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#15 SPRING 2016 | HEALTH INFORMATICS

GO-GO-GADGET OR LUDDITE?
Wearable technology and the CALD community

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Times are changing

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CEO WELCOME

Adjunct Professor Kylie Ward FACN, ACN Chief Executive Officer

Welcome to the Spring edition of The Hive, which features a number of informative and insightful articles from our members on the theme of Health Informatics. With emerging communication and information technologies rapidly transforming work practices and health care delivery, it is fitting to explore how nurses can bring their leadership and expertise to the health informatics space within this edition of The Hive.

Nurses are well placed to advocate for their patients to become active participants in their own care by assisting them to become more e-health literate. In their article, Is it time to influence policy development to enable nursing informatics to transform learning at point of care?, Carey Mather MACN and Associate Professor Elizabeth Cummings MACN explore this concept and dicuss embracing nursing informatics in the form of mobile learning.

Advocacy and leadership within the health informatics space is further examined by Dr Elise Sullivan FACN in her article, Go-Go-Gadget or Luddite – Wearable technology and the CALD community. Reflecting on nursing in the digital world, Dr Sullivan discusses how wearable health technologies can dramatically improve patient outcomes for people from culturally and linguistically diverse backgrounds.

Just as technology has facilitated advanced methods of care, it has also provided nurses with new and improved ways to further their education. In her article, Digitalisation in health – Times are changing, Gabrielle Koutoukidis MACN writes of the importance of educational institutions including health informatics within the curriculum to ensure that the next generation of nurse leaders are educated and equipped to use emerging health technologies.

Reflecting on my own experiences at the Garma Festival in early August, I have also written an article that highlights the importance of embracing individuality and finding balance in our professional lives. As the leader of Australia's preeminent professional nursing body it is my responsibility to create a supportive environment that fosters individuality and creativity for the teams I influence, as we work together to advance nurse leadership to enhance health care.

Recently I attended a number of events in Hong Kong and China to speak about ACN initiatives for advancing nurse leadership. This opportunity was created by our President Adjunct Professor Kathy Baker AM FACN (DLF). Kathy was invited by the President of the Hong Kong College of Nursing and Health Service Management, Dr Alice Tso, to present to their nursing leaders. I believe true leadership is when you create opportunities for others to grow and Kathy did just that for myself and RDNS Executive General Manager of Care, Quality and Innovation, Fiona Hearn MACN. It was a privilege to watch our ACN President promote Australia, our exceptional health system and our College on the world stage.

I hope you enjoy this inspiring read!

PRESIDENT'S REPORT

Adjunct Professor Kathy Baker AM FACN (DLF), ACN President

Since my last report, The Australian College of Nursing (ACN) has launched a number of exciting new initiatives to further drive our leadership and engagement within the Australian nursing and health care community. Over the past three months, we have seen a substantial increase in membership and expect this growth to continue as ACN strengthens its presence in every state and territory to secure a position of influence today, and into the future.

Engagement with the next generation of nurse leaders is a key consideration for ACN moving forward as Australia's preeminent professional nursing organisation. The launch of two new membership options for EN and RN undergraduate students has been an important step in supporting our future nurse leaders as they transition from the safety of their educational institutions into the workforce. As a part of our new undergraduate membership, ACN is now offering student members two complimentary one-hour career coaching sessions administered by our Members and Fellows.

As a further commitment to investing in the future of our profession, ACN has also developed a new framework for our Emerging Nurse Leaders (ENL) program. The first stage of this prestigious program will support nurses completing their undergraduate, honours or masters level pre-registration program as they prepare to take their first steps on their clinical leadership path.

As a powerful presence in the Australian health care system, ACN provides a platform for members to connect with leaders in nursing, health and government. At this year's National Nursing Forum we arranged for The Hon Sussan Ley MP, Federal Minister for Health, Aged Care and Sport, and the Hon Mary Wooldridge MP, Victorian Shadow Minister for Health to address delegates alongside an exceptional line-up of speakers from across the nursing and health care professions. It was an honour and a privilege to have Ministers of Federal and Victorian State Parliament speak at ACN's signature event this year.

ACN makes a significant contribution to health care at a local, national and international level. As the President of this innovative and creative organisation, I was recently invited to speak at the Hong Kong College of Nursing and Health Service Management (HKCNHCM) Symposium by the HKCNHCM President Dr Alice Tso. ACN CEO Adjunct Professor Kylie Ward FACN and one of our valued members, Fiona Hearn MACN, also had the opportunity to participate in a panel discussion at this important event. It was a wonderful experience and a fantastic opportunity to connect with influential nurse leaders from all over the world.

Keeping in line with our commitment to attract and retain a dynamic and talented workforce, ACN recently appointed Michelle Gunn MACN as the Executive Director of our Professional and Leadership Division. Michelle is an impressive nurse leader who will be a dynamic force in steering ACN's strategic intent of advancing nurse leadership to enhance health care. We are thrilled to have such a high calibre individual join our exceptional executive leadership team.

COMMUNITY AND PRIMARY HEALTH CARE NURSING WEEK

The Community and Primary Health Care Nursing Week: Nurses where you need them national campaign ran from the 19–25 September 2016.

This important initiative aimed to raise awareness of the current and potential contribution of community and primary health care (CPHC) nursing to the health care system and highlight its impact on the wellbeing of individuals and those in local communities.

Nurses working within primary and community care are well placed to meet the health inequalities experienced in the Australian population, especially in rural, remote and vulnerable populations. They can help bridge the often fragmented health care system and support continuity of care.

Community and Primary Health Care Nursing Week was a great success and fantastic opportunity to promote and discuss the vital role CPHC nurses play in our local communities. ACN was delighted that 13 organisations registered as supporters of this important initiative. We were also excited that 18 registered events were held in support of Community and Primary Health Care Nursing Week.

Visit our website: www.acn.edu.au/CPHCNW to read stories from CPHC nurses, researchers and organisations in our 2016 Community and Primary Health Care Nursing Week eBook.

ACN would like to thank Australian Mushrooms and the Australian Commission on Safety and Quality in Health Care for their generous sponsorship of this campaign.

ACN Members, Fellows and staff celebrating Community and Primary Health Care Nursing Week at our Canberra office on Wednesday 21 September.

ACN CEO AND PRESIDENT REPRESENT ACN AT INTERNATIONAL NURSING EVENTS

Adjunct Professor Kylie Ward FACN, Adjunct Professor Kathy Baker FACN and Fiona Hearn MACN representing Australian nurses at international nursing events in Hong Kong and China.

ACN CEO Adjunct Professor Kylie Ward FACN and ACN President Adjunct Professor Kathy Baker AM FACN (DLF) recently represented ACN at the Hong Kong College of Nursing and Health Service Management Symposium. Kathy was invited to give an address and Kylie participated in a panel discussion about leadership in nursing alongside one of our members, Royal District Nursing Service Executive General Manager of Care, Innovation and Quality, Fiona Hearn MACN.

Kathy also facilitated opportunities for Kylie and Fiona to speak at the No. 7 Advanced Practice Nursing Meeting in Guangzhou, China on Wednesday 14 September. They spoke to over 850 nurses and nurse leaders at this event about community and primary health, and advancing nurse leadership in Australia.

The 9th International Council of Nurses (ICN) International Nurse Practitioner/Advanced Practice Nursing Network Conference was also held during this time and Australian nurses were strongly represented by an exceptional line-up of speakers.

ACN MEMBER PRESENTATION ON NURSING INFORMATICS

In collaboration with Elsevier Australia, ACN held a member presentation on nursing informatics in our Sydney office on Thursday 1 September. Chief Professional Practice Officer of Elsevier Clinical Solutions, Michelle Troseth MSN RN DPNAP FAAN gave the presentation, reflecting on her wealth of knowledge and experience in digital health.

Michelle is a world-renowned leader in nursing informatics with over 25 years' experience in co-designing and implementing evidence-based practice and technology infrastructures to support patient-centered care and interprofessional integration at the point of care across hundreds of health care settings.

This presentation was a great opportunity for Members and Fellows to learn more about the importance of nursing informatics, usability and clinical application.

To watch a video recording of the presentation, head to our YouTube channel: www.youtube.com/watch?v=wJh4akbpjU8.

INTERNATIONAL SOCIETY FOR BURN INJURIES ISSUES PRACTICE GUIDELINES ON BURN CARE

Following the formulation of practice guidelines that addressed the care and management of burn injuries in developed countries, the International Society for Burn Injuries (ISBI) has updated these recommendations to guide the improvement of care of burn patients in resource-limited settings.

Given the modesty of service, as well as lack of access to scientific publications and critical appraisal expertise among burn care givers in developing countries, ISBI proposed practice guidelines in an endeavor to standardise burn care worldwide.

INTERNATIONAL COUNCIL OF NURSES CONDEMNS SYRIAN ATTACKS ON HEALTH PERSONNEL IN JOINT STATEMENT

In a joint statement, The International Council of Nurses (ICN) and the World Medical Association (WMA) have said that the persistent and targeted attacks on doctors, nurses, emergency medical personnel and other health workers in Syria has reached unprecedented levels that should alarm the world.

The two organisations confirmed their support of the UN resolution (2268) which calls for a cessation of hostilities in Syria, and ceasefires of sufficient periods for the provision of humanitarian aid.

ACN LAUNCHES NEW NURSE INFORMATICS AND COSMETIC NURSING COIs

ACN is proud to announce the introduction of two new communities of interest (COIs) to our suite of special interest groups.

We have established a Cosmetic Nursing COI for nurses with a professional interest in this area of nursing practice. ACN will be working towards launching a code of conduct for cosmetic nurses as part of the work of this special interest group at the inaugural National Cosmetic Medicine Summit taking place in March next year in Sydney.

ACN is also in the process of launching a new Nurse Informatics COI. This special interest group will be for nurses interested in the use of digital information and communication technologies to enhance health care.

To join either of our new COIs, please log in to MyACN and update your preferences under 'Communication' in the 'Engagement' tab, or alternatively email us at membership@acn.edu.au.

ACADEMIC

MR JAMES BONNAMY MACN

Health services in Australia, as in most countries, are experiencing a surge of interest and investment in electronic health. Health informatics is a term which describes the acquiring, storage, retrieval and use of health care information, such as patient pathology results, to enable collaboration among health care providers (Australiasian College of Health Informatics, 2016).

