury Centre for Mental Health, London, UK.

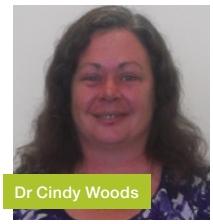
Victorian Department of Health. 2013, *Nursing observation through engagement in psychiatric inpatient care,* Department of Health guideline, Mental Health, Drugs and Regions Division, State Government of Victoria, Melbourne.

Victorian Department of Health. 2013, *Nursing practice – working with people prescribed and undergoing electroconvulsive therapy,* Department of Health guideline, Mental Health, Drugs and Regions Division, State Government of Victoria, Melbourne.

Victorian Department of Health. 2013, *Providing a safe environment for all - Framework for reducing restrictive interventions,* Mental Health, Drugs and Regions Division, State Government of Victoria, Melbourne.

WHO CARES FOR MENTAL HEALTH NURSES AFTER DISASTERS?


Professor Kim Usher FACN


Dr Cindy Woods


Dr Caryn West MACN

By Professor Kim Usher FACN, Dr Cindy Woods and Dr Caryn West MACN

On the night of 3 February 2011, category 5 Tropical Cyclone Yasi struck the North Queensland coast near Mission Beach. The associated destructive winds and rain wreaked havoc across the northern region and coastal communities between Townsville and Cairns. Although there was no recorded loss of life, the impact of Cyclone Yasi has been profound in terms of infrastructure damage, damage to vegetation including commercial crops, economic impacts and psychological distress. Yasi is ranked as one of the most powerful forces of nature to have crossed the coast of Queensland since records commenced. Survivors of this disaster experienced widespread property losses and damage, significant life changes, financial distress, and stress-related mental health conditions such as post-traumatic stress disorder (PTSD) (Usher et al. 2013), similar to the mental health experiences of survivors of similar disasters (Boscarino et al. 2003).

Most of the previous research related to the mental health impact of disasters has focussed on survivors and there has been very little to-date to address these issues among mental health nurses and other health professionals. Mental health nurses from the community are usually called upon to deliver mental health care even though they, too, have experienced losses and emotional distress similar to others in the community. Health professionals, whether local or deployed to communities post-disaster, may also experience vicarious psychosocial distress related to the repeated exposure to the stories of trauma they hear on a daily basis (Cukor et al. 2011). Furthermore, health professionals in rural and remote areas are expected to play a key role in disaster relief but generally they are less prepared for such a role than their urban counterparts (ICN 2009). In disasters such as cyclones, delivery of the initial mental health care and support for members of the community is left to the local mental health nurses as affected communities are often cut off from outside help for days and deployed staff may take weeks to arrive in the community.

After Cyclone Yasi we became interested in how caring for others during the post-disaster period affected mental health nurses, especially as these events are increasing in our region (Fritsch & Zang 2009). As a result we undertook a study to explore the experience of mental health nurses delivering psychosocial care to the traumatised communities. Nine mental health nurses (eight females) responsible for delivering psychosocial care to the people of the affected coastal areas were recruited to the study. Data were gathered through in-depth, semi-structured interviews where the nurses were asked questions including, “Tell me what it has been like working with the communities recovering from the cyclone?” and “How did you manage working with the traumatised communities?”

Participants reported how being a local and having also experienced the cyclone helped them to connect with the survivors, which they perceived as a strength.

> *“I actually found it as a strength. It gave me that ability to instantly connect with a person, sharing of stories, I found it actually a positive thing in my role.”*

The concept of growth from traumatic events has been previously reported (Hyatt-Burkhart 2014). While this does not take away from the negative impact of traumatic events, it does indicate that some professionals do find such an experience an opportunity for positive change.

Others, however, reported experiencing conflict related to undertaking the role of carer while also being a survivor. These participants expressed experiencing conflict due to the need to remain professional while maintaining boundaries between themselves and their clients. They also reported finding it difficult to put aside their own experiences and emotions in order to support others.

> *“I guess after the cyclone we were so glad to be alive, you know, you go to visit someone and they just want to hug you and cry and that was really hard to sort of keep boundaries between clients and be professional as well as a member of the community.”*


A street in Townsville post-Cyclone Yasi

"Mental health nurses from the community are usually called upon to deliver mental health care even though they, too, have experienced losses and emotional distress similar to others in the community."

Torn shade sails at a car lot in Townsville

The participants reported feeling overwhelmed by their own trauma, which combined with the 'vicarious trauma' (Ehrenreich 2002) related to the stories they heard from survivors, affected their ability to care for others. Sole operators in small rural communities, in particular, felt unsupported and struggled to deal with their clients' and their own trauma. One mental health professional reported taking time off work and another worked in a different community post-disaster because she could not cope in the dual role any longer.

> *"…you do eight and a half to nine hours every day and there's no break. Because as soon as you have a break, there's someone else that sees you. Someone else that wants to talk. Somebody else that needs your help… And also who cares for the carer's family? Because there was no one for me… But I found myself in a lot of tears. Just from being overwhelmed. Understanding the vicarious trauma, understanding that I was taking on their bits too, so taking on all their trauma and then taking on my own trauma and then deciding to take on my daughter's as well on weekends. It's enormous and it feels like it never, ever finishes."*

Unfortunately, while the mental health professionals worked all day providing support to distressed members of their community, they went home at the end of their shift to the same problems faced by other members of their community, including damaged houses and distressed family members. However, there was often no one available to listen to their stories or offer them support.

The urge to help can be overwhelming and mental health workers' own needs may be neglected in the drive to help others. As a result, these nurses experienced signs of emotional distress, which may culminate in 'compassion fatigue' (Figley 2001) where the nurse is no longer able to care for others. Mental health workers who were able to access support services were appreciative of the support; however, those who could not access support felt isolated and overwhelmed, which affected their capacity to provide care for others.

It is therefore important to remember that while mental health nurses and other professionals are vital after disasters, they too need to be supported and cared for after these traumatic events. Many of these nurses may have been severely traumatised by the event yet struggled to continue to do work to help others come to terms with the trauma that resulted from the disaster. Mental health nurses need to understand how disasters can affect them and look to support networks and colleagues to cope better during the aftermath of disasters. Service providers must recognise the impact of these events and the potential trauma experienced by mental health nurses and ensure the necessary support is available for them when necessary.

Author details

Professor Kim Usher is Head of School of Health, University of New England, NSW and member of the Centre for Research Excellence in Chronic Care, James Cook University, Cairns, QLD.

Dr Cindy Woods is Senior Research Officer, College of Medicine and Dentistry, James Cook University, Cairns, QLD.

Dr Caryn West is NHMRC Postdoctoral Fellow, Centre for Research Excellence in Chronic Care, James Cook University, Cairns, QLD.

References

Boscarino, J., Sandro Galea, J., Ahern, H., Resnick. & D. Vlahov. 2003, 'Psychiatric Medication Use Among Manhattan Residents Following the World Trade Center Disaster.' *Journal of Traumatic Stress.* Vol. 16, no. 3, pp. 301-306.

Cukor, J., Wyka, K., Mello, B., Olden, M., Jayasinghe, N., Roberts, J., Giosan, C., Crane, M., & Difede, J. 2011, 'The longitudinal course of PTSD among disaster workers deployed to the World Trade Center following the attacks of September 11th.' *Journal of Traumatic Stress,* vol. 24, no. 5, pp. 506-14.

