thehive

#5 AUTUMN 2014

Australian College of Nursing

Voice of influence

LEADING AND DEFINING
advanced practice nurses

BREAST CANCER CARE
in Eastern Arnhem Land

MANAGING OLDER PEOPLE
with diabetes

Australian College of Nursing
Caring for your career

CPD and nurse re-entry scholarships

Continuing Professional Development (CPD) scholarships are available for nurses and midwives to attend a short course or professional conference in 2014.

Nurse re-entry scholarships are also available for nurses and midwives to undertake an accredited nurse re-entry course that will lead to re-registration with the Nursing and Midwifery Board of Australia.

Applications open March 2014 for activities to be undertaken between 1 January 2014 and 31 December 2014.

Scholarships are available for registered nurses, enrolled nurses and midwives.

All areas of practice are eligible. Examples are:

- Emergency departments
- Aboriginal Medical Services
- Aged care
- Community care
- Midwifery
- Mental health

For more information call **1800 117 262** or **1800 116 696** or visit **www.acn.edu.au**

An Australian Government initiative supporting nurses and midwives. The Australian College of Nursing, Australia's professional organisation for all nurses, is proud to work with the Australian Government as the fund administrator of these programs.

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#5 AUTUMN 2014 (March–May)

PUBLISHING DETAILS

ISSN 2202-8765

Distributed quarterly

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ABN 48 154 924 642

Printing
Webstar

Get published with the Australian College of Nursing
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Cover:
Community of Interest Key Contact: Lauren Raffaele MACN

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)

"It is my hope, that this year will see the professionalism of the Australian nursing cohort brought to the fore, and growth in our knowledge and numbers."

The upcoming year promises to be a busy one for the Australian College of Nursing (ACN). While we plan our year ahead, I'd like to send my encouragement to those of you who are undertaking new research in 2014, our newly registered nurses and all of our members who are taking on new challenges this year. It is my hope, that this year will see the professionalism of the Australian nursing cohort brought to the fore, and growth in our knowledge and numbers.

In this edition of *The Hive*, we share a broad range of insights from the Communities of Interest. Marija Bindley shares her cultural experience as a nurse in Eastern Arnhem Land, Trisha Dunning looks at the experience of older people with diabetes, and Jane Douglas shares the initial stages of her research into the experiences of early career nurses.

The Hive also presents us with the opportunity to profile our members. Karen Glaetzer is a nurse practitioner specialising in palliative care, Lauren Raffaele is a Community of Interest Key Contact who is seeking more dialogue of advanced practice nursing, and Liz Hutchings is a passionate nurse and Key Contact for the Hunter Valley ACN Region who used to work in forensic imaging. We also take this time to acknowledge Bob Weaver, a recent addition to the Australia Day honours list. Each member's story is significant and contributes to nursing.

Contained within this edition, we have also included a 'call to action' for you, our members to spread the word, and posters, for the ACN Nursing and Health Expos. The centrefold is a poster detailing the 2014 expo series for you to place within your workplaces and universities. Let's work together to grow our profession and promote workforce retention.

PRESTIGIOUS HONOUR

Robert (Bob) Weaver OAM MACN

Bob Weaver received the Medal of the Order of Australia (OAM) in this year's Australia Day Honours for service to the community, particularly through nursing in mental health and disability services. ACN would like to extend our congratulations to Bob for his commitment to his clients and the nursing profession.

Nursing is a career I fell into, but caring for and supporting people with disabilities is something I am passionate about; it has been a most fulfilling and interesting career.

I commenced nursing in 1975 and from early on took a leadership and management path. I undertook further studies in management at Sydney University and later in Disability Nursing at Western Sydney University. During the past 40 years, I have demonstrated an ongoing commitment to people with disability and their families. My advocacy for people with an intellectual disability saw me appointed to then, NSW Guardianship Tribunal (1988–2001); the first nurse appointed and, certainly, 'the icing on the cake' of my nursing career.

Nursing people with intellectual disabilities involves a holistic approach to care, emphasising the person's abilities, relationships with family, rights, self-determination, independence and decision making. I've been privileged to watch many firsts – the first few steps, the first solid meal, the first successful potty training, first day at school, first day at work and the list goes on.

We are now about to enter the 'new world' of disability care and support with the introduction of the National Disability Insurance Scheme (NDIS). There is much still to be done. Health care of people with disabilities is well below what is deemed as average health care for people without disabilities, and life expectancy is much lower. With the advent of the NDIS, the role of the nurse in disabilities will change; it is an exciting time to be a nurse in the area of intellectual disability and I look forward to the next phase with open eyes, with knowledge and passion.

The amazing and humbling honour of my OAM is shared with all who walked this journey with me. The senior nurses who provided me with experience, knowledge and mentorship. My nursing colleagues, friends and family. My life partner of 30 years Bob Zarb, also a nurse, who died in 2009 from Motor Neurone Disease, who allowed and encouraged me to build networks and communities of people willing to make change. And to Bobs' mother, Ruby Zarb, who lived with us for 15 years; a warm and loving woman with a great intellect and an infectious laugh.

MEMBER UPDATE

WELCOME ACN FELLOWS

STEVEN CAMPBELL FACN

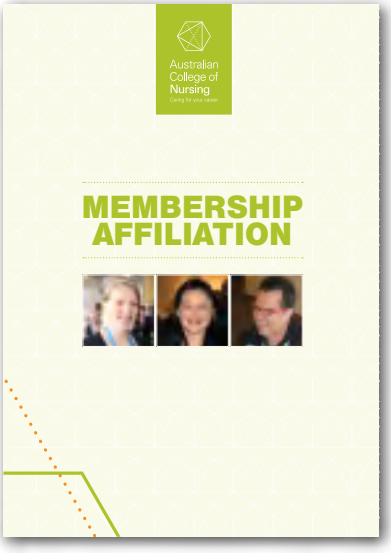
Head of School, School of Nursing and Midwifery, University of Tasmania

I am delighted to become a Fellow of ACN. My passion is nursing and patient care. In partnership with patients and carers, nurses can have the single largest impact upon the health services of Australia. In merely working to their graduate status, and to their full scope of practice, this can be achieved. I look forward to working with colleagues to achieve an even better health service for Australians through even better nursing care.

BRENDA CLOSE FACN

Director of Nursing and Midwifery, Weipa Integrated Health Service, Napranum Primary Health Care Centre, Queensland Health

I am proud to be a nurse, and as an Indigenous woman, am passionate about health and wellbeing particularly for Indigenous people. I have had amazing life experiences – both personal and professional, because of my nursing career. Fellowship to ACN is an honour and I appreciate the acknowledgement this affords me. I aim to continue to give to my profession what I've had the privilege to experience.



NEW! ACN MEMBERSHIP AFFILIATION

ACN has developed a new opportunity for health services and other organisations that employ nurses to become an ACN Membership Affiliate. ACN affiliated organisations can offer their nursing staff a highly reduced membership rate (up to 25%) to become professionally active through ACN membership.

The affiliation package also includes a scholarship of $2,000 value to use for any ACN course, one free general membership for the main contact of the organisation, and promotion of their affiliation status and organisation through ACN media. For details, fees and conditions, please contact membership@acn.edu.au or by phone on 1800 061 660.

ACN Membership Affiliation is ideal for organisations that are committed to investing in their employee's career and their professional development.

ACROSS THE STATES

During the latter part of 2013, ACN Regions held local networking events to establish connections between ACN members. These opportunities were invaluable in creating momentum for the year ahead. Now the networking is underway, many of the Regions will look to identify professional issues and developments important to members.

The ACN Regions have been established to enable greater opportunity for members to come together, whether it be for a friendly catch-up or to attend a locally organised event. Members within the Regions have connected both virtually and face-to-face, with Regions having the flexibility to allow members to connect through whichever method suits them. Members are encouraged to contact their Region Key Contact and discuss the opportunities possible for their Region. Visit the ACN Engagement page on ACN's website **www.acn.edu.au** to find out who the Key Contact is in your Region.

SYDNEY SOUTH ILLAWARRA REGION

KEY CONTACT: Renee Callender MACN
renee.callender@acn.edu.au

Our Region has been focussed on opening up discussions surrounding key issues and developing structures for the Region, via email, and via the ACN 3LP discussion forum. Our inaugural networking event will be held early in 2014, with a date to be released soon.

ACN Members within the Sydney South/Illawarra Region, who would like to get involved, or have any issues to discuss, are encouraged to contact me.

NT NORTH REGION

KEY CONTACT: Beverley Turnbull FACN
beverley.turnbull@acn.edu.au

The ACN NT North Region members met at the Vietnam Saigon Star in Darwin in early December to reflect on achievements, challenges and changes in 2013 as the newer ACN structure has developed. We enjoyed good food, and especially enjoyed good fellowship and wine.

(L) Suresh Sharma, Beryl McEwan
(R from rear) Bev Turnbull, Libby Webb, Flora He

BRISBANE REGION

KEY CONTACT: Belynda Abbott MACN
belynda.abbott@acn.edu.au

Belynda Abbott, Claire Stewart and Susan De Vries

On Sunday 15 December 2013, at the Victoria Park Golf Club Bar and Bistro, the ACN Brisbane Region held its inaugural networking/ Christmas breakfast. The event was a success with 20 ACN members in attendance from all different health care arenas. It was a wonderful opportunity to forge bonds and connections and strengthen each other's voice within our nursing profession. I personally have gained a couple of new colleagues with similar passions from our first networking event.

PERTH REGION

KEY CONTACT: Cheryle Poultney MACN
cheryle.poultney@acn.edu.au

Cheryle Poultney and Lisa Ferri

Over 25 members of the ACN Perth Region gathered together on Monday 2 December 2013 for a Christmas cocktail function hosted by Karen Gullick MACN, Director of Clinical Services, Hollywood Private Hospital.

I welcomed guests and discussed future options for ongoing functions and education for members in the Region. This was the first function for the region's members and it was good to see both new and older members attend. Everyone took the opportunity to catch up with local news, both professional and personal, and to partake of the great food and wine.

HUNTER VALLEY REGION

KEY CONTACT: Liz Hutchings MACN
liz.hutchings@acn.edu.au

Welcome to the New Year! Are you a Hunter Valley Region ACN member? If you are, we want to hear from you. Our priority is to represent you and undertake activities that are not only relevant but of interest to you. We are looking for ideas for regional events and articles for publication. I would like to take this opportunity to encourage all Hunter Region ACN members to consider becoming involved with our activities in 2014. We look forward to hearing from you.

NURSING: A CAREER CHANGE FOR THE BETTER

Profile: Elizabeth Hutchings MACN

HEALTH PLANNING PROJECT OFFICER, HUNTER MEDICARE LOCAL, NSW
ACN KEY CONTACT, HUNTER VALLEY REGION

"Nurses are not only by the bedside in hospitals; we are also in the community, in research, in government policy-making, in advocacy, and in business enterprises."