Health informatics is now its own speciality with emerging job titles such as Nurse Informaticist, Director of Clinical Informatics and Health IT Consultant. Nurse Informaticists are responsible for evaluating and selecting health care technology, determining end user requirements and helping customise software functionality to improve collaboration (Health Informatics Society of Australia, 2016).

The role and scope of practice of health informatics specialists is expected to increase rapidly with the advent of electronic personal health records. In fact health informatics is ranked the number one job opportunity in an emerging industry (Morsani College of Medicine, 2016).

A number of Australian universities now offer Master of Health Informatics degrees to help health professionals better understand information technology and to provide IT professionals with specific knowledge about application of IT in health care. There are also a number of Biomedical and Health Informatics Post-Doctoral Fellowships available throughout the world.

The Health Informatics Society of Australia (2016) provides a national focus for the science and practice of health informatics and publishes its findings in the electronic Journal of Health Informatics. Membership is drawn from consumers, clinicians and researchers, and is multidisciplinary in recognition that health informatics aims to enable better health care collaboration.

With the explosion of health-related mobile and smartphone applications, electronic personal health records and national patient databases, the relevance of health informatics has never been more apparent.

MANAGER

ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

Nurses have used information and data to assess patients and make judgements about care, since the role began. Intrinsic to our nursing care, is observing, monitoring and reporting. What has changed in the 21st century are the tools that we have at our disposal that support our access to that information, and that help us decide what to do with it.

Health informatics is business as usual for nurses, what has shifted, is the world in which we operate. This is evident when I reflect on how, as a nurse leader, I am required to make decisions around where and how to allocate resources, such as staff, equipment and supplies. Sophisticated tools are now at my disposal, thus allowing a more sound decision to be made. The same now applies to the care that we provide, whether it's having an integrated Electronic Medical Record that is able to take live data, signal a patient's deterioration and make recommendations regarding the best contemporary evidence-based methods of providing care for that deterioration, that supports us to use our clinical judgement; or to monitor a person's blood glucose while they are working at their day job, and signal to them that they need food or insulin, so they are able to take care of themselves.

I see the role of the nurse leader in the health informatics space as the navigator, translator and the role that supports the use of this amazing technology. One that allows the nursing workforce the space to grow and adapt, and that enables what we intrinsically do every day to be supported and enhanced by technology to provide the absolute best contemporary and patient-centred care.

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CLINICIAN

MS TOMICA GNJEC MACN

Health informatics has been defined in the context of e-health and as an umbrella term of the two elements of health informatics (examination and movement of health data to support health care) and telehealth (direct website delivery of information or health care to a recipient) (Standards Australia: e-health, 2010). Over the past 10–15 years the health care environment has experienced a revolution in work practices and an increasing use of communication and information technologies to aid the delivery of health care.

Recently I cared for an older gentleman who had travelled from interstate to visit family. He presented to our local emergency department on a weekend with symptoms of stroke and the inability to be able to verbally share the events surrounding his admission, nor his past history. With no linkages to a centralised online e-health database and not having been a patient in our health jurisdiction previously, assessment and plans for his management, including requesting of appropriate imaging, were challenging and heavily reliant on recall of information from attending family members.

E-health remains a work in progress in our country as in many other developed countries. In times to come, national access to vital health information will promote the ability to be able to accurately and in a timely manner communicate with patients and other care providers.

Successful implementation and management of a national e-health infrastructure (such as in Denmark) would not only enhance the prevention, diagnosis and treatment of illness, including health promotion, (Australian Nursing and Midwifery Council Accreditation Council, 2014) but also reduce the incidence of mistaken interpretations and related adverse patient outcomes (Jolly, 2011).

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HISTORIAN

DR MADONNA GREHAN MACN

We tend to associate the concept of health informatics with modern computing systems, a mechanism to organise information whereby researchers can investigate a population's health and disease status. Applying computer technology and cross disciplinary collaboration to mass data sets is relatively new, yet the science of recording, arranging, and interpreting information to understand disease has a long history.

In their detailed drawings of the human body, anatomists Leonardo da Vinci and Andreas Vesalius sought to understand how organs contributed to debility and death. An instructive example of early epidemiology comes from a diagram of Napoleon's army as it marched through Russia in 1812. This marvellous plan catalogues the various mishaps and ill-health which flayed the army.

Forty years later, during the Crimean War (1853-1856), Florence Nightingale's analysis of what was killing the soldiers at Scutari earned her a Fellowship of the Royal Statistical Society, the first given to a woman.

As governments instituted compulsory registration of births, deaths and marriages, these milestones became the bedrock for understanding populations as communities. Insurance companies, often associated with churches and lodges, used this data to frame premiums and related pay-outs at death. Their business was to categorise diseases, a discipline called nosology, and interpret patterns of disease and ill-health.

Francis Gustavus Paulus Neison, an actuary in Britain in the 1840s, is considered a giant of that country's statistical understanding of disease. Britain's William Farr was the medical doctor who applied nosology effectively. In Victoria, William Henry Archer, a protégé of Neison's, introduced nosology in Australia.

Modern day computing systems are a tool for analysing what was, for years, done on paper.

EARLY CAREER NURSE

MS LAURIE BICKHOFF MACN

For frontline nurses eager to spend more time delivering care and less time completing yet another form, health informatics offers a unique opportunity.

Health informatics, especially the subspecialty of clinical informatics, focuses on the development of tools which make our care safer and more efficient. Crucially, however, it recognises the importance of collaborating with those who will actually use these tools – our frontline nurses and other members of the multidisciplinary team.

Too often in health, our ward nurses are the last to find out about new initiatives or policies that will affect their work. Too often non-clinical duties or tasks are delegated to frontline nurses for no other reason than they are the only set of hands available. Too often the expertise and knowledge of clinical nurses is overlooked when it comes to designing new IT systems and implementing change.

Health informatics seeks to rectify this and give clinicians the skills and opportunities to not only be involved, but lead the development of new informatics tools.

In the constantly expanding digital world, health care must ensure it is not left behind and through health informatics, nurses can lead the way, safeguarding patient privacy and person-centred care as we venture forth.

> "Too often the expertise and knowledge of clinical nurses is overlooked when it comes to designing new IT systems and implementing change."

GO-GO-GADGET OR LUDDITE? WEARABLE TECHNOLOGY AND THE CALD COMMUNITY

By Dr Elise Sullivan FACN

Dr Elise Sullivan FACN

I attended the Wearable Health Technologies and CALD Communities event, hosted by the Centre for Culture, Ethnicity & Health (CEH) in Melbourne in July. The purpose of the seminar was to offer ideas and insights on a new research program that will explore how wearable health technologies can improve the health of people from culturally and linguistically diverse (CALD) backgrounds. Wearable technologies are things like activity trackers, smart watches, health apps, personal heart rate monitors and the latest innovations in health focused on personal wellbeing. Now this is right up my alley – I love my gadgets!

Nursing was well represented by our host, Stream Leader, Research, Policy and Evaluation at CEH, Dr Ruth DeSouza MACN, and Bendigo Health's Chief Nursing Information Officer, Janette Gogler, who presented on how technology is being used to keep patients at home and out of hospital.

Wurundjeri elder Uncle Colin Hunter opened with a Welcome to Country. His message was powerful. He reminded us that our borders are open – it's a big country. I was conscious that, apart from Colin, most, if not all of us in the room had either immigrated or come from immigrants to Australia – and he welcomed us to this country as his ancestors did before him.

I see many of us as immigrants in this new digitalised world. The digital natives among us were born into an era of ubiquitous computing technology – arbitrarily anyone born after 1980. If that is not you, then you may have felt like a foreigner in a strange land at some point, where you didn't know the language, the norms; the tools were unfamiliar. Many of us feel confounded by the myriad of new technologies, apps and online connection possibilities.

But these technologies can level the playing field for people who are from CALD backgrounds. These technologies could improve communication and connectivity between individuals and health care providers. They could improve the health literacy of people who struggle with English, enabling them to take a more powerful and central role in their health care.

Partner with Deloitte Digital, Sean McClowry, made the observation that undeveloped countries have leap-frogged our more developed nations in certain technologies. For example, they are going directly to clean, renewable energy. Is this because necessity is the mother of invention? Or is it that there is no other alternative desperately trying to remain relevant and resisting attempts to progress. Where there is no investment – and I mean that literally and figuratively – there is little resistance.

So I have great hope for this research. I believe that anything they find will be of relevance well beyond the CALD communities they study, so long as the existing alternatives are not so rusted on that we cannot see the possibilities these new ideas present.

NURSING IN A DIGITAL WORLD

The worlds where nurses work are becoming progressively more digitalised and technologically complicated. The people nurses care for are becoming less passive recipients of their care and more active participants – they know more, they want more control. Governments are driving this shift in policies and funding, such as Consumer Directed Care and the National Disability Insurance Scheme.

As people gain health literacy and a greater command over their own vital signs and wellbeing, they will be better equipped to take the lead in their own care. So where does this leave nursing? How will these new technologies affect the roles nurses currently perform? How can nursing respond to these developments without undermining or slowing progression? How do we keep in front of the wave? How do we use these tools to enable people to be healthier?

I believe that advancing informatics and wearable technologies provide an

> “As people gain health literacy and a greater command over their own vital signs and wellbeing, they will be better equipped to take the lead in their own care.”

opportunity for nursing to reshape our role from being the ‘doer’ to being the ‘sense maker’; the mentor and coach, the teacher, the enabler. Their clients, families and friends are always asking nurses what they think. Our opinions matter. These are great opportunities to adopt these roles. To offer really well-informed views and the voice of reason. Nurses help by encouraging people to retain their self-determination, providing the information they need to make good decisions and access the tools and technology to retain this self-control.

Over 70% of registered nurses were born before 1980 – digital immigrants by the popular definition. By that definition, less than 30% of registered nurses and midwives across Australia are digital natives. We need them to welcome us and guide us in this new world. Our nurse informaticians, such as Janette Gogler, are our experts in this world. We need them to help us make sense of this, to gain the new knowledge and skills to make the transition so that we do not become the ‘luddites’ and the ‘resisters’ to progress.

