ACN

thehive

#10 WINTER 2015 | SUPPORTING OUR NURSE LEADERS

UNDERSTANDING DIFFERENCES
reflection on clinical placement in Lao

THE NATIONAL NURSING FORUM
special preliminary program and speaker profile lift-out

REGIONAL ROUNDUP
International Nurses Day

Clinical Care Standards

Clinician Fact Sheet:

Antimicrobial Stewardship

The goal of the Antimicrobial Stewardship Clinical Care Standard is to ensure that a patient with a bacterial infection receives optimal treatment with antibiotics. This means that patients are offered the right antibiotic to treat their condition, the right dose, the right route, at the right time and for the right duration. This should be based on accurate assessment and timely review as to lessen the risk of adverse effects and reduce the emergence of antibiotic resistance.

UNDER THIS CLINICAL CARE STANDARD

A patient with a life-threatening condition due to a suspected bacterial infection receives prompt antibiotic treatment without waiting for the results of investigations.

A patient with a suspected bacterial infection has samples taken for microbiology testing as clinically indicated, preferably before starting antibiotic treatment.

A patient with a suspected infection, and/or their carer, receives information on their health condition and treatment options in a format and language that they can understand.

When a patient is prescribed antibiotics, whether empirical or directed, this is done in accordance with the current version of the *Therapeutic Guidelines* (or local antibiotic formulary). This is also guided by the patient's clinical condition and/or the results of microbiology testing.

When a patient is prescribed antibiotics, information about when, how and for how long to take them, as well as potential side effects and a review plan, is discussed with the patient and/or their carer.

When a patient is prescribed antibiotics, the reason, drug name, dose, route of administration, intended duration and review plan is documented in the patient's health record.

A patient who is treated with broad-spectrum antibiotics has the treatment reviewed and, if indicated, switched to treatment with a narrow-spectrum antibiotic. This is guided by the patient's clinical condition and the results of microbiology tests.

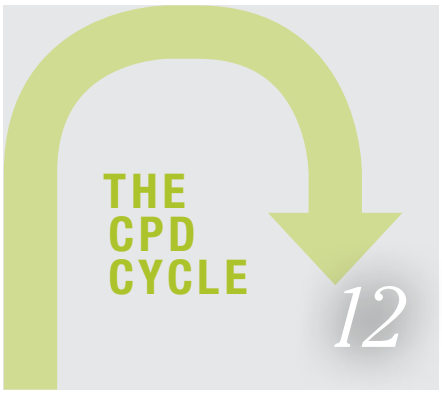
If investigations are conducted for a suspected bacterial infection, the responsible clinician reviews these results in a timely manner (within 24 hours of results being available) and antibiotic therapy is adjusted taking into account the patient's clinical condition and investigation results.

If a patient having surgery requires prophylactic antibiotics, the prescription is made in accordance with the current *Therapeutic Guidelines* (or local antibiotic formulary), and takes into consideration the patient's clinical condition.

More information on the Clinical Care Standards program is available from the Australian Commission on Safety and Quality in Health Care website at **www.safetyandquality.gov.au/ccs.**

thehive

#10 WINTER 2015
SUPPORTING OUR NURSE LEADERS
(June – September)



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PUBLISHING DETAILS

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WELCOME

Adjunct Professor Debra Thoms FACN (DLF)

“We feature a number of insightful and inspiring articles to get you thinking and motivated about where you might want to take your career as an existing or future nurse leader...”

Welcome to the winter edition of *The Hive.* In this edition we adopt the theme *Supporting our nurse leaders* where we focus on some of the ways in which our nurse leaders are working to help drive systems change and get the best possible outcomes for patients, communities, and the profession. We feature a number of insightful and inspiring articles to get you thinking and motivated about where you might want to take your career as an existing or future nurse leader, including how you might identify, build, and demonstrate those leadership qualities needed to get you there.

We have important articles by Molly Pullukaran and Leone Pike who take a practical approach in discussing the continuous professional development (CPD) and management educational elements involved in developing an effective nurse leader. Complementing these is Laurie Bickhoff’s pertinent and timely article on the role of social media in supporting and enhancing nurse education – a must read for even the most technologically averse nurses.

Adding to these articles are some very inspiring and motivating stories that will no doubt remind all of us why exactly we became nurses. Mandy Cleaver provides a personal and touching piece on life as a palliative care nurse, Musette Healey offers a poignant reminder of how such small, seemingly insignificant gestures can make such large, life-changing differences in other peoples’ lives, and Elisabeth Coyne, Josea Arneli Polong Brown, and Hazel Rands give a first-hand account of a nursing placement in Laos, where students got to experience the social determinants of health first hand, and also learn invaluable skills in how to overcome cultural and communicative barriers to deliver the best possible care.

In addition to these, we have the ‘Policy Snapshot’ from ACN’s Policy Team, contributions from our regular columnists, interviews with some of our Communities of Interest (COI) Key Contacts regarding their experiences as nurse leaders, the ‘Regional Roundup’, a lift-out of the Preliminary Program for our National Nursing Forum 14-16 October 2015, and finally, information on a newly launched initiative: The ACN Melbourne Region Leadership Group. We hope you enjoy the read.

PUBLICATION GUIDELINES

We love to see member submissions in *The Hive*. If you’re interested in having your submission considered for publication please follow our publishing guidelines.

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

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

Spring 2015 - Nursing Leadership - standards for practice and why we need them

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

OUT AND ABOUT

The last few months have been busy with various meetings, including the International Council of Nurses (ICN) 2015 Conference in Korea. Staff in the Sydney Office have been preparing for their relocation to the new Parramatta office, which is on track to open its doors on Monday 20 July 2015. Once opened, it will see all Sydney services situated together on one floor.

I was pleased to be able to attend part of the History Conference auspiced by the History Community of Interest (COI). An interesting range of speakers were on the program and the theme of *Disrupting Discourses: new views on nursing history* was evident. The Primary and Community Health COI has also been active, preparing for the Primary and Community Nursing Week which is to be held from 21-27 September 2015. It is good to see the COIs active in this way and thanks must go to the members who have taken a lead role in assisting them to bring these activities to fruition.

Much of June was taken up with activities related to the ICN. The President Carmen Morgan and I first attended the Global Advisory Panel on the Future of Nursing (GAPFON) convened by the Sigma Theta Tau International Honour Society for Nursing. The two day meeting workshopped priority issues in health care and strategies to address these, including what success would look like. There was considerable discussion among attendees on the issues identified and also on how the GAPFON work aligned with work being undertaken by other organisations, such as ICN. In addition, there was a discussion on the Human Resources for Health work by the World Health Organisation (WHO), and also on the failure of WHO to fill the Regional Nurse Adviser position in the Western Pacific Regional Office. A media release was issued at the end of the meeting, which can be found here: https://www.nursingsociety.org/Media/Pages/GAPFON_FirstMeeting_2015.aspx. And for more information on GAPFON go to www.gapfon.org .

Carmen and I then attended the Council of National Representatives (CNR) meeting of the ICN. CNR is the venue for the members of ICN to provide guidance to the Board and management on key issues and strategies for ICN to pursue. An area of focus at the meeting included Human Resources for Health (HRH). The CNR was addressed by Jim Campbell, Executive Director of GHWA and Director of HWF, WHO. Jim also spoke at the ICN Conference. The need for nurses to engage actively with the development of the new HRH plan was highlighted and the following press release was issued: http://www.icn.ch/images/stories/documents/news/press_releases/2015_PR_19_HRH_Strategy_Press_statement.pdf

The Opening Ceremony for the Conference was held at the Olympic Stadium and we were honoured to have the President of South Korea, President Park, and the Director of WHO, Dr Margaret Chan, attend. The Conference Program was packed with keynote, main and concurrent sessions http://www.icn.ch/. Regular reminders were made regarding minimising the risk of MERS, and while we were well aware of the potential threat, the outbreak did not impact on our participation.

This will be my last column in *The Hive* as I leave to take up the role of Chief Nurse and Midwifery Officer with the Australian Government on 31 August. I have found my time at ACN to be challenging and rewarding and look forward to seeing the organisation continue advancing nurse leadership as a means of improving health care.

“This will be my last column in The Hive as I leave to take up the role of Chief Nurse and Midwifery Officer with the Australian Government on 31 August. I have found my time at ACN to be challenging and rewarding and look forward to seeing the organisation continue advancing nurse leadership as a means of improving health care.”

MEMBER UPDATE

ACN HISTORY CONFERENCE HELD THIS WEEK IN SYDNEY

This week there was a variety of papers presented at the ACN History Conference, which took a fascinating look at *Disrupting discourses: new views on nursing history.* ACN values the opportunity for members to network with colleagues who share similar areas of professional interest and it was fantastic to see everyone come together in Sydney. Many thanks to all the conference committee members for their hard work and involvement in bringing you the event this year.