Nursing is a second career for me. I started my working life in the photographic trade which culminated in working in the forensic imaging section of the Australian Federal Police. It became time for a career change and I decided to return to university and study nursing.

On graduation I worked in a small rural hospital in Queensland where I was exposed to a wide range of patients and conditions which, on reflection, while tough, was one of my most rewarding experiences in the profession. We moved from Queensland to be closer to family. The Hunter region is a beautiful part of Australia and a great place to raise our children. Since moving to NSW I have been involved in research, first in breast cancer clinical trials and now in population/public health.

In nursing I love the transferability of skills, the flexibility and mobility, and the human dimension of meeting people at their points of need. I have also been very fortunate that I have worked in environments where there is a strong collegiate atmosphere, essential on those difficult days!

However, I believe the system is complex. Learning the 'ins and outs' of the health system can be difficult even when you are exposed to it every day. We should always consider the general public and our patients – if we as health professionals have difficultly navigating the system, what chance do outsiders have? As nurses, we must always be advocates for our patients and their families who need additional services and support even when the system appears to be against you.

A nursing issue specific to my Region includes the issue of workforce. It is always of concern in our profession. Attracting and retaining staff is an ongoing challenge and requires a concerted long term-effort.

The Hunter Valley region is large and has a diverse population with even more diverse health needs. But the health concerns of our region are similar to other areas of Australia; chronic disease and its management, an ageing population, and access to services, particularly in the regional/rural areas.

The biggest challenge facing the nursing profession is the widely publicised limit of employment opportunities for newly graduated nurses and nurses who have just completed their graduate year. Coupled with an ageing workforce, it is essential that proactive measures are taken to ensure these nurses remain in the profession. I believe that with innovative solutions, such as expanding the graduate program into other areas, for example in general practice and community nursing, much can be done to retain these nurses. It is essential that new nurses be given opportunities to develop their skills under the guidance and mentorship of senior clinicians and in an environment that fosters learning. The profession will be poorer if these new clinicians are lost.

There are many misconceptions about nursing – but one relates to the role nurses play within the broad definition of the health profession. Nurses are not only by the bedside in hospitals; we are also in the community, in research, in government policy-making, in advocacy, and in business enterprises. Nurses are integral not only to the provision of care but also to the shaping of health policy and effective health programs.

But in nursing, whether you are on the ward or in research, positive outcomes are always top priority. As nurses we meet people in often trying circumstances, at points in their lives where things are difficult. Through the care that nurses can provide we will have a significant impact on our patient's journey and their long-term health outcomes.

Contact: elizabeth.hutchings@acn.edu.au

UPCOMING CONTINUING PROFESSIONAL DEVELOPMENT

March – April 2014

March 2014

REGIONS IN NSW

4–5 The deteriorating patient – clinical decision making
RN/EN | Two days | 14 CPD hours | Coffs Harbour

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

10–12 Teaching techniques for nurses
RN/CNS/CNE/CNC | Three days | 21 CPD hours | Wagga Wagga

14 Understanding dementia
RN/EN | One day | 7 CPD hours | Burwood

20–21 Chronic and complex disease self-management
RN | Two days | 14 CPD hours | Burwood

24–26 Clinical assessment – models of assessment and care
RN/EN | Three days | 21 CPD hours | Burwood

28 ECG – introduction
RN/EN | One day | 7 CPD hours | Grafton

REGIONS IN WA

10–11 Chronic and complex disease self-management
RN | Two days | 14 CPD hours | Perth

26–27 Physical health care in mental health
RN/EN | Two days | 14 CPD hours | Perth

REGIONS IN SA

4–5 Chronic and complex disease self-management
RN | Two days | 14 CPD hours | Adelaide

19–20 The deteriorating patient – clinical decision making
RN/EN | Two days | 14 CPD hours | Port Augusta

REGIONS IN QLD

12 Aged care funding – fast-tracked and fun
RN/EN | One day | 7 CPD hours | Sunshine Coast

20 Assessing and managing vascular access devices
RN/EN | One day | 7 CPD hours | Brisbane

REGIONS IN TAS

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

REGIONS IN VIC

6–7 Understanding team nursing and leadership
RN | Two days | 14 CPD hours | Melbourne

27 Health informatics: nursing in the digital age – introduction
RN/EN | One day | 7 CPD hours | Melbourne

REGIONS IN ACT

25–26 Infection prevention and control
RN/EN | Two days | 14 CPD hours | Canberra

April 2014

REGIONS IN NSW

2–3 Wound management
RN/EN | Two days | 14 CPD hours | Burwood

4 Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Bathurst

7–8 Organ and tissue donation awareness
RN | Two days | 14 CPD hours | Coffs Harbour

10 X-ray interpretation
RN | One day | 7 CPD hours | Burwood

30–2 May Understanding mental health
RN/EN | Three days | 21 CPD hours | Burwood

REGIONS IN WA

3 Immunisation update
RN | One day | 7 CPD hours | Perth

10 ECG – introduction
RN/EN | One day | 7 CPD hours | Geraldton

REGIONS IN SA

8 Immunisation update
RN | One day | 7 CPD hours | Adelaide

REGIONS IN ACT

8–9 Pain management
RN/EN | Two days | 14 CPD hours | Canberra

Skills/knowledge required: Beginner Intermediate Advanced

NSW Health This course attracts no fees for employees of NSW Health. Places are limited.

LEADING AND DEFINING ADVANCED PRACTICE NURSES

Profile: Lauren Raffaele MACN

CLINICAL NURSE, ROTTNEST ISLAND NURSING POST, WA
ACN KEY CONTACT, ADVANCED PRACTICE COMMUNITY OF INTEREST

I started my nursing career in 2005. I completed a graduate program, and then worked on surgical wards and in the high dependency unit. I was lucky to have some fantastic role models early in my career. I worked with some very experienced nurses who strove to provide best practice care, and this has shaped my philosophy toward nursing. Nursing is a career of constant learning, adaptation, critical thinking, accountability and reflection.

I moved into emergency nursing in 2008. Again, I have worked with, and learnt from amazing role models in that area. I love the challenge of emergency nursing, especially the variety and unpredictability of clinical presentations I see on any given day.

During my time in the emergency department I did some work with graduate and student nurses in supervisory and support roles. I enjoy working with early career nurses and students, helping them put the theory and practice together, and assisting them to use their critical thinking skills to make safe decisions.

I have been in my current role at Rottnest Island Nursing Post for just over a year now. Rottnest Island is 20km offshore from Perth, thirty minutes by ferry. Despite its proximity to tertiary hospitals, it is essentially an isolated care setting, which can present challenges. In the Nursing Post, we provide care for the resident and tourist populations visiting the island. There is a Nurse Practitioner/Nurse Manager role, and two clinical nurses. We are without doctors for around half the year. The role entails high levels of autonomy.

I have enjoyed every moment of my role at Rottnest. The role requires advanced clinical skills and a high level of decision making. This realm of nursing fits with my ethos of continuous learning, development, and accountability. It has opened my eyes to the many nurses providing care at advanced levels across the country and peaked my interest into the various care settings comprising advanced practice nursing.

I am now enrolled in my Masters of Nursing (Nurse Practitioner) studies, through Curtin University of Technology.

As the Key Contact for the Advanced Practice COI with ACN, I hope to participate in and disseminate dialogue about the various role definitions of advanced practice nurses, along with practice issues identified by the community of nurses themselves. The role definitions and classification of advanced practice is an issue currently receiving attention. We could ask, 'Are all nurses practicing in an advanced or extended role being acknowledged for their level of practice?' There is a grey area as you move into the realm of advanced practice, with some nurses practicing at an advanced level without any formal recognition or role title that reflects this, and other nurses with higher role titles. There are inconsistencies across the states and territories in terms of scope of practice. The clinical nurse consultant or clinical nurse specialist roles can blur into the nurse practitioner (NP) role, however the NP role has clearly defined legal standing whereas the others do not.

I look forward to seeing the results of the upcoming survey being conducted in 2014 by Glenn Gardner FACN and Christine Duffield FACN, exploring the roles, levels and titles of the nursing profession which will hopefully provide insight into these issues.

Contact: lauren.raffaele@acn.edu.au

ACN MOVEMENT DISORDERS AND PARKINSON'S COI

CPD Course

Movement Disorders & Parkinson's COI is proudly sponsored by Lundbeck

On 2–3 December 2013, the ACN Movement Disorders and Parkinson's COI members, Victor McConvey MACN, Mary Jones MACN and Susan Williams MACN presented at a two-day course sponsored by Lundbeck, proud sponsors of the Movement Disorders and Parkinson's COI. The course titled, *Nursing patients with movement disorders,* aimed to introduce nurses to Parkinson's disease and other illnesses in the spectrum of movement disorders.

Participants gained increased knowledge of evidence-based medical and surgical treatments and the importance of the nursing role and its place in the multidisciplinary team.

Great presenters – a wealth of knowledge, happily shared. A great educational experience run by nurses for nurses. Have had lots of very interesting talks and ideas put forward. Thank you so much. Will encourage colleagues to attend next time. It is very reassuring to see that what we are doing every day is best practice.

Very well presented. Much needed, would be useful as a regular course on CPD calendar.

I've done a lot of courses and this has been one of the best if not the best in 40 years. Thank you!!

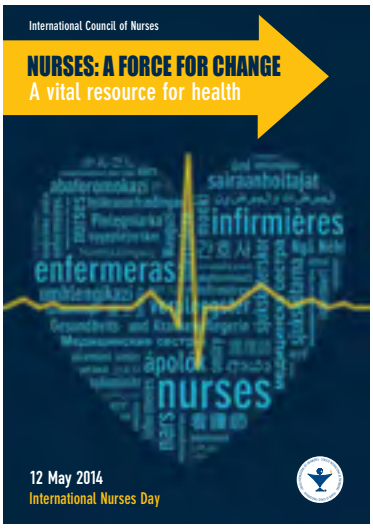
An excellent program. This course is fundamental to good/high quality nursing care in neurology especially PD.

This is the best 2 days I have spent in the last 20 years. Excellent course. Well run.

Due to the positive feedback received from participants, ACN is considering repeating the course for those who were unable to attend in December. If you are interested in attending the course this year, please contact Stefanie Dosen at **engagement@acn.edu.au** to express your support in ACN pursing this endeavour.

INTERNATIONAL COUNCIL OF NURSES UPDATE

The International Council of Nurses (ICN) is a federation of more than 130 national nurses' associations representing the millions of nurses worldwide. The Australian College of Nursing is the Australian member body of ICN.



NURSES: A FORCE FOR CHANGE – A VITAL RESOURCE FOR HEALTH
INTERNATIONAL NURSES DAY 2014

International Nurses Day (IND) is celebrated around the world on 12 May, the anniversary of Florence Nightingale's birth. The ICN commemorates this important day each year with the production and distribution of the IND Kit. The IND Kit contains educational and public information materials, for use by nurses everywhere.