Melbourne University lecturer Suneel Jethani presented the alternative view. He cautioned against the unquestioning use of wearable technology and the data that it generates about our bodies. The risk is that in the process of distilling our beings down to a set of numbers, we objectify ourselves and risk losing the essence of the human. Suneel explained that new health data should be points of reference to frame more powerful questions that will illicit the whole story. Nurses are so well placed to keep sight of the human in all of this. Technology will not quickly replace good clinical judgment – nor will it replace the human capacity for empathy.

Delegates at the Wearable Health Technologies and CALD Communities event.

A presentation at the Wearable Health Technologies and CALD Communities event.

A JOURNEY AT MONASH HEALTH FROM A CHIEF NURSING INFORMATION OFFICER'S PERSPECTIVE

By Adjunct Associate Professor Naomi Dobroff, RN, MPH, MACN
Chief Nursing Information Officer
Monash Health

Adjunct Associate Professor Naomi Dobroff MACN

In March 2015, when I was appointed the Chief Nursing Information Officer at Monash Health, there were only two of us in Australia. Now, almost 18 months later, there are six people with this job title but many more equivalent senior nursing and midwifery informatics roles are being appointed around the country. This is an extremely exciting time for our profession but also for the health informatics community as these roles become more commonplace within our health services.

The Chief Nursing Information Officer role is a pioneering role yet it rests firmly on the shoulders of those nurses and midwives who have been working, publishing, influencing and agitating in the health informatics space for many years. The highly publicised mixed success of Electronic Medical Records (EMR) being implemented in Australia, as well as international literature and documented experiences, have supported the need for these senior roles. The Advisory Board (2014) tells us that 92% of nurses in the United States of America are dissatisfied with their EMR. This is a sobering percentage for those of us working to engage and excite workforces in anticipation of an EMR implementation.

Yet, health informatics and EMR systems are really the only way forward. How else can nurses and midwives keep up with the pace of patient throughput, the changes in best practice and the complex care requirements of our patients? Duplicated forms, checklists and the other workarounds that are required within a paper-based record system do not support nurses and midwives to provide the best care to their patients. I have often heard paperwork described as taking time away from patient care rather than supporting the care our patients require and deserve.

Further to the issues identified above within our paper-based systems and the dissatisfaction with EMRs, are the Americanised scopes of practice embedded within the major EMR vendor's products. These don't always reflect the contemporary partnerships and practices between medical, nursing, midwifery and other health practitioners within the Australian context. Also some of our interdisciplinary models of care are not well catered for and require review and change.

It was quickly identified, when my role commenced, that Monash Health nurses and midwives needed to go on a health informatics journey. We knew we were headed towards an EMR and we also knew that much work was required to get our profession ready prior to this happening. A strategy was developed, in consultation and collaboration with the nursing and midwifery executive leadership team, led by the Chief Nursing and Midwifery Officer. Our partnerships with Deakin and Monash University ensured academic input into the strategy as well. Monash Health is a large public health facility with six major sites and over 40 community sites. With over 7,000 nurses and midwives employed with Monash Health, we needed to identify a path forward. This involved breaking down the work and the associated nursing and midwifery governance structures and hierarchy into more manageable sections.

The result was to establish four separate but interrelated working groups. Each group reviewed and described an aspect of our current systems in areas such as scope of practice, documentation, workflows and levers for decision-making in care. These discrete areas of work were completed by June 2016, providing a current state analysis of our existing paper-based systems, the drivers behind our decision-making and the

current tools we use to inform practice and fundamental nursing and midwifery care principles.

This work currently underway is not a small undertaking. So far we have established that nurses and midwives at Monash Health use up to 22 different assessment and observation tools to understand their patient's care requirements within just one fundamental nursing and midwifery care principle, such as hygiene. Nurses and midwives have to then analyse this information to plan, implement and evaluate care interventions for their patients in that area. These assessment tools currently have multiple areas of duplication. Our nurses and midwives spend significant time and effort rewriting the same information often in an attempt to make communication clearer, and plans and outcomes better understood because they are the lynchpin to a paper-based information process. Basic computerised handover tools further complicate this process, yet support nurses and midwives to undertake care provision in a complex system. We have also established that some improvements can be made in the paper-based system prior to embedding this within an EMR.

At Monash Health, we are not undertaking this work just for the purpose of description and a pre-EMR implementation status observation. We are planning to inform the EMR through developing a minimum data set which can be drawn from by nurses and midwives in developing, implementing and evaluating their patient's plans of care. This would not only ensure an end to duplication and workarounds in the current paper-based system but also support nurses and midwives to analyse and customise their patient's care using health informatics.

Nurses and midwives are used to using data for their decision making, understanding trends and aligning interventions.

Many nurses and midwives at Monash Health haven't been aware that they have been working within a health informatics framework. Nurses and midwives are used to using data for their decision making, understanding trends and aligning interventions accordingly. We know that having a well-developed EMR will change our methods for data capture, reduce duplication and support our analysis and clinical judgement. That is the exciting promise of health informatics moving into the future.

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IT IS TIME TO INFLUENCE POLICY DEVELOPMENT TO ENABLE NURSING INFORMATICS TO TRANSFORM LEARNING AT POINT OF CARE?

By Carey Mather MACN, Lecturer, School of Health Sciences, University of Tasmania and
Associate Professor Elizabeth Cummings MACN, Course Coordinator Doctorate of Health, School of Health Sciences and Graduate Research Coordinator, Nursing & Midwifery, University of Tasmania

The recent inception of the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia (NMBA), 2016) and Continuing Professional Development (NMBA 2016) are an opportunity for leadership by nurses to embrace nursing informatics in the form of mobile learning at point of care. Nurses are well placed to be advocates for their patients to become active participants in their own care by identifying and assisting them to become more e-health literate. If nurses are to advance health promotion and education of patients, now is the time to consider harnessing mobile technology.

Interactions at point of care are opportunities for nurses to recognise their informal learning; enable self-directed learning; promote continuing professional development; and support lifelong learning strategies, in real-time, rather than accessing information away from the workplace. Additionally, it is an opportunity for undergraduate students to develop mutuality with patients and understand their 'lived' experience while empowering them to discern credible web-based resources and participate in their own care.

The rapid increase in the use of digital technology has led to the situation where acceptability of applications such as social media has outpaced the development of policy or guidelines to govern their use in health care environments (Mather & Cummings 2015). The International Council of Nurses (ICN) has developed fact sheets on nursing informatics (2009) and social media (2015), which are holistic in approach. Some individual Australian professional bodies, higher education institutions and health care organisations have also developed policies and guidelines about appropriate use of social media and mobile technology (Australian College of Nursing (ACN), N/D, Australian Health Practitioner Agency Regulation (AHPRA), 2013, Australian Nursing and Midwifery Federation (ANMF), 2014, 2015).

The release of the Australian Nursing and Midwifery Federation (ANMF) National Informatics Standards for Nurses and Midwives (2015) adds to the progress of policy development related to nursing informatics. There is opportunity for influence by nurses to promote computer (Domain 1) and information literacy (Domain 2) (ANMF, 2015) by using mobile technology for learning at point of care.

The integration of work and personal life afforded by digital technology further complicates the traditional boundaries between workplace and private life that can cause confusion for health professionals (Pauleen et al., 2015). In many Australian organisations, nurses can use their digital technology until their shift begins, then it must be put away. Nurses generally can no longer browse for answers, seek direction from peers or colleagues, ask an expert or use their clock or calculator in their mobile devices (Mather, Cummings & Marlow, 2013, Mather, Cummings & Allen, 2014). Until informatics governance is addressed in both educational and health care settings, harnessing the benefit of digital technology for learning will be unachievable.

The new Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards state they 'reflect current nursing practice in all contexts' (NMBA, 2016, p. 2) and an analysis of the criteria within the standards demonstrates the use of mobile technology for mobile learning can become embedded as a learning and teaching strategy for the benefit of patients, students and registered nurses. However, currently the intent of these standards is not supported with policy at a national level.

It can be argued that nurses need to leverage governance at a systems level to enable this new andragogy to be implemented at an individual level. Cultural change in health care environments to allow access and use of mobile technology for mobile learning at the workplace needs to occur simultaneously with the employment of nursing graduands from courses where the Australian Nursing and Midwifery Council (ANMC) mandate of inclusion of health and information technology in undergraduate curricula (ANMAC 2012) has been implemented. Teaching digital professionalism within the curriculum is an essential component of ensuring students are prepared for the twenty-first century workplace. Using digital technology in nursing has been compared with the use of a stethoscope, which is now a ubiquitous part of nurses' professional tool kit. Now is the time for nurse leaders to transform learning at point of care by progressing informatics governance to enable this new andragogical approach to be used by registered nurses and students within organisations.

If nurses are to advance health promotion and education of patients, now is the time to consider harnessing mobile technology.

The impetus to update workplace policies and guidelines to include mobile technology for learning will enable nurses to remain contemporary in health service delivery and management, and become aligned with other health professions already using this technology. Modelling safe and appropriate use of mobile technology by registered nurses at point of care will promote the normalisation of this form of learning and teaching within the workplace, and has the potential to improve patient outcomes.

There are potential issues to overcome. Thinking critically and analysing nursing practice (Standard 1) includes the expectation that accessing mobile technology would occur only when it is safe to do so (Standard 6). Similarly, engaging in therapeutic and professional relationships will rely on sound decision-making by nurses about choosing when it is appropriate to support and direct people to resources to optimise health-related decisions; and share knowledge and practice using mobile learning that supports patient-centred care (Standard 2). Providing safe, appropriate and responsive quality nursing practice (Standard 6) can be achieved if the use of mobile technology is employed effectively and efficiently to provide information at the right time and place, and in real-time.

Maintaining the capability for practice (Standard 3) is where mobile learning serves to enhance nursing at point of care. This standard demonstrates the value placed on the nurse-patient relationship and the capacity of nurses to advance e-health literacy, health promotion and education of their patients using mobile technology. It can be used for learning and teaching of students without leaving the bedside, and if appropriate, can include the patient in knowing about their own care. The Registered Nurse Standards for Practice, and self-directed learning within the registration standard for Continuing Professional Development (NMBA, 2016), show there is scope for the inclusion of this learning and teaching strategy at point of care. Leadership by nurses for the development of salient governance to enable the inclusion of mobile technology for learning is essential for the future of contemporary nursing practice.