THE NATIONAL NURSING FORUM – ORATOR ANNOUNCEMENT

At this year's National Nursing Forum, ACN will host a special Luncheon event with guest Orator, Dr Rosemary Bryant FACN. Rosemary was the first Commonwealth Chief Nurse and Midwifery Officer, holding the position from July 2008 to June 2015. During her time in the role, Rosemary gained broad experience in policy development, in both nursing and the broader health sector. We are looking forward to Rosemary's Oration at this year's Forum.

Early bird registrations close this month, secure your place at www.acn.edu.au/Forum_2015

LEADERSHIP FIRST – FINAL WORKSHOP TO BE HELD IN PERTH 23-24 JULY

It's not too late to secure your place at the final Leadership FIRST workshop in Perth at the end of July. These workshops have received outstanding feedback from attendees who have taken part in the two day program. The program is designed for the new and current leaders who want to harness neuroscience to become even more effective in their role.

Book your place at www.acn.edu.au/leadership

GENEROUS BEQUEST FROM FORMER FELLOW

In October 2014 ACN was very sad to learn of the passing of Miss Dorothy 'Joan' Clifton of Leederville Western Australia, at the age of 82. Joan had been an active and passionate member and Fellow for over 36 years, having originally joined Royal College of Nursing, Australia (RCNA) in October 1975.

In 1990 Joan helped set up a Scholarship to celebrate the life and career of her dear friend Joyce Wickham. The Joyce Wickham Memorial Scholarship Fund is awarded annually to a Member undertaking their Doctoral studies in Nursing. The scholarship is an integral part of the ACN Grants and Awards scheme that supports ACN members.

Joan Clifton has ensured that her support for ACN will continue through a very generous bequest which will be used for the ongoing funding of the Joyce Wickham Memorial Scholarship Fund. Joan's generosity has ensured that this beneficial award will continue to help and support ACN Members well into the future.

ELECTION OF DIRECTORS 2015

Members entitled to vote will shortly receive a call for nominations for three positions on the Board of ACN. Members are encouraged to consider nominating suitable people (including themselves) to join the ACN Board of Directors. The ACN Board has a critical role in setting the strategic direction for and overall governance of ACN. The information sent to members outlines the key requirements for the role. The Board is keen to recruit members who are actively engaged in the profession and willing to work towards ACN's purpose of Advancing Nurse Leadership. The election will occur during September (please make sure your contact details are up to date) with the outcome announced at the AGM to be held in Brisbane in October. New Directors will take up their role at the December Board meeting.

Community and Primary Health Care Nuring Week: National Campaign

The Australian College of Nursing (ACN) is seeking support from nursing organisations for the 2015 Community and Primary Health Care Week: Nurses where you need them.

Supporters will be acknowledged on the ACN website and in the eBook.

Please email **events@acn.edu.au** to find out more.

CHANDLER MACLEOD
UNLEASHING POTENTIAL

Supporting our nurse leaders

Finding the balance between nursing and HR management

Caring isn't just a profession, it's an attitude, and with experience comes additional responsibility. That's why supporting our nurse leaders and allowing them to focus on patient care is so important.

We recognise the challenges nurse leaders face: achieving facility compliance, juggling skills shortages, meeting patient needs, reducing risk and managing junior nurses. We understand that everyday nurse leaders are faced with balancing the HR responsibilities of leading a team and managing the day-to-day care of patients.

With over 10 years' experience in recruitment, consulting and workforce management in the health sector Chandler Macleod provide tangible and effective HR outcomes. Our team of experienced Health recruitment consultants and Organisational Psychologists provide tailored HR solutions to some of the region's biggest health care providers including not-for-profits, Government departments and private service providers.

Our breadth of service, rigorous processes and cutting-edge methodologies are designed to address some of the unique challenges of the sector. Our service offering includes:

Recruitment - Specialising in permanent, temporary and contract staffing services we are commitment to helping build BestFit™ teams to meet increasing patient demand.

- Nursing and Care Workers
- Allied Health Professionals
- Mental Health and Social Workers
- Health Management and Administration

Workforce Management - As a specialist long term partner, our aim is to provide nurse leaders with strategies, tools and services to enable day-to-day workforce management and long term workforce planning.

- Workforce planning and rostering
- Retention strategies
- Payroll management
- HR services

HR Consultancy - Unleash the potential of individuals, teams and organisations through tailored talent assessment and organisational development products and services.

- Assessment for selection
- Safety assessments
- Professional and leadership development
- Organisational culture assessment and development

Outsourced clinical care - Providing allied health services to aged care residential facilities and at home, by blending health care expertise, commercial acumen and commitment to care.

- Physiotherapy, Podiatry, Dietetics and Pain Management Services
- Accreditation compliance and ACFI expertise
- Management, delivery and reporting of care services provider to patients at over 280 facilities across Australia

If you're looking for assistance managing the HR functions of your team or facility contact Chandler Macleod today, or visit chandlermacleod.com/clients/health-recruitment

SUPPORTING OUR NURSE LEADERS

ACADEMIC

Dr Melissa Bloomer FACN

Creating and sustaining positive work environments is not just the manager's responsibility

In the context of our ageing population, rising rates of chronic illness and the resulting increase in demands placed on our health workforce, never before has it been so important for nursing, as a profession, to take time to consider our own health.

The Australian College of Nursing published a White Paper titled *Nurse Leadership* (available on the ACN website). This White Paper highlights how nursing currently represents more than half of all registered health workers in Australia and future workforce projections indicate that we are likely to face significant shortages of nurses into the future (HWA2012). Aside from the obvious, which is to invest in and prioritise nursing recruitment, it is also timely that we reflect on how to care for our existing nursing workforce.

ACN's White Paper highlights that creating a positive work environment, which is one in which nurses feel supported in the delivery of effective and high-quality care, is the responsibility of all. While most would say that nurse leaders in any organisation bear some responsibility for ensuring a positive work environment for nursing staff, which is true, they are not solely responsible. Each and every nurse must also take some responsibility and ownership of how they can contribute to a positive workplace environment for themselves and their team.

Some simple ways to do this might include

- *leading and contributing to quality improvement initiatives in the workplace;*
- *committing to ongoing professional development and sharing knowledge and expertise with colleagues;*
- *modelling the right values and behaviours; and*
- *caring for each other.*

While these measures may seem small, a small change by each nurse is sure to create some much bigger momentum. Give it a go.

References on next page

CLINICIAN

Ms Tomica Gnjec MACN

Interdisciplinary collegiality – an essential ingredient in today's health care environment

In the middle of a night shift a few weeks back my colleague and I experienced the full definition of 'emergency' in our Emergency Department, with an influx of critically unwell patients.

Time critical assessment, planning and management by the attending nursing and medical personnel became the overarching priority for the night. This crazy pressured shift was surprisingly manageable through the exceptional collaborative leadership of our Emergency Registrar, senior Medical Registrar and the nursing team co-ordinator. Despite the intensive care demands and needs, optimal patient management was achieved through defined leadership roles, a clear and open articulation of the care plan, and the feedback and acknowledgement of input from all involved team members.

A study by Nancarrow et al. (2013) identifies a number of characteristics suggested to form the basis of effective interdisciplinary team work: a supportive team environment; positive management and leadership attributes; appropriate skills mix; focus on quality and outcomes of care; and respect and understanding of roles. Woods (2012) similarly asserts the value of an 'interprofessional team philosophy' which is clearly defined, supported and communicated to the entire organisation, developed through structures and leadership training for clinicians, education, and the development of interprofessional position statements and team charters.

Theory and related experience suggests a multi-pronged approach is needed to foster strong interdisciplinary collegiality. I believe the onus of such an approach is on all clinicians and managers, and that collegiality must serve as a basis for our professional relationships. This can only lead to improved and open communication and supportive structures that optimise our ultimate care goal - patient outcomes.

References on next page

ETHICIST

Professor Mary Chiarella FACN

Not all nurse leaders are in formal leadership roles, but I want to write about those who are, both in and out of nursing. Why do nurses take on such roles? Because they want to make a difference: to the lives of clinical nurses, to the organisation of patient care, and to the organisation of health care.

Those of us who nurse are passionate about nursing, and recipients of our care, both good and bad, also become passionate about nursing. But the majority neither know what we do nor realise the compassion, art and science that is bound up in nursing care. Often we are seen as a large component of the budget due to our workforce numbers. The evidence that we make a difference is incontrovertible, but the push for economies in health is primal. Thus nurse leaders have a critical educational role to educate other leaders, whose decisions may impact on the lives of nurses and patients, about the need for an appropriate workforce to provide optimal care.

To do so, nurse leaders often need to learn to be bilingual. In addition to understanding nursing issues, they need to understand the imperatives of their business colleagues and to speak in the languages of economics and business, particularly where they are performing non-nursing roles. Nurses are at the forefront of many senior healthcare organisations. The vast majority look back on their work as nurses with deep affection and great appreciation for the skills they gained.

