ACN

the hive

#7 SPRING 2014

SAVING INDIGENOUS NURSES AND MIDWIVES *from historical oblivion*

DISILLUSIONMENT IN NURSING: *a rite of passage?*

CLINICAL SUPERVISION IN AUSTRALIA: *dancing on the head of a pin*

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Odette Best MACN

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CEO REPORT

ADJUNCT PROFESSOR DEBRA THOMS FACN (DLF)

Debra Thoms FACN (DLF)

In the spring edition of *The Hive* we are highlighting the role of standards for practice in nursing and health care. Our 'Special Feature' showcases an article from our Policy team, *From 'Competency Standards' to 'Standards for Practice'* focussing on the history of standards for practice, the recent Nursing and Midwifery Board of Australia shift from competency standards to standards for practice and the review process that preceded the shift. Caroline Ayre's article, *Australia left behind*, discusses the Grattan Institute's call for radical changes to the health workforce internationally. Closing our 'Special Feature' is an article by Dr Edward White, *Clinical supervision in Australia: dancing on the head of a pin*, which details how the closing of Health Workforce Australia has opened an opportunity to remodel the way clinical supervision is conceptualised and add clarity to the understanding of clinical governance in Australia.

I'm pleased to introduce a new ongoing feature in this edition of *The Hive* – our 'Regular Columnists'. Welcome to ACN members Laurie Bickhoff, Melissa Bloomer, Cheyne Chalmers, Mary Chiarella, Tomica Gnjec and Madonna Grehan, who will be *The Hive*'s regular columnists for the next 12 months. Our columnists have each written a response to the theme of standards for practice. It's interesting to read six different perspectives on this issue; ranging from a newly registered nurse to an experienced nurse in a managerial position.

This edition also features an article by Dr Odette Best, *Saving Indigenous nurses and midwives from historical oblivion.* Odette has a passion for preserving the historical records of Indigenous nurses and midwives, and is committed to ensuring they are recognised in the health care industry for the services they have provided for over a century.

Our 'Your say' section features an article by Melissa Bloomer. Many of you would have read previous articles from Melissa. This time she's writing as a health care consumer about the struggles her husband, and in-turn the rest of her family, have experienced in trying to seek recognition and treatment for his diagnosis of Lyme disease.

This edition contains a pull-out poster promoting the 2014 ACN National Nursing Forum. Please be sure to share 'far and wide' so we can inform as many people as possible about the Forum and the many opportunities that will be provided there.

PUBLICATION GUIDELINES

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

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

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

Summer 2014 – Mental health

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

OUT AND ABOUT WITH THE CEO

Debra Thoms FACN (DLF) and Raymond Chan FACN

I was just leaving for Geneva and the International Council of Nurse's (ICN) meetings when the last issue of *The Hive* was being prepared, so I am pleased to provide you with an update on these meetings as well as some other activities I've undertaken over the past three months.

ICN: A series of meetings were held in Geneva, immediately prior to the World Health Assembly in May 2014, which I attended with the ACN President. Details for these meetings were included in the most recent Board Communique. Attending these meetings provides a great opportunity to network with overseas colleagues but, more importantly, to gain an understanding of the challenges nurses face in many different parts of the world as well as the contributions being made to health care.

In late September/early October we will be hosting the ICN Workforce Forum in Sydney. This meeting is held annually and last year was in Ireland. It brings together a small number of representatives from around the world – this year we are expecting attendance from Iceland, Japan and Ireland to name a few. This meeting provides an opportunity to hear about key workforce issues and discuss the approaches being taken in various countries to address issues of nursing workforce.

Commonwealth Department of Health: I attended a Policy Roundtable at the Commonwealth Department of Health. Several speakers from overseas were attending the Australian Practice Nurse Association conference and the opportunity was taken by the Department to host a round table to discuss various aspects of primary health care provision and the role of nurses within those systems. International guests included Professor Madrean Schober who spoke on advanced practice in primary care nursing international. The primary health care nurse role in the UK was presented by Dr Richard Hatchett and provided some insights into how the role has developed over time in that country. Closer to home we also heard from Barbara Docherty on the primary health care nurse role in NZ.

Registered Nurse (RN) Standards: I was pleased to be invited to participate with the team being led by Professor Andrew Cashin FACN that is undertaking the review of the RN Standards for the NMBA. This is very important work and, to-date, we have had one face-to-face meeting and will be meeting regularly via teleconference as the research work progresses.

WHO Collaborating Centre (WHO CC) at UTS, Sydney: The next intake of the Leadership Program, which brings together nurses from across the South Pacific, commenced in August. Each year the WHO CC Advisory Committee meet and we discuss matters related to the performance and progress of the work of the CC. There was also a reception at which we were able to recognise the wonderful contribution of Pele Stowers from Samoa. Pele was involved in the setting up of the CC and has been a continuing supporter of its work as well as a leader with the South Pacific Chief Nurses group.

FGM Learning: July saw the launch of the FGM Learning website which was a project undertaken with our colleagues at the Australian College of Midwives and funded by the Commonwealth Department of Health. If you have not seen the site I encourage you to visit it at **www.fgmlearning.org.au.**

Queensland University of Technology (QUT): I was invited to provide the Graduation Address at QUT in July, which I accepted with pleasure. This was a wonderful ceremony and it was an added bonus to be there to see ACN Fellow Raymand Chan receive his PhD – congratulations all round!

NSW Health Nursing and Midwifery Excellence Awards: Towards the end of July I was able to participate on the panel to select the winners of the NSW Health Nursing and Midwifery Excellence Awards – these will be announced at a ceremony in September. This was a very positive process and wonderful to see the excellent work of nurses and midwives recognised in such a public way.

ANNUAL GENERAL MEETING

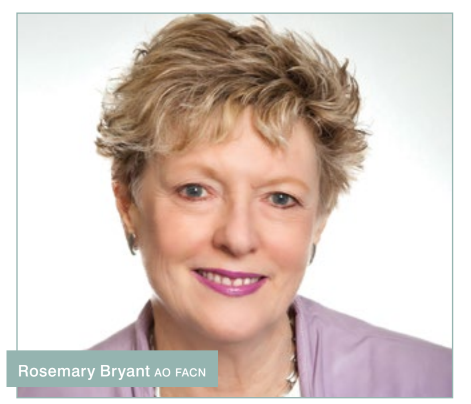
Australian College of Nursing: Annual General Meeting notification

ACN extends an invitation to all ACN members to attend the ACN Annual General Meeting to be held at the Adelaide Convention Centre on Sunday 2 November 2014 from 4:00PM – 5:00PM.

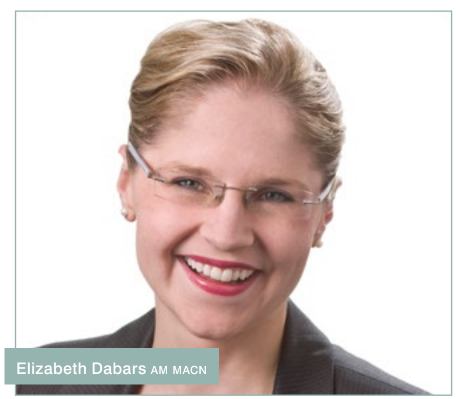
MEMBER UPDATE

QUEEN'S BIRTHDAY 2014 HONOURS LIST

Congratulations to the following Fellows and Members who were recognised in the Queen's Birthday Honours list.


Rosemary Bryant AO FACN

Molly Carlile AM FACN


Elizabeth Dabars AM MACN

Jose Aguilera OAM FACN

Kathleen Challinor OAM

Jennifer Andrews PSM FACN

ORDER OF AUSTRALIA

Dr Rosemary Bryant AO FACN

For distinguished service to the profession of nursing through national and international leadership, and as a supporter of access and equity in health care.

MEMBER OF THE ORDER OF AUSTRALIA

Mrs Molly Carlile AM FACN

For significant service to community health through seminal contributions to organisations providing palliative care, and to the performing arts.

Adjunct Associate Professor Elizabeth Dabars AM MACN

For significant service to medical administration, particularly to nursing and midwifery, and to community and mental health organisations.

MEDAL OF THE ORDER

Mr Jose Aguilera OAM FACN

For service to nursing, and to professional organisations.

Mrs Kathleen Challinor OAM

For service to nursing in the field of audiometry.

PUBLIC SERVICE MEDAL

Ms Jennifer Andrews PSM FACN

For outstanding public service to nursing in Queensland.

MEMBER UPDATE

ACN BOARD UPDATE: A NEW STRATEGIC DIRECTION TAKING SHAPE

As previously advised, the key outcome of the Board Strategic Planning workshop was to focus ACN more clearly on nurse leadership. This new direction provides ACN with the opportunity to position itself as the national organisation for nurse leaders and aspiring nurse leaders.

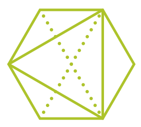
It is exciting to report that significant progress has been made over the past few months in operationalising this new strategic direction.

ACN PURPOSE STATEMENT

The new ACN purpose statement sets a clear vision and direction for ACN.

ACN is the national professional organisation for all nurse leaders: nurses with an interest in leadership, nurses aspiring to leadership roles and nurses in leadership roles across the Australian health system. The leadership capabilities of all nurses play a critical role in the delivery of health services to the Australian community. ACN is an advocate for the nursing profession, advancing the skills and expertise of nurses to provide leadership in their contribution to the policy, practice and delivery of health care. ACN encourages and supports nurses to develop and grow to become nurse leaders who are able to contribute by providing professional, economic and health perspectives.

ACN TAGLINE AND LOGO



To align with the new direction ACN's new tagline is *Advancing nurse leadership.*

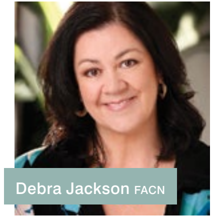
ACN will also be moving forward with the use of the ACN acronym logo.

NATIONAL NURSING FORUM

Members will be provided with a comprehensive update regarding the *2015-2018 ACN Strategic Plan* at the Member's Day, which will be held on Sunday 2 November. A cornerstone leadership initiative will also be launched so we encourage all members to attend this event.

In the next edition of *The Hive* we will feature the role and responsibilities of ACN Board members.

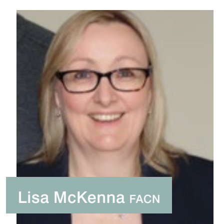
WELCOME TO ACN FELLOWSHIP



Debra Jackson FACN

Professor Debra Jackson FACN

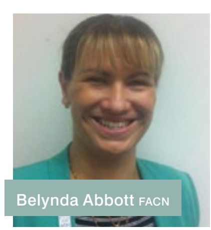
I am delighted and honoured to be admitted as a Fellow of the Australian College of Nursing. This represents the culmination of my nursing career to date. It is a great privilege to be able to work alongside other ACN Fellows and Members to contribute to a strong and sustainable nursing workforce, and to enhanced health outcomes for Australia's diverse population, and for international communities.



Lisa McKenna FACN

Dr Lisa McKenna FACN

I am very honoured to be achieving Fellowship of the Australian College of Nursing after many years of membership. This status represents the culmination of many years of commitment to nursing practice and academia, and demonstrates recognition of my vast contributions as valuable to the profession. I look forward to continuing to make exciting and significant contributions to the nursing profession and ACN into the future.



Belynda Abbott FACN

Ms Belynda Abbott FACN

I am deeply honoured and humbled to be awarded Fellowship of Australian College of Nursing. This is my badge of honour and commitment to my contribution to ACN and to the nursing profession. Becoming a Fellow has further strengthened my passion to continue to embrace, guide and inspire the future generation of nurses and to provide a professional voice, networking opportunities and a voice of influence towards the future of nursing.

Q&A WITH THE CEO

ADJUNCT PROFESSOR ANNETTE SOLMAN FACN

Each edition of 'The Hive' features a 'Q & A' session with ACN's CEO, Debra Thoms. This series of articles profiles current nurse leaders and provides our members with an insight into their personal journey to a position of influence and leadership.

Debra Thoms FACN (DLF)

Annette Solman FACN

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

Annette – Growing up in an environment where questions were encouraged and there were expectations that you would do your best created a strong work ethic, an enquiring mind, challenging the present thoughts and situations, seeking to understand and to learn more.

There have been significant people in my life that have provided support throughout my career and created opportunity for me to have a range of experiences. I have undertaken a number of university degrees to support the development of my thinking and sought out opportunities to move into a range of roles.