Ehrenreich, J.H. 2002, *A Guide for Humanitarian, Health Care, and Human Rights Workers,* State University of New York, New York.

Figley, C.R., ed. 2001, Treating Compassion Fatigue. Brunner/Mazel, Philadelphia, PA.

Fritsch, K. & Zang, Y. 2009, 'The Asia Pacific Emergency and Disaster Nursing Network: promoting the safety and resilience of communities.' *The South East Asian Journal of Tropical Medicine and Public Health,* vol. 40 (Supp 1), pp. 71-8.

Hyatt-Burkhart, D. 2014, 'The Experience of Vicarious Posttraumatic Growth in Mental Health Workers,' *Journal of Loss and Trauma: International Perspectives on Stress & Coping,* vol. 19, no. 5, pp. 452-461, DOI: 10.1080/15325024.2013.797268

International Council of Nurses (ICN). 2009, Fact sheet: Disaster Response. International Council of Nurses. Available at: http://www.icn.ch/matters_disaster_response.htm (accessed 20th April, 2013).

Usher, K., Buettner, P., West, C., Mills, J., Woods, C., Mason, M., Boon, H., & Chamberlain-Salaun, J. 2013, 'Preparedness for and impact of Tropical Cyclone Yasi in North Queensland, Australia,' *Prehospital and Disaster Medicine,* vol. 28, no. 3, pp. 1-7.

Photographs

A street in Townsville post-Cyclone Yasi - By Rob and Stephanie Levy from Townsville, Australia (Flooded Streets South Townsville) [CC-BY-2.0 (http://creativecommons.org/licenses/by/2.0)], via Wikimedia Commons

Torn shade sails at a car lot in Townsville - By Rob and Stephanie Levy from Townsville, Australia (Parry Used Cars) [CC-BY-2.0 (http://creativecommons.org/licenses/by/2.0)], via Wikimedia Commons

THE NATIONAL NURSING FORUM

ACN presented a dynamic and inspiring program for The National Nursing Forum in Adelaide from 2–4 November, to over 250 attendees from around Australia. The central theme of 'Staying ahead of the game' set the stage to explore the current nursing climate, hear from leading presenters and share knowledge amongst colleagues.

Members' Day

Over 100 ACN members joined the Members' Day to hear the latest news from ACN on the new strategic direction and 2015 initiatives. With the launch of ACN as the national organisation for *advancing nurse leadership,* we saw the unveiling of the new *Leadership@ACN* program; a series of leadership development opportunities, forums and leadership practice standards aimed at building leadership capability within the nursing workforce.

ACN State Matters was also launched; a series of events that will be held across the country in each state and territory in 2015. State Matters will have a local focus and present the opportunity to share knowledge and hear from leading presenters on issues affecting each state.

Oration and Investiture of Fellows

The evening of the Members' Day saw the magnificence of The University of Adelaide's Elder Hall provide the perfect backdrop for the moving Oration delivered by Professor Roianne West. Professor West, Professor of First Peoples Health at Griffith University, said that whilst Indigenous Australians experience appalling health, she feels there is enormous hope; for there is much that nurses can do together with Indigenous Australians to advance their health outcomes.

A total of nine ACN Fellows were invested and Professor Debora Picone AM FACN (DLF) was invested as an ACN Distinguished Life Fellow.

Elizabeth Matters, Liz Hutchings and Belynda Abbott at their investiture to Fellowship

Roianne West delivering her Oration

Thank you to everyone who engaged with us on social media throughout the Forum. The hashtag #ACNForum14 was used 1,597 times over the three days. Check out our Facebook and Twitter pages to see more highlights from the Forum.

www.facebook.com/acnursing

www.twitter.com/acn_tweet

Elizabeth Grant MACN, Julie Watts MACN, Debra Thoms FACN (DLF) and Forum Poster winner, Renee Callender MACN

Forum program

The Forum program sought to address key questions raised about how to adapt and thrive in the complex and often challenging health environment. Dr Keith Suter impressed the plenary with the exceptional delivery of his keynote *What are the drivers of change and how can we respond?* Dr Suter offered valuable insight into how we approach change, environmental scanning, the challenges of change and how to make sense of changes once they occur. Delegates also enjoyed presentations by invited speakers Brian Dolan, Adjunct Professor Susan O'Neill MACN, Professor Christine Duffield FACN and Professor Glenn Gardner FACN.

Forum delegates also heard from over 45 concurrent presenters on a variety of topics and in numerous practice areas including acute care, aged care, rural and regional, chronic and complex care and community and primary health care. Interactive workshops across four topic areas challenged Forum delegates to build new skills, interact with colleagues and think creatively to solve problems.

Keith Suter

Geraldine Burton delivering her workshop *Difficult dialogues: Begin with the end in mind and end with a new beginning*

Fashions on the Field Dinner

Delegates joined in the Melbourne Cup festivities at the Fashions on the Field Dinner, sponsored by Chandler Macleod Health, with special guest speaker and culinary icon, Maggie Beer. Maggie inspired us all with her story of starting out as a nurse, her journey to the Barossa Valley and building blocks for A Good Food for Life for All initiative to highlight the importance of healthy nutritious food for those in aged care.

We look forward to seeing you again in 2015 at The National Nursing Forum, *Advancing nurse leadership*, in Brisbane.

With thanks to our major Forum sponsors

Government of South Australia
SA Health

HESTA
An Industry SuperFund

CHANDLER MACLEOD
HEALTH

CONGRATULATIONS 2015 ACN GRANT AND AWARD RECIPIENTS

ERIC MURRAY QUIET ACHIEVER AWARD $1,000

Awarded to an ACN student who is considered to be a quiet achiever.

Natasha Keir

On completion of the ACN Graduate Certificate in Breast Cancer Nursing, Natasha was offered the role of Specialist Breast Care Nurse at St Andrew's War Memorial Hospital in Brisbane.

Natasha focusses on individualised holistic care of patients with benign or malignant breast disease. She believes she is in a unique position to support breast cancer patients and their families from diagnosis throughout the continuum of care.

Natasha will use the award to participate in the Breast Cancer Nurse Practicum at Westmead Hospital.

MAYLEAN JESSIE CORDIA SCHOLARSHIP $800

Scholarship awarded in collaboration with the Cordia family for professional development.

Ralph Tramm MACN

Ralph is a PhD scholar at the Australian and New Zealand Intensive Care Research Centre at Monash University. He is investigating short and longer term health related outcomes in patients receiving extracorporeal membrane oxygenation (ECMO) at the Alfred Hospital in Melbourne. Ralph has a 20 year critical care nursing background and worked for many years at a large ECMO referral Centre in Germany before moving to Australia.

Ralph will put the scholarship towards attendance at the EURO-ELSO Conference, Germany.

LAURA SAUNDERSON TRUST SCHOLARSHIP

Three scholarships were awarded for aged care nurses in Western Australia to undertake professional development.

Lynette Tring

Lynette is a registered nurse with more than 25 years' experience. She currently works for Baptistcare WA, as Clinical Educator.

In her role she delivers training to staff working in residential care, community care and disability services. Lynette is also enrolled in the Bachelor of Dementia Care at the University of Tasmania.

She will use the scholarship funds to attend the Alzheimer's Disease International Conference.