Some nurses have argued that these leaders have "left" the profession, and this has latterly led some of them to feel alienated from their nursing roots and outside the profession. It is critical that our nursing alumni are celebrated by us and retained in spirit, as their ability to influence both political and management aspects of patient care may be greater than those inside the profession.

SUPPORTING OUR NURSE LEADERS

MANAGER

Adjunct Professor Cheyne Chalmers FACN

Supporting our Nurse Leaders

Nurse leaders are one of the most important roles in the health system, and being a nurse leader of any level can be challenging, sometimes thankless, and at the same time, intensely rewarding. As nurse leaders we are tasked with setting and maintaining the standards around great nursing care, ensuring that at all times those nurses we lead are skilled and resourced to be able to provide that care. The health care consumer of the 21st century is well informed and has high expectations; they know what good care looks like and are not afraid to voice their concerns when those expectations are not met.

As part of my leadership responsibilities, I support and mentor other nurse leaders in my organisation, as well as across the sector. I find that nurse leaders often cite professional isolation as a common challenge to their roles. Being responsible for setting and maintaining standards of great care within budget is at times a fine balancing act, and the nurse leader is often in the firing line of their staff and managers whilst they achieve this.

Ensuring we support our current and future nurse leaders is crucial to the ongoing functioning of the health system. The ability for nurse leaders to access purposefully designed development and mentorship programs is key. A challenge that Australia has, however, is that we do not seem to have a clear united view on what Leadership development for nurse leaders of all levels should look like. How do we create the nurse executives of the future? How do we grow our Nurse Unit Managers? At the very local level, I strive to achieve this, however it is now time for a more global cohesive approach. I challenge the executive nursing voices in Australia to respond.

NEWLY REGISTERED

Ms Laurie Bickhoff MACN

Follow the leader

I don't want to talk about leaders. I want to focus on followers. We tend to overlook their impact and dismiss them too easily as 'groupies', 'sheep' or people just trying to jump on the bandwagon. We underestimate their effect. There's a great TED Talk by Derek Sivers which discusses how to start a movement, in which he says the "first follower transforms the lone nut into a leader". This is where their power lies.

A leader's strength is determined by their followers. Not by the number of them, but by something far more important. It's how many they inspire that is crucial. It's how many they inspire to champion their cause. It's how many they inspire to take action, big or small. It's how many they inspire to do better, to expect better, to be better. A leader might be the stone that breaks the surface of a pond, but it is their followers who are the ripples, and who end up making the waves.

So what is a follower? Let's be clear, obeying and following are completely different concepts. Legal requirements, hierarchy or obligation play no role in following. To be a true follower, you have to connect with the leader. Their message resonates within you. Their goals are ones you share. Their ideals, values and beliefs align with yours. Their vision ends up becoming your mission.

Following is a choice, not a command. Choose who you will follow wisely. Remember the power your decision has. Which lone nut will you transform today? After all, following is its own form of leadership.

"Nurses are at the forefront of many senior healthcare organisations. The vast majority look back on their work as nurses with deep affection and great appreciation for the skills they gained."

– Mary Chiarella

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POLICY SNAPSHOT

In the second quarter of 2015, the ACN Policy team worked on a range of submissions to Government and other stakeholders.

MEETING WITH THE FEDERAL MINISTER FOR HEALTH, SUSSAN LEY

On 28 April 2015 ACN's Chief Executive Officer, Debra Thoms, met with the Federal Minister for Health, Sussan Ley, to discuss a range of issues concerning nursing and the overall health system. Issues discussed included the role of primary and community health nurses, the importance of transition to practice support for newly registered nurses and the contribution of scholarships to supporting the nursing and midwifery workforce.

SENATE INQUIRY INTO HIGHER EDUCATION AND RESEARCH REFORM BILL 2014

In late February, ACN submitted a response to the Senate Education and Employment Committee's inquiry into the Higher Education and Research Reform Bill 2014. ACN welcomed the proposed changes to the Higher Education Loan Programme (HELP) but expressed concern that universities may introduce a student contribution for students enrolled under the Research Training Scheme (RTS).

ACN fears that any cost additional to the existing financial burden for students undertaking a research higher degree in nursing may dissuade prospective researchers from undertaking research training. ACN argued that maintaining and building research capacity is critical to maximising the nursing profession's contribution to practice, education and policy in health care. A lack of researchers may leave nursing with a starkly reduced capacity to generate the empirical evidence required for the profession's clinical, education and policy activities. ACN recommended that nurses who undertake a research higher degree be exempted from paying the student contribution.

TASMANIAN GOVERNMENT'S DELIVERING SAFE AND SUSTAINABLE CLINICAL SERVICES WHITE PAPER EXPOSURE DRAFT

In mid-May of this year, ACN submitted a response to the Tasmanian Government's consultation on the *Delivering Safe and Sustainable Clinical Services White Paper – Exposure Draft March 2015.* In its submission, ACN provided comment on a number of key issues relating to improving patient care outcomes, health literacy, primary health care and workforce planning.

ACN encouraged the Tasmanian Government to inform the reform process through the active involvement of nurse leaders. Nurse leaders at operational and policy levels are able to make valuable contributions to the improvement of clinical outcomes due to their insight into health care delivery. Nurses can further contribute to improving quality of care through involvement in clinical governance and health research. ACN highlighted:

- the important role that nurses play in patient education, with a recommendation that the role be expanded to improve the Tasmanian population's level of health literacy;
- the potential of primary health care nursing services to increase their contribution to the Tasmanian health system, including through the prevention of unnecessary hospitalisation and re-hospitalisation; and
- the provision of local training pathways for local graduates as an important measure for ensuring the future supply of nurses, which is particularly important given that the nursing profession constitutes the largest proportion of the health workforce, and it is ageing.

AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY'S (AHPRA) REGULATORY PRINCIPLES FOR NATIONAL SCHEME

In May 2015, ACN provided feedback to AHPRA's survey on the *Regulatory Principles for the National Scheme.*

ACN supported the use of the *Regulatory Principles* to guide the work of AHPRA and the Boards. In particular, ACN supported the Principles' focus on protecting the public, the use of minimum regulatory force to achieve protection, and the upholding of professional standards. However, ACN recommended the addition of a ninth principle: "We work collaboratively with our stakeholders", to reflect the need for the National Boards to work closely with other bodies at jurisdictional level, as well as health professional bodies and health service providers, to fulfil their remit.

Further, in its submission, ACN argued that while the *Regulatory Principles* are easy to understand at a conceptual level, more information is needed to support their application. ACN recommended that AHPRA, through the Boards, undertake steps to improve health practitioners' knowledge of the existence of the *Regulatory Principles* and their purpose.

AUSTRALIAN NURSING AND MIDWIFERY ACCREDITATION COUNCIL'S (ANMAC) REVIEW OF RE-ENTRY TO THE REGISTER MIDWIFE ACCREDITATION STANDARDS USED TO ASSESS AND ACCREDIT RE-ENTRY TO THE REGISTER MIDWIFERY PROGRAMS OF STUDY

In May 2015, ACN provided feedback to ANMAC's review of *Re-entry to the Register Midwife Accreditation Standards* (the Standards) used to assess and accredit Re-entry to the Register Midwifery Programs of study. Overall ACN was supportive of the Standards and expressed minimal concern with the proposed Standards and associated Criteria.

ACN'S ENGAGEMENT WITH NACA: EARLY 2015

The National Aged Care Alliance (the Alliance) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. As an active member of the Alliance, ACN has contributed to a range of its internal and external deliberations since the start of the year. ACN representatives attended the Alliance's February meeting in Canberra and participated in discussions about the planning and implementation of current aged care reform measures. Included in these discussions were matters relating to the work of the Aged Care Sector Committee and key areas of the aged care reform: Home Care, Commonwealth Home Support Programme, My Aged Care, Quality Indicators, Residential Care, and Reducing Red Tape in Aged Care. The meeting included briefings from the Australian Department of Social Services (DSS) and from Senator the Hon Mitch Fifield, Assistant Minister for Social Services. The Minister reinforced the Federal Government's agenda to fundamentally change approaches to aged care in Australia and to increasingly move in the direction of Consumer Centred Care.

In March, ACN provided input into the Alliance's advice to the Aged Care Sector Committee on how the Aged Care Sector Statement of Principles could be used to guide future aged care policy. ACN also provided direct input to the Alliance's April 2015 policy submission to the Commonwealth Home Support Programme (CHSP) consultation on the CHSP Manual for Providers, the CHSP National Fee Policy Consultation Paper, and the Good Practice Guide for Restorative Care Approaches (incorporating wellness and reablement).

http://www.naca.asn.au

All of ACN's submissions can be accessed on ACN's website, www.acn.edu.au/advocacy.