The IND theme for 2014 is *Nurses: A Force for Change – A vital resource for health*. The content of this year's kit, including the poster image, are available as downloadable documents for use by individual nurses, associations, health ministries and health institutions. Though mainly planned around 12 May each year, IND activities continue for much of the year by nurses and others. We encourage nurses everywhere to make extended use of the IND Kit, through individual action and group activities. Visit **www.icn.ch** to learn more.

ICN INTERNATIONAL CONFERENCE: *GLOBAL CITIZEN, GLOBAL NURSING*

19–23 JUNE 2015
SEOUL, REPUBLIC OF KOREA

This international gathering of thousands of nurses will explore the importance of cross-cultural understanding and global cooperation in nursing. The Conference will provide opportunities for nurses to build relationships and to disseminate nursing knowledge and leadership across specialties, cultures and countries. The three ICN pillars – Professional Practice, Regulation and Socio-Economic Welfare – will frame the scientific programme and the dynamic exchange of experiences and expertise.

The main objectives of the Conference are:

- to advance and improve the coverage and quality of health services
- to demonstrate the nursing contribution to the health of individuals, families and communities
- to provide opportunities for an in-depth exchange of experience and expertise within and beyond the international nursing community.

KEY DATES

15 April 2014: Online submission of **abstracts** opens

7 October 2014: Online submission of **abstracts** closes

7 October 2014: Online **registration** opens

9 December 2014: Applicants notified of **abstract** acceptance

13 March 2015: Early bird **registration** closes

ICN CREDENTIALING AND REGULATORS FORUM

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

The fourth joint Credentialing and Regulators Forum, hosted by the Canadian Nurses Association in Ottawa, included participation from 15 countries. I attended alongside my Australian colleagues, Amanda Adrian, CEO ANMAC and Lynette Cusack, Presiding Member NMBA.

Main topics discussed were:

- evolving regulatory models
- outcomes of regulatory research
- quality and safety in the workplace
- continuing competence and revalidation
- education, accreditation and the transition to practice
- nurse prescribing
- inter-professional practice: implications for regulation and regulatory collaborations.

A number of countries, including Australia, provided an update of key activities or issues. Key issues reported by Australia included:

- the national registration and accreditation system has now been in place for three years and will be soon undergoing a thorough review
- a review of the process of assessment of internationally educated nurses is being carried out
- the multiple changes in government, both at the national and state level, which will need monitoring for impact on regulation and accreditation.

It was interesting to learn of issues affecting the nursing workforce in other countries; many of which were brought about due to the global financial crisis.

Bahamas – A major concern is that there is still lifetime registration for nurses.

Ireland – A graduate placement programme that employs new graduates at a reduced rate of pay, that includes an educational component, has been introduced with a mixed response.

Jamaica – There are challenges with graduate's competence level as they have limited clinical practice space and difficulty accommodating the number of students.

Japan – They have been implementing a system to introduce nurse practitioners; the model is different than in many countries and has required much negotiation with the physician community.

Portugal – There is mobility of nurses in Europe but not all countries have nursing regulatory bodies in place with structures.

Singapore – Looking at setting continuous professional development requirements in regulation.

Spain – The impact of the economic crisis has been significant; Spain has a much higher ratio of physicians to nurses than the European average however, it is nursing positions that are being lost.

USA – The National Council of State Boards of Nursing has put in place an e-notify programme which will notify employers if a nurses license is due to expire or if there has been disciplinary action.

Another thought-provoking outcome from the forum was the discussion that took place around regulatory research. The following points were captured in the discussion:

- The worrying trend in many governments is the leaning towards de-regulation of the nursing profession.
- Many nurses do not understand what regulation entails. We need to educate nurses, nurse leaders and chief nursing officers about the importance of and benefits of regulation.
- It would be useful to have minimum global regulatory standards and framework for nursing.
- There is a trend toward umbrella legislation and regulatory health structures but an emerging body of evidence from the US shows that these structures do not perform as well as independent structures.

The next forum will be held in mid-May, in Geneva Switzerland. ACN will continue to play a role in forums such as these; to inform and educate, as well as learn from other countries about the advancements and challenges they face in implementing robust and innovative regulation structures.

The full ICN Credentialing and Regulators Forum's report is available at www.icn.ch.

DEMENTIA CARE IN THE INDIAN HEALTH SYSTEM

BY DR SUJATHA SHANMUGASUNDARAM MACN, LECTURER (NURSING), COLLEGE OF HEALTH AND BIOMEDICINE, VICTORIA UNIVERSITY, ST ALBANS CAMPUS, VIC

Dementia is a major public health concern in both developing and developed countries, and is a leading cause of disability and death. Understanding dementia is quite complex, as it is not a single specific condition. Rather, it is a syndrome associated with 100 different conditions characterised by impaired brain functions such as language, memory, perception, personality and cognitive skills (Department of Health 2010). The most common types accounting for 90% of all cases are Alzheimer's disease, vascular dementia, Lewy body disease, and fronto temporal lobar degeneration. These are degenerative brain diseases and alerting the progressive course of the disorder is not possible. Although there are numerous new therapies being invented, there are no current curative treatments available for dementia.

The World Health Organization [WHO] (2012) reported that globally 35.6 million people are affected with dementia and, epidemiological studies indicate that this number is expected to grow at an alarming rate. It is estimated that numbers will double every 20 years, to 65.7 million in 2030 and 115.4 million in 2050, particularly in developing countries (WHO 2012). It is important to understand the global prevalence and impact of this burdensome condition and rapidly changing health status of people with these disorders.

PREVALENCE OF DEMENTIA

In India, the prevalence of dementia has increased considerably in the past 10 years (WHO 2012). A recent survey reported that 3.7 million Indian people have been diagnosed with dementia, out of which 2.2 million are women and 1.5 million are men (ARDSI 2012). The larger proportion of women with dementia can be explained by the fact that women live longer in India.

Studies on dementia prevalence are scattered around India; six studies in the south region and single studies from the west, east, and northern regions of India. Data is lacking in many regions of the country and the reported few studies have widely varying estimates of prevalence (ARDSI 2012). Although the coverage of evidence is good in south India, wide variability compared to studies from north pose difficulties to provide a consistent overview for the whole country.

TYPES OF SERVICES

There are a number of health services available for people with dementia which includes non-governmental organisations (ARDSI) and charitable institutions: Help-age India; Dignity Foundation; Nightingales Medical Trust; the Dementia Society of Goa; Sangath; Voluntary Health Services; and Silver Innings Foundation.

THE FOLLOWING SERVICES CURRENTLY EXIST FOR PEOPLE WITH DEMENTIA:

DAY CARE CENTRES

Dementia day care centres are designed for people with dementia who have a need for medical attention or supervised daytime care, but who do not require hospitalisation in a nursing home. In total, approximately 10 day care services operate successfully throughout India.

RESIDENTIAL AGED CARE SERVICES

These facilities manage the basic day-to-day activities of people with dementia. This may be long term care in a nursing home or short respite care. All these services are run by non-profit organisations. They are funded primarily by donations and public contributions. Health care professionals provide various therapies such as: music, art and pet therapy; yoga; light exercises; cognitive stimulation; and reality orientation.

DOMICILIARY CARE

This care is provided to people in their own homes. Services can range from caregiver training to formal nursing care. Six centres throughout India provide home based care for people with dementia. Under this scheme, the social workers or volunteers visit the families and provide assistance in the form of counselling, guidance and sometimes with activities of daily living.

SUPPORT GROUPS

While there is no definitive data about the number of support groups that are helping the families of people with dementia, they are functioning in an informal basis all over the country.

MEMORY CLINICS

It is estimated that in the last five to eight years there have been nearly 100 memory clinics functioning all over India. Memory clinics are specialised clinics that offer

Dr Sujatha Shanmugasundaram at Yercaud, Tamilnadu, India

clinical assessment, information and advice to people with memory problems. Many specialty hospitals run by public and private agencies run memory clinics or specialty geriatric clinics for people with dementia.

DEMENTIA HELP-LINES

Dementia help-lines are dedicated phone lines to address queries on dementia 24/7. These help-lines are handled by trained health care professionals who have knowledge on dementia related disorders. There are about 10 help-lines, mainly run by the national office of ARDSI and the various chapters which cater to the persons in the respective localities. Help-lines are available in Cochin, Kolkatta, Mumbai, New Delhi and Hyderabad. This shows that almost the entire country has no recourse to local help-lines and support (ARDSI 2012).

BARRIERS IN PROVIDING DEMENTIA CARE

In order to develop services for people with dementia, it is important to understand the health seeking behaviour of people with this disease. Several studies (Das et al. 2006; Shaji et al. 2005) have been conducted on health seeking behaviour of people with dementia in India. Findings showed that generally there has been very low health seeking behaviour of people with dementia due to lack of awareness. ARDSI (2010) explains that this general lack of awareness has serious consequences, such as delayed diagnosis and seeking help from formal medical care services. Worse, it is not just the general public that suffers from this poor awareness – health care services are also less informed about dementia. Prince et al. (2004) reported that a majority of people with dementia in India required help and would avail themselves to the services of private doctors, but no such services were available in 33% of cases in India.

The major barriers may include:

- stigma
- lack of awareness; feeling that nothing can be done
- low health seeking behaviour for memory problems; feeling that it is a part of the normal ageing process
- lack of training and support; services need scaling up
- lack of policy initiatives for people with dementia
- lack of funds for dementia services, research and training
- poor awareness within the medical fraternity
- 3.7 million Indians with dementia and less specialist manpower to manage them.

Seven core strategies have been developed by experts (ARDSI 2010) to address these barriers:

- Creating awareness and demand for services.
- Capacity building of health care teams.
- Providing affordable treatment.
- Effective long term care through community based programs.
- Residential respite and day care facilities.
- Development of legal services.
- Development of training services.

To conclude, there is still a long way to go in terms of effective dementia care services across India. Currently, such services are in the infant stage in this country and the gap between the need for care services and the actual available services is large. The government needs to assist with setting up and promoting the establishment of care services for dementia and to ensure these services are culturally appropriate and can be delivered within the existing health resources at all levels of care.

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A CAREER DEVOTED TO PALLIATIVE CARE

Profile: Karen Glaetzer MACN

NURSE PRACTITIONER – PALLIATIVE CARE, SOUTHERN ADELAIDE PALLIATIVE SERVICES, SA

Diversity is a unique attribute of the nursing profession across the globe. ACN's membership is indicative of the variety of practice in nursing. Karen Glaetzer is one such example, as a nurse practitioner with broad experience in palliative care nursing. In 2012, Karen was awarded the 'Ollie' Nurse Practitioner Scholarship for her contribution to the body of knowledge surrounding adolescent and young adult palliative care.