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

Annette – There is much written about the importance of a work/life balance. I see it as a goal that, at times, is not met. As a leader there are periods when the investment of time and energy is intense and other periods when you have time for reflection, further learning and relaxation. I use walking as a means of relaxation and enjoy meditation as well as reading novels.

Debra – What have been your career highlights?

Annette – Working as a registered nurse involved in direct patient care; moving into education roles where I was able to support the learning of others; engaging in research to make positive changes to the workplace practices that benefit patients and staff, and working outside of nursing to gain a range of experiences in a number of roles within health.

I feel privileged to be the Director of Nursing and Midwifery within the Sydney Children's Hospitals Network, working with such a diverse workforce and nurses who strive for excellence in the care that they provide.

I have been fortunate to be working with others in practice development both within Australia and internationally which creates opportunities to stretch my thinking and to engage with committed researchers and clinicians dedicated to improving the theory and practice of person centred care.

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

Annette – Moving from what may be seen as traditional roles in nursing, both within the hospital and community environments, to designing roles that may look quite different into the future.

Working within an adaptive leadership model to support change that is necessary to continue to develop best practice, a diverse affordable flexible nursing workforce to meet the needs of an ageing population, new diseases and community where chronic and complex diseases are emerging as the greatest challenge to the health of our society across the life span.

Debra – Has mentorship played a role in your success?

Annette – I have been fortunate to have experienced mentorship throughout my career. Those who provided mentorship have been generous of their time and in sharing of their knowledge, at the same time challenging me to think differently and to take risks.

Q&A WITH THE CEO

> *Seek out feedback from others so that you can see how others view your practices and leadership, which may be different to how you see yourself as a leader.*

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

Annette – Working with staff and engaging in conversations I find that those nurses who want to progress in their careers as leaders are often those who challenge the norms, ask many questions and offer suggestions of how things may be different to what they are now. Seeking these nurses out, offering mentorship and opportunities to lead pieces of work to have a range of experiences that both challenge and create an opportunity for learning about themselves and others.

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

Annette – There needs to be an investment in your own professional development, place yourself in situations that are difficult and challenging. Seek out feedback from others so that you can see how others view your practices and leadership, which may be different to how you see yourself as a leader. Understand your own values and beliefs and how these play out in your personal life and in the workplace. Seek out opportunities to relieve in a diverse range of roles both within and external to nursing. Work to understand the whole health system to enable a big picture view. Find a mentor who will support your development as a leader; ask questions when you do not understand, look for patterns within work to gain understanding or new perspectives, self–challenge and challenge assumptions of others within a framework of support.

Debra – Do you have a leader that you admire?

Annette – Nelson Mandela was an inspiring leader who achieved what many believed was not achievable. His influence and legacy continue today.

Debra – Do you have a favourite leadership quote?

Annette – *When a man has done what he considers to be his duty to his people and his country, he can rest in peace. I believe I have made that effort and that is, therefore why I will sleep for eternity.*

(Nelson Mandela 1918–2013)

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STANDARDS FOR PRACTICE

ACADEMIC

Dr Melissa Bloomer FACN

Why do we prioritise single rooms?

These days it seems that almost every nursing action is based on practice standards such as guidelines, protocols, recommendations or policies. This is certainly true for many clinical decisions, however, the preference for single rooms for patient care seems to have been borne out of our historical approach rather than 'best evidence'.

Single rooms are reportedly preferred by patients because they are considered more personalised and private and result in more patient control over personal information. The National Health and Medical Research Council promote the use of single rooms as part of a suite of recommendations aimed at infection prevention and control; in terms of health outcomes, there is little evidence to demonstrate benefit to the patient.

There are a number of patient populations where care is considered best managed in a single room, such as those with social and cultural issues, behaviours of concern or in need of closer monitoring. Yet, care in a single room may actually be detrimental, with patients at greater risk of adverse events and less frequent care. For those who are dying, the assumption that dying in a single room will ensure a 'good death' is short-sighted. In the absence of visitors, single rooms create social isolation which can be a bigger concern than the perceived privacy gained. Rather, the camaraderie and support that can come from the company of strangers in a shared space is preferred.

Given these competing demands on single rooms, there is an urgent need to investigate the nursing decision-making processes and prioritisation considerations associated with the use and allocation of single rooms in the hospital setting.

CLINICIAN

Ms Tomica Gnjec MACN

How do practice standards assist in ensuring quality care for patients?

Over the years practice standards have further evolved with the evolution of nursing specialisation in Australia. A number of organisations such as the College of Emergency Nursing Australasia have formulated and articulated standards upon which the unique characteristics of areas such as emergency nursing practice are outlined, and benchmarking, development, research, and best practice is founded upon.

I recently approached my Emergency Department nursing colleagues and posed the question – "How do practice standards assist in ensuring quality care for patients?"

Their responses included : "a base standard of care to follow"; "necessary for consistency of quality"; "what local health services expect of us"; "working within scope of practice"; and "governed by same protocols, standards". One pertinent response also included "practice standards only aid nursing practice when they are up-to-date with evidence-based practice".

From my colleagues' responses – understanding and adoption of generalist and area specific practice standards appears wide and varied – a scenario also likely variable from area health service to individual facilities to clinical sub-areas. Sustained current pressures within the health system have somewhat detracted and removed the focus away from the foundations of practice development and research to foci such as funding linkages to hospital performance and efficiencies.

In the coming years clinical nursing will continue to be challenged at all levels of delivery. It is important to not allow the underpinning of quality in the delivery of health to be lost in the overall health equation.

In my almost 20 years of clinical nursing – 'practice standards' have always provided the foundation for my practice – how are they applied in your clinical area and what do they actually mean for you?

ETHICIST

Professor Mary Chiarella FACN

Standards for practice: evidence and purpose

Currently the Nursing and Midwifery Board of Australia (NMBA) is systematically reviewing all the former Competency Standards: Nurse Practitioners (in force as of 1 January 2014) (NMBA 2013), Enrolled Nurses (in process) (NMBA 2012), Registered Nurses (just begun) and Midwives (out for tender) (NMBA 2014a). The term 'competency' has been removed from the new standards because there was confusion between the use of the term 'competency based assessment' in the vocational education and training sector and use of the term 'competency' in other settings (NMBA 2014b). Each review has required the revision to reflect "current (not aspirational) evidence-based practice, be contemporary, relevant and useful" (AHPRA 2013).

The standards are (overall) intended to be the core competency standards that consumers can expect; to assist in determining eligibility for entry and re-entry to the professions, both for our own graduates and for internationally qualified nurses and midwives; to provide the framework for relevant curriculum development; and to provide a benchmark where there are questions of conduct or performance (AHPRA 2013).

Evidence takes the form of observational studies, surveys, document and literature reviews, focus groups and interviews. The need to describe the standards required for our contemporary practice is critical, as this enables the community to understand the work we do. There is also a view that standards should be defined in terms of patient outcomes (Duffield et al 2011), although how that would apply to some of the contexts of practice that are recognised would require further exploration (NMBA 2014c). In addition, the standards are approved and published by the national regulatory authority, whose primary objective under the National Law is to protect the public (Queensland Government 2009). Thus, patient safety will always be a factor in the ultimate determination of the standards.

Disclaimer: Mary Chiarella provides this column in her role as an academic. The views expressed in this column are her own and do not represent the views of the NMBA, unless quoting from publically available NMBA documents.

References can be seen on page 23

STANDARDS FOR PRACTICE

HISTORIAN

Dr Madonna Grehan MACN

Standards through the ages

They are so embedded into our everyday lives and work now, that it's hard to imagine what nursing would be like without practice standards. These are the sophisticated, principle-based frameworks by which nurses' professional practice is guided and measured. In the late nineteenth and early twentieth centuries it was quite different because the terms 'nurse' and 'nursing' had numerous applications. 'Nursing' of the sick was done by families in the domiciliary environment. Religious charities provided 'nursing' to the poor. Babies were 'nursed' at the breast. Immigrants' diaries record that ships' surgeons were marvellous 'nurses' for giving expert bedside attention day in, day out, to ailing travellers at sea. 'Nursing' in these forms was an activity undertaken by a range of people, some with skills, some with education, and some with neither.

In the context of scientific developments informing medical practice and in the rise of the modern hospital, the nineteenth century brought changes. Trained nursing was seen as a potential professional mode of employment for women and hospitals needed workforces that were literate, diligent and predictable. The trouble was the variability in training. To be recognised as a professional undertaking, nursing needed to be defined as a discrete practice. Minimum 'standards' in training had to be agreed upon and implemented to guarantee a uniform outcome that was the 'trained nurse'. Professional associations fostered this process, advocating voluntary regulation in the absence of statutory regulation. Today practice standards continue to inform nursing as a discrete professional undertaking.

MANAGER

Adjunct Professor Cheyne Chalmers FACN

Leadership and standards

Over the past year, the organisation I work for has been undergoing the lengthy task of preparing for accreditation against the National Standards. As a nursing leader involved in this process I must admit I have been incredibly surprised by the journey that we have undergone. Our Health Service (and I'm sure others do as well) prides itself on its strong quality, safety and patient-centred focus and our track record of leading innovation. However, when it comes down to the level of, have we achieved against standard x and action y, and how do we know, I must admit even I have been impressed by the work that was still required.

As nursing and midwifery leaders it's easy to become complacent when you have worked in an organisation for a period of time. Everyone you work with comes to work to do a great job, and in most cases our indicators tell us we are doing OK. BUT when it comes down to it, how do you really know? The National Standards have provided us with a framework that has allowed us to ask the really scary question of how do we know. For example, how do we know our nurses are competent in aseptic technique and are able to demonstrate this every time?

I am really pleased that the National Standards exist. I see these standards as the baseline; in order to truly be a leading health service we must get the basics sorted before we can focus on the leading edge.

NEWLY REGISTERED

Ms Laurie Bickhoff MACN

Standards in the public domain

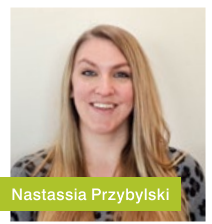
When nurses discuss 'practice standards' the focus is often clinical practice. However, these standards also refer to the NMBA Code of Professional Conduct for Nurses in Australia. These codes outline the "minimum standards for practice a professional person is expected to uphold both within and outside of professional domains in order to ensure the 'good standing' of the nursing profession." Whilst great importance is placed upon maintaining these standards within our respective workplaces; the question must be asked, do we hold ourselves to these same standards "outside of professional domains"?

Nurses are expected to maintain higher standards than the 'ordinary person in the street', with the aim to maintain 'public trust and confidence'. These standards apply to our personal lives and public behaviour. Yet, do we make these expectations clear to nurses? Do undergraduate nursing programs adequately teach students that their professional responsibilities extend past their workplace doors? Are these expectations realistic?

In today's technological age, where a phone can act as a camera and also instantaneously upload images onto the Internet, I believe upholding our professional standards in public is critically important. The legacy created by the nurses who came before us is a nursing profession held in the highest regard by the public which is consistently rated as one of the most trusted and ethical professions. It is now our responsibility to uphold and protect this reputation for the nurses who will follow us, and our practice standards are designed to guide us in this task.

“As nursing and midwifery leaders it's easy to become complacent when you have worked in an organisation for a period of time.”

FROM 'COMPETENCY STANDARDS' TO 'STANDARDS FOR PRACTICE'


Nastassia Przybylski

Marlene Eggert MACN

By Nastassia Przybylski and Dr Marlene Eggert MACN

Members will have noticed the increasing use of the term 'standards for practice' where once the term 'competency standards' was used. The Nursing and Midwifery Board of Australia's (NMBA) decision to retitle their 'competency standards' as 'standards of practice' highlights this shift in terminology. In this article we look at the history of the development of 'competency standards', describe the NMBA's process of standards review and explore the NMBA's reasons to shift the terminology to 'standards for practice'.

HISTORY

Competence is defined as the skills, knowledge, capacity and/or qualifications required to do something successfully. In nursing competency standards have been used to classify and measure nursing performance. The Australian Nursing Council (ANC) introduced the first standards as the *Australian National Competency Standards for the Registered Nurse* in the late 1980s (Chiarella et al. 2008, p. 46). The purpose of introducing competency standards was twofold: to "provide the framework for assessing competency but also serve to communicate to consumers the standards they can expect." The standards further took on an important role in the development of nursing curricula and in the assessment of student performance (Anonymous 2006, p. 14). Over time standards for enrolled nurses and midwives were added to the first 'competency standards' developed by the ANC.