Pansy Po MACN

Pansy is currently employed at Southern Cross Care WA Inc. as the Clinical Nurse Consultant for Home Care Service.

She is humbled to receive this award which will go towards a palliative care course through the Cancer Council of WA.

Elizabeth Vile

Elizabeth works at Hamersley Aged Care Home, having only recently transitioned from working in the acute clinical setting in hospitals to working in aged care. Her long term goal is to be a clinical leader in aged care.

She will use the funds to attend the Alzheimer's Disease International Conference.

SUL STUART FRASER SCHOLARSHIP $5,750

Awarded to an ACN member to undertake the ACN Graduate Certificate in Perioperative Nursing.

Tracy Orrick MACN

Tracy is a Registered Nurse who originally trained and worked in South Australia. In 2010 Tracy undertook a perioperative foundation course with her employer, Healthscope, at Norwest Private Hospital.

Tracy currently specialises in anaesthetic nursing and has a role in infection prevention and control. With this award, Tracy plans to advance her skills and knowledge during postgraduate study.

Ruth Arifin MACN

Ruth started her nursing career as a new graduate in Auburn Hospital in 2011 and has been working in Auburn Hospital theatre since 2012. After moving into theatre, she decided to pursue a career in perioperative nursing.

Ruth is looking forward to completing further studies and is hoping to be able to assist to make a change and improve this specialty area in the future.

Sandra Smithers MACN

Sandie is currently employed by Perfect Vision in Hornsby, Sydney. She has worked in the perioperative environment for most of her nursing career and is very grateful for this opportunity to gain a formal qualification in this area.

"OLLIE" NURSE PRACTITIONER SCHOLARSHIP $5,000

Awarded in collaboration with the Australian College of Nurse Practitioners to an endorsed nurse practitioner for the purpose of growing the body of knowledge on the nurse practitioner role in Australia.

Kim Boyes

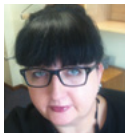
Kim is currently working as a Nurse Practitioner in Women's Health in Queensland.

Kim works with Indigenous women providing services such as cervical screening, breast screening, antenatal care, maternity health and sexual health. Kim travels around Far North Queensland providing services for women in rural and remote towns and communities

Kim will use the scholarship in consolidation of advanced practice through accessing placements.

SISTER MARGARET Y WINNING SCHOLARSHIP 2 X $10,000

Two scholarships were awarded to postgraduate nursing students at Queensland University of Technology.



Sonia Hines MACN

Scholarship awarded for doctoral studies
- *A research literacy intervention to improve nurses' evidence-based practice self-efficacy.*

Sonia has a clinical background in neurosurgical nursing and has been working in nursing research since 2006. She has developed skills in both research and education in her previous studies – Masters of Applied Science (research) and a Graduate Diploma of Education – and has recently commenced her PhD studies which encompass both areas of interest. Sonia works in the Nursing Research Centre and Queensland Centre for Evidence-Based Nursing and Midwifery at Mater Health Services in Brisbane.

Anthony Schoenwald
MACN

Scholarship awarded for doctoral studies
- *A Randomised Controlled Trial comparing Nurse Practitioner led management of an Oral Oxycodone-based plan with a standard fixed dose of Controlled-release Oxycodone, the day after Caesarean Section.*

Anthony is a Nurse Practitioner specialising in pain management and perioperative nursing. He is currently a PhD Candidate in the School of Nursing, Queensland University of Technology and is undertaking research on caesarean section pain. The purpose of the research is to examine the effectiveness of his nurse practitioner led intervention to improve pain management after caesarean section and to determine the nature and impact of caesarean pain.

EMERGING NURSE LEADERS

Katrina Horne MACN
Southern Cross University, NSW

Prior to studying nursing Katrina provided technical services (including production of mammalian cell lines for research) for one of the core partners of the Wound Management Innovation Cooperative Research Centre. This became part of the catalyst that led Katrina to undertake nursing studies via Southern Cross University (NSW). Strategic nomination of practicums is enhancing her understanding of the experiences of individuals and communities (also health workers) facing disadvantage with a focus on primary health care and chronic disease management.

Jenyfer Joy MACN
University of Western Sydney, NSW

After witnessing the strong teamwork and interpersonal skills of nurses in Oman, India and Australia, Jenyfer was inspired to undertake a Bachelor of Nursing Advanced at the University of Western Sydney. The professionalism, high calibre and compassion demonstrated by the nurses she has worked with has inspired her to work hard on developing her own talents in the hope she can contribute something meaningful to the health profession and wider community. Jenyfer believes by gaining further clinical experience and by utilising her research skills she can contribute to the advancement of the nursing profession.

Paul Kaczykowski
MACN University of Sunshine Coast, QLD

Prior to enrolling in the Bachelor of Nursing Science program at the University of the Sunshine Coast (USC), Mental Health Major, Paul gained an education on life while he worked and travelled overseas. Paul is the current President of the USC Nursing and Midwifery Student Group, a representative on the Vice Chancellor's Student Liaison Committee and a student mentor. He also volunteers in the community with Street Angels, providing support and first aid to individuals in need, and Surfriders, assisting in beach cleanups and dune restoration.

Emily Murray MACN
University of Tasmania, TAS

Emily was driven to study nursing by a desire to give back to her community through a profession that is highly skilled, scientific, and intensely personal. Emily has formerly worked for the Department of the Prime Minister and Cabinet, AusAID, and the Australian Greens. Emily's transition into nursing was precipitated by the premature death of her beloved father, and was supported by her inspiring mother and grandmother, both former nurses. Emily values integrity, tenacity and bravery, and hopes to be a strong patient advocate in an acute care setting.

Serena Ricciardone
MACN University of Notre Dame, WA

Whilst living in Ghana, West Africa with a small family experiencing the difficultly of remote health care services, Serena was inspired to enter the nursing profession. Serena is currently undertaking her Bachelor of Nursing at University of Notre Dame, Fremantle. She is passionate about student engagement for filling student representation and mentor roles. Serena is currently the President of the Notre Dame Nursing Society, the WA Student Representative for ASANNA and a WAHSN committee member. Serena will be undertaking her Graduate Program at Princess Margaret Hospital commencing in August 2015.

DOSE CYCLE: AN INTEGRAL PART OF THE PARKINSON'S DISEASE NURSE SPECIALIST'S COMPREHENSIVE HEALTH ASSESSMENT

By David Shek-Yan Tsui MACN

A comprehensive health assessment (CHA) of the patient with Parkinson's disease (PD) performed by a Parkinson's disease nurse specialist (PDNS) is often termed 'dose cycles' or 'Levodopa challenges'. The aim of a dose cycle may be to assist in diagnosis and/or investigation of symptoms by documenting the patient's degree of responsiveness to PD medications. It provides a detailed and objective assessment of a patient's motor, non-motor and any other psychosocial issues. Although the process of a dose cycle performed by a PDNS may vary between different hospitals or facilities, the nursing assessment takes a holistic approach and includes the use of various validated assessment tools to assess the different aspects of the patient's health based on the biopsychosocial model of health.

Referral and history

The process begins with a referral and patient history from the neurologist requesting a dose cycle. The rationale of the dose cycle is highlighted in the referral, and the type and dose of the challenge medication is prescribed.

The PDNS then acquires a background history of the patient's gender, age, past medical history and social living situations. More specifically to PD, the duration of disease, current PD medication regimen and presenting problem is examined.