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DIGITALISATION IN HEALTH – TIMES ARE CHANGING

By Gabrielle Koutoukidis MACN
Associate Director of Health and Community, Chisholm Institute

In 2015, I was successful in winning a fellowship from the International Specialised Skills Institute, sponsored by the Higher Education and Skills Group.

The aim of this fellowship was to explore how learning and teaching strategies for health informatics and health technology is addressed and taught in nursing and health curricula to prepare student nurses to work in the rapid, technology-changing health care environment.

This research involved me visiting The University of Minnesota (USA); University of Finis Terrae (Chile); Autonoma University (Chile) and the University of Auckland (New Zealand), over a three week period. These universities were chosen as they either have established health informatics departments and established courses on health informatics or a specific subject on health informatics within their Bachelor of Nursing programs and simulated health care environments.

In addition, whilst visiting the University Finis Terrae in Chile I met with the following health care organisations: The Hospital Traumatologico, Clinic Ensenada and the Accuhealth Centre. These experiences were invaluable and I was able to see what needs to be taught in undergraduate nursing courses.

The focus of the fellowship was to:

1. Learn how to develop, incorporate and implement learning and teaching strategies for health informatics and health technologies for nursing and health courses;
2. Learn how to establish a digital simulation health laboratory;
3. Obtain an understanding of clinical information systems, devices, privacy and confidentiality, and data and information technology;
4. Identify the knowledge that educators will require to be able to teach health informatics within nursing and health courses.

I was able to explore different teaching approaches for including health informatics and health technology in nursing and health science curricula. I was also able to identify and explore teaching resources for health informatics and technologies, and how teachers could use electronic medical health records (EMR) and e-documentation to inform students. This will assist in preparing students to use EMR in the workforce.

A common theme from all four universities was the importance of teaching students about critical thinking, so they don't just let the technology decide what they are going to do. In addition, it is important that educators use a person-centered approach in teaching, so that students don't lose sight of the individual they are caring for. Some academics have noted that students are focusing on the technologies and forgetting they are looking after a real person.

In establishing a digital simulation laboratory, it was stressed that simulation and equipment resources for health informatics need to be built around the training package/curriculum, so that spaces are flexible and can be used for different scenarios.

Professional development requirements for educators of nursing and health courses to be able to teach and support students on the use of health informatics and technologies in the health care environment was another major area that most universities stressed was important. It is also important that staff who are involved in simulation also undertake a course on simulation and debriefing.

Following the findings from the fellowship, I would recommend that VET providers and universities:

- Encourage curriculum developers of nursing, health, aged and community care courses to consider developing a discrete unit on health informatics for the health training package;
- Consider having health informatics integrated throughout specific units in nursing, health, aged and community related courses;
- Include various teaching pedagogies and approaches for including health informatics and health technology in nursing, health, aged and community care curricula;
- Utilise teaching resources for informatics and technologies;
- Give examples in class of how telehealth and telemonitoring are used so that students are aware of these applications if they come into contact with them depending on where they work;
- Provide professional development to teaching teams on health informatics and technologies;
- Ensure staff who are involved in simulation also undertake a course on simulation and debriefing;

> “This fellowship has highlighted that now is the time to ensure that students in health care courses, such as nursing, aged care and community care, are educated and equipped to be able to use health informatics and emerging technologies, safely and confidentiality.”

Gabrielle Koutoukidis MACN at the Traumatologico Hospital, Chile with Medical Director Dr Mario Reyes and nursing staff.

- Build simulation and equipment resources around the training package/curriculum. So that spaces are flexible and can be used for different scenarios;
- Ensure students have access to computer laboratories.

I would also recommend that the Australian Government ensure that EMR can be accessed by health care providers and individuals across health organisations in Australia to ensure interoperability. The nursing profession in Australia needs to discuss the possibility of a standardised language – when using EMR – so that data can be collected and used for quality improvement and research. Health care providers need to partner with universities/VET providers for use of data for real research. I also recommend that Course Advisory Groups within the VET and university sector include technology and health informatics on the agenda, to ensure they are kept updated on what the industry is using.

Health informatics is beginning to evolve more in Australia. Projects in some health care facilities are now commencing to implement electronic medical records and e-documentation. This fellowship has highlighted that now is the time to ensure that students in health care courses, such as nursing, aged care and community care, are educated and equipped to be able to use health informatics and emerging technologies, safely and confidentiality. That graduates of these type of courses are critical thinkers and deliver person-centered care in this digital age. In addition, support and education should be provided to the educators of these students.

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COACHING: AN ESSENTIAL TOOL FOR EFFECTIVE LEADERSHIP DEVELOPMENT IN NURSING

By Debra Pittam MACN

Debra Pittam MACN

Most people are not born leaders, so for most of us, becoming an outstanding leader requires learning and time. This article explains how and why leadership coaching is pivotal to leadership development and to the application of leadership theory to nursing leadership practice. It also explores the complexity of leadership, explores leadership coaching and describes the qualities of a good leadership coach.

THE COMPLEXITY OF LEADERSHIP

Effective leadership that embodies qualities such as integrity, openness, collaboration, enabling and high emotional intelligence underpins the success of organisations (Simpson, 2010). Henochowicz and Hetherington (2006) summarise in the findings from their study on leadership coaching in health care that "Health Care Leaders will need to develop interpersonal and emotional intelligence competencies in order to run increasingly complex organisations".

The leadership landscape is complex and most people are not born leaders (Zenger and Folkman, 2009). For most of us, becoming an outstanding leader requires learning and time. In addition to developing practical skills, leaders must develop skills and knowledge around emotional intelligence, human behaviour, visioning, positively influencing workplace culture, communication, networking, facilitation, modelling and mentoring to name a few.

Zenger and Folkman (2009 p. 3–6) talk about the variables that exist in the leadership role, between leaders and between contexts, and how these contribute to the difficulty in finding one overarching definition, or even definitions that are similar, of leadership. Some of the variables that they have identified and that can be applied to the health context include:

- The environments in which leadership is required are many and different. This is especially true in health with its myriad of leadership roles, constantly changing environments and its unpredictability and complexity;
- As a result, the role of leadership and the corresponding required skills change according to the level of leadership and the leadership position and role;
- Leaders are required to do different things in different roles and/or at different times;
- What leadership success looks like in health is unclear and appears to be subjective a lot of the time. In health there are leadership standards in some organisations and in some leadership courses. There is however, no consistent measure;
- What drives the need for leadership can vary;
- Expected behaviour for a leader within a leadership team can differ from the expected behaviour of a leader when they are leading a team;
- Leaders are not always in positions of authority responsible for direct reports. This is true especially in the nursing context in roles such as clinical nurse educator, nurse educator and clinical nurse specialists and consultants;
- The types of challenges leaders may face differ between leaders and between contexts;
- And the sheer number of leadership theories, models and styles in the literature as well as presented within leadership programs add another layer of complexity.

In summary, describing what comprises great leadership is difficult, because leadership as an entity and an activity, is nebulous and surrounded by inconsistencies.

It is reasonable to consider, that while leadership theory can be taught through leadership development coursework based programs, the application of theory to practice is an individual experience rather than a homogenous one. Issues that may arise for leaders, such as self-doubt, lack of confidence, managing boundaries, managing challenging emotions and conversations, relinquishing control (delegation and trust), and changes in identity or perception of self will be experienced at an individual and context specific level (Wienstock, 2011). Developing strengths around emotional intelligence, changing long-held beliefs and behaviours, and developing and maximising talents and strengths can be a challenging and intensely personal experience (Baker, 2012).

> "…describing what comprises great leadership is difficult, because leadership as an entity and an activity, is nebulous and surrounded by inconsistencies."

LEADERSHIP COACHING

Leadership coaching helps and supports people to determine areas for development, set goals, maximise their strengths and supports them as they learn what they need to know and implement the changes they need to make, in order to reach their highest leadership potential (Weinstock, 2011). It supports leaders to achieve demonstrable "…positive long-term measurable behaviour for themselves, their people and their teams" (Goldsmith, 2012, p. 3). Leadership coaching is usually provided in one of two ways (Byrne, 2007, Hays, 2008, Baker, 2011, Wienstock, 2011):

1. As part of a leadership development theoretical program for the purpose of enabling participants to apply theory to practice in the workplace. In this context, the coach generally works within an existing learning and development framework to assist the coachee to develop and reach personal leadership development goals that are related to the overall leadership development outcomes of the specific program;
2. As an end-to-end learning process that includes high challenge and high support provided by the coach for the leader over a period of time, usually six months or longer. Goal-setting and coaching is specific to the leadership development needs of the coachee (Stokes & Jolly, 2014, p. 245). These areas for development may have been identified by a sponsor, like the leaders manager or by the leader themselves.

WHAT YOU SHOULD EXPECT FROM A LEADERSHIP COACH

This type of coaching commonly lasts six months or more. Coaching occurs in the context of a relationship in which the leader is responsible for their results and enabled and supported to determine and achieve their goals. This responsibility and ownership of development results in them experiencing changes in their thinking, perceiving, believing, responding and behaving over time.

For this reason it is important that the leader experiencing coaching, should determine their own development goals. They are the ones who need to identify the areas they would like to focus on. However, to be able to do this, leaders need feedback on their current performance and behaviours. This can be achieved in a range of ways, for example, through asking stakeholders for their opinion via interview or through psychometric testing (Goldsmith2012, p. 3).

For feedback to be accepted by the leader as valid and meaningful, the stakeholders that are within their leadership context need to be identified and the relationships and the benefits of their feedback understood by both parties (Goldsmith, 2012, p. 7).

In addition, the coach should also connect with both a sponsor and the leader together to ensure that the coachee has support in their workplace as they apply their learning's and new behaviours to practice over time.

Following feedback, it is important that the leader is supported and enabled to set some smart goals to work towards over a six to 12 month period together with an action plan. The action plan can be used to document changes as they arise out of coaching and also learning's that occur between sessions. Both learning successes and goals require regular review between the coach and coachee and also between the coach, the coachee and their sponsor with new goals being set over time, to build upon those that have been met.

Finally coachees should expect their coach to follow up with them between sessions and provide resources, and advice around recommended readings so that learning is supported over time.

SUMMARY

In summary, there are a number of compelling reasons for both established and emerging nursing leaders to engage a leadership coach, including enabling the application of learning to leadership practice and to assist leaders to close development gaps.