Although the profession regarded the new 'competency standards' overall as a positive development, a discussion about their perceived limitations also ensued. Competency standards were considered to not perform well in areas such as: "identifying the minimum required level of performance in each competency; defining cultural competence; their ability to reflect the complex nature of general and advanced practice in addition to technical aspects of patient management; the validity and interpretation of competency domains and their constituent parts; their use as criteria for entry to specialist practice; and the proliferation of competency standards with varying definitions of domains and elements" (Chiarella et al. 2008, p. 52). A further issue identified was that the competency standards' terminology might be inconsistently interpreted and that the competencies "were *least* useful for position descriptions on the grounds that interpretation of each competency element is variable and inconsistent" (Chiarella et al. 2008, p. 48). On the other hand, it was acknowledged that the competencies also needed to be transferable to different nursing specialisations.

However, the biggest drawback identified was the competencies' tendency to constrain the profession's self-concept and development. Competency standards were considered to potentially diminish nursing practice because they fail to truly reflect the complexities and intricacies of nursing. Concern was also expressed that 'competency standards' may be limiting the profession's ability to adapt to new technologies by expanding nursing's scope of practice (Sutton & Arbon 1994, p. 391).

Thus, 'competency standards' have come to be viewed as a terminology which the profession has been outgrowing while adapting to the ever evolving landscape of care delivery. The profession realised that a framework of practice standards would better capture nursing's growing scope of practice and acknowledge the change in professional self-image brought about by this practice development.

STANDARDS FOR PRACTICE

Upon the commencement of the National Registration and Accreditation Scheme in 2010 the ownership of a range of nursing competency standards was passed from the ANC to the NMBA. In 2012 the NMBA began a review of all of its competency standards. The NMBA provided ACN with information on how the review of the competency standards was undertaken and of the review outcomes that caused the NMBA to adopt the concept of standards for practice.

The NMBA has appraised its standards by using an evidence-based approach which includes "a review of the national and international literature on competency standards and practice standards, an assessment of the current standards through observational studies, consultation with stakeholders through forums, interviews and extensive public consultation through publication of the draft revised standards on the NMBA website" (NMBA 2014).

The NMBA's research identified that the term 'competency standard' is commonly used in a narrowly prescribed procedural model of assessment. Thus, stakeholders often confuse the term 'competency based assessment' in the vocational education and training (VET) sector with 'competency' in other settings (NMBA 2014). In this procedural context, competency standards produce lists of skills and tasks for which nurses must demonstrate competence. The NMBA is of the view that 'competency standards' do not recognise the increasingly multifaceted

> *“...‘competency standards’ have come to be viewed as a terminology which the profession has been outgrowing while adapting to the ever evolving landscape of care delivery.”*

nature of nursing practice and the comprehensive set of knowledge, skills and attributes nurses require. Competencies also fail to indicate the standard to which nurses are expected to perform in practice (NMBA 2014). As a result of its review findings, the NMBA decided to shift from ‘competency standards’ to ‘standards for practice’ as existing standards progressively undergo review (NMBA 2014).

The NMBA defines ‘standards for practice’ as “the minimum standards that are applicable across diverse practice settings and patient/client populations for both beginning and experienced nurse practitioners” (NMBA 2014). They are a set of guidelines used towards providing safe nursing care and criteria for evaluating care in order to assure patients that they are receiving quality care.

ACN, as a professional body, has a significant role to play in facilitating its members’ contributions to deliberations about professional issues brought to the forefront of nursing’s growth and development. ACN will continue to participate in the ongoing discussions related to the ‘standards for practice’ and their applicability in the clinical practice setting.

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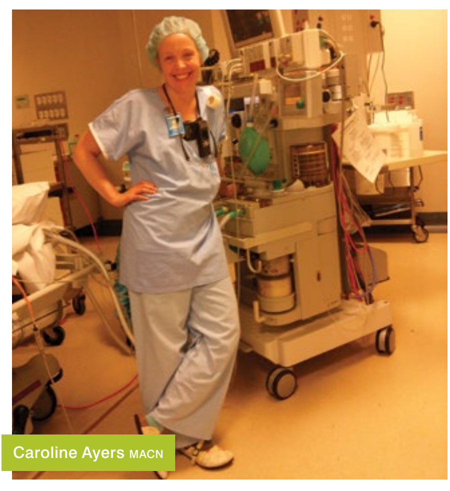
AUSTRALIA LEFT BEHIND?

The Grattan Institute calls for radical changes to the health workforce


Caroline Ayers MACN

By Caroline Ayers MACN

The Grattan Institute is an independent think-tank focussed on developing practical solutions to public policy challenges around cities, energy, health, productivity and education. Initially funded by the Federal and Victorian governments, with a contribution from BHP Billiton, the Institute is now controlled by an independent board and relies on investment income. In April 2014 the Institute's Stephen Duckett and Peter Breadon called for a radical restructuring of Australia's health workforce. The authors predicated that allowing lesser trained health professionals to play greater clinical roles could save $430 million annually, equivalent to funding treatment for 85,000 additional patients (Grattan Institute 2014a).

UNLOCKING SKILLS: THE REPORT

The *Unlocking skills in hospitals: better jobs, more care* report (Grattan Institute 2014a) focussed on expanding nurses' scope of practice in the areas of anaesthesia and endoscopy, as well as allowing allied health and nursing assistants to play greater clinical roles. Challenging Australia's status quo, Duckett and Breadon argued that:

> *This mismatch of skills and jobs is putting heavy pressure on hospitals when there are already long waiting lists for many treatments and demand is growing fast* (Grattan Institute 2014b).

The workforce reforms proposed by the Grattan Institute are far from unprecedented. Across the globe nurses and health assistants play significantly greater roles than traditionally permitted in Australia. As the Institute emphasises, professional cultures, industrial relations restrictions and vested interests have contributed to an Australian health system which restricts the responsibilities of nurses and assistive staff to a greater degree than many other nations (Grattan Institute 2014a).

Duckett & Breadon note that large numbers of nurses report their intention to leave the profession within the next 12 months, and that severe workforce shortages are predicted, particularly with regards to registered nurses. In response, the authors propose that increasing both nurses' and health assistants' scope of practice may encourage workforce improvements across the health system. Specifically, they suggest that allowing health workers to employ more of their skills will improve staff satisfaction, thus reducing the cost and inconvenience of current high rates of staff turnover.

INCREASING THE ROLES FOR NURSING ASSISTANTS

In Australian hospitals, registered and enrolled nurses perform the majority of patient care. Of particular interest to nurses is Duckett & Breadon's insistence that Australian registered and enrolled nurses spend too much time performing personal care, which not only fails to utilise their high level skills, but also detracts from complex or urgent tasks. Further, they suggest that nursing workloads force personal care tasks to be deprioritised - that is, rushed or forgotten, reducing quality of care, patient satisfaction and nurses' job satisfaction.

Nursing assistant roles vary from country to country, and range from providing cleaning and clerical work to feeding patients and undertaking immunisation, venepuncture or catheter care (Grattan Institute 2014a). Considering the evidence, Duckett & Breadon describe how the use of nursing assistants can either improve or reduce quality of care. Where assistants undertake basic tasks, for example by providing personal care, repositioning patients or answering call bells, patient satisfaction and care tend to improve. Where role demarcation between assistants and nurses is poor, and assistants undertake complex tasks, like drug administration or wound care, negative patient outcomes are more likely. Interestingly, the authors clarify that, in order to keep risk of adverse patient outcome low, nurses must maintain a

“Across the globe nurses and health assistants play significantly greater roles than traditionally permitted in Australia.”

> ❝ In Australia reliance on specialist trained medical doctors has significantly limited nurses' roles, despite skills shortages, particularly in rural and regional areas. ❞

significant level of contact with patients, and should not be displaced from the bedside by assistive staff (Grattan Institute 2014a).

Unlocking skills recommends the expansion of nursing assistants, supervised by registered nurses and involved only in less complex tasks, like bathing, feeding and moving patients, across the Australian health system. Duckett & Breadon argue that cost savings from these workforce changes should be directed towards increasing the presence and responsibilities of ward nurses. The employment of 17,000 nursing assistants across Australia, would free 37,000 hours of registered and enrolled nurse time which could then be redirected more appropriately for complex care and monitoring.

EMPLOYING SPECIALIST REGISTERED NURSES IN ANAESTHESIA AND ENDOSCOPY

Australia lags far behind other countries, specifically the US and UK, with regards to the utilisation and acceptance of advanced practice and nurse practitioner roles. In Australia reliance on specialist trained medical doctors has significantly limited nurses' roles, despite skills shortages, particularly in rural and regional areas. At the same time, evidence from both overseas and Australian trials indicates that nurses can undertake procedural roles as safely and effectively as medical doctors (Grattan Institute 2014a). *Unlocking skills* recommends the introduction of nurse sedationists and nurse endoscopists across the public health system, predicting annual savings of $28 million.

Nurse-performed endoscopy has been trialled at Austin Health in Victoria (Austin Health 2014). Duckett & Breadon point to the 170,000 less complex screening endoscopies performed annually in Australia on stable patients, and argue that $12 million could be saved annually, without compromising clinical quality, patient safety or satisfaction. In this context, Australian nurse endoscopists could undertake a three-stage training program, incorporating theoretical, simulated and lastly, supervised practice resulting in a team-based environment with nurse endoscopists remaining accountable to a supervising medical practitioner.

In addition, *Unlocking skills* argues that specialist nurses should provide 68% of procedural sedation in Australia, for patients with low anaesthetic risk undergoing non-emergency screening procedures. Whilst the report advocates for the introduction of American-style nurse anaesthetists, the authors suggest beginning with the introduction of sedation roles (Grattan Institute 2014a). A 2006 South Australian trial where experienced nurses trained for three months and were permitted to perform light sedation for simple procedures concluded that no adverse incidents occurred and patient satisfaction was maintained (Jones, Long & Zeitz 2011).

WHERE TO FROM HERE?

The NSW Agency for Clinical Innovation's Anaesthesia and Perioperative Care Network has prioritised formalising safe sedation procedures, acknowledging that non-specialist nursing and medical staff are frequently required to administer procedural sedation, despite limited skills and training (Agency for Clinical Innovation 2014). In-fact, each year a small number of patients die in New South Wales related to sedation provided by a non-anaesthesia professional (Clinical Excellence Commission 2013).

Australia lags behind the rest of the world in accepting advanced practice nurses, despite support from patients and consumers (Sweet 2010). Medical practitioners and their professional associations have voiced the loudest protests against expanding nursing roles. Sweet (2010) reports a nurse practitioner's experience of being the subject of bullying and a refusal from doctors to work alongside nurse practitioners. Reactions to the Grattan Institute's recommendations indicate that traditional distinctions between nursing and medical professionals remain deeply held. In response to *Unlocking Skills* the Australian and New Zealand College of Anaesthetists (ANZCA) state that safe and effective anaesthesia requires a full understanding of a patient's medical condition, which requires the knowledge of a medical practitioner, suggesting this remain the domain of specialist anaesthetists (ANZCA 2014).

Despite clear opportunities to improve both clinical and financial efficiencies of the Australian health care system, the expansion of nurses' scope of practice remains unlikely. Entrenched professional cultures, industrial relations restrictions and vested interests make system-wide changes extremely difficult. In the face of change, the nursing professional will need to accept both professional losses and gains. In the long term, Australian registered nurses may need to accept that any expansion of scope of practice to incorporate advanced, traditionally medical roles, will require the acceptance of assistive personnel and the delegation of a large number of traditional nursing responsibilities to nursing assistants.

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CLINICAL SUPERVISION IN AUSTRALIA: DANCING ON THE HEAD OF A PIN

Edward White FACN

By Dr Edward White FACN

The closure of Health Workforce Australia (HWA) was recently announced in the 2014 Australian Federal Budget. If all existing grants and programmes are transferred to the Department of Health, as reported, it may herald an opportunity to remodel the way clinical supervision (CS) has been conceptualised to-date and to promote a much clearer understanding of the contribution it may make to the clinical governance agenda in Australia.

The international historical development of contemporary CS has been traced back more than two centuries (White & Winstanley 2014), to the charitable organisations of Germany and England, then onwards to the East Coast of the USA. It was there that the early principles found an easy transfer to other helping professions, notably social work, counselling and, later still, psychology. Several perspicacious nurses (especially mental health nurses) also became advocates and CS began to permeate the international nursing culture.