Nursing background

Prior to leaving school I started work as a carer at a local nursing home. When I left school I started working more hours at the nursing home and decided to apply to do my general training. Just six months later, in 1979, I was accepted to do my training at Repatriation General Hospital, Daw Park South Australia. I completed it in 1982.

What lead to your special interest in palliative care?

During my training I always preferred working on the medical wards, rather than the surgical wards. I liked the opportunity to build relationships with patients, as medical patients were often re-admitted, whereas surgical patients had their surgery and rarely came back. I developed a particular interest in oncology, and in 1983 I was accepted to undertake the Oncological Nursing Course at Peter MacCallum Cancer Institute in Melbourne. This is where my interest in palliative care began, though it was often called *continuing care* at that time.

In 1988 I was contacted by the Director of Nursing from my training hospital, and invited to return to South Australia to assist in setting up a hospice, Daw House Hospice. After only six months, I was invited to help expand the community programme. Now, 26 years later, I still work for the same service, moving from a role managing the community palliative care programme 10 years ago, to becoming the first nurse practitioner in Australia in the specialty of palliative care. Being a pioneer in a new specialty has been an exciting and

interesting experience. I've watched the specialty mature and grow over the years.

The 'Ollie' Nurse Practitioner Scholarship

I applied for the 'Ollie' Scholarship when I recognised a gap in my knowledge in relation to adolescents and young adults (AYA) who require palliative care and was interested in exploring this further. Through the scholarship I was able to undertake the AYA Palliative Care topic at Flinders University. I then conducted an audit in collaboration with the AYA Cancer Coordinator in Adelaide to look back over the last five years at patients under 35 who had access to palliative care and those who didn't. These results have triggered further work with the AYA service and we are currently collaborating to prepare a paper for publication. The scholarship has also enhanced my role as a mentor to palliative care and oncology nurse practitioner candidates, as I have been able to sponsor some workshops to expand their knowledge in this area. I was also awarded a Churchill Fellowship in 2013. I am leaving in two weeks to travel overseas to further expand my knowledge about palliative care in the disability sector.

What do you love most about nursing?

I love the diversity nursing allows. It involves clinical work, teaching, research, clinical leadership and so much more. I view it as lots of different occupations rolled into one, so you never become bored.

Least favourite thing about nursing?

I was never very good at shift work. I prefer to work regular hours, which I have for much of the last 28 years, apart from intermittently needing to be on call after hours. Apart from this, I also get frustrated at times at some of the attitudes of some nurses. I think some of the caring in nursing has disappeared and the focus is on just getting the work done.

How does membership with a professional organisation enhance your professional experience?

Professional membership is crucial to feeling part of a community and staying up-to-date in relation to contemporary nursing knowledge. It also facilitates building networks and offers opportunities, such as the 'Ollie' Scholarship.

What do you see as the biggest challenge currently facing the nursing profession?

Working at a hospital that has just adopted electronic medical records, I would have to say technology at this point in time! Apart from this, workforce into the future is going to be a big challenge. It is well known that the majority of nurses are in the older age group (including myself) and as we near retirement, there are going to be huge challenges maintaining a skilled workforce.

What's the most rewarding thing about your career?

I have had the most amazing career and through nursing (and hard work) I have had opportunities I would have never dreamed of. I have travelled the world. I have taught in Vietnam, Thailand and other Asian countries, presented in Canada and studied in the USA and UK. I have received numerous awards recognising my contribution to nursing. The most rewarding part of course is the privilege to be able to care for patients as they near the end of their life, assisting them and their families to plan and prepare. My clinical role has always been important to me, as well as my mentoring role which allows me the opportunity to watch other nurses develop and find the passion to care.

THE BEGINNING OF A CAREER

ACN's Nursing and Health Expos

BY BRIANNA GUDGEON MACN, REGISTERED NURSE, RAMSAY HEALTH CARE, SYDNEY NSW

> *"Every day I come home knowing I have a little place in someone's heart because I helped them."*

Top photo: Brianna (left) in 2008 training as an EEN at Concord Hospital with colleague

Bottom photo: Brianna as a volunteer nurse in Samoa

In pursuit of the belief that every nurse should have the opportunity to grow their career and further the nursing profession, ACN is once again presenting the Nursing and Health Expos for 2014. The expos have provided an avenue for those interested in nursing in Australia to seek expert advice on education and employment opportunities. One young nurse's visit to an expo, opened up a career.

Ever since I could remember, I wanted to help people. When I was young, I would look up diseases and conditions, I had my own first aid kit and I would play 'nurse' with my mum and dad.

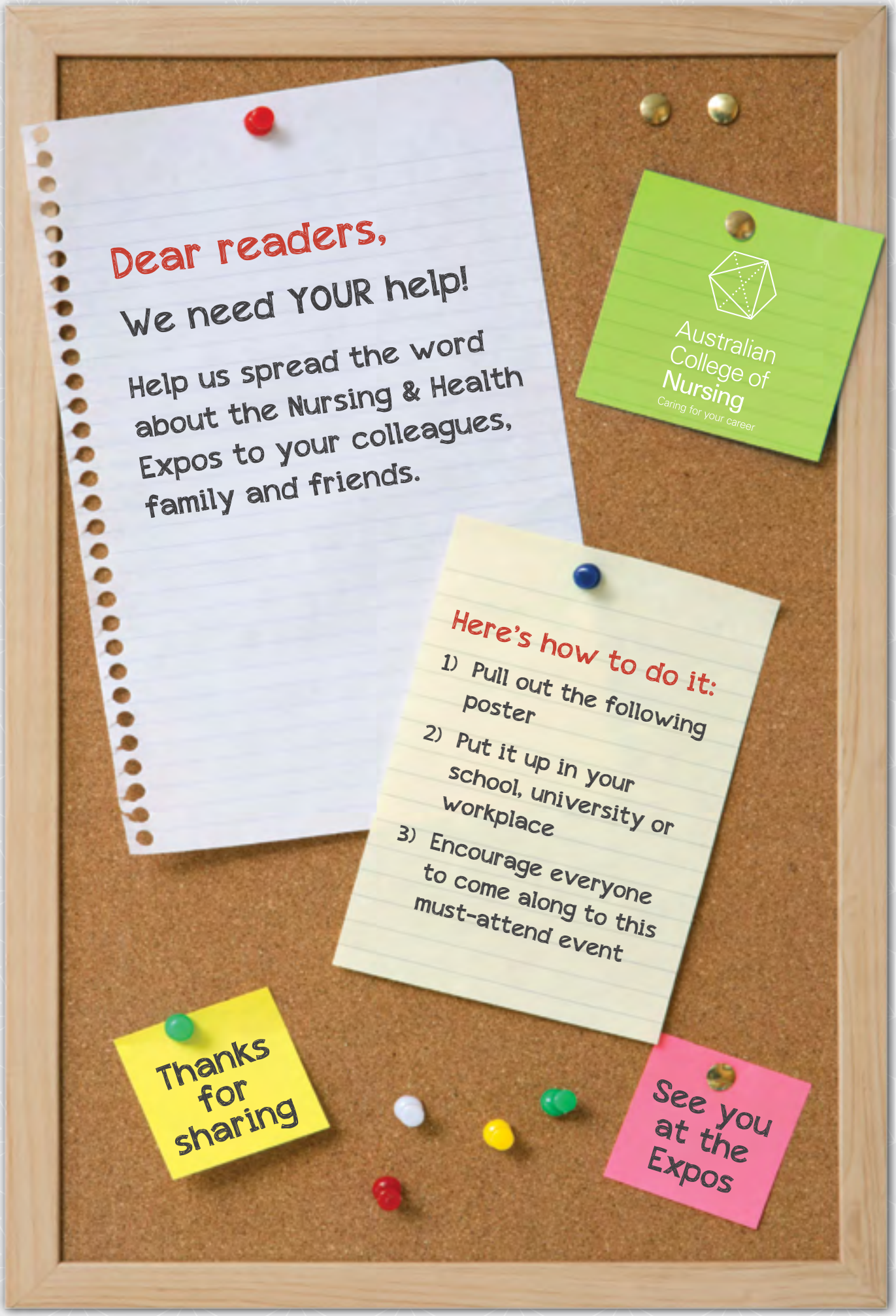
In 2007, when I was in year 12, I attended my first NSW Nursing and Health Expo, and I've continued to visit the expos since. Initially, I wanted to become a paramedic, but everyone I spoke to said that I should become a nurse first. They gave me great advice to become an endorsed enrolled nurse (EEN), before becoming a registered nurse (RN) – to take it one step at a time.

I studied at TAFE for 18 months to become an EEN. I completed my Bachelor Degree at Southern Cross University, while working as an EEN at a private hospital in Coffs Harbour. This meant I was able to put my theory into practice.

Now, I work as an RN with Ramsay Health Care. Every day I come home knowing I have a little place in someone's heart because I helped them. Patients are very vulnerable people, and sometimes all they need is for you to listen. Listening is one of the most important lessons I have learnt as a nurse.

I'd recommend the ACN Nursing and Health Expos to anyone, especially year 12 students who are interested in a career as a nurse. I always look forward to the expo and I make a day of it. It's great to be around like-minded people, listening to their stories, and they are always interested in listening to mine. Last year, I was able to practice keyhole surgery at the expo and I was actually good at it – so maybe surgical nursing is an option down the track.

I joined ACN last year and have now had this opportunity to share my nursing story and hopefully inspire others.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A MOUTHFUL OF FLIES: THE EXPLOSIVE DIARY OF A DESERT NURSE

By Sue Currie

REVIEWED BY DR MADONNA GREHAN MACN, REGISTERED NURSE, HONORARY FELLOW, MELBOURNE SCHOOL OF HEALTH SCIENCES, THE UNIVERSITY OF MELBOURNE, VIC

It's possible that at least some readers of *The Hive* have kept a diary or journal while a nurse. What was your motivation for keeping that diary? Do you still have it? Do you have a plan for it? Diaries are, by their nature, intensely personal items. For some historians and biographers they are essential sources of evidence, filling gaps in individuals' lives or providing personal perspectives on issues and historical events. Diaries are particularly useful when it comes to women's history, including research on health care, nursing practice and policy. Laurel Thatcher Ulrich's multiple prize-winning text, *A Midwife's Tale: the Life of Martha Ballard based on her diary 1785–1812* (1990), is one such example of fine scholarship in which Thatcher teased out one woman's "health" practice in eighteenth century America.

For autobiographical work, diaries are no less indispensable as Sue Currie's latest offering demonstrates. A retired general nurse, midwife and travel writer, Currie has made the most of her 1990s journals in writing *A Mouthful of Flies: the Explosive Diary of a Desert Nurse*. Currie worked as a Remote Area Nurse (RAN) at two different time points in her life, firstly in the 1960s as a young nurse and later, in the early 1990s. The contrast between these two episodes in Currie's career could not have been greater. She remembers the first period of service as almost idyllic, working in a community which valued her skills, and in which her personal safety was never threatened. The second stint threw up so many unexpected concerns that Currie's diary became a form of therapy, helping to weather her challenging employment and what she perceived to be a total lack of support, insidious bullying, and manipulation by administrators.