Leadership coaching is effective in enabling leaders to develop a positive approach to leadership and build resourceful behaviours that support this approach. Such coaching can be a complete leadership development solution and can also support the outcomes of a broader leadership development program.

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DR ROSEMARY BRYANT – A NURSE'S REFLECTION

> "The care I have received both in Thailand and Australia has enhanced my faith in nursing and re-established the reason we all go into nursing – an interest in clinical care and people."

By Anita Pak and Carolyn Stapleton FACN, ACN

Throughout her career, Dr Rosemary Bryant FACN has made significant contributions to furthering the nursing profession. From 2000 to 2008, Dr Bryant held the position of Executive Director at what was then called the Royal College of Nursing, Australia. From the period of July 2008 and June 2015 Dr Bryant held the position of Commonwealth Chief Nurse and Midwifery Officer.

Dr Bryant has faced many challenges throughout her career, but none as enormous as the one she has just overcome.

In March 2016, as a representative for the University of Technology, Sydney (UTS), Dr Bryant travelled to Laos to begin work on a project for the World Health Organization (WHO). Following her arrival, Dr Bryant suffered a subarachnoid haemorrhage. With her condition becoming critical, Dr Bryant was transferred to Udon Thani, Thailand to be stabilised.

She was then flown to Bangkok for neurosurgery where her aneurysm was clipped. After several weeks in Thailand, Dr Bryant was flown to the Royal Melbourne Hospital to continue treatment back in Australia.

Dr Bryant's nursing background, particularly that of her early training in intensive care in the 1960's, helped guide her through her stay.

Upon reflection, Dr Bryant says, "In the times I was lucid, I reflected on my days as a nurse in intensive care. The range of care today is even better than in the early days due mainly to technological developments. When I was told about the complications I had survived I reflected that if this has happened when I was working in intensive care I would not have survived."

Dr Bryant was impressed by the multidisciplinary team environment that helped address her care needs.

"The collaboration that occurs between nurses and allied health professionals was evident in both Thailand and Australia," Dr Bryant said.

For most families, seeing a family member in the intensive care unit can be both frightening and confusing. Dr Byrant's relatives, however, reported receiving fantastic support from nursing, allied health professionals and medical staff.

"Every question was answered and we can be proud of the standard of care I received," she said.

Dr Bryant has continued her recovery with extensive rehabilitation at the Royal Talbot Rehabilitation Centre in Melbourne. Working hard in her rehabilitation, Dr Bryant saw rapid gains in her strength. Now at home, Dr Bryant is independent but requires a walking stick to get around.

ACN Executive Director - Commerical Division Helen Goodall and Dr Rosemary Bryant FACN at ACN's Melbourne VIP Cocktail Function.

"The care I have received both in Thailand and Australia has enhanced my faith in nursing and re-established the reason we all go into nursing – an interest in clinical care and people," she said.

Dr Bryant has immense faith in Australia's public health system and hopes that Australia continues to have universal health care.

The Australian College of Nursing would like to wish Dr Bryant a quick recovery and thank her for her ongoing dedication to advancing the nursing profession.

OUT AND ABOUT WITH ACN'S EMERGING NURSE LEADERS

By Katrina Horne MACN
ACN Emerging Nurse Leader
(2015 cohort)

Katrina Horne MACN

My appetite for research was ignited during the course of my undergraduate nursing degree at Southern Cross University (SCU) and this interest led to an invitation to join the HealthyU team as a methodologist/ research assistant.

As health professionals, we understand that the concept of health has a broad context and is not limited to the absence of disease or infirmity (World Health Organization, 1946). The HealthyU initiative is at the grass roots of providing that context to staff, students and the wider community. HealthyU (instigated by SCU Head of School, Health and Human Sciences, Professor Iain Graham) has its roots embedded in the highly successful United Kingdom model 'Healthy Universities' and SCU is a member of the Australian Health Promoting Universities Network established earlier this year.

SCU already has many strategies in place to support staff and student health, and I have been involved with the planning and implementation of a cross-sectional study to evaluate their health and the use of health and support services. Service providers and student representatives will also be interviewed to identify any potential service or access issues. The results will be reported using a mixed-method approach, with thematic analysis of qualitative findings providing context to the quantitative survey data.

There are many benefits to evaluating and asking service users and service providers what is needed. It ensures that the individual contribution and expertise of those at the forefront of service provision and service users are 'heard,' and that their needs are identified. Education is provided through the HealthyU six pillars of health model (mental, physical, spiritual, social, financial and environmental health) with this balance (or in reality, juggle) playing a key role in both staff and student productivity, success and retention. The findings inform SCU of the potential need for future health and support initiatives, and allows demonstration of their commitment to a Healthy University from a top down approach.

This opportunity allows me to further develop my skills in research in a way that enables me to give back to the university community that I have been a part of over the time of my nursing degree. I am part of an incredible team where we can share the pillars of health with our community.

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By Jenyfer Joy MACN
ACN Emerging Nurse Leader
(2015 cohort)

Jenyfer Joy MACN

To say that commencing my second rotation in Cardiothoracic High Dependency has been exciting would be an understatement. Each day, I witness how each action we take as health professionals has a massive impact towards our patient's wellbeing. From medication administration to physical assessments, it is overwhelming to think that one error or one misguided action, can change the course of recovery for our patients. It is more overwhelming to think that each day when I walk into work, that patients and their families place their trust in me practicing with integrity.

When I first started in Cardiothoracic High Dependency, one of the educators advised me to take the medication trolley with me into the patient room. At first I did not

> “This opportunity allows me to further develop my skills in research in a way that enables me to give back to the university community that I have been a part of over the time of my nursing degree.”
>
> – Katrina Horne

question or think twice about her advice. But as I continued taking the medication trolley with me, I got questioned as to why I would take the medication trolley with me by some colleagues. I simply replied that my educator told me to. I got a mixture of responses from raised eyebrows to hearing nurses complain about me ‘taking over’ the medication trolley. The nurse unit manager, most of the team leaders and the educators supported the practice but I could see that it delayed the medication administration round for my colleagues. As a newbie nurse, I felt stuck in the middle. On one side, I had all my colleagues who wanted to finish their medications on time and on the other side I had my educators and manager who valued safe nursing practice.

> “Each day, I witness how each action we take as health professionals has a massive impact towards our patient’s wellbeing.”
>
> – Jenyfer Joy

The nurses I work with are the best of the best and are intelligent. However, errors are inevitable especially when working in a rapidly-changing chaotic environment. As a newbie nurse starting out, preventing medication errors begins with me taking the medication trolley with me and starting with one tablet at a time.

By Evan Casella MACN
ACN Emerging Nurse Leader
(2014 cohort)

Evan Casella MACN

“By learning you will teach; by teaching you will learn” goes the old Latin proverb (author unknown). It wasn’t until a recent opportunity to take the ever daunting stage of pedagogy, that I was fully able to realise the wisdom in that saying. One last-minute request from a university lecturer and a rushed agreement was all that was needed to get this very unschooled teacher into a fierce third-year evidence-based practice class.

And fierce it was. Eyes like burning laser beams, sighs like artic chills and expressions that could break even the nerve of Chuck Norris, all validated my expectations that this was going to be a tough gig. Nonetheless as the class proceeded, words began to flow, and the passion that rocketed me into nursing took the wheel. To my astonishment the class took on a life of its own as students began to actively explore and take on the classical philosophy that underpins evidence-based practice. At that moment something beautiful happened – I realised I was but a vehicle – a window if you will – by which thousands of years of knowledge could be transported into the minds of the future.

> “There is something selfless and timeless in transporting knowledge across generations; something that connects the transporter to the knowledge more intimately and allows one to contribute to a fundamental aspect of humanity – the continuation and development of knowledge.”
>
> – Evan Casella

This was a humbling realisation that taught me the importance of being a learner and a teacher. There is something selfless and timeless in transporting knowledge across generations; something that connects the transporter to the knowledge more intimately and allows one to contribute to a fundamental aspect of humanity – the continuation and development of knowledge. As German Poet Johann Wolfgang von Goethe once said “he who cannot draw on three thousand years is living from hand to mouth” (1981).

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ACN AND THE ARC – A 40 YEAR ASSOCIATION

> "I encourage others to consider representing ACN in forums where we get the opportunity to give our profession a voice."

By Tracy Kidd MACN

Tracy Kidd MACN

The Australian College of Nursing (ACN) provides valuable insights and recommendations from a nursing perspective on a wide range of health care issues at a state and federal level. ACN has representatives on various peak health bodies throughout Australia, one of which is the Australian Resuscitation Council (ARC), now known as the Australian and New Zealand Committee on Resuscitation (ANZCOR). The ARC was established in the mid-1970s and ACN (then known as the Royal College of Nursing, Australia) has been a member organisation since 1976.

My nursing background is in emergency and critical care in both metropolitan and regional settings. I have also been in nursing education roles since 2000 and currently run a continuing nursing education program throughout the Loddon Mallee Region of Victoria. I have a keen interest in nursing education in general and resuscitation education in particular.

I was nominated by colleagues to represent ACN on the ARC and it was my privilege to take up this role in April 2013. ACN is one of four nursing member organisations on the committee. Other member organisations include medical, surgical, anaesthetic, paediatric, neonatal, paramedic, first aid, surf life saving and military organisations. This diversity of expertise from around the country helps to provide a wide range of experience, perspectives and contexts to the review of issues in relation to resuscitation in Australia and New Zealand.

The ARC, whilst best known for producing guidelines, has several functions and objectives which:

- provide a forum for discussion of all aspects of resuscitation;
- foster interest in, and promulgate information regarding resuscitation;
- gather and collate scientific information regarding resuscitation techniques; to recommend a modification of those techniques where appropriate on the basis of such information;
- promote simplicity and uniformity in techniques and terminology regarding resuscitation;
- provide an advisory and resource service regarding techniques, equipment, teaching methods and teaching aids;
- foster research into methods of teaching and practice of resuscitation;
- pursue the development of standards for training;
- establish regular communications with other bodies with similar objectives, both in Australia and overseas;
- consider and advise on the means of preventing circumstances in which resuscitation may become necessary;
- do all such acts and things as are incidental, or subsidiary to all or any of the above objectives (Australian Resuscitation Council (ARC), 2016).