SOCIAL MEDIA: SENDING NURSING EDUCATION VIRAL

By Laurie Bickhoff MACN

Social media is fast becoming an invaluable tool in nursing education. It provides a wealth of information, access to conference proceedings and practical advice on how to incorporate new research into practice. Social media actively engages nurses in their learning and gives them the opportunity to connect with an international nursing community.

It is hard to overestimate the impact of social media. In the relatively short period of time since its inception, social media has had an unbelievable influence in our lives which continues to grow. By its 11th birthday in March 2015, Facebook had 1.39 Billion users, 64% of which visit the site daily and nearly a quarter login at least five times per day.

Twitter has 288 million monthly active users who send out 500 million tweets per day in 33 different languages. Since Instagram's launch in October, 2010, over 30 billion photos have been uploaded to the site and approximately 70 million more are added each day.

EVOLUTION OF EDUCATION

As technology has progressed, so too has education evolved. Many adults would remember being taught how to find a book using the card index at the library. Others fondly recall having one set of encyclopaedias at home, which were the only source of information for homework projects, all of which had to be neatly handwritten.

Today, primary school students are swapping posters for PowerPoint© presentations. Long gone are the old blackboards and dusters, replaced with smart tablets, smart phones, and even smart watches, creating a generation that will be more technologically savvy than any that have come before.

NURSING EDUCATION

Nurses are expected to be technologically aware. The selection criteria for nursing positions over the last five to ten years has routinely listed "computer literacy" as a prerequisite. Nursing informatics is a growing specialty, working to develop IT systems designed to improve patient outcomes, reduce nursing workloads and move towards those elusive 'paperless' wards and hospitals.

Nursing education has well and truly entered the digital age. Undergraduate and postgraduate courses are now routinely offered online. E-learning packages are the norm, if not mandatory education, in most health facilities or organisations.

E-Learning has already begun to breakdown what the literature says are the most common barriers to nursing education: time, access and costs. Online learning packages that can be completed anywhere and at any time give nurses the flexibility to fit their learning in with their shift work, family life and other commitments. Nurses can now undertake e-learning in the comfort of their home, when it is convenient for them, and without the costs associated with time off work or travel expenses.

E-learning has been widely adopted within nursing and it is on these foundations that social media education is built. Social media is simply the next step in the evolution of e-learning.

Using social media as a tool in nursing education promotes engagement and collaboration, while providing resources, networking opportunities, and innovative teaching techniques.

INFRASTRUCTURE AND EASE

There's no need to be able to code or build your own web site. Social media infrastructure is already in place. Social media sites are readily accessible and do not require a great deal of expertise to use. A key feature of social media is the 'point and click' or intuitive design, whereby any lay person can come along and use it, and over 90% of nurses report currently using social media in some form.

For people who may want tutorials in how to use specific sites, there are a vast number available, including specific information for nurses. For example, Paul McNamara, founder of the Meta4RN website (www.meta4rn.com), has great information available, including conference posters and journal articles with advice for nurses on how to use Twitter.

Social media is relatively low risk. Nurses do need to be aware of maintaining professionalism online and abiding by applicable social media policies, but the beauty of social media is the ability to lurk. You can create profiles and, if you choose, simply sit back, watch, read and learn without ever typing or sending a word. This is a good way for the more reluctant nurses to start. As they begin to feel more comfortable and see how others interact, they can then choose to engage with others.

CONFERENCE

Tweet reporting at conferences is a phenomenon which has gained momentum over the past few years. Tweet reporting is when conference

delegates post the key messages of a speaker on Twitter, followed by a pre-set hashtag (#) associated with the conference. The hashtag lets others follow the posts. The hashtag acts like a keyword that people can search for, and any tweets containing that hashtag will pop up.

As a delegate, tweet reporting is a great way to keep notes, including the name of the speaker, which becomes a useful reference. It also provides an opportunity to meet and chat with other people at the conference, and often 'tweet meets' (in person get togethers) are scheduled.

However, it's the conferences you are not able to attend which make tweet reporting so useful. Conferences can be expensive to attend and time off may be difficult to organise. Through following a conference's hashtag, you can follow the proceedings while sitting at home or on your lunch break. Some conferences even let you tweet questions directly to the keynote speakers or other presenters.

NETWORKING

Social media is a great way to build your professional network, past simply having an out-dated LinkedIn profile. Social media connects you with a truly global community. The "WeCommunities" is a great example of how this can happen. In another example, Teresa Chinn was working as an agency nurse in the UK but, not having one permanent workplace, began to feel isolated and started looking for a way to connect with other nurses. She turned to Twitter and created the "WeNurses" account.

From these humble beginnings, WeNurses now has nearly 14,000 followers from all over the world. It hosts regular tweet chats, with information posted beforehand, including articles, policies and protocols on the topic, which range anywhere from pressure area care to Ebola. These chats focus on evidence-based practice and how research can be translated into practice. Transcripts are also made available after the chat for those who could not participate. WeNurses has now expanded with 18 different WeCommunities, including nursing specialties, such as mental health, doctors, and allied health professionals.

It is worth taking the time to build this network. If you have questions about nursing innovations, are curious about what other countries may be trialling or are looking for resources, your network can help. Networking on social media can create opportunities to collaborate with other health professionals or organisations and raise your professional profile.

RESEARCH

Social media allows the rapid sharing of research results. It can enhance the transition of research into practice. Again by utilising your network, you can find out how others have adopted practices, issues they may have come across, how they overcame potential barriers or objections, and resources they used to help. If researchers are also on social media, you can contact them directly with questions you may have.

RESOURCES

One of the biggest benefits of social media is access to resources. There are a number of useful, evidence-based resources available on social media for nurses and educators. Nurses are a very altruistic group, and there are many Australian nurses creating and sharing nursing education resources. These include blogs, podcasts, webinars and videos. There are also sites, like SMACC and the NSWNMA, which provide convenient lists of these webpages.

However, the sheer volume of information available can be overwhelming. Just like nurses once spent hours searching textbook after textbook to find information, it can now take the same amount of time clicking link after link to find what you need. However, the hashtags, #FOAMed and #FOANed, make relevant resources easier to find.

#FOAMed (free open access medical education) was started by an Australian emergency doctor, Mike Cadogan. He introduced the concept at the International Council for Educational Media conference in 2012 as a way to collate resources and make networking easier. The movement grew and went on to spawn SMACC, the Social Media and Critical Care Conference, the third of which will be held in Chicago this year.

In 2014, this concept extended and the hashtag #FOANed began to spread. Same idea except this was free open access nursing education. Critical care is still leading the way, especially with social media gurus like Ian Miller from The Nurse Path and Jessie Spurr from Injectable Orange heading the movement in Australia.

#FOANed resources include case studies, anatomy and physiology tutorials, monitoring protocols, a huge range of infographics, step-by-step guides and journal articles. #FOANed materials are bite size chunks of easily digestible information. They take the overwhelming, jargon-ridden 20 page paper, and break it down to the key points and implications for practice. Crucially, they should provide the reference back to the original research, and often give links to other discussions on the same subject or additional resources, allowing those interested to do further reading on the subject.

Unfortunately, not all the information posted on the internet is true, especially when it comes to health care. At the moment, the majority of health information on the web is not written by health care practitioners and it is estimated only 37% of that health information is correct. Whilst most social media sites have policies against breaching copyright, they do not check the validity of content. Therefore, it is essential to check the validity and sources of the information you use and share.

ENGAGEMENT

What makes social media such an effective educational tool is the ability to engage with others. Using social media for education is about more than just posting lecture notes online. It is perhaps a little too optimistic to simply post a video and expect learning to occur. It is time to shift away from simply creating content for others to passively absorb and instead focus on stimulating discussions and critical thinking.

How well the audience is engaged is as important as the quality of the content. Through active engagement, learners process information and move short-term memories to long-term ones. Furthermore, by generating discussions and giving nurses the opportunity to assert and/or defend their opinions, social media can help nurses develop critical thinking skills.

In a time and resource poor health care environment, social media is a tool nurses can ill afford to ignore in their continuing professional education. Social media guides nursing education towards collaboration and engagement and provides a wealth of learning and networking opportunities for nurses in all stages of their career.

LEADERSHIP IN ADVOCATING CONTINUING PROFESSIONAL DEVELOPMENT

By Molly Pullukaran

The Australian Nursing and Midwifery Accreditation Council defines Continuing Professional development (CPD) as the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (ANMC 2009).

Nurses realise the need for continued lifelong learning in order to adapt to the ever changing practice environments within health care (Shanna 2013). Evidence based research continues to inform the nursing practice.

Nurses are increasingly required to assume leadership roles. This expanding scope of practice requires constant learning and upskilling. Nurses in clinical areas have expressed a number of barriers to undertaking CPD activities such as a lack of time and money to fund CPD education, inadequate staffing levels, inefficient skill mix, lack of financial assistance from their employer, difficulty obtaining study leave, and family commitments (Davids 2006). None of these are new.