In Australia, the uptake of CS has remained under-developed (Yegdich 2001) and implementation has remained patchy (White & Winstanley 2010). The HWA Clinical Supervision Support Program (CSSP), therefore, was a timely initiative. The CSSP aimed to expand clinical supervision capacity and competence across each professional area; including allied health, dental, medical, nursing and midwifery. In July 2010, a Discussion Paper (HWA 2010) invited feedback from 61 named Australian stakeholder organisations. From the outset, however, it was plain that the definition of CS would be problematic and that it would be used as a proxy umbrella term for preceptorship, mentorship, facilitation, clinical teaching, buddying and the like. Tellingly, HWA reported that "the clinical supervision of medical students had traditionally been on an apprenticeship 1:1 model".

Almost a year later, the CSSP Directions Paper (HWA 2011), referred to the terms 'clinical supervisor' and 'clinical supervision' as the "educational context of student and trainee learners and not clinical supervision in the broader sense". The HWA Chief Executive Officer confirmed that it was "important to note that some of the comments in the (earlier) stakeholder submissions were not necessarily supported by evidence" (Cormack 2011).

By then, however, the die had already been cast.

With respect to evidence, the Access to Allied Psychological Services (ATAPS) *Clinical Governance Framework* (Australian Medicare Local Alliance (AMLA) 2012), asserted that it would "promote improvement and excellence in the Medicare Local sector [also recently announced for closure] through evidence-based and innovative quality practice". In the event, however, the subsequent *ATAPS Clinical Supervision policy and procedure* (AMLA 2012) contained only two perfunctory sentences to comprise the Evaluation and Review section. It represented, therefore, something of a missed opportunity; a different type of document, which offered more evidenced-based direction and a much closer and more explicit integration between research and the policy agenda (and even a passing mention of the considerable practical challenges, which endlessly threaten the delivery of sustainable and demonstrably efficacious CS) would have been an option.

With respect to nomenclature, the New South Wales Health Education and Training Institute (HETI) commissioned a CSSP Mapping Study (Zest 2012), funded by HWA. The report ran to 235 pages. In the three-page rhetorical response, HETI emphasised the "importance of finding a balance between two competing values; inter-professional education and contextualised training" and foreshadowed so-called

> “Nothing appears to have moved forward in the 21 years since; indeed, it has probably set back a universal understanding of clinical supervision for a generation.”

‘Superguides’ for each health care discipline. The *Superguide: a handbook for supervising nurses and midwives* was expected to be published in November 2012. In the event, it was not released until the end of August 2013 and, without explanation, was then entitled *The Superguide: A Supervision Continuum for Nurses and Midwives* (HETI 2013). Membership of the Reference Group [n=17] included 10 service and education managers. Eight different types of ‘Supervision’ were tabled, in an apparently mutually exclusive manner. This has now become part of the problem itself. Several concept analyses have been published over the years; one [White *et al* 1993], funded by the national regulatory body in England at the time, described the substantive area as a ‘tautological maelstrom’. Nothing appears to have moved forward in the 21 years since; indeed, it has probably set back a universal understanding of clinical supervision for a generation.

HETI has also hosted a Masterclass series. At one such event, in Sydney on 12 June 2014, it was difficult to comprehend how *Clinical Supervision*, as presented, would be readily recognised on the international landscape. Not so much as a passing mention, for example, of the near-universal ‘Proctor’ three domain framework of CS. Rather, the presentations were again about clinical teaching, mentorship, preceptorship, or whatever. These are important matters in their own right, but are light years away from what the emerging international literature (certainly in relation to social work, psychology, mental health nursing, occupational therapy, counselling) discretely recognises as CS. Nor should CS be confused with therapy, or personal performance review, or case review. Simply saying it is, doesn’t make it so. An overarching concern, therefore, is that one health care discipline may eventually imperialise the conceptualisation of CS, such that it became the dominant and irrevocable construction of reality for all other helping professions. In such a homogenised form, it would sound the death knell of CS in Australia.

At exactly the same time as the HETI Masterclass was taking place in Sydney, the *10th International Interdisciplinary Conference on Clinical Supervision* was taking place in New York; the differences between the two events could not have been more profound. In New South Wales, the organisers of the 2013 Institute of Psychiatry CS conference are not certain that it will become an annual event. It needs to be, however, for CS to gain traction. The way forward remains for a bold, coherent and sustained CS initiative, taken by a State Government for example, in collaboration with a national professional organisation and/or a University. A sponsored Round Table would be a starting point. Any resistance is unlikely to be funding-related; witness the recent and urgent preparedness of NSW Health [2014] to commit $200,000 of public money for up to 100 mental health nurses to attend the three-day 2014 ACMHN annual conference. Imagine what could have been achieved with that level of funding, to pump-prime a realigned CS initiative in the state/nation. Meanwhile, CS in Australia continues to dance on the head of a pin.

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

Author, Ruth Rae FACN

ACN is proud to partner with Dr Ruth Rae FACN in the publication of a boxed set trilogy, detailing the important contribution of Australian nurses who served in the First World War. Wherever Australian and allied soldiers fought Australian nurses served.

The trilogy features updated editions of Dr Rae's publications, *Scarlet Poppies* and *Veiled Lives*. Her third book on the topic *From Narromine to the Nile*, although available as an e-book, will be available in print form for the first time. In recognition of the importance of identifying nurses who served a detailed Nominal Roll will form a separate addendum to the trilogy.

The trilogy will be available for purchase in March 2015 to align with Anzac and First World War centenary celebrations. Please email publications@acn.edu.au to register your expression of interest to purchase the trilogy.

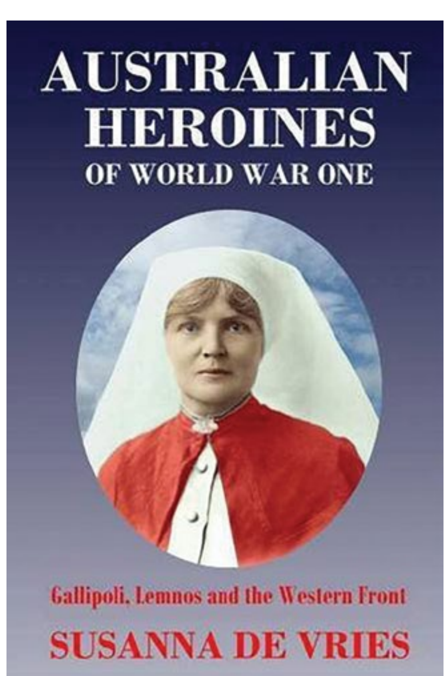
A passage from *Scarlet Poppies*

The Australian nurses were witnesses to the suffering of the Australian men. Their mere presence reinforced the memory of home – a female presence and a civilising presence. However, they were much more than this because they saved many lives by putting their back into their work. While ever 'their boys' could endure the pain of a wound, the agony of a disease, the discomfort of lice at Gallipoli or the mud of the Somme, the Australian nurses would endure the physical exhaustion of nursing and the emotional heartache of witnessing their pain. Many nurses died from the cumulative effects of their physical exhaustion soon after the war and some died during the war. None were unmoved by witnessing the death of so many young men, many their own age and many known to them personally.

AUSTRALIAN HEROINES OF WORLD WAR ONE: GALLIPOLI, LEMNOS AND THE WESTERN FRONT

Author: Susanna De Vries

Review by Susan De Vries FACN
(no relation to Susanna)



As we lead up to the Centenary of Anzac Day, this timely book is an inspiring read for any nurse.

It tells the stories of eight courageous women through diaries, letters, photos, paintings and specially drawn maps. These women had the courage, strength, compassion and tenderness for which the Anzacs are renowned. Many of them were nurses.

Sister Hilda Samsing from Melbourne became a whistle-blower when nursing aboard the hospital ship Gascon, outraged by the bungled evacuation of wounded Anzacs. She defied censorship and kept a very frank diary, which is reproduced in this work for the first time.

In 1914, Louise Creed, a Sydney journalist, was caught in the besieged city of Antwerp and made a hair-raising escape from a German firing squad.

To purchase a copy of *Australian Heroines of World War One: Gallipoli, Lemnos and the Western Front* go to www.susannadevries.com.

Brisbane's Grace Wilson, ordered to establish an emergency hospital on drought-stricken Lemnos Island, arrived there to find suffering Anzacs but no drinking water, tents or medical supplies. Grace and her nurses saved the lives of thousands who had been wounded at Lone Pine and The Nek.

In France, Florence James-Wallace, Anne Donnell and Elsie Tranter nursed near the front line in Casualty Clearing Stations, treating soldiers with hideous wounds or blinded by mustard gas. In 1918 they had to deal with an epidemic of Spanish flu which was to kill many, including nurses. These brave women returned to Australia but their heroism was quickly forgotten. Two of them received such meagre pensions, they died destitute.

This interesting work highlights the courage, tenacity and strength of the women and nurses who have gone before us. They have many lessons to teach us for today.

THE NATIONAL NURSING FORUM: SPEAKERS

ADJUNCT PROFESSOR
DEBRA THOMS FACN (DLF)

– Master of Ceremonies

Master of Ceremonies, Debra Thoms, has had an extensive career in health management spanning some twenty years that saw her commence her role as the inaugural Chief Executive Officer of the Australian College of Nursing in 2012. Debra is delighted to be your host at The National Nursing Forum in Adelaide.

DR **KEITH SUTER**

What are the drivers of change and how can we respond?
– Keynote presenter

We are living through a period of rapid change and so much seems to being going on. This keynote presentation will help nurses get a feel for the underlying drivers of change and so help detect the patterns within all the changes. With a better understanding of the process, we can cope better with change – and not just be the casualties of it.

MS **FIONA O'LOUGHLIN**

Beating the odds to stay ahead of the game
– Keynote presenter

Fiona O'Loughlin is one of the most successful and popular Australian comedians working today and one of the most sought after stand-up comedians in the world. Fiona's presentation will motivate you through her recounting the story of fighting back against naysayers and adversity, setting realistic goals, understanding disappointment, and taking nothing for granted. Fiona is a remarkable woman who will have you believing that just about anything is possible!

ADJUNCT PROFESSOR **SUSAN O'NEILL MACN**

A journey to organisational excellence
– Invited speaker

Susan O'Neill has a strong interest in organisational excellence that has led to extensive application of lean thinking principles into health care, specifically in the areas of strategy development and deployment, integrated operational planning, patient flow and practice redesign, leadership, coaching, and talent development.

Susan is the Chief Executive Officer at Albury Wodonga Health and left Melbourne in 2014 having held the position of Executive Director of Nursing of Cabrini Health for five years.

MR **BRIAN DOLAN**

Lessons on leadership, influence and culture
– Invited speaker

How to work with people you'd rather kill! – Workshop presenter

Brian Dolan is Director of Health Service 360 and works with organisations undertaking leadership development, improvements in patient flow and systems reform. He trained as a psychiatric nurse in Ireland and did his general nursing at St Mary's Hospital in London. Most of his clinical career was in emergency care as well as in academic general practice in London.

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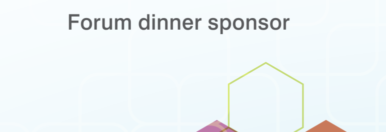

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Australians laugh less than they did 40 years ago and adults laugh less than children. Who or what is stealing our laughter and how do we get it back? Malcolm Dix is a professional comedian who can show us how to see the humour in anything, to share your mistakes with humour, reduce stress and put energy into what really matters. He has a rare insight into both humour and mental health issues – he was a social worker for 20 years and has been a comedian for even longer.

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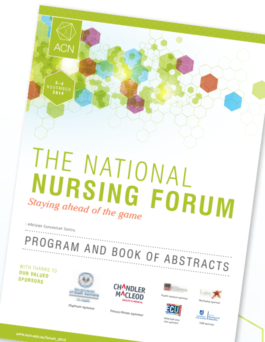


MS **GERALDINE BURTON**

Difficult dialogues: Begin with the end in mind and end with a new beginning
– Workshop presenter

Challenging conversations are a frequent and normal necessity in our lives as health professionals, yet for many there is a strong tendency to avoid them, sometimes at considerable cost to ourselves, our families, our patients, and our colleagues. This workshop explores the neuroscience and other factors behind our tendency to avoid and then focuses on strategies to prepare for, engage in and safely exit a difficult dialogue.