To her credit, and in view of the terrible experiences she writes of in the book, Currie

A Mouthful of Flies: the Explosive Diary of a Desert Nurse, Sue Currie (2013). Lyncon Pty Ltd: South Yarra

$38.25 (includes postage), available from the author: **sue.currie70@gmail.com**

asks rhetorically if she had romanticised her earlier period of employment. The 1960s, undeniably, were socially and politically very different from the 1990s, particularly when it comes to the status of Aboriginal Australians. At the time of Sue's employment in the 1960s, Aboriginal Australians did not enjoy suffrage. Many Aboriginal Australians were employed and yet were not paid wages for their work. These abysmal conditions led Vincent Lingiari and his fellow Gurindji-tribe stockmen and their families to withdraw their labour from Vestey's Wave Hill Station in 1966. Just as injustice was embedded in their working conditions, it seems likely that the paternalistic attitudes which disenfranchised Aboriginal Australians were prevalent in health care too.

The sheer passage of time underscores the importance of eye witness records which can provide a more realistic window on history. And so it is with *A Mouthful of Flies,* a harrowing account of Currie's place of employment in the 1990s. There's no doubt her working conditions at "Camel Bore" were relentless. The community expected their RAN to be available twenty-four hours a day and for all issues: big or small, urgent or non-urgent, health and non-health related. Not infrequently, she had little opportunity to sleep or have time off without interruption. There were threats of violence and intimidation. As the incessant demands of her job mounted, Currie began to question how she could fulfil her professional role as a nurse.

Currie's book is a raw and valuable record of one woman's experience as a nurse in remote Australia. Her text raises important questions about the safety of nurses at work, about appropriate governance and about the administration of remote communities. Were conditions of employment for RANs the same everywhere or was Currie just unlucky? Perhaps there are diaries penned by other nurses in similar communities during the same era? If these diaries make it into public collections, future historians will be able to draw on them in analysing and interpreting Australian health care in remote communities. I do wonder though, if many nurses keep diaries these days?

Kirsty Harris, a historian in Melbourne, has registered her concern about the potential lack of diaries available to future historians of nursing. Harris's idea is to invite Australian nurses to write a diary on just one day in the year, recording what they did in practice. As with any collection, mechanisms to collate and permit use of such material would need to be established. Perhaps an entry written around International Nurses Day would be a good start, at which nurses everywhere, at the bedside, in the community, in prisons, in the teaching realm, can collectively say "let's diarise that"!

REPORTING AND MANAGING A PRESSURE INJURY

BY MEAGAN SHANNON, SKIN INTEGRITY CLINICAL NURSE CONSULTANT, PENINSULA HEALTH, VIC

Patients of all ages can develop a pressure injury (previously known as pressure ulcer or bed sore) while in hospital. A pressure injury is defined as an area of skin that has been damaged because of pressure, friction, shearing or rubbing. Pressure injuries can be painful, difficult to treat and can lead to a longer stay in hospital.

In-line with national standards, all inpatients are examined for pre-existing pressure injuries, as well as their risk of developing a pressure injury. We do this by:

- using a world recognised and validated pressure risk assessment tool such as the Braden Scale for Predicting Pressure Ulcer Risk or the Waterlow Pressure Ulcer Risk Assessment Tool to identify patients at risk early
- monitoring patients' skin hygiene and using appropriate skin care products
- ensuring their diet is nutritionally adequate for cell repair
- using pressure relieving beds, mattresses, cushions and other appropriate equipment for patients who are identified as 'at risk'
- tracking wound progress on a wound chart
- moving/repositioning patients frequently to relieve pressure
- keeping patients' skin dry, particularly if there are continence issues.

Peninsula Health, one of 15 Metropolitan Health Services in Melbourne, manages approximately 1,000 complex wounds annually, and in the 2012-2013 year, as many as 23% of these wounds were pressure injuries, admitted or developed. This highlights how important preventing and managing pressure injuries is. Benchmarking data is collected from all hospitals and reported to the Australian Council on Healthcare Standards and performance is measured against similar hospitals in a catchment area, and against hospitals in the rest of Victoria. This includes pressure injuries developed in hospital and those developed before admission. Peninsula Health regularly record fewer developed pressure injuries than our peer hospitals and the State average.

Pressure injury classifications:

STAGE 1 (least severe) – where there is no broken skin but the area is reddened.

STAGE 2 – where there is a light loss of skin, looks like a blister or a graze.

STAGE 3 – an open wound with full loss of skin, exposing underlying tissues.

STAGE 4 (most severe) – a deep cavity wound which can include destruction of underlying fat muscle and bone.

Patients with a Stage 1 or 2 pressure injury are considered more at risk to develop a Stage 3 or 4 injury. A pressure injury can cause significant physical and psychosocial morbidity and an increase in mortality. Their treatment can be labour intensive, time consuming and costly. It has also been shown that patients who develop a pressure injury have a 50% longer length of stay than patients without a pressure injury.

Quality initiatives are continuously being implemented to improve care and prevent pressure injuries from occurring, and these are integral to improving patient outcomes and health service performance. A recent example of how quality initiatives can decrease the development of pressure injuries took place in the orthopaedic ward. Improved communication between the emergency department and the orthopaedic units, upon transfer of a patient with a fractured neck of femur, enabled staff to fit-out the bed with an alternating cell air mattress prior to transfer. This initiative, coupled with the commissioning of a 'stand by' alternating cell air mattress, has decreased the delay in the implementation of pressure relieving interventions. Prior to these initiatives, the use of the alternating air cell mattress was delayed when the patient was already transferred into the ward bed, mainly due to access to an alternating cell air mattress and reluctance to move the patient due to pain. By changing this 'routine care' for patients following hip replacement surgery, the incidence of pressure injuries developed post-surgery has decreased by 60%.

Caring for and managing pressure injuries requires a team effort from clinicians, patients and carers and a 'one size fits all' approach doesn't always work. But there are a number of strategies and pressure-relieving devices that can be used to prevent the development of a pressure injury. Regular repositioning or introducing a turning regime specific to patients' needs is still considered best practice for pressure relief. If the skin is reddened on bony prominences when turning a patient, then the turns may need to be more frequent.

TIPS FOR ENSURING BEST PRACTICE IN WOUND AND SKIN CARE:

- Ensure all skin integrity documents align with national safety and health service standards.
- Report all developed and admitted pressure injuries in your clinical care through appropriate channels such as incident reporting, hand over, documentation and family discussions.
- Undertake regular audits of pressure injury care and prevention to ensure best practice is in place for each patient.
- Regularly evaluate available wound products to ensure optimal wound outcomes are achieved.
- Ensure skin integrity and pressure injury prevention remains a priority for ongoing clinician education programs, supported by evidence.
- Consider developing 'skin integrity resource nurse' roles in clinical areas so that support and education is readily available.
- Make the most of the multi-professional teams available to you, such as podiatrists, dietitians, occupational therapists, physiotherapists and medical staff. By working together, you can ensure the best outcomes for your patients.

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KEYNOTE SPEAKER
DR ALEX WODAK

Dr Alex Wodak AM was the Director of the Alcohol and Drug Service, St. Vincent's Hospital, Sydney, from 1982 until he retired in 2012. He helped establish the first needle syringe programme and first medically supervised injecting centre in Australia when both were pre-legal. Dr Wodak will bring his extensive experience to the conference and will deliver a keynote on the current drug policy debate.

The collapse of the case for drug prohibition: what will the next drug policy be?

After more than half a century of global drug prohibition, the drug market continues to expand and become more dangerous with increasing production and consumption, falling prices, rising purity, sustained high availability and more than 70 new drugs identified in 2012. The Global Commission on Drug Policy, comprising more than twenty major international leaders, acknowledged the failure and futility of global drug prohibition in 2011 and called for more debate about future drug policy. In Australia few tried to defend drug prohibition in 2012 after the release of two reports on drug law reform by Australia21. The threshold step is to redefine drugs as primarily a health and social, rather than primarily a criminal justice issue.

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COELIAC DISEASE:

a commonly misdiagnosed chronic disease

BY SHERRIE LEE MACN, REGISTERED NURSE, ACN EMERGING NURSE LEADER, RAMSAY HEALTH, HILLCREST PRIVATE HOSPITAL, QLD

Sherrie Lee

“Once diagnosed, a full gluten free diet must commence, omitting all products containing wheat, barley, rye and oats. Improvement should be seen and symptoms should disappear after a short time.”

Coeliac disease is commonly misdiagnosed. It is an autoimmune condition to which a person is genetically predisposed (Green 2008). Gluten, a protein found in wheat and other grains such as barley and oats, is ingested and broken down to gliadin fractions, which interact with the immune system, causing an allergic reaction (Green 2008). Inflammation occurs from an immune response, which leads to the damage of the intestine, causing villi atrophy (Green 2008). The main role of the villi is to increase the surface area of the small intestine for increased absorption of nutrients (Martini & Bartholomew 2010). Thus, if the villi are damaged, malabsorption of nutrients occurs, leading to symptoms of coeliac disease.

Coeliac disease is very common and approximately one in 100 people are diagnosed with the disease and many more have been misdiagnosed (Hsieh & Twigg 2011). For others, it remains undetected, possibly due to limited knowledge of the symptoms of this disease.

Symptoms can include:

- bloating
- weight loss or gain
- constipation
- diarrhoea
- itchy skin
- abdominal pain and cramps
- nausea and vomiting
- lethargy
- anaemia
- dyspepsia (indigestion)
- polydipsia (thirst)
- polyuria (frequent urination)
- foul smelling faeces.

To diagnose coeliac disease a person requires a blood test. The blood test will determine if serum folate, gliadin antibodies and endomysial antibodies are present (Harris, Nagy & Vardaxis 2010). An endoscopy is also required and a biopsy is taken of the duodenum to assess if the villi are damaged (Harris, Nagy & Vardaxis 2010).

Once diagnosed, a full gluten free diet must commence, omitting all products containing wheat, barley, rye and oats. Improvement should be seen and symptoms should disappear after a short time. If found to have coeliac disease, lactose intolerance is also common (Dellsperger 2010). If so, omitting dairy products is necessary, however, calcium requirements still need to be met (Dellsperger 2010). It is important to mention, that foods removed from the diet that cause reaction need to be replaced by alternatives such as rice or corn, and consuming cheese (which is low in lactose) instead of drinking milk in large quantities, may be required.