Motor examination

Prior to the assessment, the patient with Parkinson's disease (PWP) is withheld from dopaminergic medications from the night prior, so they will attend the assessment initially in their pre-medicated state also known as their 'OFF' state and a baseline assessment is performed. A challenge dose of PD medication is then administered, usually at a slightly higher dose than the patient's normal regimen, and the changes in Parkinsonian symptoms throughout the medication cycle of the challenge dose are recorded.

The motor component of the examination is built around the Unified Parkinson's Disease Rating Scale (UPDRS) that was revised by the Movement Disorders Society in 2008 (Goetz et al. 2008) from the 1987 version (Fahn et al. 1987). The UPDRS Part III is used to objectively score the severity of the patient's PD symptoms in their 'OFF' state then compare the repeated assessment result in their medicated state known as their 'ON' state. The difference in score forms a percentage to highlight the level of the improvement using the formula below.

[(OFF score – ON score) ÷ OFF score] x 100 = Improvement in %

Example: If the OFF score was 48 and the ON score improved to 25
[(48-25) ÷ 48] x 100 = 47.9% improvement

Other assessment tools of the motor examination include the 9-hole peg board test which records the time taken to place nine wooden pegs into nine holes in the patient's 'OFF' state versus their 'ON' state. This assessment tool has been criticised for its simplicity; however, other literature has proven its legitimacy in the assessment of PWP, particularly, their upper limb and cognitive function (Earhart et al. 2011). In addition, a gait assessment is added to examine the nature, the velocity, the amplitude and mobility of the patient's walking. This is performed in both the patient's 'OFF' and 'ON' state to provide objective data to compare the patient's level of improvement.

To enhance the accuracy and reliability of the clinical records, video evidence of the assessment is recorded with the patient's signed informed consent.

Cognitive examination

PD is a multi-system disease with symptoms that affect motor function, non-motor function and cognitive function. Hence, it is vital for a PDNS to be able to assess the patient's multifaceted aspects of the patient's PD.

Glossary

Gait: The pattern of how a person walks.

'OFF': The pre-medicated state of a person with PD characterised by poor or absent motor function, with increased PD signs and where mood may be negatively affected.

'ON': The optimally medicated state of a person with PD characterised by good or improved motor function and mood may also be improved.

To assess a patient's cognition, the Montreal Cognitive Assessment (MOCA) is used. The MOCA has been shown to be more sensitive in cognitive screening than the traditional and well-renowned Mini Mental State Examination in patients with PD (Dalrymple-Alford et al. 2010). It is a simple 30 mark assessment that captures a glimpse of the patient's cognitive status in areas of executive and visuospatial abilities, memory, attention, language, abstract thinking and orientation. If the patient requires a more extensive examination of cognition, the more exhaustive Addenbrook's Cognitive Examination, which covers similar areas of cognitive function, is implemented (Crawford et al. 2012).

Psychosocial assessment

A PD quality of life questionnaire (PDQ-39) is the most commonly used questionnaire in PD. It consists of 39 questions that measures the eight areas of a patient's health including mobility, activities of daily living, emotional wellbeing, stigma, social support, cognition, communication and bodily discomfort (Tan et al. 2004).

Depression and anxiety are a major component of a PWP's non-motor symptoms. These symptoms sometimes can be more troublesome than the motor symptoms of PD. A scale such as the Hospital Anxiety Depression Scale is used to screen and monitor the levels of depression and anxiety (Bjelland et al.2002).

With the introduction of dopamine agonist medication, there is a risk of developing a detrimental side effect known as Impulse Control Disorder (ICD). ICD is a condition where the patient has an uncontrollable urge to engage in detrimental behaviour and can manifest in many ways such as compulsive gambling, hyper-sexuality, over-eating, over-spending, punding and other obsessive compulsions. To screen for the risk of this serious side effect, a Questionnaire for Impulsive-Compulsive Disorders in Parkinson's Disease - Rating Scale is recorded (Weintraub et al. 2012).

Due to the fact that PD is a chronic illness, often the stress of carers and spouses are extremely high and caring for the carers becomes part of the role of the PDNS. A carer's burden questionnaire known as Cambridge Behavioural Inventory (Wedderburn et al. 2008) in conjunction with the Zarit Burden Interview (Zarit et al. 1980) can be implemented to assess the carer's burden. This is an extremely helpful tool not just from a psychosocial perspective but also if a change in treatment strategies has been successful, a reduction in the carer burden score would be an excellent objective indicator of improvement rather than over dependence on a patient's subjective experience.

Finally, because the autonomic dysfunction and the use of PD medications can cause and exacerbate postural hypotension, a postural blood pressure in PWP's 'OFF' and 'ON' states is measured as this may impact on the titration of dosages and frequency prescribed by the neurologist.

Impressions and recommendations

The role of the PDNS is not to make a medical diagnosis. However, it is an important aspect of the PDNS role to collate the data and have the ability to interpret the results of the assessment to form a nursing diagnosis. Interpreting results require the expertise of the PDNS beyond just collating objective data but having the ability to report subjective observations that may be neglected from using assessment tools. These may encompass situations where the objective scoring of the assessment tools do not provide a true reflection of the patient's actual condition or functional improvement.

Based on the results of the assessment, the PDNS then provides the neurologist with an impression of the patient's condition and a summary of the assessment outcomes with a focus on the rationale for the referral.

The neurologist then considers the results and recommendations made by the PDNS and potentially make changes in the management of the patient. These changes may include changes to medication regimen, treatment options, investigative procedures and even potentially altering a patient's original diagnosis.

The future of Parkinson's disease nurse specialists

The assessments performed by PDNS may vary from different hospitals and facilities. However, as reflected in an international audit performed in 2006 by the World Health Organization in conjunction with the European Parkinson's Disease Association and the International Council of Nurses, their consensus view recommends that there is a need for uniformity in the practice of PDNS both in Australia and internationally. It will be an important challenge for the current PDNS in Australia, as well as other countries, to examine the need to standardise assessment processes of the PDNS, to establish an accreditation process and career pathways for the PDNS and to ensure that PDNS around Australia and internationally are practicing in a standardised, evidenced-based setting and providing appropriate recommendations for the wellbeing of the PWP (McFall-Austin 2009).

Author details

David Shek-Yan Tsui is a Clinical Nurse Consultant in Parkinson's Disease & Movement Disorders, Westmead Hospital, NSW.

Email: David.Tsui@health.nsw.gov.au

David would like to acknowledge Laraine McAnally, Retired Clinical Nurse, for her valuable mentoring.