MS **LISA SMITH**

Unlocking your creative minds at work
– Workshop presenter

Do you remember why you got into this "business" in the first place? Getting caught up in the day to day makes it hard to lift your head and see the difference you can make. This session will help you check in with making that difference as well as giving you a toolbox of techniques to restore your creativity, build your resilience and find better ways to solve problems.

DR **JACKIE CRISP** FACN

MindtheBrain: a workshop for humans working as, and with, human beings being human – Workshop presenter

Contemporary neuroscience is providing valuable insights into fundamental drivers of human experiences and behaviour. This workshop provides participants with the opportunity to actively explore the ways that working with, rather than against, the realities of being human can improve work engagement, performance and contribute to more positive workplaces.

RESEARCH COLLABORATION: STUDENTS ARE WELCOME

By Marnie Hitchins

A collaborative research study in Queensland is tapping into the enthusiasm and intelligence of nursing students by training and employing third-years as research assistants, data collectors and analysts in contract research projects.

Researchers from James Cook University's (JCU) Centre for Nursing and Midwifery Research (CNMR), the Far North Queensland Medicare Local and the Cairns and Hinterland Hospital and Health Service are trying to determine why emergency department (ED) presentations to Cairns Hospital have been increasing at a greater rate than the national average.

To answer this question, CNMR researchers recruited 14 nursing and medical students to survey every willing and able person who presented to the ED.

Researchers asked participants for information regarding their reasons for coming to the ED. They also asked where they would usually go for medical treatment and what physical and psychological factors influenced their decision to choose the ED over other treatment options.

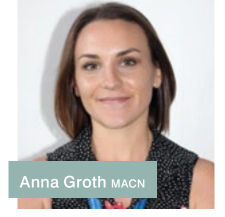
In other phases of the project, hospital Emergency Department Information System (EDIS) data have been analysed and patient focus groups have been convened. Unstinting faith in the local ED has been noted as one of the key reasons that people choose the ED over other health care options.

Most people who come to the ED with 'non-urgent' conditions do have general practitioners and a large percentage have sought medical advice in the days prior to presenting to the ED. Worry, anxiety and uncertainty, rather than the severity of the medical condition itself, however, appears to be a significant motivator to come to the ED, where people perceive there is a wide range of services, professionals and diagnostic tools available.

ACN Emerging Nurse Leader Anna Groth MACN, a third-year nursing student from JCU, has been collecting, collating and analysing data.

"Often, I would ask someone why they had come to the hospital and they would speak about being in pain but if you asked them about whether they came for the pain or because they were anxious about the pain, they would say they had come to the hospital because of the anxiety," explained Anna. "It is such a huge difference – the motivation – coming for the pain or the anxiety."

Jane Mills FACN



Anna Groth MACN

Anna said the project opened communication lines between people from different organisations including government, university, health service, hospital, and the community, leading to collaboration and learning for all.

Benefits for the students included early career exposure to the research process, in which they learnt about data collection, analysis and research methods. The students also had the opportunity to practise communication skills, learn about the organisational cultures of universities and hospitals, and work alongside health professionals and patients in a research environment.

Students commented that, because the power dynamics were different from that of clinical experience (they were not seen as health professionals by patients, nor as 'student nurses' by health staff members), they gained insights into the hospital environment they might not otherwise have had.

Anna said she learned a lot personally; the ED research experience has catapulted her into another area of interest, in which she can see herself working in the future.

"Research and policy will be a part of my future. I've gained a deep interest in the treatment of women since doing this study," said Anna.

"I have become very interested in domestic violence and the way women are treated in the health service and in the society as a whole. I was blown away by the struggle that people have with the system in trying to find support. They are so lonely. I recognised things, being in the ED, that I would like to research, and have already started exploring the issues."

CNMR Director Associate Professor Jane Mills FACN said the recruitment and inclusion of students in research projects is part of a broader plan within the CNMR to build undergraduate research capacity.

Jane said the CNMR also offered internships to undergraduate students to work on research projects alongside experienced scholars, academics and researchers.

"JCU strongly supports the inclusion of undergraduate students in research studies where they can gain valuable knowledge, skills, and experience while also making a contribution to building the evidence base about health care issues of importance to people living in the tropics," said Jane.

"It's a win-win situation where experienced researchers benefit from the students' enthusiasm and familiarity with contemporary research principles, and students increase their awareness of the importance of research to professional practice."

It is clear to all parties involved that the inclusion of nursing students is benefitting the quality of the project as much as it is benefitting students' learning and work experiences.

Author details

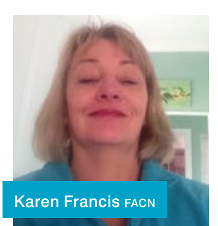
Marnie Hitchins is the Research Officer, Centre for Nursing and Midwifery Research, James Cook University, Cairns, QLD.

MANAGING A TRAIN CRASH IN A RURAL SETTING: A MENTAL HEALTH SUPPORT PERSPECTIVE

Linda Malone

Chris Druce

Judith Anderson FACN


Karen Francis FACN

By Linda Malone, Chris Druce, Dr Judith Anderson FACN and Professor Karen Francis FACN

Responding to natural or human induced disasters has become an integral part of health and emergency services operations (Karger, Owen et al. 2012, Mintz 2013). The impetus for Australia developing a disaster planning framework was the advent of Cyclone Tracey in 1974 that resulted in 90% of Darwin's buildings being destroyed and people being left without food, water and housing (Rowlands 2013). The preparedness of staff and their employers has been the primary directive of the disaster planning framework (Baack and Alfred 2013, Rowlands 2013). Being prepared is vital in any geographic setting but in rural locations it is paramount to managing the situation or the event escalating to a catastrophic event.

In May 2010, the XPT train enroute from Sydney to Broken Hill collided with a front-end loader working on the railway line near Newbridge, a small village of approximately 90 people (Australian Bureau of Statistics 2007). It was mid-morning when state rail authority workers were working on the railway lines undertaking routine maintenance and repairs.

The Local Health Service received confirmed intelligence through NSW Ambulance that multiple agencies were required to respond to a train derailment with an unspecified number of casualties. Upon receiving this call the Health Services Disaster Plan was activated and nearby health facilities were advised to prepare for receiving casualties of an unspecified number and triage category.

Within 5-10 minutes a second report came from NSW Ambulance that the incident had resulted in the death of one person and minor injuries for two others. This led to a change in focus from mass casualty management to emergency psychological care in responding to the mental health wellbeing of the state rail authority workers and the passengers on the train (Macdonald 2009). This was consistent with the acknowledgement that the physical safety of these people had been ensured and that dealing with the psychological reality of their situation in a social context was the emerging priority of this traumatic event (Bracken 2001).

DEALING WITH THE SITUATION

As the focus was now orientated to this mental health emergency, the issue arose of how best to transport mental health teams to the location. Initially, the offer to send a specialist mental health team to the location was declined; however, as the afternoon progressed and the passengers were not able to be extracted from the scene due to a difficult geographical location, the need for mental health support became apparent. Through the Mental Health Controller for the health service, one community health team was dispatched to Newbridge with information regarding how to access mental health support.

On arrival, the mental health team found 76 passengers ranging in age from newborns to elderly clients including non-English speaking and Indigenous Australians. Specific cultural groups require special consideration when exposed to deceased persons (Bolton and Tang 2004, Deeg, Huizink et al. 2005). There was a significant number of people to deal with at the one time. Children are usually dependent on their parent or caregiver to protect them physically and emotionally. However, in this situation parents were also witnesses to the traumatic event which could have affected their ability to protect their child effectively (Hornor 2013).

Another significant group of people to deal with were those from non-English speaking and different racial backgrounds. No interpreters were available at the scene. Although people from non-English speaking backgrounds may have dealt with concrete concepts, such as buying a train ticket, more abstract concepts such as symptoms of stress and who to contact if these became apparent was not so easily managed in a different language. Studies suggest that minority groups are less likely to seek treatment for post-traumatic stress disorder than others (Roberts, Gilman et al. 2011).

Our ability to obtain basic details for each passenger to allow for follow up was beyond the available resources at the time. Many passengers were in transit, some were transient visitors to the end destination and we had insufficient paperwork available to collect individual information on each passenger or worker.

The ability to obtain basic details for each passenger to allow for follow-up was beyond the available resources at the time. Many passengers were in transit, some were transient visitors to the end destination and we had insufficient paperwork available to collect individual information on each passenger or worker. In order to establish a way for passengers to access mental health services should they require them, the health service provided a range of generic material with relevant information for ongoing support if required. The Mental Health Emergency Care Rapid Assessment Program (MHECRAP) team was alerted that any person who continued on their journey may seek counselling services. Mental health teams at the final destination, Broken Hill (550km away), were also notified of possible referrals (Bolton and Tang 2004). This was not an ideal situation as it was reliant on self-referral.

LESSONS LEARNED

This experience demonstrated the need to improve communication processes to be able to liaise with teams en route to the incident. Insufficient tabards were available for the teams sent to the location to identify them as health workers. In dealing with people who have been exposed to a traumatic event without incurring a physical injury, basic items such as multiple copies of paperwork were required to enable the collection of contact details and follow-up to support them after this traumatic event.

The focus in dealing with emergency events such as this had centred around the effects of physical trauma. This event made us realise the importance of immediate and long term mental health support to victims. Since this time, all responses or planning have incorporated the requirement to include early distribution of counselling and contact information to the affected community and groups.

Natural or human induced disasters will continue to occur, requiring ongoing vigilance and investment by health and emergency services and government. Training staff and developing realistic plans that are operational is tantamount to ensuring public and environmental safety.

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Professor Karen Francis is the Head of School, Charles Sturt University, School of Nursing, Midwifery and Indigenous Health, Wagga Wagga, NSW.

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SAVING INDIGENOUS NURSES AND MIDWIVES FROM HISTORICAL OBLIVION

Odette Best MACN

By Dr Odette Best MACN

Odette Best is a hospital trained Registered Nurse and Senior Lecturer in the Oodgeroo Unit at the Queensland University of Technology. Through bloodline Odette is a Gorreng Gorreng (Wakgun Clan) and a Boonthamurra woman; through adoption she is a Koomumberri woman. These are Aboriginal Nations within Queensland.

Odette has worked clinically for over a decade within Aboriginal medical services and women's prisons, and as Director of Nursing for the Chief Nursing Officer of Queensland Health. She holds a Bachelor of Health Sciences (University of Sydney), a Master of Philosophy (Griffith University) and a PhD, (University of Southern Queensland). As a PhD student, Odette found her passion for delving into the history of Aboriginal Australian women and their pursuit of Western nursing qualifications.

It may come as a complete surprise to hear that Indigenous women have worked as nurses and midwives within the Australian health care system since at least the 1890s. I became interested in our forebears' participation as nurses back in 2004 when I was an academic at the University of Southern Queensland. At the time I was developing a documentary for Bush TV (bushtv.com.au) in Rockhampton. The program, called *I'm a Nurse,* captured stories about Aboriginal nurses who had worked in Australia since the 1950s. I had not long completed my Masters studies and a colleague (who subsequently became my academic supervisor) said to me "there's a PhD in that".

Learning about the Indigenous women who had worked between 1950-2005 was a surprise to me. This area of under researched Australian history became a passion which I've continued to explore and, in recent years, have extended. It's a challenging field, with issues familiar to many historians. There may be many documentary records about Indigenous nurses, hidden in publicly accessible archives and collections, but individuals may not easily be identified as Indigenous. Another enormous challenge is to question widely-held assumptions. Historically, Aboriginal people have been positioned within a deficit model and cast as recipients of health care. So it's assumed that Indigenous people did not deliver care in any way, were not part of formal training schemes, or were not in paid employment. More evidence is emerging that counters those assumptions. Aboriginal women have worked as nurses and midwives within Australia as far back as the 1890s and, who knows, perhaps earlier. Their contribution is a hidden but significant element in Indigenous and Australian history.

My aim in researching these women is to add to the discourse of Aboriginal people's provision of care within the Western health care system. These individuals can then be included in Australian nursing and midwifery history. We, as a nation, know so little about Aboriginal women and our labour history. For me this is also about paying respect to our 'Professional' Elders. Those who have paved the way for other Aboriginal women to become nurses and midwives, who have contributed to the health of Indigenous communities, deserve recognition. It's a useful area of historical inquiry.

National and international research suggests that the higher participation rates of Indigenous nurses and midwives the greater the impact is on the health of Indigenous peoples. Including stories about our ancestors' roles in health care history may lead to a re-imagining and a re-telling of our own history and possibly new understandings about how Indigenous peoples have intersected with white Australia, at least within the health care labour force.