Women of childbearing age, if thought to have coeliac disease, need to be careful and aware. As previously mentioned, a person with coeliac disease is genetically predisposed, and it is possible for the next generation to have the disease. Furthermore, a woman with untreated or undiagnosed coeliac disease can have reduced fertility, menstrual irregularities, earlier menopause, increased risk of miscarriage, preterm labour and other adverse pregnancy outcomes (Clark 2011; Norouzina 2011). Treatment involves following dietary guidelines and incorporating important vitamins and minerals, such as folate and iodine during pregnancy (Clark 2011). Furthermore, ‘intestinal mucosal damage generates a wide spectrum of symptoms due to malabsorption, resulting from autoimmunity’ (Norouzinia et al. 2011, p. 1537).

There is also a known link between coeliac disease and the development of osteoporosis. A person’s ability to absorb vitamins and minerals may also be at risk, affecting calcium

and vitamin D uptake; increasing the risk of osteoporosis (Pocock & Noakes 2011). However, lifestyle factors such as smoking and a lack of exercise also increase this risk (Pocock & Noakes 2011). It is recommended that adults with coeliac disease have regular bone density tests (Pocock & Noakes 2011). Bone mineral density usually improves or stabilises once gluten has been excluded from the person's diet (Evans & Sanders 2010). If the person is diagnosed with osteoporosis, strategies can be implemented, such as increased exercise and vitamin D supplements to prevent or delay potential future complications of osteoporosis.

Similarly, diabetes mellitus often co-exists with coeliac disease (Hsieh & Twigg 2011). Statistics show that as many as 4–10% of people who have been diagnosed with type 1 diabetes mellitus also have coeliac disease (Hsieh & Twigg 2011), however a person with diabetes and coeliac disease may have different symptoms, if any symptoms at all, making diagnosing coeliac disease extremely difficult.

In summary, coeliac disease is easily diagnosed with a blood test and endoscopy and despite ongoing research and technological advances, there is still limited understanding of coeliac disease in the general population. The importance of an accurate diagnosis cannot be underestimated and every person diagnosed will have their own journey with coeliac disease.

Article acknowledgement: Melissa Bloomer FACN, Lecturer, Monash University, School of Nursing and Midwifery

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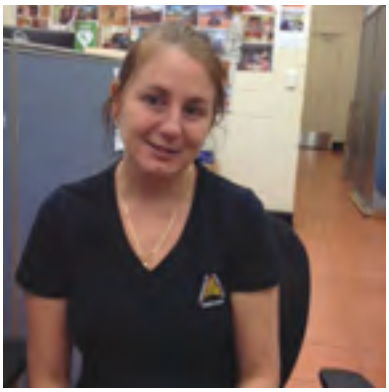
PROVIDING BREAST CANCER CARE IN EASTERN ARNHEM LAND

BY MARIJA BINDLEY, REGISTERED NURSE, LAYNHAPUY HOMELAND ABORIGINAL CORPORATION, NHULUNBUY NT

Marija was a recent student of ACN's Graduate Certificate in Breast Cancer Nursing. Her experience, shared among her fellow students, demonstrated sensitivity and an understanding of Australia's Indigenous communities and their relationship to their health.



Marija Bindley

I live in Nhulunbuy, a remote area of East Arnhem Land, Northern Territory (NT), and work for the Laynhapuy Homelands Aboriginal Corporation as a remote area nurse; very much a primary health promotion role. To be honest, it's the best job I've ever had and I'm probably the happiest I have ever been. I believe it's not just because of the fantastic lifestyle; a mixture of beaches and bushland. I believe it's the people who live here that make it such a wonderful place to work and live.

I travel on a daily basis either by light plane or 'troopy' to the homeland communities. My role varies according to the needs of the community and the different programs I coordinate. As a generalist RN I facilitate clinics with the support of the health workers if available. Emergencies and illness take priority; however, my main role and focus is on women's health. As a women's health nurse there is always a lot to do, whilst always being respectful of cultural traditions, practice, values and attitudes.

With regards to breast cancer, my role is focussed on the very beginning, starting with teaching the women how to be breast aware and how to do a breast self-examination. Current recommendations of the National Breast Cancer Centre (2004) for early detection of breast cancer include breast awareness – women should be aware of how their breasts normally look and feel, and be aware of any new or unusual changes.

> *"…the woman's greatest fear is probably not the cancer treatment, but the fact that she has to leave her country, her homelands, her family."*

I see the women in the clinics and run women's days where all the women get together and we talk 'women's business'. I find these days to be a fantastic two-way learning process. Quite often it's not just me doing the talking and learning, the women teach me their ways as well. I find talking about breasts with the Indigenous women very easy, as they hold the belief that women have breasts to feed their babies for as long as possible. During these talks I use a breast model to demonstrate how to feel for lumps, but the women usually examine themselves within the group; this information is then taken away and handed down to the younger women. Some communities do have their younger women present at the meetings. I leave this purely up to the community. We also discuss screening mammography of asymptomatic women. Breast Screen NT visit once a year, and it is my job to coordinate and educate the women who need this, as well as discuss what possible outcomes may arise. In the four and a half years I have been in my job, we have had one woman diagnosed with breast cancer that was picked up via screening. She is a survivor and

shares her breast cancer story with other women to promote breast awareness.

When I first meet and have to care for a patient newly diagnosed with breast cancer, I would have to say the most difficult part is informing the woman she will need to travel to Darwin and stay there a while. I know no matter how well the treatment options are explained to her, the woman's greatest fear is probably not the cancer treatment, but the fact that she has to leave her country, her homelands, her family.

The first question she will usually ask is, "Can I have an escort?" An escort provides beneficial emotional support and assists with translating, if required. If an escort is approved their travel expenses are paid for by the Patient Assisted Travel Scheme. Sometimes it's an effort to obtain the necessary approval. If an escort is not approved our corporation will pay the expenses. The escort is chosen several ways. Usually the family will allocate someone; however, if no one is available then Laynhapuy Health's Indigenous Senior Cultural Advisor will nominate a worthy candidate and liaise with family regarding the issue. Sometimes the Advisor escorts the client herself.

Unfortunately, at times it's not even the woman's decision whether or not she will have any investigative, diagnostic, or invasive treatment. Quite often it's a family or community decision, and whilst I may not always agree with the decision made, I don't believe my own values or beliefs influence any care planning or delivery. In my role I provide the most accurate information from start to finish in a cancer journey, and I put it into terms that are easily understood, so the best decision can be made without any influences.

Sometimes the woman is informed of her cancer by specialists whilst already in Darwin having a triple test to confirm diagnosis. She will then usually ring her family back home, and me. She may not return until treatment is finished. This is not only a very worrisome time for the woman, but also her family she has left behind. I think this is why the family bond and structure is so strong and close-knit within Indigenous communities.

From a professional point of view there is so much more I would like to learn about caring for patients with breast cancer. I'd like to learn more about the disease itself, more about the treatment options and time frames. I would also like to learn more about what happens when my patient reaches Darwin for treatment. Who will be her first point of contact? Will this person lead her through every step of her journey whilst she is there? What treatment will be offered? How long will she be there? Furthermore, I would like to *one day* be the specialist breast care nurse they come into contact with at the hospital and lead them through the journey, to hopefully see them return home, well.

Upon reflection of my role, I've realised that not only must I have a good understanding of breast awareness, cancer and treatment options, but also awareness of cultural sensitivities, traditions, values and the language of the Indigenous population in East Arnhem Land. Having an understanding of how Indigenous people live, helps me understand their rationale of why and how they do the things they do. The women of Laynhapuy Homelands communities are strong, they are leaders, they are respected, and will take the time to listen to 'our story' if it can be translated into a way that they can understand; I respect them for that.

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MANAGING OLDER PEOPLE WITH DIABETES:

can age-specific guidelines help health professionals plan proactive individualised care?

PROFESSOR **TRISHA DUNNING** AM FACN (DLF), CHAIR IN NURSING AND DIRECTOR CENTRE FOR NURSING AND ALLIED HEALTH RESEARCH, DEAKIN UNIVERSITY AND BARWON HEALTH

SALLY SAVAGE, PSYCHOLOGIST, DEAKIN UNIVERSITY AND BARWON HEALTH

NICOLE DUGGAN MACN, DIABETES EDUCATOR, DEAKIN UNIVERSITY AND BARWON HEALTH

Globally more than 18% of people aged 60–75 have diabetes, which represents 35% of diabetes in adults (IDF 2013). The prevalence in older Australians is 16.8%, and a further 16.8% are at high risk of diabetes and will most likely present with one or more diabetes-related complications. Symptoms are often atypical, thus the diagnosis can be missed or attributed to other causes including 'old age'. Significantly, diabetes is a leading cause of death in older people. Importantly, 'older people' are highly individual and cannot be defined by age, although age 65 is increasingly accepted as 'old', hence, the findings of well-designed research cannot always be generalised to older individuals.

DIABETES IN OLDER PEOPLE

Diabetes is metabolically different in older people from younger people. For example, fasting plasma glucose may not be increased in older people with type 2 diabetes (Amer et al. 1991; Menielly & Elliott 1999). In addition, overweight and lean older people are different. Overweight older people are usually insulin resistant but have relatively normal insulin secretion. In contrast, insulin action is relatively normal in lean older people but insulin secretion can be impaired (Meneilly 2011). Consequently, overweight older people might benefit from insulin sensitising medicines such as Metformin, whereas most lean older people need insulin soon after diagnosis.

Renal glucose threshold increases with age and glycosuria might not occur until the blood glucose is very high. Likewise, older people often do not feel thirsty and can be at risk of fluid and electrolyte deficits if they become dehydrated and/or hyperglycaemic. Therefore, it is important that health professionals screen older people for diabetes, for example during annual health checks, hospital admissions or when the individual presents with an infection, or wounds do not heal.

DIABETES COMPLICATIONS AND OTHER COMORBIDITIES

Persistent hyperglycaemia and longer duration of diabetes are associated with diabetes complications (Meneilly 2011), which, with other concomitant comorbidities lead to physical, cognitive, sensory and functional decline, which affect self-care, independence, life expectancy and quality of life (Kirkman et al. 2012). Significantly, vascular dementia, Alzheimer's disease and diabetes are inter-related (Tolppanen et al. 2013). Severe hypoglycaemia is associated with dementia in type 2 diabetes (Yaffe et al. 2013; Whitmer 2009), and depression is common in older people with diabetes (Cahoon 2012).

Geriatric syndromes and delirium are more common in older people with diabetes. Delirium has multiple causative factors including medicines such as hypnotics, sedatives, narcotics and anticholinergic agents (Inouye 2003), cardiovascular and renal disease, infections, hypoglycaemia, and hyperglycaemia. The latter is associated with electrolyte changes ketoacidosis and hyperosmolar states.

KEY CARE PRINCIPLES

Very little category one evidence exists to support most diabetes care recommendations for older people with diabetes because they are often excluded from studies. Best practice care must be holistic, person-centred, and, ideally, planned with the individual and/or their family carers.