It is important for educators to gain an insight into what actually motivates nurses to undertake CPD (Katsikitis et al. 2013). Our role is to empower nurses to be proactive and not just reactive when it comes to continual learning. It has to be a genuinely empowering experience. There is a lot of personal commitment involved in continual learning and this is why we need to make it worthwhile for nurses to engage with us. The challenge is how to keep CPD engaging and relevant.

There is no shortage of CPD education providers. They can be found in-house, in health care facilities, and through external education providers. Most often, CPD education is focused on knowledge and skill acquisition, as can be illustrated by the image of an iceberg. The part of the iceberg visible above the water represents clinical skills. The part of the iceberg under the water represents soft skills.

A lot of what we consider to be personal and professional qualities from the above definition of CPD belongs to this group of skills. These are the skills that help teams work together using appropriate communication techniques, understanding personality traits, resolving conflict, and applying the knowledge of emotional intelligence, in the workplace. A nurse who is equipped both in clinical and soft skills is more likely to stay in that position, meaning less turnover which in turn saves training costs for the facility.

There are a lot of CPD events focused on acquiring clinical skills, but importantly we also need to provide CPD events which cater to soft skill acquisition. Some may attend a CPD event to keep up to date and learn new skills, whereas some may undertake a CPD activity to confirm their practice. Attending a CPD event must be personally rewarding, something that not only refines the clinical knowledge and skills required for clinical practice, but also helps to build on personal qualities and manage team dynamics.

We need to look at innovative ideas to provide CPD events after hours, thereby providing flexible options for nurses working shifts. There never seems to be enough appropriately timed CPD activities for shift workers. Therefore, the question we need to ask ourselves is, are these programs timed to meet our needs or the needs of the nurses who work various shifts?

Other factors that can contribute towards the provision of effective CPD include carrying out a needs assessment and tailoring the activity to the learning need. Plan to offer a wide range of events that use multiple methods of learning, in keeping with the current trends, for example online short courses, webinars and workshops. The learning outcomes from any CPD activity needs to be able to transfer skills and knowledge to bedside practice and enhance the quality of care that patients receive.

We must take into consideration the various learning styles and domains of learning, integrate adult learning principles, and use emotional intelligence in the teaching and learning processes (Mortiboys 2014). We must ask if the activity involves a lower order or higher order learning. Similarly, personality types, cultural diversity, and intergenerational needs must be considered. It becomes somewhat of a balancing act but when a CPD activity is planned in view of these factors the learners will be more engaged.

Teachers should take steps to ensure that they develop and nurture their own skills and perhaps the best way to engage others in professional development is to lead by example. They should talk to students, team members and colleagues about how they can enhance their practice. If teachers were to promote and value their own professional development, it is likely that others would follow.

There is anecdotal evidence to suggest that another unaddressed barrier that affects nurses' motivation to actively pursue continuing education is their perception of 'not being able to contribute'. We do remarkably little to address this need.

Past experiences of being rejected, not having ideas acknowledged, not being consulted regarding policy changes and having difficulty accessing information, all act as a barrier. There is no intrinsic motivator

for nurses to invest their time, money, and energy into something which may never gather sufficient momentum to be implemented.

Let us never underestimate the capacity of our colleagues to contribute to genuine and lasting change. There are many creative ways that nurses can contribute; it does not always have to be in research, publication, policy writing, and designing critical care pathways. For example, they can start by discussing existing policies/pathways: why do we do what we do? Where did the evidence come from?

It is important to get to know nurses' strengths and to provide them with the opportunities to use them, such as through their reviewing of existing policies, demonstrating a procedure during clinical facilitation, mentoring, precepting, conducting an in-service or bedside clinical demonstration, helping put together workbooks for new staff, present case studies, lead a journal club.

Many of our colleagues may have negative experiences of learning, and a fixed mindset. Encouraging a growth mindset can help to break out of fixed beliefs about one's ability and this increases self-belief and consequently motivation (Dweck 2006). We need to work both on skill sets, and mind sets.

Lead group reflective exercises initially to help nurses understand the process and then encourage and support them to continue with individual reflection. Orient nurses to the CPD cycle (NMBA 2013) and provide guidance to plan for personal and professional development. Run group sessions on 'how to document your CPD portfolio'. Encourage nurses to share the new knowledge within the team, challenge current practice if it is not evidence based and provide support to implement best practice.

I believe being a leader is a choice. Prospective nurse leaders need role models. This is where the need for educational leadership comes in. Taking the initiative to bring about a change in nurses' attitudes towards CPD can be challenging. Intent alone is not enough, action is needed.

Jack Welch, former CEO of GE, once said: "A Leader's role is not to control people or stay on top of things, but rather to guide, energize and excite". As leaders we cannot settle for less, we need to stand for something; what do you stand for?

Some key questions we need to ask ourselves are:

Do I demonstrate leadership through teaching?

Do I make an effort and take interest in incorporating new technologies into my teaching?

We want nurses to leave CPD learning activities feeling inspired, encouraged, resourceful, challenged and ready for action. This is why we need to make these sessions engaging and memorable (Abrahams 2014).

Continuing Professional Development is at the heart of the nursing profession; we need to remain mindful of why we do this work. We are aiming to equip, enable and empower nurses to transform our workplace, to create the solution - to be the solution.

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UNDERSTANDING DIFFERENCES: REFLECTION ON CLINICAL PLACEMENT IN LAO

By Dr Elisabeth Coyne MACN, Josea Arneli Polong Brown and Hazel Rands

For the last six years, third year nursing students at Griffith University have completed an immersion community development project in northern Laos, working alongside local health workers and translators to provide primary health care to remote villages in the Seuang Valley. Little English is spoken in this district, so groups work with Lao translators to run health promotion sessions, complete health assessments and provide treatment for minor illnesses and injuries. As an immersion placement, students and staff live in very basic homestays in the villages where they are working. This provides additional insight for students into the impact of social determinants of health, as they observe first-hand the local living conditions and limited resources. Students completing the placement gain an understanding of global health issues as their own cultural and ethical values are challenged.

Study abroad programs have been successful in providing students with an experience which enables them to develop skills of critical thinking and reflection. In fact both students and faculty participating in immersion placements describe the experiences as transforming and rate highly the opportunity to practise basic nursing skills and engage in the primacy of caring (Kundrik Leh, Waldspurger Robb, & Albin, 2004; Ryan, Twibell, Brigham, & Bennett, 2000). Reimer Kirkham et al. (2005) found that students placed in innovative clinical settings in developing countries witness extremes of poverty and health care inequities that can be confronting. Students also become critically engaged in 'making sense' of this as they seek to understand the challenges of marginalization within these vulnerable communities (Maltby & Abrams 2009).

Students are encouraged to write self-reflection journals during the placement and reflect on personal changes. This helps them work through the challenges of the placement and develop into a student ready for graduation. One student has reflected on her personal journey during the placement and her development as a nurse.

MOBILE CLINIC: FROM ASSESSMENT TO DISPENSARY

Our days in the clinic start off as a calm before the storm. The villagers line up at 'Reception' and wait to be seen. In reception the patients are triaged as family groups and acuity. For example, pregnant mothers and small babies take priority. However, once they come through to assessment we hit the ground running. In our 'village clinic' there were three assessment tables each with three students, a translator and a health care worker. The process of assessment begins with a four way conversation between the student, translator, health care worker and the patient, with the supervisors overseeing the three groups. The patients explain why they have come in and after a few questions and some physical assessment, a basic diagnosis is made. After more discussion with the health care worker, an agreement is reached and treatment decided on.

As a student nurse it was on these assessment tables that I was able to build on my physical assessment and critical thinking skills. When a client complained of a cough that sounded wet I would immediately listen to their lung sounds, listening for crackles or wheezes. Prior to this I had no idea what to do when someone in a clinical setting complained of a wet cough or what I should be listening for. I am now more confident in my skills as a nurse. I learnt to ask the questions to expand on the actual complaint. The assessment and diagnosis process also provided me with practice to think about how to treat the patient and family in these remote village areas. Health education became a big part of the interplay between patient and student via the translators and health workers.

On this trip I was able to conduct physical health assessments, detect abnormalities in chest sounds and heart beats, and differentiate between an ear infection, a dirty ear, and a busted ear drum. From this experience I was also able to further develop my critical thinking skills. As a student it was our job to ask the villagers the preliminary and follow-up questions regarding their health and then inform the health care worker of their situation. At first I didn't know what to ask, and the questions that did come out had no particular order to them. I am now more confident in my investigative questioning and critical thinking skills. I know what questions need to be asked in order for me to fully understand what is wrong with the client and be able to help them.