There is a dearth of literature outlining the experiences of Aboriginal women who undertook formalised and recognised nursing qualifications at hospitals throughout Australia. Occasionally serendipity provides some direction. One of my most important discoveries was in 2007 during my PhD research. I was surfing the web. I'd done many searches on <Aboriginal nurses>, <Indigenous nurses>, <history> and so on, without much luck. One evening I came across a blog about the town of Armidale in New South Wales. The blog was written by a local historian, Greg Belshaw, who noted that a midwife from the Armidale region, May Yarrowyck, was Aboriginal. Greg wrote that May had formal training in midwifery, from a hospital in Sydney. Historian Judith Godden FACN (Hon) who was undertaking research on Crown Street Women's Hospital (now closed) also told me she had found a

> *“National and international research suggests that the higher participation rates of Indigenous nurses and midwives the greater the impact is on the health of Indigenous peoples.”*

reference to May Yarrowyck in the hospital's records. It was these two snippets of information that then led me to uncover and examine the life and work of May Yarrowyck through her non-Indigenous family, as May's mother had died in childbirth and May had no children herself. This midwife is just one of several I am investigating at the moment.

Another interesting and revealing area of my research in Aboriginal heath care history is the 'native nurses training schemes'. These programmes operated and were administered on Aboriginal reserves and missions in Queensland during the 1940s. To-date, my focus has been the training schemes at the Woorabinda Aboriginal Settlement in Central Queensland, and the sister missions of Palm Island and Cherbourg. I'm examining how the schemes were established against the backdrop of the health issues for Aboriginal people and I'm looking at what nursing roles the 'native nurses' undertook in their communities.

Aboriginal women have told me that there was no training, no formalised nursing education in these programmes, so from a political perspective I am unpicking terms like 'training' and 'scheme' to understand how the schemes worked.

Through this research, it's my aim to save these Indigenous women from historical oblivion by retrieving and preserving their voices, their stories, and their experiences of contributing to Australian health care.

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Author details

Dr Odette Best is the Senior Lecturer, Oodgeroo Unit, Queensland University of Technology, QLD.

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REGIONAL ROUNDUP

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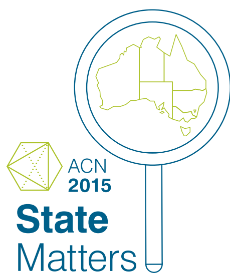

Region Key Contacts were contacted in March 2014 and asked for input into what is going to be an exciting new member benefit, an annual ACN hosted local conference in each state and territory.

With the purpose of engaging members and addressing topical issues in the health sector, the one-day conferences will allow members the opportunity to discuss key policy issues and state based factors affecting their nurses.

As our key members on the ground in the various Regions, Key Contacts were asked to suggest three topics for consideration around issues facing nursing in their state/territory, as well as suggested locations. Following receipt of this information and some internal workshopping, ACN is thrilled to announce that we will be launching ACN State Matters in 2015.

Each state and territory will be provided with the opportunity to come together to discuss issues relevant to their state, hear from related speakers, and participate in professional development activities such as leadership workshops.

We thank those Key Contacts and Region members who provided input and look forward to sharing more with you about an ACN State Matters conference coming your way.

A year on, ACN Regions are making the most of providing opportunities for members to come together whether it be for a friendly catch-up or to attend a locally organised Region event.

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

BRISBANE REGION

On Wednesday 4 June Brisbane Region Key Contact Belynda Abbott attended the Queensland Government Department of Health's launch of the Ministerial Taskforce on Health Practitioner Expanded Scope of Practice Report on behalf of ACN. The Ministerial Taskforce was a collaborative and consultative process involving allied health, nursing, medicine, education, and hospital health service professionals. Discussions centred on radically changing the way health care is delivered to the community; through skilled and expert allied health professionals, making a greater contribution to improving health services through improving patient access to services, reducing wait times in emergency departments, and improving patient flow through evidence based models of care that expand the scope of practice of allied health professionals. Thank you, Belynda, for attending on behalf of ACN.

Belynda Abbott FACN
ACN Key Contact Brisbane Region
belynda.abbott@acn.edu.au

HUNTER VALLEY REGION

Liz Hutchings has undertaken a review of membership postcodes within her Region, to help inform proposed regional/outer regional activities. Liz hosted the first Region event in Newcastle; however, recognises the importance of subsequent regional activities being held in outer regional locations such as Maitland, Singleton and Lake Macquarie. Members will be surveyed regarding their education interests and collegiate needs, thereby providing a greater understanding of regional members' interests.

Liz Hutchings MACN
ACN Key Contact Hunter Valley Region
liz.hutchings@acn.edu.au

NORTHERN TERRITORY NORTH REGION

ACN would like to thank outgoing NT North Region Key Contact Lesley Brown for her work and commitment to ACN during her time as Key Contact of the Region. We wish Lesley well in her new role in North Queensland.

ACN would like to encourage NT North Region members to participate in an upcoming survey to help determine how best to meet the needs of the membership. In addition to this, members who may be interested in the Key Contact role for the NT North Region, or willing to participate in a working group to assist the Key Contact in running activities for the Region, please contact **engagement@acn.edu.au** for more information.

NSW SOUTH REGION

Following a successful inaugural event for the NSW South Region, International Nurses Day Breakfast held in Wagga, Tania Jobson, in collaboration with the Murrumbidgee Local Health District, is looking to establish a local nurse networking group. An initial informal meeting has been held and was well attended by an enthusiastic group of nurses. Watch this space for more activity in the NSW South Region.

Tania Jobson MACN
ACN Key Contact NSW South Region
tania.jobson@acn.edu.au

ADELAIDE METRO/SA SOUTH REGION

Roma Dicker attended the Flinders University Nursing and Midwifery Careers Fair in July, promoting ACN and the activities of the Region. As this was not Roma's first attendance at such an event, she was well versed to speak with the 300+ graduating students that were interested in hearing about ACN and, in particular, local education opportunities. Thank you, Roma, for agreeing to do this year in and year out.

Roma Dicker MACN
ACN Key Contact Adelaide Metro /SA South Region
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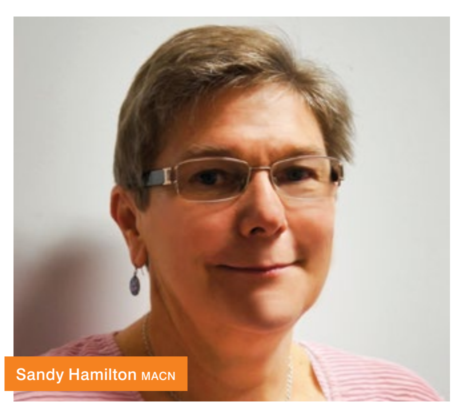
PROFILE

AN RN WITH 'HEART'

Profile: Dr Sandy Hamilton MACN
ACN Key Contact, WA Goldfields-Midwest Region


Sandy Hamilton MACN

Sandy is a registered nurse whose background is in cardiology, cardiovascular prevention and cardiovascular and diabetes research. Sandy has extensive experience in cardiovascular nursing, having worked in acute clinical cardiology, cardiovascular prevention and lipid disorders. She has also worked in clinical research at the School of Medicine and Pharmacology, Royal Perth Hospital coordinating a variety of research studies in lipids, lipoprotein metabolism and diabetes. Sandy's PhD focussed on residual cardiovascular risk in statin-treated type 2 diabetic patients and was entitled *The Effect of Combined Therapy on Arterial Function in Statin-treated Type 2 Diabetic Patients*.

Sandy works as an academic, focussing on research and nursing education, at the West Australian Centre for Rural Health (WACRH) and is based in Geraldton (Midwest WA). Sandy has a strong commitment to rural health care, cardiovascular prevention, chronic disease management, including self-management, health promotion, health research, and effective knowledge exchange (research translation). Her research interests are concentrated on primary and secondary cardiovascular prevention including cardiac rehabilitation, family health history, and research translation. She co-leads research at WACRH. Sandy has a commitment to graduate and postgraduate education and is highly motivated in advancing nursing education at WACRH. Sandy is a facilitator of the Flinders Chronic Condition Management program and UWA Teaching on the Run workshops and is trained in DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed).

Thank you, Sandy, for your continued involvement with ACN.

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MS YVONNE WHITTAKER FACN

Yvonne Whittaker FACN

Yvonne joined Royal College *of* Nursing, *Australia* in 1973 and transitioned to ACN in 2012.

Yvonne was a proud Alfred [Hospital] *trained nurse who graduated just at the end of the war. She worked in several places including Cloncurry and Warrnambool and finally joined the staff at Bacchus Marsh where she met her friend and mentor Johnnie (Miss Johnson but always known as Johnnie). She joined Johnnie and Aunty Marj (Mrs Graham) and they ran St Helen's Private Hospital in Hobart for many years.*

Yvonne attended the College of Nursing Australia in 1969 to study Community Health Nursing. She was invited to join the academic staff of the college in 1972 – her brief, to write a full Diploma in Community Health Nursing Course. After she had completed two of the three terms she claimed she had taught them all she knew. Solution – write to 50 universities across the UK, USA and Canada seeking just the right programme for her further education. In the meantime she kept working on the course, carried a full teaching load and joined me and others in flying visits to regional hospitals to assist clinical nurses to manage the rapid changes occurring in nursing and nursing education at the time.

She completed a Master's Degree in Health Sciences at McMaster University in Hamilton [Canada] *in 1978. She was then invited to join a group of health professionals studying primary health care and how to teach it at McGill University in Montreal* [Canada]. *She was awarded a Kellogg Fellowship for this period.*

DR BETTY MARGARET ANDERSEN AM FACN (DLF)

Betty Andersen AM FACN (DLF)

Betty joined The College of Nursing (TCoN) in 1968 and was extremely active throughout her four decade membership. ACN is proud of her contribution to our organisation and to the profession more broadly. Her work as a missionary, nurse, midwife, and nurse educator made Betty a true nurse leader.

Betty had a passion to learn as is exemplified by a career spent exploring new and better ways to advance nursing. Her belief that 'problem-based learning' provided the flexibility needed to continuously reappraise practice has become a cornerstone of contemporary nursing. Her long career as a nurse educator has also influenced many generations of nurses and helped advance our profession beyond measure.

In 1986 Betty was awarded an Order of Australia (AM) in recognition of her long service to, and far reaching influence of, national nursing practice and education in Australia. In recognition of Betty's outstanding contributions to the field of nursing and to TCoN she was awarded a Life Fellowship, the highest honour that we can bestow on a member.

Betty's legacy will live on in her research and her students.

Betty was a nurse leader who has left a significant legacy.

The models of nursing and education developed by Betty Andersen were used to great effect in subsequent consultancies, research and educational initiatives undertaken by nurses across Australia and the world, in Indonesia, Thailand, South Africa, South Korea, India and The Maldives. Many of these initiatives were AusAID sponsored projects for capacity building in nursing and midwifery. On retirement Betty worked in Indonesia under the auspices of the World Health Organization.

Betty and her colleagues ensured a sound basis for emergence of clinically sound nursing research, referred to today as evidence based practice. The major drivers for the stimulus material were always to be authentic experiences from the world of health care. Nursing actions were to be underpinned by contemporary knowledge.

(Extract of a speech delivered by Dr Margaret McMillan OAM at Betty's thanksgiving service.)

[We began to try and] *establish our own continuing nursing education business. Within four or five months we were running courses for the State Government, had enquiries from regional hospitals and employed six staff. Within 12 months we had to find a new place to live and found ourselves running refresher courses for Tasmania as well as metropolitan and regional hospitals. Either Yvonne or I lived in a caravan in Tasmania while the other was at headquarters and we passed each other at the airport. What an exciting and exhilarating, if exhausting, experience. Over the time from 1984 to 1990 we assisted some 1,500, mostly married women, to re-enter the workforce.*

So another aspect of life and nursing presented itself and we bought the leasehold of a nursing home with Yvonne as the Manager. She learned the role and all the bureaucratic red tape quickly and bucked against it where she could.

Expanding her skills was never far from her mind so a course of acupuncture seemed appropriate, including time in China to augment her experience. She followed this with a course in Chinese Massage with another study trip to China. Many residents benefitted from her ministrations as did I and several staff. …we sold the home and retired in 2001 when Yvonne was 75.