The ARC guidelines are produced using a pre-determined stepwise process and after consideration of all available scientific and published material. Guidelines are then only issued after acceptance by all member organisations. ANZCOR is also part of the International Liaison Committee on Resuscitation (ILCOR). Where ILCOR drives the international scientific evidence review process, the job of the ARC is to develop guidelines to reflect local implementation of resuscitation science.

The ARC meets three times per year and holds the biannual Spark of Life Conference. At each meeting, held across two days, we hear reports from the Executive Committee, all state branches and the sub-committees. Currently the sub-committees are Basic Life Support, Advanced Life Support, Acute Coronary Syndromes, First Aid, Paediatric and Neonatal. As of March 2016, there is also an Education and Training sub-committee that I have become a part of. Each member is also given the opportunity to provide any relevant feedback, information or events from the member organisation they represent. During the course of the meeting, guidelines that are due for review are discussed at each stage of the review process. Most recently, this focus has been driven by the ILCOR process that resulted in 47 of the 75 existing guidelines being replaced in January 2016. The new guidelines draw on the findings within the latest international consensus statements on resuscitation released in October 2015.

Outside of this international process, there are guidelines and issues to be followed up locally. These are sometimes driven by national updates by peak bodies that will impact resuscitation practice in Australia. One example of this was the Australian Society of Clinical Immunology and Allergy (ASCIA) that held a summit on Allergy and Anaphylaxis in August 2014. The ARC was asked to be present as one of the key stakeholders in this summit, the first of its kind in the world. Both myself and another nursing representative from ARC attended the summit and participated in the subsequent working groups. This collaboration resulted not only in the production of a national allergy strategy for Australia; it also resulted in updates to the ARC guidelines in order to ensure that recommendations were consistent between the two organisations.

ARC also acts as a resource for anyone wanting authoritative material on resuscitation and regularly responds to queries from individuals or organisations. Sometimes there is also a need to respond, as a committee, to controversial publications that may cause confusion regarding best practice for resuscitation. These responses are published as press releases on the website. Some of the issues addressed in this way have included therapeutic hypothermia after cardiac arrest and also concerns with the Automated External Defibrillator Deployment Registry.

In my time on the ARC, I have had the opportunity to learn a great deal from many others on the council. I have helped to review guidelines, represented the ARC at other forums, been involved in educational activities, been involved in the running of the Spark of Life Conference and helped to provide both a nursing and a rural/regional perspective when needed. I encourage others to consider representing ACN in forums where we get the opportunity to give our profession a voice. It is both a privilege and an honour to do so.

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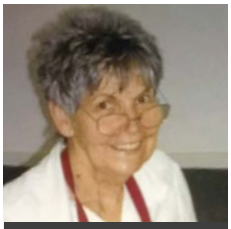
WALK LIKE THE EAGLE! NURSES PROVIDE THE BALANCE IN AGED CARE DELIVERY

By P.D. Macbeth MACN



P.D. Macbeth MACN

Have you ever watched an eagle? Those glorious wings soaring, effortlessly floating on the thermals; keen eyes observing all below, watching for opportunities; the magnificent master of the environment they survey. Coming down to land is not so pretty but capable. Neatly folding those glorious wings, with feet spread for a balanced landing, the eagle proceeds to walk very carefully.

Walk like the eagle – very carefully! The Canadian Cree philosophy (Wilson, 2008) on life's vagaries immediately springs to mind when I think about ageing patients. I see the ageing process very similar to the eagle in its glory. Human beings floating through their middle lives, healthy, functional and glorious, and as they move into the sometimes debilitating changes that old age brings, they must also fold life experiences, spread their feet to maintain their balance, and like the eagle, move forward with considered care.

The proven increase in numbers of ageing persons in our society has meant new challenges for all organisations competing to provide quality care to people categorised by this new cultural phenomenon. History reminds us that nurses have always made significant contributions to patients' recovery in hospitals; while community nurses use their skills to enable people to function capably in their home environment. With the necessary influx of inter-disciplinary practitioners and emerging scientific discoveries; the diversity of nursing practice is pivotal to effectively inter-connecting allied health practitioners and engaging participants in care. Taylor (1994, pg. 3) said "as a human relationship, nursing is made therapeutic by the humanness of interpersonal encounters."

AIM

The aim of this article is to show that the primary health care nurse plays a pivotal role in the mix of allied interdisciplinary practitioners, who in providing current programmed consumer-directed-care, tend to segment the patient/consumer into disease components. When practitioners collaborate mindfully in interaction and cooperate with the holistic community nurse in an ethically viable relationship; this trust enables, empowers and recognises that patients are an active participant in their own wellness and wellbeing.

METHOD

The methodology is using an overarching qualitative genre; an authentic ethnographic approach combined with Indigenous philosophies of respect, reciprocity and relationships. Knowledge that embraces reflective and retrospective narrative, tells the stories of how people feel rather than categorising and stereotyping people into groups that are conveniently politically, geographically, statistically and culturally expedient. The evidence is in the multiple works of researchers, academics and conversations with colleagues that advise and inform the discussion. Confidential formal and informal referrals between practice nurses, doctors, pharmacists, podiatrists, diabetic educators and dieticians is the key to effectively working together for best outcomes for the patient.

BACKGROUND

Looking at the past informs the present context. In the 1970's and 1980's, following an ability-threatening injury, trauma or other health-limiting episode in their lives, damaged and vulnerable people were hospitalised for quite long periods of time, sometimes many months, as their bodies healed. The orthopaedic ward consisted of young people (predominately male) following accidents and 'old' women (post-menopausal) with fractured hips, confined in their bed and restricted by a Hamilton Russell traction for at least three months. Hospital-based nurses working with vulnerable people needed to learn special skills to be able to address and understand the physiological, psychological and social changes to these patient's lives. Emphasis was on ethical clinical duty of care and professional one-on-one contact with the patient; and to a lesser degree, knowledge of the patient's home environment and the extended network of significant people in their lives.

In the late 1980's and into the early 1990's, there was a need to reduce length of stay costs by freeing up beds for an increasing number of people being admitted and sometimes being re-admitted to hospitals that could have been prevented by careful consideration of their home circumstances. Diagnostic Related Groups (DRG's) and Casemix policies were introduced and formally implemented in practice. It was at this time, predominately motivated by two pilot papers, one from the Prince of Wales Hospital in Sydney and the other by a specialist orthopaedic nurse working in the Royal Rehabilitation Hospital in Perth, that I ventured into the community to help people immediately cope with changes at home after leaving hospital. I discovered the greatest limitation to mobility was uncomfortable and neglected feet. This simply resulted in a morbid fear of falling, which is consequential to an increasing sedentary lifestyle. I was in my professional element and I had learned the skills. Attention to primary prevention

and reducing risk factors that have further implications for deteriorating health, is the necessary ideology that motivates and energises the professional foot-care nurse.

The Australian Government announced on 20 April 2012 a decade-long plan to reshape aged care. They explained that they were "committed to assisting people to remain living in their own homes for as long as possible, with the number of operational Home Care Packages to increase to around 100,000 across Australia" (Australian Government Department of Health, 2016). These consumer-directed-care packages relied on allied inter-disciplinary health practitioners working in collaboration with traditional health care service providers and controversially changed the dynamics of acceptable and recognised home care. The art, science and spirit of nursing care remains relevant in the mix. As suggested by the Australasian College of Care Leadership and Management we need to:

"Develop the skills needed to build strong partnerships in care delivery...Both nurses and care staff...need to have higher skills of person-centred-support that connect the greater power of choice now placed in the hands of consumers" (2015).

The Australian College of Nursing is attentive to primary and preventative health care rather than having a determined focus on the implications of disease for effective health care delivery. Adjunct Professor at Sydney University and Past President of the Australian Medical Association Doctor Kerryn Phelps said in response to a question regarding the current clinical focus on disease and the need for preventative health care at the 2016 Aged Care Conference that "we should invest in nurse prevention...rather than spending money on expensive tests."

In an interview with Dallas Bastian on Nursing Review, Anne Marie Hill stated that health care services need to "focus on prevention and risk reduction; and firstly take more seriously, chronic disease prevention as it equates to 66% of the total burden of disease" (Bastian, 2015). She noted that "at least 31% of the total burden of disease in Australia is preventable" (Bastian, 2015).

The increasing incidence of aged person's falling has been of concern to health workers for over two decades. Falls health science previously centred on awareness of, and implications for the possibility of aged persons falling who are diagnosed with a chronic disease, medication and general debility. It is encouraging to see the field moving into prevention techniques. The following testimonies attests to the seriousness of this work:

1. Dr Ann-Maree Vallance, summarising her research in an interview on aged care insight said "the nature of a major fall is obvious – loss of independence and admission to aged care, improving voluntary motor control will have a significantly positive effect on families and communities" (Bastian, 2016).

2. Bronwyn van der Merwe (2016) stated on Nursing Review that "wearable devices made to track and log data are putting the focus on self-monitoring and reducing costs." Her concern is Australia's health system is "incentivised by activity-based, rather than value-based outcomes."

3. As a foot-care nurse, I am very much in tune with Jill Campbell, a PhD candidate at Queensland University of Technology, when she says that it is necessary to shift paradigms from preventing specific individual skin injuries to a more comprehensive view of skin safety and integrity as a whole (Campbell et al., 2016).

I once worked with a patient who had been living alone, quite isolated, on an outback property more than a hundred miles from town. Brought in to the hospital to be seen by the aged care assessment team the attending doctor asked me to visit her for foot, nail and skin care. Walking into the four-bed ward I saw two patients opposite her tittering and whispering behind their hands, entertained by this skinny, scrawny, unkempt, possibly frightened, resisting and defiant woman with wary watchful eyes, who reminded me of a feral kitten. I focused all my attention on her, probably ignoring the other patients and the staff that popped in and out. I, another stranger, first had to gain her trust and confidence in my touch, as she screeched "what are you doing?"
I calmly went about preparing the ritual tasks to relax her and so that she would know that I wasn't going to hurt her. Once her skin had been cleaned, toe and finger nails duly trimmed, buffed and smoothed, and there was no skin lesions that could potentiate problems, I began mindfully using a moisturiser to gently massage the dry skin on her arms and lower legs to improve viable skin tone. The whole room went absolutely quiet, and it was then that we heard the sound; she was purring! Just like a kitten. I didn't know human beings could purr; but this one did. How sublime was that?