After the patients finish in the assessment area, the family groups are walked to the pharmacy where the medication is kept and dispensed by the health workers. In both Assessment and Pharmacy we provided education regarding their treatment regime (e.g. take 1 tablet 2x a day for 10 days) and ensured their understanding by using the talkback method. In addition to this, the translators would translate the instructions in Lao in case they forgot. After this experience I am a lot more confident in effectively relaying information to a patient regarding their treatment. It was here that I learnt to get creative with the way I deliver information, realising and understanding that not everyone will take in and respond effectively to verbal instruction, and how other methods, such as charades, may be a useful way of presenting information.

The clinics also carried out maternity checks and home visits for new born babies. These maternity checks consisted of us checking the baby's position within the womb and associating it with any pain the mother may be feeling, and listening to the baby's heartbeat, determining whether it was normal or not. The baby checks were a full post natal check with baby weight and breast feeding concerns discussed with the translator. Home visits were also done with patients unable to get to the clinic. These visits had a level of apprehension as you never knew what you were going to see once you arrived at the patient's house. In these visits we saw anything from end stage tuberculosis to stroke and children sick with gastroenteritis. The supervisor would go through the questioning process with the translator and as a student we would complete the physical assessment. These visits provided a real insight into how the villagers cared for their sick and increased our awareness of the importance of health education, particularly with medication advice.

EMPOWERING THE COMMUNITY: HEALTH PROMOTION FOR MEN, WOMEN AND CHILDREN

Our clinical placement in Laos included delivering health promotion sessions for the villagers. For the men, we ran a manual handling session; for the women a maternity session, focusing on pregnancy and delivery; and for the children we ran a session focussing on proper hand washing techniques and teeth cleaning. We had also taken a variety of glasses to Lao to be dispensed after a basic eye test. The older women in particular develop poor eyesight from their weaving and the basic glasses provide them with the ability to keep weaving and earning an income.

During the clinics I was able to listen to the villagers' health complaints and this helped me to see the importance of primary prevention. Staying in their homes and seeing how they lived also gave us a degree of understanding regarding their lifestyle concerns. A lot of the men and women who came to see us would complain of back, neck and shoulder pain due to the heavy lifting nature of their work. Panadol and Voltaren were given to help ease the pain. However, what was going to make a difference in the long run was proper manual handling techniques and doing neck, back and shoulder exercises prior to commencing work. Realising the importance of this was one thing. What was challenging however was helping the villagers to see the importance of it as well. When they came to see us there were times where it seemed as though they were hoping for a miracle cure, that we'd have a pill that could take all their pain away. Unfortunately, that was not the case and we would emphasise the importance of proper manual handling and the need to stretch. However it seemed as though this information fell on deaf ears, which was disheartening. As the Griffith nursing groups build trust and connection with the villagers we hope that these new ideas for health begin to stay with the villagers.

For the children, hand washing was important to help limit the spread of diseases and infections, but perhaps a more pressing issue was teeth cleaning. Quite a number of the children we saw had rotting, decaying teeth as a result of poor mouth hygiene, therefore it was imperative that we conducted a session promoting mouth hygiene. We conducted a tooth brushing demonstration to show the children how to properly clean their teeth and why it was important to do so. Afterwards we invited a few of the children to come up, in front of their peers and demonstrate this new skill they learned. As we handed out the toothbrushes to the children you could see their faces light up. This was really encouraging to see. By the end of the session every child we saw had brushed their teeth. However, what was discouraging was seeing the other uses the children had for their toothbrush, such as digging in the ground. At first I was confused as to why we promoted brushing teeth to the children, however, after seeing them come through the clinic with their families and seeing the damage that poor oral hygiene causes, I finally understood. I learned that it is much easier to bring about a change in behaviour if you start earlier. It is much easier to prevent diseases in adulthood if you practice good personal hygiene younger and develop that habit. And it is much easier to bring about a positive change with a new generation than with a generation set in their ways. We may not see immediate changes in health promotion, but over time we hope to create a culture where teeth cleaning is the norm in helping to prevent decay and mouth problems.

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CULTURE: COMMUNICATION IS KEY

As part of this clinical practicum we worked in partnership with local translators, health care workers, and the Lao people to better provide holistic care. In this situation the language barrier would have probably been the most frustrating aspect of the placement. Frustrating in that we were not able to directly communicate with the people we saw. This made developing a therapeutic relationship quite difficult. However, the translators were amazing to work with and the Lao people were quite patient with us.

Perhaps, what set this placement apart from others was that we were immersed in the Lao culture through living in homestays in the villages. I was thankful for this, as it helped us to better understand the Lao people. For example, we would have a lot of children in the different villages come in with chest infections. Having spent most nights in the village we knew that the children would sit around a fire at night, every night, inhaling the smoke and dust. Knowing how they lived we were able to understand how some things came about and therefore, were able to educate them on how to stay healthy, such as not sitting too close to the fires at night so as to limit the amount of smoke and dust inhaled. Immersing ourselves in their culture helped us provide a culturally safe environment, where we did not go in there and try to change their way of life, but we knew and understood their daily lives and were able to offer a few suggestions to help them stay healthy.

I was able to experience things that I would not have been able to in an ordinary hospital setting. From this experience I've come away a better nurse and hopefully, a better person as well. I don't want to say that I had a life-changing experience in Laos, as I don't want to set up that expectation for future students. However, what I can say is that I came back from Laos different. I left Laos humbled and was challenged with my pride, selfishness and greed. I know that these are traits that people don't want to attribute to themselves, but after being/living in Laos and immersing myself in their culture and way of life, I can honestly say that I have a lot to learn. I can give more and take less, I can appreciate more and complain less, I should be thankful for what I have and know that I am blessed.

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THE NATIONAL NURSING FORUM

14–16 October 2015

Advancing nurse leadership

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PRELIMINARY PROGRAM AND SPEAKER PROFILES

This year's National Nursing Forum, *Advancing nurse leadership,* in Brisbane will provide nurses from around the country the chance to hear from an international and local speaker line up highlighting current issues, challenges and opportunities faced by today's nurse leader. The Forum program includes highly topical sessions for attendees and will open up discussions on important and complex matters for nurse leaders who play a critical role in delivering health services to the community.

LIFT OUT

Preliminary program

Day one – Wednesday 14 October

8:00am	**Registration open, tea and coffee in exhibition**
9:00am	**MC introduction — Mr Scott Williams** If you love to laugh (and who doesn't?) then it's time you met Australia's Laughter Specialist Scott Williams. Affectionately known as 'The Doctor', Scott is not only a naturally funny comedian, delivering a rich blend of clean, smart comedy and hilarious audience participation but also a world class emcee and keynote presenter.
9:05am	**ACN President welcome** **Ms Carmen Morgan FACN**
9:10am	**Keynote — Ms Sue Hawes FACN, PwC** **Do you see what I see? Advancing nurse leadership** Our ability as nurses to lead and influence has never been more critical or more threatened. We need to use our expertise in health care in a different way and find our collective voice. Our conversations need to move from the problem to implementing the solutions. We need to seek out new opportunities and mobilise our ideas – quickly.
10:00am	**Keynote — Professor Anne Marie Rafferty, King's College London** **Leveraging leadership for policy and system change** This presentation considers the pivotal role that strong nurse leadership plays in setting the culture and parameters for change. It argues that leadership is first and foremost a moral enterprise- not just doing things right but doing the right things. Anne Marie will draw on a wide range of evidence to demonstrate how we leverage leadership for sustainable change.
11:00am	**Morning tea**
11:30am	**Concurrent session one** More than 30 presentations will run across three concurrent sessions in the program. Sessions will include specialty streams within nurse leadership in the areas of clinical practice, research, management and education.
1:15pm	**ACN Luncheon** **A special event at this year's Forum, the ACN Luncheon will include an Oration by Dr Rosemary Bryant FACN, investiture of Fellows or Distinguished Life Fellows for the year and a three course lunch.** **Proudly supported by Chandler Macleod**
3:15pm	**ACN interactive session**
5:15pm	**Close of Forum day one**
5:30pm	**ACN AGM**

Day two – Thursday 15 October

7:00am	**Yoga in the park**
8:00am	**Registration open, tea and coffee in exhibition**
9:00am	**Keynote — Mr Alan Lilly, Eastern Health** **Lessons and reflections on leadership** In this presentation, Alan will reflect on leadership research and the characteristics of successful leaders. He will also discuss and talk about his own leadership journey and based on personal reflections, he will conclude with some tips on what he believes is at the core and heart of successful leaders.
9:45am	**Keynote — Ms Veronica Casey FACN, Nursing Services Queensland Health** **Advancing nursing leadership – trials, tribulations and transformation!** Throughout the world nurses are consistently rated as the most trusted profession, therefore, nurses have an accountability that can't be ignored, that is, to ensure patients, families and communities receive the best possible health care. This presentation will reflect on the lessons learnt through a hospitals journey to nursing excellence and how transformational leadership can and did make a difference.
10:35am	**Official book launch, Dr Ruth Rae FACN** **The History of Australian Nurses in the First World War: An ACN Centenary Commemorative Trilogy**
10:45am	**Morning tea and poster presentations**
11:30am	**Concurrent session two**
1:00pm	**Lunch**
2:00pm	**Concurrent session three**
3:30pm	**Afternoon tea** **Proudly supported by HESTA**
4:00pm	**Panel discussion — Challenges and opportunities for today's nurse leader** Our international and local guest speakers will lead a discussion on the way forward for nurse leadership in Australia. **Panel:** **Professor Anne Marie Rafferty (UK)** **Mr Brian Dolan (NZ)** **Mr Alan Lilly (AU)** **Ms Veronica Casey FACN (AU)**
5:00pm	**Close of Forum day two**
6:30pm	This year the HESTA Australian Nursing Awards Dinner will be held in conjunction with the Forum. Delegates attending the Forum can purchase tickets at the ACN group booking rate, it will be a night not to be missed!