References

Bjelland, I., Dahl, A., Haug, T. & Neckelmann, D. 2002, 'The Validity of the Hospital Anxiety and Depression Scale. An updated literature review', *Journal of Psychosomatic Research,* Vol. 52, No. 2, pp. 69-77

Crawford, S., Whitnall, L., Robertson, J. & Evans, J. 2012, 'A systematic review of the accuracy and clinical utility of the Addenbrooke's Cognitive Examination and the Addenbrooke's Cognitive Examination-Revised in the diagnosis of dementia', *International Journal of Geriatric Psychiatry,* Vol. 27, No. 7, pp. 659-669

Dalrymple-Alford, J., MacAskill, M., Nakas, C., Livingston, L., Graham, C., Crucian, G., Melzer, T., Kirwan, J., Keenan, R., Wells, S., Porter, R., Watts, R. & Anderson TJ. 2010, 'The MoCA: well-suited screen for cognitive impairment in Parkinson disease', *Neurology,* Vol. 75, No. 19 pp. 1717-25

Earhart, G., Cavanaugh, J., Ellis, T., Ford, M., Foreman, K. & Dibble, L. 2011, The 9-hole PEG test of upper extremity function: average values, test-retest reliability, and factors contributing to performance in people with Parkinson disease', *Journal of Neurologic Physical Therapy,* Vol. 35, No. 4, pp. 157-163

Fahn, S., Elton, R., Marsden, C., Calne, D. & Goldstein, M. 1987, R*ecent Developments in Parkinson's Disease,* 2nd Edn, MacMillan Healthcare Information, Florham Park, New Jersey, pp. 153-163

Goetz, C., Tilley, B., Shaftman, S, Stebbins, G., Fahn, S., Martinez-Martin, P., Poewe, W., Sampaio, C., Stern, M., Dodel, R., Dubois, B., Holloway, R., Jankovic, J., Kullisevsky, J., Lang, A., Lees, A., Leurgans, S., LeWitt, P., Nyenhuis, D., Olanow, C., Rascol, O., Schrag, A., Teresi, J., vanHilten, J. & LaPelle, N. 2008, 'Movement Disorder Society-sponsored revision of the unified Parkinson's disease rating scale (MDS-UPDRS): scale presentation and clinimetric testing results', *Movement Disorders,* Vol. 15, pp.2129-2170

McFall-Austin, T. (2009), Parkinson's Disease Nurse Specialist Core Competencies, *European Parkinson's Disease Association,* Kent, United Kingdom

Tan, L., Luo, N., Nazri, M., Li, S. & Thumboo, J. 2004, 'Validity and reliability of the PDQ-39 and the PDQ-8 in English-speaking Parkinson's disease patients in Singapore.' *Parkinsonism Related Disorders,* Vol. 10, No. 8, 493-499

Wedderburn, C., Wear, H., Brown, J., Mason, S., Barker, R., Hodges, J. & Williams-Gray, C. 2008, 'The utility of the Cambridge Behavioural Inventory in neurodegenerative disease', *Journal of Neurology Neurosurgery Psychiatry,* Vol. 79, No. 5, pp.500-503

Weintraub, D.,Mamikonvan, E., Papy, K., Shea, J., Xie, S. & Siderowf, A. 2012, 'Questionnaire for Impulsive-Compulsive Disorders in Parkinson's Disease–Rating Scale, *Movement Disorders,* Vol. 27, No. 2, pp. 242-247

Zarit, S., Reever, K., & Back-Peterson, J. 1980, 'Relatives of the impaired elderly: correlates of feelings of burden', *The Gerontologist,* Vol. 20, pp. 649-655.

GOING FOR GOLD IN WA: LEADERSHIP AT OSBORNE PARK HOSPITAL

By Marie Slater MACN and Lorraine Beaty MACN

Following a stringent application and review process, Osborne Park Hospital (OPH) became the first Australian health care site to be awarded Designation with the American Nurses Credentialing Centre (ANCC) Pathway to Excellence Program, in March of this year. This achievement is even more significant as OPH is only the second health care site outside of the United States of America to attain this designation. The program is managed by the ANCC to promote excellence in nursing and acknowledge hospitals that create a positive nursing practice environment. ANCC also offers the Magnet Recognition Program which caters for primary or tertiary hospitals. The ANCC Pathway to Excellence Program targets secondary hospitals - such as OPH.

Osborne Park Hospital is a 207 bed secondary public hospital specialising in elective surgery, rehabilitation, aged care and women's and newborn services. The hospital undertook the program to provide formal acknowledgement of its commitment to creating a positive work environment for nurses and midwives and ability to deliver quality nursing and midwifery care.

Achieving this designation took over 12 months and involved a number of steps including self-assessment, report preparation and submission, report review, and an externally conducted staff survey to validate the report claims. The process was a valuable exercise for all levels of nursing and midwifery staff and highlighted our strengths, which increased morale and teamwork.

After determining our suitability for assessment, the next step was more comprehensive and involved the compilation of an extensive report to be submitted for review. The report framework required the hospital to meet all of the specified twelve practice standards, each containing a range of criteria demonstrating how OPH is an ideal workplace for nurses and midwives.

In preparing the submission, comprehensive supporting evidence was necessary to show how the various practice standards were integrated into the hospital's operating policies, procedures and management structure. These standards focussed on the workplace, a balanced lifestyle for nurses and strategies that support nurses on the job.

Before being able to prepare such a comprehensive submission, a significant amount of internal review was required. A Steering Committee, comprising nursing staff at all levels and relevant administration representatives, was formed in January 2013 to oversee the process.

Staff engagement and participation was identified as being pivotal to our success; this commenced immediately via information sessions in all clinical areas across all shifts.

Interested staff were also asked to nominate to be a 'Pathway Champion' representing their specific clinical area by providing two-way communication between the Steering Committee and staff.

The theme, *Going for Gold,* was chosen by the Steering Committee, and this Olympics concept provided a cohesive and engaging brand that lasted the duration of the project.

A hospital wide program launch was held in April 2013 with an OPH Olympics event. This fun and entertaining concept involved three teams, representing the hospital's three clinical areas, competing in 12 Olympic events designed to highlight the 12 practice standards.

This fun, social and visual initiative was the perfect way to create awareness, energy and enthusiasm for the Pathway to Excellence Program. Following such a successful start, the challenge for the Steering Committee was to maintain and build on this enthusiasm for the duration of the process.

A number of initiatives were implemented to provide ongoing and sustainable communications to midwifery and nursing staff, both via the Pathways Champions and through other information channels.

Dedicated *Going for Gold* noticeboards were installed in each of the clinical areas and provided a forum to communicate essential information and updates. In addition, a *Going for Gold* newsletter was regularly produced and circulated with specific information, while general updates were included in the monthly OPH staff newsletter.

Once nursing and midwifery staff were suitably engaged and aware of the upcoming process, the hard work of preparing the submission commenced. Between March and October 2013 evidence to meet each of the 12 standards was collected, reviewed and prepared for inclusion in the report documentation.

Because of the need to demonstrate the specific ways OPH met each criterion, it was essential to provide detailed and thorough information. Appendices, providing documented evidence, were an important part of the process, and a number of written statements from staff were used to validate the claims. In addition, policy documents, guidelines, photos and other hard copy evidence were collected for inclusion.

The final submission was professionally prepared and came to over 1,000 pages, with most of the document comprising of the evidence provided in the appendices.

The team of ANCC credentialed surveyors in America independently assessed copies of the submission. After a period of waiting, OPH received news that the submission had passed the first hurdle in the designation review process.

LEADERSHIP AND MANAGEMENT

OPH staff celebrating the launch of the survey


OPH nurses and midwives

A staff survey was the next step for the ANCC to ensure that the nursing and midwifery staff validated the information in the submission. Before receiving news of the positive assessment of the submission, the Steering Committee had already begun to prepare for the staff survey to ensure the staff were ready.

In keeping with the *Going for Gold* theme, a torch relay worked its way through the clinical areas with a copy of the final report for nursing and midwifery staff to review. A mock Olympic torch was made to accompany the report on its journey and a torch handover event was held between the Coordinator of Nursing and a Champion representative as it moved between the clinical areas.