SUMMARY

Community nurses provide the balance between the plethora of practitioners providing programmed care and connecting with the lived experiences of aged and debilitated persons who are the recipients of that care. Collaboration between nurses and allied practitioners is the key to cost-effective preventative care. Participatory action is emphasised in ordinary human relationships. Foot care nursing exemplifies this as a ritual ceremony that attends to the mundane in ageing people's lives and encourages patient participation; when due to limited vision and reduced physical capability they are unable to competently do it alone. The resulting sedentary lifestyle neglects basic needs and further impacts negatively on optimum health and outcomes for social and emotional wellbeing. Just like the eagle landing after a glorious flight, human beings also need to fold our experiences, reset our balance, embrace a new kind of independence and move forward with considered care.

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WHAT HAPPENS WHEN WE HAVE THE COURAGE TO EMBRACE WHO WE TRULY ARE?

By Adjunct Professor Kylie Ward FACN
Chief Executive Officer, ACN

Adjunct Professor Kylie Ward FACN

I have made it my life's purpose to honour and protect those things that make me different. To acknowledge rather than dismiss or supress my individuality. And I look for this in others. I look for what makes individuals, and the people in the team around me, different and how this can be celebrated.

From 4–7 August 2016, I attended the Garma Festival to better educate myself on Aboriginal culture and listen to concerns expressed by Aboriginal leaders regarding health, economy, constitution and culture. Arriving at the Garma site in Nhulenbuy was like walking on an artist's palette. The richness of the colours of the trees, the sky and the earth – the green, the blue and the dusty red. The air was fresh and the sky reminded me of how small we each are individually.

Walking into the campsite I realised that Garma was going to be like every society, community and gathering with a ranking system. I didn't attend with a corporate group rather as an individual. The symbolism of this meant that I got a small tent, no campfire setting, no facilitated discussions with local people and no invitation to the formal dinner. I also very much missed appliances I have become accustomed to like hairdryers and straighteners that form part of my preparation ritual. Apart from this, I got to attend the education sessions, the art and culture sessions, the ceremonies and feel naturally connected to mother earth.

My intention in attending this event was to listen and to learn, and to see if there was something I could do as CEO of ACN and a member of the Close the Gap Steering Committee that would be relevant and effective.

The ceremonies were stunning and it felt very special being invited to join in the dancing. The spirit and energy of the sacred land was grounding and, with the calmness of the environment, my non-dominant senses had a chance to be exercised. Listening extended not just to the education forums but to the environment. The wind through the trees sounded like a gentle chatter and the birds created a beautiful background melody.

I knew very few people and being relatively new in this role (eight months), I wasn't connected to who I 'should know'. I decided to allow universal intelligence to play a hand in who I met. I knew intuitively that I would meet who I needed to meet and that the answers would come as they were meant to. And of course, this approach worked beautifully.

There is nothing like breaking bread with people. The conversations and the people you meet by having a communal eating place gives me a newfound respect to go and have lunch in my staff cafeteria and workplace, rather than eating at my desk so I can keep working.

Words that keep coming through in people's messages and that strongly resonated with me throughout this experience were unity and balance. Balance to me has never meant working eight hours, playing eight hours and sleeping eight hours every day. It means following your heart and feeling good about what you do. Unity resonates within me as acceptance of differences, not the disease of sameness, and from standing in compassion and not judgement, towards others.

Balance for me professionally means doing my job well, no matter how many hours it takes because it feels right and I'm passionate about it. I'm privileged to work in a supportive environment and as a leader it is my responsibility to create that for the teams I influence. Everyone has the right to feel fulfilled, stretched and a part of something great.

Following the Garma Festival, I visited Gove District Hospital and met with the General Manager Lisa Pullen, Community and Primary Care Director of Nursing Janet Rigby, and Acting Director of Nursing and Midwifery, General Manager Mary-Clare Arkoll. What an inspirational team of nursing leaders. Thousands of kilometres are covered and just as many people to care for by this highly skilled clinical workforce. I was reminded how important remote area nurses are and what an exciting, challenging and important career this is. You really have to be here amongst it to understand the complexities of access, weather, logistics, cultural sensitivity and the importance of relevant education and professional development to keep the nurses highly skilled.

From trauma nursing to chronic disease management, these incredible nurses get to see such diversity. They are so important to the wellbeing of communities throughout such arid lands of our vast and beautiful country. I am still understanding how I can make a difference professionally to respect Aboriginal and Torres Strait Islander (ATSI) peoples, and contribute to improving their health outcomes and experiences. I will not learn this alone. I will work closely with The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives CEO Janine Mohamed and others who will guide me.

Personally, my take home message was wise words from the Former Australian Human Rights Commission, Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Goodah. He shared with me that everyone thinks about what they can do externally. He suggested to start from within. Learn the land I was born upon. Acknowledge this land each time I meet ATSI peoples. I have enjoyed taking Mick's advice. I grew up in Emu Plains, NSW. The local Darug people were known as the Mulgoa who lived a hunter-gatherer lifestyle governed by traditional laws, which has origins in the Dreamtime. I will continue to enjoy discovering the traditional owners of the land I was privileged to be raised upon. I encourage each of you to do the same.

ACN CEO Adjunct Professor Kylie Ward FACN with the Recognise team.

ACN CEO Adjunct Professor Kylie Ward FACN and South East Sydney Benevolent Society Aboriginal Senior Practitioner Sharlene McKenzie.

ACN CEO Adjunct Professor Kylie Ward FACN at Gove District Hospital with Acting Director of Nursing and Midwifery, General Manager Mary-Clare Arkoll, and Community and Primary Care Director of Nursing Janet Rigby.

ACN CEO Adjunct Professor Kylie Ward FACN at the Garma Festival.

Former Australian Human Rights Commission Aboriginal and Torres Strait Islander Social Justice Commissioner, Mick Gooda, with ACN CEO Adjunct Professor Kylie Ward FACN.

Leader of the Opposition and Shadow Minister for Indigenous Affairs and Aboriginal and Torres Strait Islanders, Bill Shorten, with ACN CEO Adjunct Professor Kylie Ward FACN.

ACN CEO Adjunct Professor Kylie Ward FACN with Brigid Coombe MACN.

MY BLACK SATURDAY – A NURSES' JOURNEY TO REBUILD HER LIFE FROM ASHES

> "Before the fires, I dreamed of becoming a Gerontic Nurse Practitioner... This dream went out the window as my life as I knew it became consumed by the fires."

By Jane Carey, MACN, IGKHS, RN, B.Ap.Sci (Adv Nsg), M.Ed.St (Res Meth), M.Nsg.Sci (Nurse Pract)

Jane Carey MACN

On Saturday the 7 February 2009, a day now known as Black Saturday, a series of bushfires burned in the state of Victoria under the worst bushfire weather conditions ever recorded. The deadly combination of high winds, extreme heat, low humidity and the most severe drought in Australia's history lead to a number of uncontrollable blazes across the state. The fire completely destroyed the towns of Kinglake, Narbethong, Flowerdale, Marysville and Strathewen, while many other towns suffered serious damage. The total area destroyed that day was more than a million square kilometres – the size of a small country (N/A, 2016).

As a result of the fires 173 people died, 414 people were injured, 2,030 houses were destroyed and 3,500 structures were ruined with thousands more suffering serious damage (N/A, 2016). With damages equivalent to 400 Hiroshima-style atom bombs going off, this was the worst recorded bushfire in world history (N/A, 2016).

Black Saturday had an incredible impact on the life of my husband and I. We lost everything we owned, apart from our cars and the clothes we were wearing. My cheeky cat perished in the bushfires and my beautiful little dog had a stroke from the stress of living in a caravan for 16 months following the destruction of our home. We were the family historians and we lost a lot of heirlooms and family keepsakes, which we had been collecting over the years. My husband lost his beloved motorbike too.

We suffered a significant financial loss. Like so many others, we were underinsured and didn't have enough money to rebuild. Due to a diagnosis of Post-Traumatic Stress Disorder and Agoraphobia in 2013 as a result of the fires, I am no longer able to work. This has meant my husband has gone back to work, significantly slowing the progress on the house and limiting our earning capacity. Our income has reduced by 50% of what it was before the fires.

However, we lost more than just tangible items that day. We also lost our lifestyle and our sense of community. Before the fires, my husband and I would just do as the day dictated – whether that be watching the trees in the rain from our verandah, a drive in the country, or coffees and cake on Lygon Street. Now our lives revolve around rebuilding our home and our lives.

Our community also became divided after the fires into those who lost their homes and those who didn't. People became greedy, people became 'victims', and life became difficult.

I read an article once, where a survivor had likened this experience to walking through a solid door and having it slammed shut on you, with you never being able to open the door again. Unfortunately, my door has a window in it and I can see through it to what my life used to be like.

Before the fires, I dreamed of becoming a Gerontic Nurse Practitioner. I was well on my way to achieving this dream, having just completed my Masters of Nursing Science (Nurse Practitioner) Degree and awaiting my results. This dream went out the window as my life as I knew it became consumed by the fires.

The results for my thesis arrived via email, after I contacted the university from my mother's house two days after the fire (my results had been posted to my house the Friday before). I received a High Distinction for my thesis. My thesis focused on Drug Administration and Drug Interactions in the Aged Population. I earned high enough results to become a member of the Gold Key International Honour Society but by the time we had rebuilt our home and I was ready and able to return to work, this reality had

The deadly combination of high winds, extreme heat, low humidity and a severe drought lead to a number of uncontrollable blazes across Victoria.

become only a dream again, as the rules had changed, and my degree from the University of South Australia, was no longer recognised.

In one day, our whole lives changed and we have been rebuilding them ever since. Following the hurried evacuation of our beloved home and within 12 hours of us arriving at the evacuation centre, the State and Commonwealth Government, and Red Cross arrived and we were able to register with them and start accessing services that would assist us on the long road to rebuilding our lives.

We had nowhere to live, no food, no clothes or personal hygiene items. All the things you take for granted, we lost. Three days after the fires, my husband's friends dropped off a caravan for us to stay in. We stayed in the caravan on one of our son's co-workers land in Whittlesea. We had never met them before but they let us live on their block, using their power, water and bathroom facilities for three weeks. Staying in Whittlesea meant I was able to visit the Bushfire Relief Centre each day and find out what was available to us. We were provided with access to telephone providers, insurance companies, government agencies, banks, the Red Cross, church groups and various charities. During this time, Pete resigned from his job, which he had held for about 20 years.