Day three – Friday 16 October

8:00am	**Registration open, tea and coffee in exhibition**
9:00am	**Workshops** **1. Professor Anne Marie Rafferty, King's College London** **The resilient leader or: How to survive the craziness of healthcare and flourish under pressure** **2. Dr Gail Prileszky and Brian Dolan** **What was I thinking? New ways of thinking, influencing and GROWing SMART goals** **3. Sue Hawes FACN, Director PwC** **Know yourself – know your team** **4. ArjoHuntleigh, Principal partner The National Nursing Forum** **What's the risk**
11:00am	**Morning tea**
11:30am	**Keynote — Professor Diana Slade, University of Technology, Sydney and Hong Kong Polytechnic University** **Better bedside handover communication: training nurses in the interactional and informational skills of well-structured patient centred handovers** Ineffective communication between clinicians and between clinicians and patients remains a leading cause of avoidable patient harm across healthcare settings internationally. In this presentation, I will detail the Better Bedside Handover training that has now been delivered to more than 360 nurses at an Australian metropolitan public hospital.
12:15pm	**Closing keynote — Mr Scott Williams** **The happy human** Don't miss your final opportunity to hear from The Doctor as he closes out the Forum in style!
1:00pm	**Lunch**
2:00pm	**Forum close**

HESTA Australian Nursing Awards

Speaker profiles

Mr Scott Williams

Scott, aka The Doctor, is funny, quick, fresh, energetic, sure-fire, bright, original, a natural blonde, unpredictable, crowd-pleasable, unputdownable! We look forward to welcoming Scott at our Forum in Brisbane to be our host and entertain us with his charming style.

Professor Anne Marie Rafferty

Professor of Nursing Policy, former Dean, Florence Nightingale Faculty of Nursing and Midwifery, King's College London

Anne Marie trained as an RN, BSc University of Edinburgh; clinical researcher MPhil (Surgery) University of Nottingham and a historian (DPhil Modern History) Oxford University. She was seconded to the Department of Health to work with Lord Ara Darzi on the nursing contribution to the reform of the National Health Service in 2008. She was a member of the Prime Minister's Commission on the Future of Nursing and Midwifery 2009-10 and awarded the Nursing Times Leadership Award in 2014. She held the Distinguished International Visiting Professorship at the Bloomberg Faculty of Nursing, University of Toronto in 2014 and holds Visiting Professorships at the National University of Singapore, European Observatory on Health Systems and Policy in Berlin and Brussels.

Ms Sue Hawes FACN

Director, PwC

Sue has worked as a nurse for over 30 years. She started her nursing career when there were 3 Nursing Registers, and specialised in working with children and young people with physical and intellectual disabilities. Today Sue works as a consultant and is a Director in PwC's National Health Practice. Sue considers being a nurse to be a privilege, as it gives permission to interact with people when they are at their most vulnerable. Every day is an opportunity to make a difference, ask critical questions and practice the values that are core to who you are.

Mr Alan Lilly

CEO, Eastern Health

Alan Lilly joined Eastern Health as Chief Executive in April 2009. Alan commenced his health career as a Registered Psychiatric Nurse in the early 1980s before completing post graduate education and training as a Registered General Nurse. He emigrated from England to Australia in 1986 and later completed a Graduate Diploma in Health Services Management and a Master of Business in Health Administration.

Ms Veronica Casey FACN

Executive Director, Nursing Services
Queensland Health

Veronica has held diverse roles over her 35 years as a Registered Nurse and Midwife covering clinical leadership roles, quality management and change management positions. In the last 17 years Veronica has held executive leadership roles within Queensland Health and since 2006 she has served as the Executive Director of Nursing and Midwifery Services for the Metro South Hospital and Health Service.

Professor Diana Slade

Professor of Applied Linguistics and Director of the International Research Centre for Communication in Healthcare, University of Technology, Sydney and Hong Kong Polytechnic University

Diana has over 30 years of experience in researching, teaching and publishing in applied linguistics, linguistics and organizational communication. Her main research areas are the description and analysis of spoken English, and on communication in organisational and workplace settings.

Dr Gail Prileszky

Consultant, Qualitas Consortium Pty & Director, RGJK Consulting Ltd

Gail has over twenty years nursing and midwifery experience in clinical and research roles in the UK and New Zealand, centred on women's health, maternity and community based health care. A former Quality Coordinator for Maternity Services, Gail is skilled at evaluating how patients and staff experience healthcare systems and applying those perspectives to initiate improvement in clinical practice.

Mr Brian Dolan

Director, Health Service 360

As one of our most popular presenters at the 2014 Forum ACN is delighted to welcome Brian back. Brian Dolan is Director of Health Service 360 and works with organisations undertaking leadership development, improvements in patient flow and systems reform. He trained as a psychiatric nurse in Ireland and did his general nursing at St Mary's Hospital in London. Most of his clinical career was in emergency care as well as in academic general practice in London.

Registration fees

Forum	
ACN Members	
Early bird full	$650.00
Standard full	$750.00
Day delegate	$400.00
Non-members	
Early bird full	$850.00
Standard full	$950.00
Day delegate	$500.00
Students	
Early bird full	$450.00
Standard full	$550.00

HESTA Australian Nursing Awards Dinner	
ACN Forum delegate	$100.00
Individuals not attending ACN Forum	
Individual ticket	$115.00
Group booking (8 or more guests)	$100.00

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OPPORTUNITIES FOR NURSE LEADERSHIP

By ACN Policy Team

Nurses play a critical role in the provision of equitable, cost-effective, high quality health care. They are the backbone of the health system with their large and widely distributed workforce, and their comprehensive skills sets. Nurses provide holistic care to individuals, families, and communities from a range of backgrounds, and in a wide mix of locations and settings. They are clinicians, coordinators, carers, communicators, managers, innovators, and advocates, among other things. Above all, many are leaders, whether in formally recognised leadership positions or not. Typical of this leadership is their ability to enable others to achieve collective goals, and to provide support, motivation, coordination, and resources. Nurse leaders offer known benefits to the health care sector, with their impact on the health and wellbeing of patients, and on the effectiveness, efficiency, and sustainability of the broader health system, well documented (Goetz et al. 2011; Kieft et al. 2014; Morris 2012).

Nurse leaders have a particular opportunity to improve the workplace conditions of their nursing colleagues. Specifically, nurse leaders have an opportunity to help overcome the substantial issues that inhibit the role of nurses in shaping the future of the health system, especially those of professional isolation, horizontal violence, and cultural barriers to integrated care.

PROFESSIONAL ISOLATION

Professional isolation can present significant challenges to nurses. Geographical, social, professional and cultural isolation can all have adverse effects on nurses' professional development and practice. An isolated professional environment can affect nurses in a range of settings and locations. It tends to be particularly prevalent however in areas such as general practice where there may be only one nurse on staff, and rural and remote locations where nurses may not only be isolated from other nurses, but also from other health professionals. Nurses who work in these settings and who want to build or expand their leadership skills and capabilities may find it difficult to gain support to access leadership education, training or experience.

Geographical isolation in particular can affect the level of infrastructure and support services available to sustain a nurse in their practice. Specific difficulties can arise relating to skill and knowledge development, intellectual stimulation, and professional 'burnout', all of which can hinder the recruitment and retention of nurses, and the development of nurse leaders (NRHA 2005).

Nurse leaders are aware of, and skilled at managing, organisational power structures which allows for their effective contribution to the shaping of policies that can address the negative impacts of professional isolation. They are able to address the barriers by professionally developing nurses who work under isolated conditions. Nurse leaders can put strategies in place to advocate for practice relief, cultural transition supports, and incentives that support the professional development of nurses. Further, they can support the profession with improved connectivity which will help to provide nurses and emerging and current nurse leaders with the intellectual stimulation, collegiality, and increased skills, knowledge and capacity they require and desire. For example, telemedicine, e-learning, email, and teleconferencing with professional mentors and peers all show promise in helping to mitigate the effects of isolation (Williams 2012). Engagement in these activities would in turn help to build leadership capabilities and support nurse recruitment, retention and wellbeing; particularly in areas of known difficulty. Access to these developmental opportunities would allow nurses and nurse leaders to develop the leadership skills necessary for practicing with greater autonomy, and for leading and managing health care teams. Nurses with good supports for the lifelong learning that professional development entails will make a better contribution to addressing the challenges the health care system faces, leading to improved patient access, patient experience and outcomes.