A staff information booklet was also produced and distributed to all nurses and midwives. This booklet contained background and examples of information from the report as supporting evidence for each of the 12 standards. All of these initiatives took place during the formal review process to maximise the awareness and knowledge of staff in relation to the Pathway to Excellence Program and the specific tasks the hospital undertakes in relation to the various practice standards.

Following review of the documentation by ANCC surveyors, OPH received formal notification that the individual staff survey would be held via an electronic format during a three week period between January and February 2014. Each survey would be completed online and take approximately 15 minutes.

A positive survey result could only be achieved with a staff participation rate of at least 70%, and then a 75% favourable response rate for the hospital from those surveyed.

Awareness, encouragement and simple processes were needed to ensure that at least 70% of nursing and midwifery staff completed their individual survey. A hospital wide parade of Steering Committee and Pathway Champions proceeded through the hospital to raise awareness and encourage participation. Direct access to the survey was loaded onto specific computers in the clinical areas as well as in the staff computer training room. Staff were also given time during their shift to complete the survey. The 70% participation rate was achieved in the second week of the survey being open which was the first hurdle completed.

Following the conclusion of the survey, the only thing left to do was wait for the final result. In early March 2014 notification was received that we had achieved the required 75% positive response rate and were awarded the designation of a Pathway to Excellence Organisation for a three year period.

This is a significant and special achievement for the hospital, especially given the challenges faced along the way. Time differences between America and Western Australia made direct communication more difficult. Interpreting some of the American terminology used in the program into the Australian context was also problematic in some instances. And, in preparing the submission, it was difficult to explain some of the cultural, health care, workforce and work practice differences between the two countries.

The Pathway to Excellence designation highlights that OPH is a positive work environment which is motivating for our current staff and also makes us a workplace of choice when recruiting new nursing and midwifery staff.

From a nursing and midwifery executive point of view this designation also recognises the world class quality of OPH's nurses and midwives and confirms the excellent standard of nursing practice at OPH. Our nurses and midwives deserve this acknowledgement for their commitment to patient care, creating a safe workplace and striving for excellence through ongoing training and development.

The next step is ensuring that OPH continues to meet the standards required for this designation and builds on the positive outcomes achieved during the application and review process.

Author details

Marie Slater is the Nurse Co-Director, Osborne Park Hospital, Perth, WA.

Lorraine Beaty is the Nursing and Pathway to Excellence Program Coordinator, Osborne Park Hospital, Perth, WA.

"A hospital wide parade of Steering Committee and Pathway Champions proceeded through the hospital to raise awareness and encourage participation."

REGIONAL ROUNDUP

WITH THANKS

As the year draws to a close it's hard to believe that it has been over 12 months since the implementation of ACN Regions and Communities of Interest (COI). What a busy year it has been for ACN, the many Region and COI Key Contacts and members who have dedicated their valuable time organising opportunities for members to come together.

Over the last year, approximately 40 Region activities were held across Australia providing unique networking and continuing professional development (CPD) opportunities. A number of our COI members contributed significantly to articles for our publications, highlighting professional issues identified from within their COI.

The ACN Member Engagement team would like to sincerely thank all our ACN Key Contacts and Region and COI members for their ongoing support and participation in 2014 and we look forward to working with you in 2015.

Members are encouraged to contact their Key Contacts and discuss the opportunities possible in their Region and COI. Visit ACN's Engagement page on ACN's website, www.acn.edu.au/engagement, to find out who the ACN Key Contact is in your Region or COI.

Kate, Stefanie and Rebecca from the ACN Member Engagement team

CENTRAL AND SOUTH GIPPSLAND REGION

Latrobe Regional Hospital (LRH) facilitated a one day *Risk assessment, formulation and management in mental health* workshop for nurses across all general, mental health, community and primary care settings.

During the workshop nurses were given the opportunity to discuss the relevance of risk assessment in their workplace and were shown how the skills they already possess are tailored to assess and manage risk scenarios where mental health issues are present.

The nurses who attended all felt the workshop fulfilled their expectations and enjoyed the day. On evaluation, it was decided the workshop would have benefitted from a general overview of mental health conditions and presentations. LRH looks forward to running this workshop again and supporting all nurses working with people who present with mental health conditions.

Cayte Hoppner MACN
Member, ACN Gippsland Region

HUNTER VALLEY REGION

In August, a small but lively group of ACN Hunter Valley members met for morning tea. This was the region's first gathering and was used not only as a meet and greet event, but as an opportunity to discuss future ACN Regional events.

I am keen to commence planning activities for 2015; if you have any ideas on possible activities or would like to become more involved in the group, please contact me at liz.hutchings@acn.edu.au.

In the interim, we hope to circulate a short six question survey to Hunter Valley Region members to assist in the development of the 2015 activities plan and to gauge our members' interests. I look forward to meeting you at future ACN Hunter Valley Region events.

Liz Hutchings FACN
Key Contact, Hunter Valley Region

NSW SOUTH REGION

On a lovely sunny afternoon at the end of August, the ACN NSW South Region held its inaugural networking meeting, in the rear courtyard of Cafe Cache in Wagga Wagga. Commencing with informal introductions and coffee and cake we discussed a variety of topics including a group brainstorm to help a colleague identify employment options in the region.

The meeting progressed into a discussion of the educational and technological needs of the nurses present at the meeting, specifically CPD areas of interest.

The CPD areas of interest identified include:

- Wound management
- Utilising modern technology
  - accessing information online
  - navigating the education system
- Navigating 'The System'
  - educating and supporting overseas trained nurses working in Australia
  - Understanding the Australian medical system

ACN NSW South Region members, watch this space for a range of activities coming your way in 2015!

Tania Jobson MACN
(Outgoing) Key Contact, NSW South Region

REGIONAL ROUNDUP

BRISBANE REGION

The Brisbane Region's Winter Dinner event in August was a chance for nurses to get together and discuss an important and topical issue. The topic was *Death over dinner.* Our guest speaker, Dr. Sarah Winch, RN, PhD, Senior Lecturer in Health Care Ethics at the University of Queensland Medical School, engaged participants in a relevant and significant discussion around end-of-life issues.

Throughout the event, more than 30 nurses from around Southeast Queensland sat around the dinner table, listened to Sarah's presentation and then shared their experiences and stories. The discussion centred on the best way to handle the end of people's lives.

The event was modelled on a growing international movement toward the frank discussion of end-of-life issues. This movement encourages both 'Death over Dinner' (deathoverdinner.org) as well as 'Death Cafes' (deathcafe.com). The general idea is that if people start to talk more openly about dying they might be able to have a better experience of death. Although these are movements from the general public, nurses are affected by the death denying nature of our society and can have a positive impact on opening up these difficult discussions.

Sarah shared the story of her husband's sudden death from cancer and his difficult decision, at the age of 48, with two children, to terminate treatment. She discussed her death-bed promise to him to write a book to help others who would not be able to get the assistance he had from her.

The sharing of her personal story led to Sarah discussing some of the cases that she has worked with as she teaches Health Ethics to medical students and consults. For example, there was the story of a man whose dying wish was to go surfing for one last time and the hurdles the health care system can put in place.

Sarah's book, which was five years in the making, is entitled *Best Death Possible: A guide to dying in Australia.* As per her dying husband's wish, she made the book straightforward and accessible for anyone not familiar with the health care system. Her book is available via 'booktopia'.