Maintaining independence, functional status and quality of life by reducing the symptom and medicine burden is important. Consequently, proactive risk screening and pharmacovigilance are essential (Sinclair et al. 2012; Dunning et al. 2013; NPS 2013). Many commonly prescribed medicines

such as antipsychotic medicines, long acting sulphonylureas, and sliding insulin scales should be avoided or used with caution in older people (AGS Beers Criteria 2012). Regular blood glucose monitoring is essential, especially when older people with diabetes are prescribed glucose lowering medicines, to identify hypo and hyperglycaemia and guide decisions about medicine doses and dose intervals, diet and activity.

A comprehensive care plan should include:

- Proactive assessment to identify risks such as nutritional deficiencies, increasing frailty, hypo and hyperglycaemia. All of these factors are associated with increased risk of pain, falls, geriatric syndromes, delirium, and depression and compromise functional status, which affects driving ability, self-care and medicine self-management.
- Considering risk/benefit, functional status and life expectancy when planning care and prescribing medicines initially and when changing the care plan/medicine regimen.
- Setting individualised goals and targets according to health and functional status. For example, HbA1c 7–7.5% (53–58 mmol/mol) could be appropriate for a functionally independent, relatively healthy older person but unsafe for a frail older person and people with dementia where HbA1c up to 8.5% (69 mmol/mol) might be safer. Generally, blood glucose range between 6–15 mmol/L should avoid hypoglycaemia and significant hyperglycaemia.
- Regularly reassessing the individual and their care plan; during annual health and diabetes complication assessments and when health status or treatment changes.
- Proactively discussing plans to stop driving including motorised wheelchairs and farm equipment, moving to supported accommodation and for end of life care.
- Managing cardiovascular risk as safely and effectively as possible using a healthy diet, regular activity, lipid lowering agents, aspirin and antihypertensive agents. The latter should be carefully titrated to avoid postural hypotension and the attendant falls risk.
- Managing hyperglycaemia, to promote comfort, prevent dehydration and the associated risk of ketoacidosis, hyperosmolar states, falls, pain, delirium and depression.
- Developing an appropriate plan to manage intercurrent illnesses (sick days) that suits the individual and revise the plan when the person's self-care capability declines.
- Incorporating general health checks such as mammograms, pap smears, prostate checks and immunisation into the care plan.
- Providing support and education for family carers and involving them in care decisions where possible.

Caring for older people with diabetes is challenging. Hyper and hypoglycaemia symptoms often go unrecognised. Physical, sensory and cognitive changes are common, and influence self-care safety. Proactive medicine management and pharmocovigilance is essential. Care must be individualised and communicated among health professionals. Guidelines can facilitate best practice care.

CONSENSUS GUIDELINES THAT CAN BE USED TO PLAN CARE FOR OLDER PEOPLE WITH DIABETES

- *Guidelines for Managing Older People with Diabetes in Residential and Other Care Settings*
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  http://www.adma.org.au/clearinghouse/cat_view/4-guidelines.html).
- *Guidelines for Managing Older People with Type 2 Diabetes*
  International Diabetes Federation (IDF) 2013
  www.idf.org.
- *Diabetes Mellitus in Older People*
  Sinclair et al. 2012
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EARLY CAREER REGISTERED NURSES: HOW DO THEY STAY?

BY JANE DOUGLAS MACN, REGISTERED NURSE, ASSOCIATE DIRECTOR FOR PROFESSIONAL PROGRAMS, AUSTRALIAN NURSING AND MIDWIFERY ACCREDITATION COUNCIL, PHD CANDIDATE (UNIVERSITY OF WOLLONGONG), ACT

Jane Douglas

"Working as an educator and lecturer in community, clinical and university settings has given me the ability to view the nursing experience of others through a variety of lenses."

For further information about this study please contact Jane Douglas at jane.douglas@mac.com

The nursing workforce in Australia and around the world faces severe shortages (Allen et al. 2010; Chenoweth et al. 2010; Tourangeau et al. 2010). Several reasons suggested for this predicted shortage include:

- an increased need for health care workers due to changing demographics (National Health Workforce Taskforce 2009)
- an ageing workforce with the average age of registered nurses (RNs) working in Australia in 2011 being 44.5 years (Titulaer et al. 2012)
- difficulty retaining early career nurses (Crow et al. 2005).

The number of places available in entry level nursing courses leading to registration has increased in an attempt to assist in meeting the projected requirements of the nursing workforce in coming years (Gaynor et al. 2006). It is also important however, to retain nurses following graduation and commencement of employment. The retention of nurses with experience has been shown to lead to better patient outcomes (Allen et al. 2010), suggesting a need to find ways to retain experienced nurses rather than simply replacing experienced RNs who leave the health care workforce, with new entry level RNs.

There is a lack of research into the experiences of early career nurses. This research study (commenced in 2011) investigates the experiences of nurses who have been registered and working in Australia for one to five years. The study has grown from a long-standing interest in issues surrounding the nursing workforce, including my own experience as an RN: working in environments with minimal support; working as a manager and the difficulties faced when attempting to staff clinical environments and; the difficulty associated with watching friends, colleagues and early career nurses make the decision to leave the profession. Working as an educator and lecturer in community, clinical and university settings has given me the ability to view the nursing experience of others through a variety of lenses. These experiences, combined with a belief in and passion for nursing as a profession, has led to this investigation into workforce retention in nursing, with a particular focus on how early career nurses remain within the profession.

There has been much written about nurses exiting the system with varied hypotheses regarding the reasons for this. Studies have examined nurses' intention to leave (El-Jardali et al. 2009) or stay (Ellenbecker et al. 2007), retention (Duffield et al. 2011), as well as behavioural characteristics associated with nurses and nursing students that may or may not affect their choice of career (Ely et al. 2010). Rather than investigating intent or character traits, this study asks participants to reflect upon their experiences and in particular, significant events within their clinical working life since registration as a nurse. It seeks to examine factors that lead to early career RNs making the decision to remain within the profession following their first postgraduate year and asks the questions, 'what are the significant experiences that you remember' and 'what and how did you learn from these?'.

Narrative enquiry is used to examine common themes emerging from the stories of early

career nurses, investigating strategies employed by or offered to these nurses that enable them to continue with their nursing careers. The result of such analysis will offer ways forward in developing structures and frameworks that support current and future nurses that assist them to continue and flourish within the profession of nursing. The development of such strategies will aim to capture and retain nurses' vital experience within the profession, ultimately leading to improved patient and client outcomes.

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Disclaimer

The information contained in this article is the work of the author as part of her PhD and in no way reflects the views or work of ANMAC. Jane's research findings will be published in an upcoming edition of The Hive.

FILMING HISTORY

BY LEONIE KEEN MACN, ENDORSED ENROLLED NURSE AND FILMMAKER, QUEANBEYAN DISTRICT HOSPITAL, NSW

Aside from being a nurse ACN member, Leonie Keen, is an award winning filmmaker and has made a documentary movie about the Queanbeyan District Hospital, titled 'QDH: from Old to New' (2013). In this film, Leonie reflects on the wide-ranging history of her workplace.

Leonie Keen

> *"…researching the history of QDH and interviewing people associated with it, has allowed me to better understand, and appreciate, how nursing has developed in my workplace."*

In 2006, a decision was made to build a new Queanbeyan District Hospital (QDH) and demolish the existing one. It was an exciting time for Queanbeyan because we needed new facilities, but having worked at QDH since 2001, I knew that the 'old' hospital held an important place in people's lives. The QDH was built in 1846, originally as a Benevolent Asylum which catered for the poor. Over time, the hospital had grown up around it and many Queanbeyan locals had worked on constructing its numerous additions. The old building seemed full of stories. Patients would tell me proudly that their entire family had been born at QDH, that they'd worked there, or that family members had died peacefully there. Others were grateful for the care they'd received from hospital doctors and nurses. And it wasn't just patients; nurses, doctors and others seemed to have stories about the old building.

I thought it would be a good idea to make a documentary film about the history of the old QDH, before it was gone forever. I have a Bachelor of Communication (Film and Television), majoring in Health Promotion. I was hesitant about such a mammoth task as my first major film feature, and it did turn out to be a steep learning curve technically, but I really wanted to capture what the QDH looked like in real life, and record the stories I knew were out there.

The film is almost an hour long. It's chronologically organised, and opens with images of the town in the mid-1880s with dirt roads, horses and carts. I talk about the work of the Benevolent Asylum, which in its first year admitted six patients who stayed an average of 68 days. The patients then tended to be itinerant men, presenting with injuries, but often intoxication, opium addiction, syphilis, or disabilities such as blindness. Matron Mary Rusten was the asylum's first combined nurse-cook-housekeeper. She lived at the institution with her husband who had the job of wardsman.

Investigating Queanbeyan's health history was fun and rewarding. I discovered that even in the 1850s, some pretty advanced surgery was done at the QDH. One was the removal of a large facial tumour from a 62 year old man. Despite the fact that it extended from his lip to half way down his chin, he recovered and was discharged within a month! This is remarkable really, given the prevailing conditions at the time: patients' toilets were essentially thunder-

Left to right: Old hospital built in1933
Queanbeyan Hospital Nurses 1933
Matron Rusten and husband
Nancy Monk – a retired nurse featured in the film

boxes over an open pit. Typhoid and other diseases were common ailments and there was no understanding of germ theory or infection as such. Perhaps the man's recovery was hastened by his hard work? During Matron Rusten's term, all patients assisted in cleaning the wards during their convalescence.

Making the film gave locals an opportunity to talk about what the QDH meant to them. I filmed Nancy Monk, a retired nurse, dressed in a nurses' uniform from the 1970s as she wandered around the grounds of the QDH and the Matron's cottage. Maria Lukacs, an Assistant in Nursing at QDH talked about aged care, recalling the exceptional nursing work of the Confused and Disturbed Elderly Unit which operated in the 1980s, and the consequences of its closure in 2004. Bonnie Missins, a nurse and midwife who worked at QDH for over fifty years, shared her memories about her career, explaining what nursing was like in the 1950s. Bonnie emphasised the good professional relationships that nurses had with local doctors at the time, and talked of the changes in the way patients are cared for, particularly the elderly.

Narelle O'Rourke is another registered nurse from Queanbeyan who's featured. She talked about her aunt, Mary Bowers. Mary's place in Queanbeyan history is legendary; she was awarded the Order of the British Empire for services to nursing and the community. In the film, Narelle explains that Mary travelled on foot to attend midwifery patients at home, always carrying her midwife's bag. The children of Queanbeyan believed that Mary's bag actually contained the baby she was going to deliver! It seemed to them that Nurse Bowers always had the bag with her when entering a house, and when she left that house, a new baby had miraculously appeared inside.

In making *QDH: from Old to New,* I have learnt a lot about the history of my profession as it developed at QDH. I was not aware, for example, that in the past, nurses had to live-in at QDH, or that until the 1950s nurses were not permitted to work if they were married. It's been wonderful for me to record what the health setting looked like in the past and what it looks like now, the nurses' uniforms, the various sorts of technology used by nurses and the types of ambulances and other vehicles used for patient transport or home visits. There are really interesting episodes in QDH's history too, such as the local industrial unrest in the late 1940s. This led to power blackouts at the QDH which happened without warning, and some operations were carried out with lighting by hurricane lamps or candles.