We bought five acres in Kilmore [Victoria] *and built a home overlooking the large dam. After some time Yvonne felt the need to get involved and joined the Board of Directors of the local Community Health Service. Six years later, just after her 88th birthday, she resigned having worked hard with her fellow Board members to build the new super clinic for Nexus Primary Care.*

I have known Yvonne for more than 40 years. We have shared a home for 30 years and Bonnie, our border collie, has just stopped looking for her.

Farewell my dear friend.

(Extract from Yvonne's eulogy delivered by Joan Evans.)

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OUR BATTLE FOR TREATMENT OF A DISEASE THAT DOESN'T EXIST

By Dr Melissa Bloomer FACN

Melissa Bloomer FACN and Steve Bloomer

I want to share a story with you. This is a story about my family and the challenges we have faced in seeking medical help and navigating the system.

My husband and I met nearly 20 years ago and married in 1997. Steve was working for the Defence Force and for the first 10 years of our marriage we moved around Australia, with seven houses in the first seven years, five of those years served in Queensland.

In 1999, Steve began to have some health troubles. He developed pain in his knees, which was diagnosed as chrondomalacia patella. For several years he managed with this condition by taping his knees for any physical activity and limiting his physical activity to those times when he had to do it, like his compulsory morning physical training (PT) sessions. But his knees continued to deteriorate and in 2001 he was referred to an orthopaedic surgeon for bilateral arthroscopies. While there was some evidence of minor damage, the findings were not consistent with the amount of pain Steve was experiencing.

Around the same time, Steve began to develop several food allergies. Despite not having any food allergies before, Steve was no longer able to tolerate wheat, dairy or salicylates in his diet. He had also developed fatigue which was impacting on his ability to get through a whole day at work without a nap. Steve sought medical advice from a civilian doctor, who diagnosed Steve with depression and prescribed anti-depressants. Having a diagnosis of depression while serving in the Defence Force is not something any soldier would admit to so he kept this quiet, hoping that his symptoms would reduce. At no time did we, or any of the health professionals we dealt with, consider that there might have been any association between Steve's depression, fatigue, knee symptoms and food allergies.

A couple of years later, still experiencing the same symptoms, Steve discharged from the Defence Force and we relocated to Melbourne. While his problems continued, they seemed more manageable given that Steve now had a desk job that didn't include compulsory PT. As far as his diet was concerned, Steve became more aware of his food allergies and with the help of a naturopath, was able to live life with a restricted diet to minimise his symptoms.

Despite avoiding exercise, and maintaining his strict diet, Steve's symptoms continued to worsen and he began to have other symptoms that were first thought to be unrelated. He had persistent recurrent tonsillitis, epididymitis, shingles, thrush, eye infections and most recently a 'granuloma annulare' formed on his neck. Grannuloma annulare are associated with conditions of impaired immunity (Thornsberry et al 2013). As a nurse, logically I could not really see the connection between all of these symptoms, but I knew that they were related somehow. So we began to seek further medical help.

> *"As a nurse, logically I could not really see the connection between all of these symptoms, but I knew that they were related somehow."*

> *“Even with my knowledge of the health system and working at the local health service, why can’t I get the system to work in our favour?”*

We were referred to an orthopaedic surgeon about his knee pain, who then referred us to a rheumatologist suspecting rheumatoid arthritis. Once he tested negative for that, we were referred to a psychiatrist again, assuming his issues were of a psychological nature, despite us knowing that a psychological diagnosis could not explain the physical symptoms. The bizarre infections continued and we tried again for help. Lupus was the next suspected diagnosis and we went back to a different rheumatologist for investigation but he was not able to identify any autoimmune diseases. By this time Steve was forced to use a wheelchair for mobility and he could no longer stand to shower. His prostate and bladder had also become affected and he was becoming more vague and confused. Sensing our desperation, the rheumatologist sent us to an immunologist who openly declared that he had no idea what was wrong but he ordered a multitude of blood tests. To our surprise and devastation, Steve tested positive to Lyme disease. Lyme disease is a vector-borne disease caused by the bacteria Borrelia bergdorfori which is transmitted by a tick infected with the bacteria (Levi et al 2012). Often described as ‘The Great Imitator’ because it can imitate many other diseases such as chronic fatigue syndrome, fibromyalgia, multiple sclerosis, Parkinson’s disease, motor neurone disease, lupus, Alzheimer’s disease and so on, Lyme and its co-infections can affect any organ in the body including muscles and joints, the heart, gastrointestinal system and neurological system (including the brain). There is no cure for chronic Lyme disease, rather, treatment aims for remission and to improve quality of life (Lyme disease Association of Australia 2014).

While it’s fair to say we knew very little about Lyme disease and were upset with this diagnosis, we were also somewhat relieved to finally have a name for his bizarre range of symptoms, thinking that now that we know what it is, we can get treatment. So far, this is not how it has panned out. In North America, Lyme disease is the seventh most common ‘notifiable’ disease (Beard 2014) and health professionals know how to treat it. The biggest issue in Australia is that there is a lack of consensus that Lyme disease exists. Recently, the Australian Government Chief Medical Officer, Professor Chris Baggoley, established a clinical advisory committee to advise him on Lyme disease in Australia, and despite the growing numbers of sufferers, this committee concluded that they still needed more proof before the government can acknowledge the existence of an indigenous form of Lyme disease (Department of Health 2014).

In practical terms, what this means is that Australian doctors and health professionals are not educated about Lyme disease, and most remain sceptical about its existence. This lack of understanding has contributed to the misdiagnosis and continued suffering of many people. For us, this has resulted in us facing sceptical doctors who are ill-informed or naive about Lyme disease, even to the point of questioning the legitimacy of the positive blood test result received from one of the major tertiary hospitals in Melbourne.

While we have found much solace and support in online support groups for sufferers of Lyme disease both here in Australia and overseas, we have had to battle every step of the way in seeking treatment. Given my husband’s specific symptoms and co-infections, we were recommended that he undergo intensive antibiotic therapy including intravenous, intramuscular and oral antibiotics, combined with antivirals, an anti-parasitic agent, a napthoquinone and several herbal medicines. However, given that these drugs are all being prescribed ‘off label’, we are not able to purchase them at the PBS subsidised price. His treatment regime is costing us over $2,000 per month for the medications plus the cost of doctor visits and consumables. To complicate matters further, we have been unable to get a PICC line (Percutaneously Inserted Central Catheter) for Steve’s IV treatments because this requires an infectious disease consultant’s approval. So not only am I his wife, but now I am also his nurse, cannulating him in order to deliver his intravenous antibiotic infusions myself at home.

With a background as an acute hospital and ICU nurse, I can manage his care needs and medication regime, but when I can’t access appropriate support it becomes significantly more challenging. Even with my knowledge of the health system and working at the local health service, why can’t I get the system to work in our favour? Instead we are left to battle this hideous pervading disease with little support from the health system. Thankfully we have a great support network of family and friends who provide us with support in the way of an occasional cooked dinner.

What concerns us is that not only are there likely to be thousands of people out there with Lyme disease who are yet to be diagnosed or who have been incorrectly diagnosed, how are they to get affordable treatment they so desperately need if the government is yet to acknowledge the existence of Lyme disease in Australia, and our doctors are ignorant to the disease?

I write this article for the purpose of sharing our story and our battle, first in getting a diagnosis, then with fighting for affordable treatment. Thank you for taking the time to read it.

You can contact the author and her husband at **austhaslyme@gmail.com.**

For more information about Lyme disease in Australia go to **www.lymedisease.org.au.**

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DISILLUSIONMENT IN NURSING: A RITE OF PASSAGE?

Laurie Bickhoff MACN

By Laurie Bickhoff MACN

In Australia, it is estimated nearly 20% of nurses will leave the profession within their first year of practice (National Nursing and Nurse Education Taskforce [NNNET] 2005). Internationally, this figure ranges from between 35% and 60% (Halfer & Graf 2006). Many have speculated on the reasons for this, with high workloads, the difficulties of shift work and unrealistic expectations of what nursing entails all given due consideration (Halfer & Graf 2006). However, as I entered my second year of practice, I began to wonder what role disillusionment plays in this exodus of newly trained nurses.

Disillusionment, to me, occurs when you feel your passion dwindling, when you suddenly find it that little bit harder to get ready for work, when you start feeling a sense of dread as you walk onto the ward. This wasn't caused by long hours or ever increasing workloads coupled with diminishing resources. It wasn't caused by physically demanding duties or the lack of a social life due to shift work. It wasn't caused by dealing with things that might not look or smell that great. Unfortunately, it was caused by the people around me and an almost institutionalised lack of power, not only for nurses, but, more importantly, for our patients.

I was dismayed and frustrated to hear how many of my colleagues, from all health professions, referred to patients. I was disheartened to see how easily some could dismiss the suffering we see and the heartache I felt. I was overwhelmingly saddened to realise not everyone had the same passion for their profession or empathy for those we are charged to care for as I did.

This culminated for me towards the end of my first year of practice. There wasn't any one big incident; more an accumulation of things that were gradually wearing me down. I had a worried patient confide in me that they had been too scared to push the call button on the previous shift because of the response they would receive from the nurse. I saw patients constantly being made to fit into everyone else's schedules, regardless of their requests. It seemed everyone was more important than the person we were there to help.

I heard patients referred to as 'cactus' or described in the notes as 'unsalvageable', meaning there was no chance of the patients making meaningful recoveries. I wondered, is this really how we refer to people? Or did we forget they were actual human beings we were talking about?

I had other health professionals dismiss me with comments such as nurses "just wipe bums all day" or roll their eyes at me when I raised my concerns. When I dared to challenge or question, I was met with comments of "I miss the old new grads". I felt tired, washed out and was beginning to wonder whether I could stay in this profession without losing myself.

Luckily, I found some inspiration. I listened to a presentation by Drew Dudley, a well-known American academic and motivational speaker, where he discusses the idea of 'lollypop moments'. These are small moments when the people we see and work with every day demonstrate leadership. They aren't big, grand, over the top statements. They are small gestures which, often unknown to the person who did it, have an amazing impact on the lives of others. I was lucky enough to have some of these lollypop moments, just when I needed them. These few sparks were all that I needed to reignite my passion for nursing.

The first spark came from an RN2 caring for a patient at the end-stage of a number of diseases, who had expressed to the nursing staff multiple times her wish to simply be made comfortable, as she knew this was the end of her fight. Despite this, the patient was not only receiving active treatment, but was also currently documented for full resuscitation if she deteriorated.

The nurse raised the issue with the medical registrar asking him to have a discussion with the patient regarding her wishes and planning end-of-life care. The registrar dismissed her, saying "well that's not what the consultant wants". The nurse wasn't satisfied and responded "it's not their choice; it's the patient's decision". This nurse had the courage to stand her ground and make sure her patient's voice was heard, which ultimately led to the patient's wishes being honoured.

The next spark came soon after. I was working with a nurse who came from a different cultural background to me, where it was seen as impolite to question anyone in authority, especially if you were female. This meant even if a doctor was accidently standing in her way, she would prefer to simply wait, rather than ask them to move.

Then one day, we had a patient who deteriorated rapidly and was in a very critical condition. This nurse suddenly became one of the best clinical leaders I have witnessed. She led the team; questioning orders, prompting treatments, suggesting causes and outlining the options available. I soon

> “...this was about her patient. She was going to ensure her patient received the best care and outcome possible. When it was about her patient, rather than herself, she found her voice.”

realised the difference; this was about her patient. She was going to ensure her patient received the best care and outcome possible. When it was about her patient, rather than herself, she found her voice.

There were a number of smaller incidents that soon followed. Sparks came from the senior consultant who re-educated her advanced trainee on the importance of listening to the nurses and acting on their concerns. Sparks came from our ward social worker, who day after day demonstrated his passion for helping and advocating for those with no voice and often no options. Sparks came from the medical residents who expressed their gratitude when you picked up a mistake and were heartfelt in their appreciation of the work nurses do.

The brightest sparks came from my patients and their relatives. It was their “thanks”, their “you don't know how much that means”, their “you'll be back tomorrow won't you?”, their squeezing of my hand, that reminded me why I do what I do. I didn't have to search for inspiration; I was surrounded by it. The trick was to change my focus.

Perhaps all nurses are disillusioned at some point during their careers. Perhaps it happens multiple times. Perhaps it is a rite of passage, with those who make it through the other side, the ones with a true passion for nursing, who turn around and help a colleague on their journey.