Susan M De Vries FACN
Member, ACN Brisbane Region

ADELAIDE METRO/SA SOUTH REGION

At the end of August a number of Adelaide Metro/SA South Region members came together for a planning meeting. The purpose of the meeting was to provide an opportunity for members to meet and discuss future directions for the Region, to plan future meetings and to provide feedback to ACN regarding a number of topics.

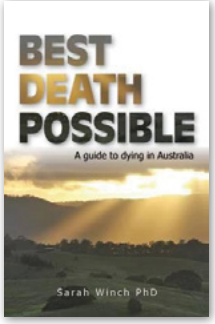
A number of current concerns in South Australia were identified and discussed among the group such as:

- EPAS, the eHealth system being introduced by SA Health
- Legislative changes to police checks required for working with vulnerable groups
- Mandatory reporting; supporting staff through process and outcomes
- Aged care concerns
- Work opportunities for new graduates
- Transition to retirement for older nurses
- AHPRA

Following this very productive meeting, a CPD event titled *Advanced care directives, advanced care planning* was planned and successfully took place in Adelaide on 9 October 2014. Over 15 participants were in attendance, including speakers Kathy Williams, Principal Policy Officer (Ethics) Policy and Legislation Unit, SA Health, Ellie Nitschke, Office of the Ageing and Sandra Bradley FACN, PhD candidate.

If you would like to support the Adelaide Metro/SA South Region in 2015, please contact engagement@acn.edu.au.

Roma Dicker MACN
Key Contact, Adelaide Metro/SA South Region



MELBOURNE REGION

ACN's Annual Gertrude Berger Oration and Symposium was held 16 October with Lindy Marlow, State Wide Facilitator Victorian Refugee Health Program, delivering the Oration. Titled *Today, Yesterday and Tomorrow – a focus on refugee health, community nursing and transcultural nursing,* the Oration was followed by a panel discussion consisting of panellists Professor Grant Russell, Head of School of Primary Health Care, Monash University, Marcia George OAM FACN, Clinical Lead, Cardiac Rehabilitation Program at ISIS Primary Care Ltd, and Koula Neophytou, the coordinator of community programs for Multicultural Health and Support Service, a program of Centre for Culture Ethnicity and Health.

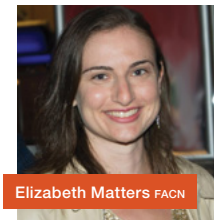
With around 30 people in attendance, participants gained an understanding of the health needs of refugees in Victoria and the importance of the role of refugee health nurses in workforce development.

One of the themes highlighted during the session was the need for a collaborative response to refugee health in Victoria. As the bulk of the care of refugees is provided through the mainstream health system, primary care has a vital role in collaborating with general practice and hospitals. It was determined that if primary care is strengthened, morbidity and mortality will improve. A take-away message to all those who attended was that high quality primary care results in health equity, which makes a big difference to the poor and disadvantaged.

Jenny Newton FACN
Key Contact, Melbourne Region

"...nurses are affected by the death denying nature of our society and can have a positive impact on opening up these difficult discussions."

WHY WORKING ON YOUR HOLIDAY IS STILL A MARVELLOUS IDEA



Elizabeth Matters FACN

By Elizabeth Matters FACN

This time last year, I wrote an article for *The Hive,* entitled *Why working on your holiday is a marvellous idea*, in which I recounted my experiences of professional visiting in Germany and the beneficial results that these opportunities had on my practice. I urged readers to consider the possibility of making such visits when they are next travelling in the hope that others could find global networking as useful and exhilarating as I had. Little did I know what wonderful things would eventuate over the following 12 months as I received the opportunity to reciprocate the hospitality shown to me and host the first two undergraduate nursing students, Ellinor Pick and Alice Mueller, from the University Hospital, Heidelberg in southern Germany, at my own hospital in Sydney. These students, who visited us for five weeks in their summer holidays, were also to discover that working on your holiday is a marvellous idea.

How it came about this time?

Thanks once again to the wonderful networking opportunities at the 2013 ICN Congress in Melbourne, I had the contact details for some colleagues working in Heidelberg who are responsible for preparation and Bachelor courses for nursing students. Their students have the opportunity to undertake some of their placement hours in an overseas location and, although many students had been placed in a variety of countries in the past, none had ever visited Australia. My colleague asked if I could recommend a hospital which might take two second year students for five weeks. Not knowing anywhere which already had such a program in place and keen to reciprocate the great hospitality that I had received in Germany, I convinced my hospital management to let me endeavour to develop an international internship program from scratch.

Developing the program

Developing a 25 day program of activities for nursing students, who were not able to perform any direct patient care for insurance reasons, was not without its challenges. I quickly realised that the traditional model of student placement, in which the students buddy with a bedside nurse on the floor, was not going to be successful for such a long period when there was no opportunity to perform bedside care. In addition, German nursing students undertake 2,500 hours of clinical placement during their course versus our 800 mandated hours so these second year students already had practical nursing ability far beyond their Australian counterparts. For this reason, a completely new program had to be written which turned the focus of the experience from the acquisition of practical nursing skills to activities which would enhance the students' intercultural competence, understanding of the differences between the two health systems and also encourage them to engage with a wide variety of unfamiliar people in their second language.

Given these considerations, I constructed a program which included five distinct learning strands focussed on the cultural and historical context of Australia, the organisational structure of our health care system, different nursing roles available within the Australian health care system, exposure to different clinical specialties (including community nursing and Aboriginal health nursing) and skills development through participation in a number of hospital study days along with their Australian colleagues. The students completed a specially prepared workbook of activities which asked them to engage with their patients and Australian colleagues through a series of interviews and observation activities and to constantly reflect and critically analyse what they were observing in comparison to the structures they were familiar with in their home context.

In addition, I was keen to make this program a beneficial one for our hospital and I wanted to encourage the Australian nurses to take the opportunity to meet and learn from the students. For this reason, I incorporated a number of discussion groups and interviews into the program where both the Australian nurses and German students had the opportunity to ask questions of the other side. On the final day, the students presented a 30 minute talk to their Australian colleagues in which they compared what they had seen in Australia with practices in

Ellinor, Elizabeth and Alice

“German nursing students undertake 2,500 hours of clinical placement during their course versus our 800 mandated hours so these second year students already had practical nursing ability far beyond their Australian counterparts.”

Ellinor and Alice exploring the Blue Mountains

Germany. This session proved extremely interesting for all who attended and a highlight of the program. For students who came from a country where it is common to nurse with a nurse:patient ratio of 1:10 or 1:15 and where no ward has a Nurse Educator, our hospital with its 1:5 staffing ratios and ward based education programs seemed like Utopia.

They expressed their amazement at the time which our nurses had available to spend administering medication to each patient, dealing with their patient’s psychosocial needs and participating in further development activities which simply did not exist at home. As the presentation progressed, the students insightfully discussed the differences between the German and Australian approaches to infection control management, ward layout, documentation, falls prevention and quality control, illustrating their points with photos from both countries. It was evident from their analysis that they had absorbed more than a superficial impression of how our hospital and health system functioned and could see where their own system could improve and where it could share its strengths with systems such as ours. Their comments were eye opening to our staff who saw that while our working conditions, were no doubt challenging at times, they were actually the envy of other similarly advanced nations. On other issues, the staff saw that there were other approaches to some of our core practices from which we could learn. Quite simply, the presence of international visitors in our workplace provided us with a different prism through which to view ourselves which proved valuable and illuminating.