It's certainly been a challenge to document the history of QDH in my first feature film. I've learnt a lot about the practicalities of filming, but researching the history of QDH and interviewing people associated with it, has allowed me to better understand, and appreciate, how nursing has developed in my workplace. This project has really stimulated my interest in nursing history, so I plan to do more.

Leonie Keen's DVD ***QDH: from Old to New*** is available at the QDH Kiosk ($20, $25 pp) with proceeds to Queanbeyan District Hospital Auxiliary.
For more information call **0416 620 104**.

THE VOICE OF INFLUENCE:

member contributions to ACN's policy agenda

"These communication channels and engagement structures connect the ACN policy team to the frontline of nursing, and allow us to gather information and advice from nurses across Australia."

ACN members play an important role in ensuring nurses' voices are heard at the highest levels. The second half of 2013 saw a large number of ACN members participate in consultations, working groups and the development of submissions to government and non-government organisations. This high level of engagement is a testimony to the commitment and drive of ACN members to contribute to the development of the profession.

In order to tap into the expertise of our membership, ACN utilises a number of communication channels, including the 3LP online forum, surveys and ad-hoc working groups. ACN policy staff also identify members with specific expertise on the membership database or through the ACN Communities of Interest and gather local knowledge by contacting ACN Regions. These communication channels and engagement structures connect the ACN policy team to the frontline of nursing, and allow us to gather information and advice from nurses across Australia. This article looks back on some of the highlights of policy work undertaken in the second half of 2013.

REGULATION AND ACCREDITATION

As a key national professional organisation for nurses, ACN is highly active in the regulation and accreditation space. These issues can have a lasting impact on the working lives of nurses, their scope of practice and ultimately the shape of Australia's health care system. In 2013, ACN provided feedback on a number of significant Nursing and Midwifery Board of Australia (NMBA) initiatives.

In September, an ACN working group was formed to consider the NMBA's proposed registration standard for the endorsement of registered nurses and midwives to supply and administer medicines under protocol. Members of the working group participated in two teleconferences to tease out the complexities of this highly politicised topic. By consulting with the working group, ACN policy staff were able to develop a better understanding of the potential implications of the NMBA's proposal. ACN argued that the proposed registration standard would be a positive development for consumers and the nursing profession, but noted there may be some implementation issues to work through.

Later in the year, ACN asked members for their perspectives on the challenges of re-entering the nursing workforce in order to inform a submission to the NMBA's re-entry to practice consultation. ACN members expressed their concerns about the clinical proficiency of some nurses who return to practice after a long career break, while also acknowledging the need to facilitate nurses wishing to return to practice. ACN's submission argued in favour of a nationally consistent approach to re-entry that promotes workforce flexibility and ensures public safety.

SAFETY AND QUALITY

Safety and quality in health care is a priority for ACN and attracts a high level of interest from ACN members. ACN developed a response to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) consultation on health literacy. ACN's response was informed by extensive feedback received from members with a passion for the promotion of health literacy. The members who contributed to the development of ACN's response were drawn from a diverse range of specialties and professional backgrounds. Their expertise gave ACN insight into the day-to-day challenges of addressing poor consumer health literacy in the community.

Members also contributed to the review of a handbook developed by ACSQHC to improve the quality of care for people with cognitive impairment in acute care. Members who contributed to the review included nurses with backgrounds in geriatric nursing and stroke care. While ACN members were broadly in support of the document's aims, it was noted that the handbook required further development to improve its usefulness. ACN's submission welcomed ACSQHC's initiative in developing the handbook, but also made several suggestions for its improvement based on the feedback received from the membership.

CLINICAL ISSUES AND STANDARDS

In late 2013, a group of ACN members with expertise in diabetes reviewed a South Australian report on systemic issues of concern with the HbA1c blood test. Members who contributed to the review included a number of credentialled diabetes educators and members with a background in health promotion. In light of the feedback received from this review group, ACN was able to provide a nursing perspective on

the importance of multidisciplinary diabetes care, consumer education and well-designed laboratory reporting.

EDUCATION

ACN recognises that the quality of the health care system depends to a large degree on the education of its clinicians. As a result, ACN frequently contributes a nursing perspective on issues affecting the education of nurses and other health professionals. ACN provided feedback to the National Blood Authority's consultation on its *Draft National Education and Training Strategy*. ACN was also invited to provide feedback to the Australian Medical Council on the accreditation of the educational programs of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. ACN's submission was developed jointly with the Australian College of Midwives. The submission highlighted the gains to be made through the interprofessional education of nurses, midwives, obstetricians and gynaecologists.

PUBLIC HEALTH

ACN's policy work promotes the role of nurses in addressing public health issues. In October, the policy team called on the Disaster Health Community of Interest to inform a submission on Australia's revised pandemic influenza plan, produced by the Department of Health. As a significant and widely distributed part of the health care workforce, nurses are critical to any successful response to a pandemic. However, the revised pandemic influenza plan included only limited mention of the roles of nurses. ACN's submission noted that nurses are ideally placed to manage vaccinations, undertake triage and initiate other pandemic response procedures. ACN also argued that widening prescription rights for nurses during an emergency could be a highly effective public health measure.

A GROWING MEDIA PRESENCE

In July 2013, ACN issued a hard-hitting media release critical of the Labour Government's proposal to cap tax deductions for self-education expenses. A number of members contacted ACN to voice their concern that the proposed cap could prevent them from pursuing further education. ACN's media release emphasised the need to support nurses to maintain and extend their knowledge and skills.

In the lead up to the Federal election, an ACN media release asked Australia's major political parties to address the challenges facing Australia's health care system, including the predicted nurse workforce shortage.

In December, a media release was distributed expressing ACN's concern over the disbandment of the Immigration Health Advisory Group, which included an ACN member representing nurses working with refugees and asylum seekers.

MEMBER INVOLVEMENT

Contributing to ACN's policy work is a great way to make your voice heard on the issues that are important to you. ACN's policy team relies on members' contributions to inform our policy work and members' views assist us in keeping our work anchored in the real world of health care delivery. The policy team is keen to hear from members at every stage of their career, from nursing students through to nurse leaders. Contributing to ACN's policy work is a wonderful opportunity to share your expertise, learn about new policy initiatives and be at the forefront of understanding changes in health policy.

We would like to thank all the members who strengthened ACN's voice in 2013 by providing valuable feedback on policy submissions.

IF YOU WOULD LIKE TO BE INVOLVED IN POLICY WORK:

- look for opportunities advertised in the *ACN eNewsletter* under the heading 'Policy'
- respond to any direct email you may receive inviting you to participate
- check the ACN website, **www.acn.edu.au/advocacy**
- contact the policy team with your ideas or to ask how you can contribute, **policy@acn.edu.au**
- discuss opportunities for involvement with Marlene Eggert, Policy Manager on **02 6283 3431** or email **marlene.eggert@acn.edu.au**.

To see a list of ACN's submissions and media releases in 2013, visit **www.acn.edu.au**.

PRIORITISING PLACEMENTS TO REACH THE GREATEST AREA OF NEED

In December 2013, NAHRLS introduced the Prioritisation Checklist in response to the overwhelming locum support requests received and the fixed number of placements remaining this financial year.

NAHRLS is funded to undertake a fixed number of placements per financial year. NAHRLS is funded to fill 931 nursing placements and 164 allied health placements until June 2014 and, to-date, NAHRLS has filled 781 nursing and 111 allied health placements. This means that there are only 150 nursing and 53 allied health placements remaining until June 2014.

General Manager, Mark Ellis said, "The number of placements NAHRLS has been able to fill this financial year has been a great result for the programme and allows the continued provision of health care to Australian's in rural and remote areas when health professionals need to leave their area of practice. This increase in usage, however, requires us to prioritise all future requests for backfill to ensure that remaining placement numbers are distributed effectively to reach the greatest area of need."

This Prioritisation Checklist incorporates the eligibility criteria available on the NAHRLS website and includes the following:

- Rurality
- Purpose of leave
- Professional details
- Other details

In assessing the rurality of the locum placement, the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) tool will be used. The ASGC-RA uses five categories to classify geographic locations:

- Very remote Australia (5)
- Remote Australia (4)
- Outer regional Australia (3)
- Inner regional Australia (2)
- Major cities of Australia (1)

Mark Leddy, Practice Manager for Camperdown Clinic in Victoria. Using the NAHRLS Locum Service for CPD leave ensures that staff members maintain their accreditation and Camperdown Clinic are adequately staffed during their absence.

Eligible applicants must be located within categories 2 to 5, except Aboriginal medical services which may be located in any category. The level of rurality is used to prioritise applications.

NAHRLS was initially established to cover CPD leave only. In early December 2011, the Department of Health granted the extension of the NAHRLS leave policy to include other forms of short term leave such as personal and annual leave.

While all forms of short term leave are considered within the checklist, CPD activities and CPD activities combined with other professional development take priority over annual and other leave. Locum support is provided to cover periods of leave of up to 14 days and Locum support is not to be provided for vacant positions under any circumstances.

Professional details relates to CPD required for national registration or ongoing professional credentialing. If you are required to undertake CPD to continue to practice within the scope of your profession, this will increase your priority score.

The priority score of a locum support request will increase where the health professional can meet the other, less weighted, selection criteria including sole practitioner status, period since previous leave, manager's approval (where applicable), details of sector, and details of CPD activity.

For further information, please visit our website www.nahrls.com.au or freecall 1300 NAHRLS (1300 624 757)

PRELIMINARY NOTICE – PCC2014

Preventing Cervical Cancer 2014: Integrating screening and vaccination

5th – 7th December 2014 MELBOURNE, VICTORIA AUSTRALIA

Following the success of the two previous conferences, a third conference has been scheduled for late 2014.

PCC2014 will provide an update on developments across all aspects of cervical cancer prevention and will facilitate a free flow of communication between the different divisions and disciplines.

This major health conference will bring together international and Australian experts in cervical screening, vaccination and cancer epidemiology to debate and explore current and future directions in the prevention of cervical cancer in Australia and within resource poor settings, particularly in our region.

The dates of the conference will coincide with the 50th Anniversary of the establishment of the Victorian Cytology Service.

PCC2014 will be held at the Sofitel, Collins St Melbourne and the networking dinner will be held at Melbourne's iconic Arts Centre.

PCC2014 will provide a forum for leading experts to share their vision and influence policy development in the prevention of cervical cancer.

For further information and ongoing notification about this important conference please email PCC2014@vcs.org.au

VCS

PCC2014 CONFERENCE 5-7 December 2014 Preventing Cervical Cancer: Integrating Screening and Vaccination.

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