As I continue my nursing career, I now look for the brightness that I know is always there, far outshining the negativity that we have to deal with. I stockpile my ‘lollypop moments’, knowing the amazing examples of kindness and leadership I see every day, will help me grow and become a better nurse, and hopefully, I might be able to be a spark for someone else.

You can listen to Drew Dudley's talk at **www.ted.com/talks/drew_dudley_everyday_leadership.**

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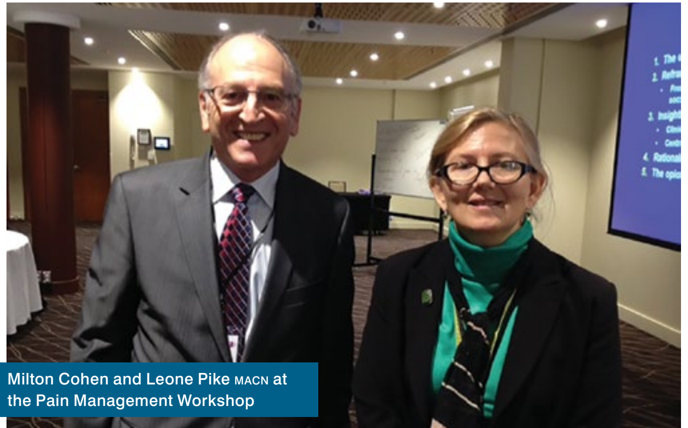
PAIN, PILLS AND PERCEPTION: ANYTHING BUT PLAIN

By Leone Pike MACN


Milton Cohen and Leone Pike MACN at the Pain Management Workshop

The complex issue of chronic pain and treatment approaches was the subject of a preconference workshop conducted at the 2014 Drug and Alcohol Nurses of Australasia conference.

As a former Drug and Alcohol Clinical Nurse Consultant (D&A CNC), I relished the task of organising this workshop. During my work as D&A CNC, I had enough consultation and liaison referrals in acute general hospitals to realise the complexities of pain management and the murky overlap with issues of substance dependence. A typical consultation may have involved seeing a patient who had four volumes of notes and had undergone multiple abdominal operations that might have included division of adhesions. Such a case often left all the professionals at a loss, not to mention the poor patient whose expectations of treatment might have been met with a denial of the reality of their pain, despite their perception.

Given my professional background, I was more than keen to hear the excellent presenters secured for the workshop, which included a professor of pain medicine, a nurse practitioner, a consumer and a pain team nurse.

THE PRESENTERS

Professor Milton Cohen, a specialist pain medicine physician at Sydney St Vincent's campus and a leader in the development of pain medicine as a discipline, was the first presenter. Professor Cohen talked about an individual's perception of pain; nociception of pain (when tissue damage is occurring); the development of neuropathic pain and the central sensitisation of the nervous system (Woolf 2011).

After my years as a general acute nurse and a mental health nurse, with some knowledge of neurochemistry/neurobiology, I found Professor Cohen's discussion around the constellation of complaints that are linked with pain disorders such as post-traumatic stress disorder, irritable bowel syndrome, migraines and panic disorder and many more (Ablin 2006) provided fascinating food for thought.

Opioid prescription, an always controversial and current hot topic, was addressed by Professor Cohen with clarity and balance. When discussing the ethics of opioid prescription in chronic non-cancer pain (CNCP), Professor Cohen addressed the tension between 'opiopyllia' and 'opiophobia' and cited an article by Rich (2007) that explores this tension in more detail. He discussed the principles of opioid prescription as:

1. comprehensive assessment
2. failure of adequate trial of other therapies
3. contractual approach to opioid usage
4. practical considerations
5. response to apparent increase in dosage requirements.

Professor Cohen provided four citations to support these principles: RACP (2009), Cohen and Wodak (2010), Faculty of Pain Medicine (2010) and Cohen and Wodak (2012). He continued with discussion of the issues of long term effectiveness, safety, tolerance and 'hyperalgesia'. He then addressed the unsanctioned use of opioids. Professor Cohen thanked Dr Alex Wodak (a prominent Sydney addiction specialist) when he presented a venn diagram explicitly illustrating the 'overlapping markets' of addiction and pain.

Almost as an aside, Professor Cohen spoke of the idea that the mere mention of the words used to describe pain had been found to actually cause pain. I was especially interested in this idea and found an article in the literature entitled *Do words hurt? Brain activation during explicit*

Overlapping markets

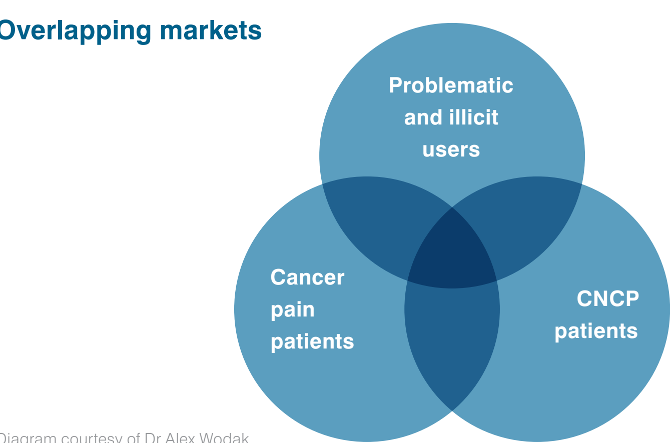


Diagram courtesy of Dr Alex Wodak

> *“ Some might argue that it is advantageous politically to call a pain or a drug and alcohol problem a ‘disease’ and others might argue that it is detrimental to the individual’s perception of themselves and their recovery, to label them. ”*

and implicit processing of pain words (Richter, Eck, Straube, Miltner and Weiss 2010). Therapists and pain sufferers must do a lot of talking about, and say a lot of words that describe pain. My thoughts ran to cognitive behaviour therapy and I saw another intersection with drug and alcohol counselling. I also started to think of transference and related issues in the therapeutic relationship and I plan to investigate the idea that the pain sufferer talking about pain might cause the therapist to feel pain.

How Professor Cohen managed to pack all that and more into one hour demonstrated the sophistication of his knowledge, understanding and experience and his great expertise underpinned by his compassion. The big messages from Professor Cohen’s presentation were the public and personal costs of pain, the importance of neuroplasticity, the importance of the dynamic interactions of the whole person and his argument to move to a socio-psychobiological treatment model.

The workshop continued with a consumer of treatments for ongoing pain who privileged participants with insights into her personal story. This consumer was an articulate and determined person. This consumer was anything but the stereotypical ‘giver-upper’ or ‘weak’ person as some people may stigmatise those with chronic pain, along with, for that matter, substance dependent people. This consumer story included multiple operations and medical interventions, overuse of alcohol, tensions with the general practitioner over opioid prescription, suicide attempts, great financial losses and grief around life events prohibited by chronic pain. This story resonated with not only a number of the pain consults I had attended, but also with many of the drug and alcohol clients I had worked with. The point made earlier by Professor Cohen around the resultant poverty of chronic pain hit home.

Positives from the consumer’s story included some wonderful personal goals achieved, that seemed to follow from effective management of the pain through a pain team much like the team that Nurse Practitioner, Amal Helou works with.

Amal gave an excellent presentation on the multidisciplinary approach to the management of pain. She described the need to get to know the individual, to develop rapport, build the therapeutic relationship, and involve multiple disciplines to address the whole person. This idea reinforced the ‘dynamic interactionism’ that Professor Cohen had described earlier when he addressed pain management issues.

Amal’s presentation also emphasised the ideas of early intervention and use of anticonvulsants to assist in the prevention of neuropathic and ongoing pain. This is another large area of intersection with mental health and the prescription of anticonvulsants for many mental health disorders. The use of these drugs in relation to perception, behaviour, mood and thinking continues to be of great interest.

THE DISCUSSION

Two topics emerged as slightly controversial and contested over the course of the day.

The first was the use of ketamine. Having always referred to ketamine in the illicit context in my D&A CNC days, I have a number of articles ready to read to try to form my own opinion based on the evidence. I think there was some general consensus that there are sometimes some unexpected reactions to ketamine.

The second was the notion of whether to call pain, or chronic pain a ‘disease’. This is another age old debate in the drug and alcohol sphere. Some might argue that it is advantageous politically to call a pain or a drug and alcohol problem a ‘disease’ and others might argue that it is detrimental to the individual’s perception of themselves and their recovery, to label them. This issue of nomenclature could be approached from a biological, psychological, sociological or philosophical context and demands much more discussion than is possible here but remains of interest for a person with my background.

The workshop concluded with some great case studies facilitated by Linda Pope, an active committee member of the Pain Interest Group-Nursing Issues; and a nurse with 10 years’ experience working in a multidisciplinary pain team.

The studies helped consolidate all the content from the day. The drug and alcohol nurses working through the cases demonstrated the ‘cross-over’ of therapeutic strategies between drug and alcohol and pain and just how complex such cases can be.

Participant feedback about the workshop was positive and great thanks are owed to our presenters. I consolidated my learning, gained some new knowledge and came away with plenty of food for thought: individual perception of pain, neuroplasticity, cross over with mental health and drug and alcohol, use of opioids, use of anticonvulsants, use of ketamine and the notion of pain as a disease. The most important message of the day was the need for multidisciplinary, individualised, holistic care and the vital role that nurses play in the care of those with ongoing pain and/or drug and alcohol issues.

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Resources

Agency of Clinical Innovation - www.aci.health.nsw.gov.au/chronic-pain.

Chronic Pain Australia - www.chronicpainaustralia.org.au/

Pain Australia - www.painaustralia.org.au

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RN/EN | Two days | 14 CPD hours | Canberra

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17 Pharmacology update
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23 – 24 Palliative care NSW Health
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23 – 24 Physical health care in mental health
RN/EN | Two days | 14 CPD hours | Burwood

24 – 25 Understanding team nursing and leadership
RN | Two days | 14 CPD hours | Burwood

30 – 31 Orthopaedic update
RN/EN | Two days | 14 CPD hours | Burwood

30 Organ and tissue donation awareness NSW Health
RN | One day | 7 CPD hours | Burwood

31 Organ and tissue donation awareness for perioperative nurses NSW Health
RN | One day | 7 CPD hours | Burwood

WA

9 – 10 Nursing patients with intellectual disability
RN/EN | Two days | 14 CPD hours | Perth

VIC

16 – 17 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Melbourne

20 – 21 Nursing patients with movement disorders
RN/EN | Two days | 14 CPD hours | Melbourne

SA

23 – 24 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Adelaide

TAS

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

November 2014

NSW

7 Nutrition and patient health outcomes
RN/EN | One day | 7 CPD hours | Burwood

13 – 14 Palliative care NSW Health
RN/EN | Two days | 14 CPD hours | Lismore

13 – 14 Infection prevention and control
RN/EN | Two days | 14 CPD hours | Burwood

17 Introduction to management of stomas
RN/EN | One day | 7 CPD hours | Burwood

20 – 21 Wound management
RN/EN | Two days | 14 CPD hours | Burwood

25 – 26 Pain management
RN/EN | Two days | 14 CPD hours | Burwood

27 Understanding dementia
RN/EN | One day | 7 CPD hours | Bega

27 – 28 Self-management strategies for chronic disease NSW Health
RN | Two days | 14 CPD hours | Coffs Harbour

VIC

7 Immunisation update
RN | One day | 7 CPD hours | Melbourne

TAS

13 – 14 Wound management
RN/EN | Two days | 14 CPD hours | Hobart

WA

27 – 28 Rehabilitation nursing
RN/EN | Two days | 14 CPD hours | Perth

Skills/knowledge required: Beginner Intermediate Advanced

NSW Health This course attracts no fees for employees of NSW Health.

All course fees, dates and locations subject to change without notice. For more information please see our website www.acn.edu.au or contact Student Services via email studentservices@acn.edu.au or phone 02 9745 7500.

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ACN

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ACN Endorsement logo and CPD hours

Displaying ACN's logo on your endorsed programs, promotional materials and certificates, clearly indicates that you are a quality provider of nursing education and training. Nurses attending an ACN endorsed program can have the confidence that the program has met high standards consistent with the CPD requirements set by ACN. The allocation of CPD hours to programs also helps nurses to meet the 20 CPD hours required as part of their annual renewal requirements of authority to practice.

Which activities can be endorsed?

Endorsement may be for a single activity such as a workshop, conference, seminar, DVD, online learning package, short course and/or any other program of study. CPD training providers can apply for ACN endorsement by completing the Endorsed Program Application on the ACN website at www.acn.edu.au/endorsement.

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Australian College of Nursing