We returned home, to live in the caravan on our land, on Wednesday 25 February 2009, with black cockatoos flying overhead to welcome us home. The caravan had no bathroom or toilet facilities. Initially we were able to use a neighbour's bathroom facilities but after a while, we found it difficult and awkward. At this time, we would only shower one day per week, with washes between, when we could find a communal shower with gas or water. This continued until the day of my birthday, almost six months after the fires and five months after we moved back onto our land, when we received a portable shower and toilet through the generous donations received by the Victorian Bushfire Authority.

Throughout this experience, the church, charities and community organisations were wonderful. They were there for us and they were of help to us in many ways, from giving us petrol vouchers so we could travel to purchase tiles or paint, to providing us with the money for curtains, a water pump, a heater for the caravan in winter, replacement gas cylinders and an air fryer so I could cook food for Christmas dinner. They also provided us with a 'start-up pack' for when we moved back into our home. This included a mattress, fridge, washing machine, sheets, towels, and more.

There were many types of services available to help us during this time, from the RSPCA giving us beds for our dogs to local farm suppliers offering us discounts on services to assist with the rebuild. The most important service, aside from those offered by the church and charities, would have been our case management.

We had two registered nurses assigned to our case, Bernadette and Janet, as well as a social worker, Jane. They were brilliant. They were there for us through our dark days and our shining days, and alerted us to anything that may have been of benefit to us.

We nicknamed Bernadette 'St. Bernardette' and call Janet 'her partner in crime' for the help and support they have so kindly given to us. Bernadette was our primary case manager but Janet frequently visited with her and was there for us too. On one occasion, our builder and his crew were less than happy with us as we had drunk

Devastation after the Black Saturday bushfires

champagne (for morning tea) to celebrate either Bernadette or Janet's 50th birthday and forgot we were meant to buy them lunch! From champagne at 9:00am, to celebrating birthdays, to warm jackets in winter, to sheet music and a laptop from Bernadette's own home for Pete, to a special pillow from her physiotherapist so I could sleep properly, to assistance with filling in Grant papers, to a market umbrella to protect us from the sun – our St. Bernard-ette and her partner in crime were an endless source of comfort and support during this time. To this day, we still see Bernadette and Janet, and now call them friends.

In January 2011, when Queensland had floods, Bernadette rang me to ask me what I would have liked to receive in the first days after the fires, as she was going to Queensland to work with the flood victims. My response: a toothbrush; toothpaste; a face washer and a cup of coffee! Bernadette indicated she was going to ensure she provided these to the people who needed them. This is just a small example of the kind of person that Bernadette is.

There have been many people who opened their wallets and hearts to help us out over the years. Without their generosity, we would not have been able to rebuild our home or lives. This is humankind at its best. The people of Victoria gave us the money and support we needed to rebuild our lives. This is what community is – looking out for each other and making sure each other is okay.

Our friends and our family were also an enormous support. Friends gave us items, friends-of-friends gave us items, and our family were there to offer moral support, and a hot shower and a hot meal when we visited. You always like to think that your family and you friends will always be there for you when you need them. This is so true in our case.

We replaced my husband's beloved Yamaha TRX 850 motorbike last weekend. When explaining why we did this to my mother, she asked what I needed to allow me to heal. My reply was to turn the clock back to 2008. I still dream of my pre-bushfires home, when life was simpler and we had a lifestyle we enjoyed.

Since 2009, life has been tough but we are tougher, and we have survived. We will continue to survive the challenges we are faced with and to be a couple who are there for each other. At the end of the day, we are still here and that is what matters.

References

N/A 2016, Black Saturday Fires, viewed 19 September 2016, <http://blacksaturdayfires.com/>

Editor's note:

ACN would like to take this opportunity to acknowledge nurses like Bernadette and Janet who go above and beyond their job description to offer support, comfort and care to people in disaster situations. Whether it's disaster preparedness, response or recovery, nurses bring expertise and leadership to many disaster management teams and operations. If you are a nurse working in disaster management or have a professional interest in disaster health, join our Disaster Health Community of Interest (COI). Visit our website: www.acn.edu.au/regions-communities to join this special interest group.

ACN would also like to extend our deepest sympathies to all those who lost their lives, loved ones, pets, livestock and homes as a result of the Black Saturday bushfires.

NURSING THAT TAKES YOU PLACES

Captain Katrina Kelly

Nursing in the Army has given Captain Katrina Kelly opportunities not available in a civilian career. Katrina has trained as an aviation nurse and practiced her skill from helicopters and ships; she's deployed on operations; undertaken graduate study; and even undertaken training roles.

She said her deployment to Afghanistan in 2014-15, in a United Kingdom-led mentoring mission, was her most satisfying role so far. Deployments test individuals' professional, mental and physical capabilities. Nurses in a deployed environment play a role in primary health care, pre-hospital emergency care, evacuation of casualties, and surgical support.

Katrina demonstrated that she has what it takes, receiving a commendation for 'distinguished performance of duties in warlike operations' for her work in Afghanistan. "I was there for seven months and my work focused on health and well-being management, primary health care, emergency and working with soldiers," Katrina said.

During that deployment there was a mass casualty from an insider attack at a Defence University. Katrina's citation states that her level-headed actions following this attack had a "force multiplying effect that aided the critical treatment and extraction of 14 casualties".

Back in Australia, Katrina is currently the officer in charge at the Soldier Recovery Centre in Darwin. The centre works collaboratively with health professionals to assist wounded, injured or ill soldiers with a wide range of complex needs. Katrina said the work changes on a daily basis and it's very rewarding. "What I like most is the ability to influence the stigma of injury and mental health; and assisting soldiers to get from point A to point B in a really positive environment."

Katrina said her Army career has also enabled her to expand her qualifications. She has completed a Graduate Certificate in Emergency Nursing; will complete a Masters (Nurse Practitioner) this year; and is currently studying for an additional Graduate Certificate in Rural and Remote Nursing.

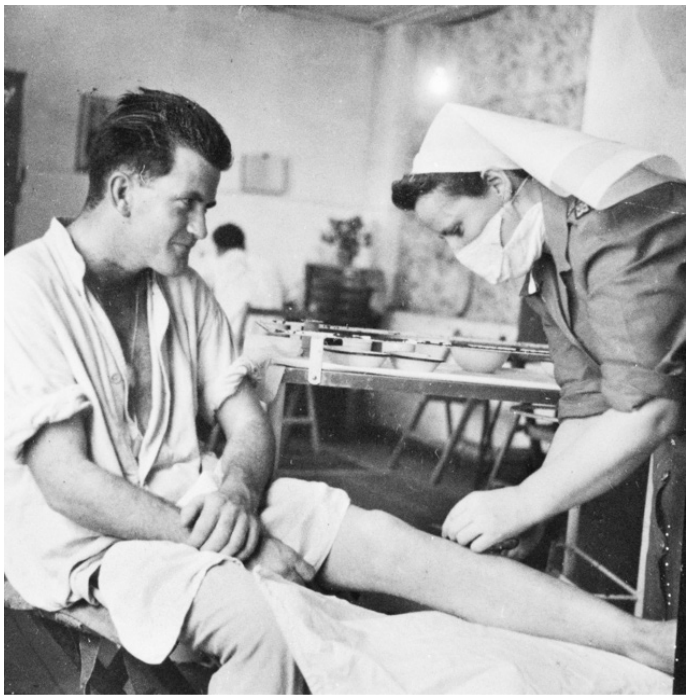
The Army has also provided her with the opportunity to develop her leadership skills. Army Nursing Officers take on management, administrative and command positions. These roles develop their skills and professional opportunities beyond the purely clinical.

It is a career that offers variety, challenges, travel and the means to gain experience and skills that are in high demand. The Army recruits Nursing Officers from most specialisations, and is especially seeking nurses with postgraduate, general, emergency, perioperative and intensive care qualifications.

To find out more visit defencejobs.gov.au/army or call 13 19 01.

COLONEL NELLIE JANE ESPIE

AM RRC FACN



> "Nell was a valued Fellow of ACN, distinguished nurse leader and trailblazer for women in the Australian Defence Force."

Born in Oatlands, Tasmania, in 1924, Nellie (Nell) Jane Espie trained as a nurse through the 1940s. She trained at the Royal Hobart Hospital, King George V Hospital, and at the Tasmanian Department of Health. She also undertook Nursing Administration and Community Health Nursing courses at ACN (then the College of Nursing). After a number of years nursing, Nell joined the army when the Korean War broke out.

In 1951, Nell was commissioned as a Lieutenant with the Royal Australian Army Nursing Corps (RAANC) and posted to Ingleburn, NSW. From here, she went on to be a Charge Sister and Ward Sister in Japan, Korea, Duntroon, Malaya, Queensland and Victoria. Nell then became Matron of the Australian Field Hospital, Vung Tau, in South Vietnam in 1969.

Throughout the course of her career, Nell was promoted through the ranks to Captain, Major, Lieutenant Colonel, Colonel Director of Nursing Services, Queens Honorary Nursing Sister, and the RAANC Honorary Colonel and Representative Honorary Colonel. In 1981, following a distinguished career and after 30 years' of service, Nell was discharged from the army. At that time she was Matron in Chief of the RAANC and Director of Army Nursing.

Following retirement, Nell returned to her home town in Tasmania where she established a state branch of the RAANC. Nell later became the RAANC's National President. She held this position from 1990 to 1994, and was awarded a life membership in 1997. Over her 50-year involvement with the Oatlands Sub-Branch of the Returned and Services League of Australia (RSL), Nell also served as the Treasurer and President. In 1995, she was made a Life Member of the RSL and in 2004, received a Meritorious Service Medal.

Nell was the driving force behind many committees, including the Florence Nightingale Trust, and worked tirelessly to assist many veterans, war widows and dependants in obtaining their entitlements through the Department of Veteran Affairs. She received many awards for her service to our country and our profession. Her accolades include a National Medal, the Royal Red Cross, Member of the Order of Australia, and the Centenary Medal.

Nell was a valued Fellow of ACN, distinguished nurse leader and trailblazer for women in the Australian Defence Force. She was an inspiration to all nurses and will be missed by the many people whose lives she touched.

ACN would like to extend our deepest sympathies to her family and friends at this time.

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