The effect of such a program on the students and their hosts

I had little doubt that the nursing students who participated in the program would find the experience of visiting a new country an exhilarating one and, indeed, it was clear by the end of the internship that both students had enjoyed the experience immensely. This impression was confirmed by their final evaluations in which one wrote:

> *“The team and the people I met were awesome and so friendly! I hope and I think other students will do this experience because you have the best opportunity to learn something real for your education and life. Thank you!”*

The other student commented:

> *“I had a great time at NSPH with all the people we were working with… The organisation was fantastic and all the people we met were friendly and very open to spending time with us.”*

What was less certain was whether the staff who interacted with the girls would view the program in the same positive light or whether they would see it as yet another demand on their time and an imposition with which our hospital could do without. Having experienced more first-hand international collegiality than most, I was convinced of the benefits of such a program but would my feeling be shared by my colleagues? After the students’ departure, I collected feedback from the staff who had been involved with the girls and was delighted with the positive reactions which the experience had evoked. The vast majority believed that the program had positive benefits for the hospital and that they had learnt to view things differently after teaching the students. As one bedside nurse put it:

> *“I think that meeting the German students was a great experience for us and them. As a teaching hospital we are used to welcoming and helping students on our ward but the international students made it such a different learning experience. The way they are educated and practice in Germany is so different to here and I loved the presentation they gave comparing their experience in Sydney to their own hospital in Heidelberg. I hope this will become an ongoing program.”*

The idea of incorporating international placement into nursing programs is becoming more mainstream around the world and it is generally regarded as a beneficial opportunity for the students who participate. What we learnt, as a hosting hospital, was that such programs are just as interesting for the hosts as for the visitors and do not take enormous resources to integrate into the normal hospital day. The students were not bored and we were not overburdened. Conversely, we discovered that simply comparing our differences and realising our shared goals made the visit an inspiring, successful and positive experience for all involved.

If any readers are currently involved in running programs for international students or would be interested in promoting something similar in the future in their own workplaces, please get in touch. I would be delighted to share tips and ideas: matterse@ramsayhealth.com.au.

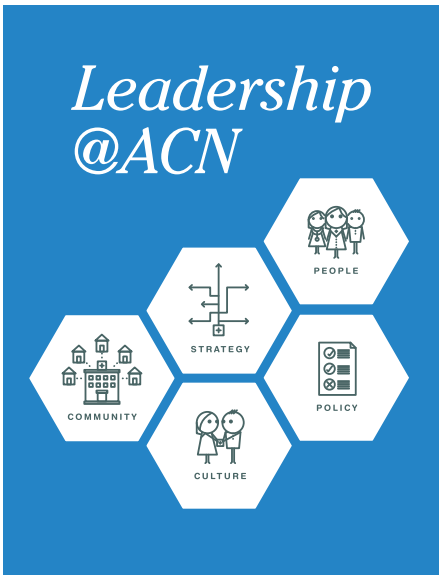
Author details

Elizabeth Matters is a Nurse Educator at North Shore Private Hospital, NSW.

2015 = NEW OPPORTUNITIES

ACN is an advocate for the nursing profession, advancing the skills and expertise of nurses. To enhance the leadership capabilities of our nursing workforce, ACN offers a diverse range of educational opportunities for professional growth.

LEADERSHIP@ACN



The health care environment is becoming increasingly complex and there is a clear link between nursing leadership, patient outcomes and recruitment and retention. A nurse's leadership capability plays a critical role in how health services are delivered to the community. That's why ACN developed the *Leadership@ACN* program. Each program is designed to challenge and support the unique needs of nurses with different levels of experience - be they in a formal leadership role or interested in leadership.

For more information visit our website at www.acn.edu/education or email acn@acn.edu.au.

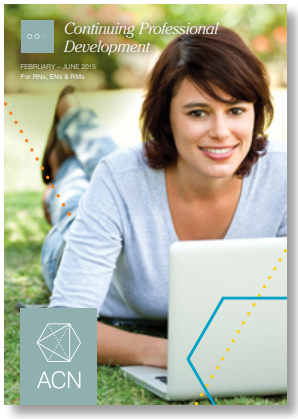
ACN STATE MATTERS

State Matters is a series of seminars aimed at providing nurses with the opportunity to engage with each other and hear from leading local presenters on key policy issues and state based factors. State Matters will be held in each state and territory throughout 2015.

TRAINING AND ASSESSMENT COURSES HANDBOOK

This handbook outlines a range of opportunities for enrolled nurses (ENs) and registered nurses (RNs) in the Training and Assessment division. These include Nationally Recognised Training (RTO no. 91474) which includes: HLT51107 Diploma of Nursing (Enrolled-Division 2) excluding medication management; HLT61107 Advanced Diploma of Nursing (Enrolled/Division 2 nursing); and TAE40110 Certificate IV in Training and Assessment. Professional development courses also include Principles of emergency care for both RNs and ENs, and Immunisation for RNs and NSW midwives.

CONTINUING PROFESSIONAL DEVELOPMENT HANDBOOK



Our CPD courses and webinars cater for all nurses, in every stage of their career. ACN clinical courses are co-developed with industry partners, ensuring participants engage in current evidence-based practices and are career-focussed, assuring a valuable experience.

POSTGRADUATE STUDIES HANDBOOK

This handbook contains an overview of each of the 15 Graduate Certificate (GC) courses and nearly 80 Distance Education subjects offered by ACN as well as subject overviews, important dates and how to apply. Students may study the GC courses to achieve a tertiary award in their specialty or may choose to study single subjects. Distance Education subjects are now offered wholly online.

WITH THANKS TO THE 2014 ACN SPONSORS

Corporate partner

HESTA An Industry SuperFund

Insurance partner

Guild INSURANCE

Communities of Interest sponsors

Healthy Ageing & Leadership and Management

CHANDLER MACLEOD HEALTH

Movement Disorders and Parkinson's

Lundbeck

Nursing and Health Expo sponsors

NSW GOVERNMENT Health

State Government Victoria

Government of Western Australia
Department of Health
Nursing and Midwifery Office

The National Nursing Forum sponsors

Government of South Australia
SA Health

HESTA An Industry SuperFund

CHANDLER MACLEOD HEALTH

Guild INSURANCE

anmac Australian Nursing & Midwifery Accreditation Council

Lundbeck

AUSTRALIA ECU EDITH COWAN UNIVERSITY

University of South Australia | School of Nursing and Midwifery

As a Nursing Officer in the Navy, Army or Air Force, you'll have opportunities that you won't get in the private sector. For instance, your patients will be your co-workers, as well as civilians on deployment. You will get the chance to lead a team of health professionals and provide humanitarian aid. You'll have the opportunity to further your career, specialise and progress into senior roles. Along with adventure, you'll enjoy job security and excellent working conditions. You'll also receive a favourable salary with subsidised accommodation and free medical & dental care. If you're a Registered Nurse and would like further information call **13 19 01** or visit **defencejobs.gov.au/graduate**

NOW RECRUITING: NURSES.

NURSING OFFICER
IT'S NOT YOUR GENERAL PRACTICE

NAVY ARMY AIR FORCE