HORIZONTAL VIOLENCE

Effective nurse leaders can play a key role in addressing the underlying causes of horizontal violence. Horizontal violence is described as intergroup conflict and is manifested as overt and covert non-physical hostility such as sabotage, infighting, scapegoating, and criticism (Duffy 1995). It is an act of subtle or overt aggression perpetrated by one colleague toward another. The aggressive act may be physical, verbal, or emotional, with examples including belittling words or gestures, sarcastic comments, fault-finding, and ignoring or minimising another's concerns (Longo 2007).

Evidence suggests that horizontal violence is relatively pervasive in the nursing profession, with studies reporting incidence rates ranging from 17.6% to 75% (Purpora et al. 2012). Many more cases are believed to go unreported (Duffy 1995). Horizontal violence is a serious issue not just for nurses affected by it, but also for the patients in their care. The occurrence of horizontal violence is shown to have significant effects on patient outcomes, nurse care performance, and, more broadly, on the health system. For example, Purpora et al. (2012) find an inverse relationship between horizontal violence and patient care, where the quality and safety of patient care decreases as the incidence of

Continues on next page >>>

horizontal violence increases. Other studies demonstrate how nurses who are subject to horizontal violence may experience physical and psychological symptoms, such as frequent headaches, gastrointestinal problems, anxiety, depression, frustration, and loss of self-esteem (MacIntosh 2005; McKenna et al. 2003; Randle 2003). Inevitably, the personal distress that can result from horizontal violence leads to workforce issues, such as low job satisfaction (McNeese-Smith 1999) and high nursing turnover (McKenna et al. 2003).

In their examination of the underlying causes of horizontal violence, Duffy (1995) and Purpora (2012) argue that a structural oppression occurring between the medical and nursing professions is largely to blame. They find that horizontal violence is often attributed to the characteristics of the person acting violently: that they are simply 'angry', 'rude', or 'arrogant', for example. Rather than reducing it to individual characteristics, however, Duffy (1995) argues that the oppression of the nursing profession is correlated with nurses' adoption and internalisation of the subordinating norms and values promoted predominantly by the medical profession and health administrators. This situation is believed to create an environment of tension and hostility between nurses as some nurses actively seek to kowtow to, and often promote, the very oppressive values, norms, and behaviours they are subject to in order to advance their careers. Some argue that the low self-regard and passive positions taken by some nurses further fuels and perpetuates the oppression and associated horizontal violence (Duffy 1995; Purpora 2012).

Tackling horizontal violence requires nurse leaders to address the structural oppression imposed on the nursing profession. For example, nurse leaders need to empower nurses to have the confidence to practice with autonomy, to question orders and practices and contribute meaningfully to policy and health systems debates and decisions. Nurse leaders play a pivotal role in building nurses' confidence in their abilities, and in supporting nurses' capacity and willingness to challenge undue authority or subordination. Leadership requires courage. Nurse leaders need to have the courage to develop leadership and critical thinking skills in the workforce they direct.

FOSTERING COLLEGIALITY

Integrated health care is increasingly viewed as a solution to the duplication, delays, waste, mistakes, and sub-optimal care commonly associated with a fragmented and siloed health system (Xyrichis & Lowton 2007). Integrated care involves a process of shared planning and action towards common goals, including effective coordination, communication, joint decision making, shared authority, and joint responsibility for outcomes (Lindeke & Block 1998).

It is generally accepted that no single profession can, on its own, adequately address the complex health needs of individuals, families, communities, and populations, without the meaningful input of other health and social care professionals (Lindeke & Block 1998). Teams with greater occupational diversity report higher levels of overall effectiveness, and the innovations developed by successfully collaborating multidisciplinary teams are often more profound and have significantly higher impacts on both patient care and broader organisational functioning (Borrill et al. 2000). Moreover, evidence suggests that client/patient dissatisfaction and other negative quality outcome indicators can sometimes be traced to non-collaboration amongst health care professionals (Hanson & Spross 1996).

Despite what is known about the benefits of integrated care, and how to achieve it in theory, its practical development and application has proven somewhat difficult. Lindeke and Block (1998) put this intractability down to a number of constraints, including those relating to power and authority, and remuneration structures. The authors maintain that positional power in collaborative activities depends on status, which in health care, is closely associated with prestige and title. In interdisciplinary activities, participants are imbued with positional power that may be symbolic of their profession and/or gender. The unequal power base of participants working together may affect the perceived legitimacy of the speaker and thus inhibit their ability to provide input and influence decisions (Lindeke & Block 1998).

Xyrichis and Lowton (2007) support this idea with their assertion that professional identity can cause conflict and act as a barrier to positive relations in the team, consequently stymying effective teamwork. Cook et al. (2001, p. 148) find this to be the case in their examination of the relationship between GPs and practice nurses, quoting a GP as saying:

> *It's sometimes difficult for us to let go of our power base, and as they (nurses) take on more responsibility for developing the service, we can feel that our role is being eroded.*

In another example, Rutherford and McArthur (2004) also find that the differential status of team members can have implications for effective teamwork, where perceived differences may inhibit participation in the decision making processes. In their examination of the primary health care sector in the UK, Xyrichis and Lowton (2007, p. 151) specifically argue that "Although team goals should be developed from within an interprofessional agenda, there is a tendency for the medical profession to assume a leadership role within primary and community healthcare teams and to dominate decision making and goal setting".

Overcoming identity related barriers to better integrated care requires a rebalancing of the power asymmetries between professions, especially between the medical and nursing professions. Power and authority must be negotiated between participants if genuine and effective team collaboration is to occur. Romer and Whipple (1991, p. 215), in distinguishing cooperative care from collaborative care, maintain that "work remains cooperative when the emphasis of a task is on helping one another, but a transition from cooperation to collaboration occurs when authority is renegotiated and shared. Authority involves the power to enforce obedience, to influence, or to inspire. Authority, power, decision making, and accountability must be redefined within the collaborative structure."

To realise this, nurse leaders must focus on building strategies to support interdisciplinary collaboration, which must have the attributes of equal input and participation in decisions. This will entail educating other health professions about the roles, responsibilities, skills, and capabilities of nurses. Most importantly, any strategy to create truly collaborative teams requires professional development for nurses to equip them with the skills and confidence to lead change in the workplace, to rebalance the power asymmetries, and to renegotiate sometimes anachronistic hierarchical structures.

CONCLUDING COMMENTS

Many opportunities exist for nurse leaders to make a positive change to the broader nursing profession, and with it, the provision of health care. Clinical nurse leaders are critical to the identification of issues with the potential to undermine quality of care, such as poor working

relationships in the nursing or health care team. Their collaboration with executive leaders and other health professionals will be vital to identifying and implementing the solutions necessary to improve the functioning of the team.

At the executive level, nurse leaders can influence an organisation's strategic direction through their expertise in service delivery, resource allocation, workforce planning and development, governance arrangements, and quality assurance (White 2011). Executive nurse leaders are therefore well placed to take up opportunities to advocate for the strategic development of the nursing and broader health workforce, in turn ensuring that health services are able to meet the challenges of the future.

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THANK GOODNESS YOU'RE HERE: SOME PERSONAL THOUGHTS AND REFLECTIONS ON THIS NURSING SPECIALTY

By Mandy Cleaver

Sometimes I feel this job takes me away from my reality – or at least gives me another one. The words I hear people say ring in my ears: "just because I have cancer doesn't mean I have to stop living", or "I can't do anything I'm just waiting to die". The images I see are forever burned into my mind. Like the adoring yet devastated look a husband gives his wife as she discusses what medical interventions she would accept and which ones she wouldn't. Or the little dog on the bed, resting its head on the shoulder of its owner – who's now at peace. The pup quiet and still – until the doctor tries to come near his patient to examine and confirm "life extinct", then, and only then, does the pup growl. The moments I get to be a part of – from the most privileged through to the most traumatic. When people choose to die at home, it can be a beautiful and peaceful experience for both the person and their family, but sometimes it isn't. You see, the mix involves illness and accompanying symptoms, family dynamics, stress, fatigue, and change. It's real. It's frontline.

Then I switch straight back to being wife and mum, go home and iron hubby's work shirt, take the kids to after school sport and help with long division maths homework (argh, been a while!). Sometimes I want to scream out, "oh my goodness today was intense!" Of course, I have never, and would never do that. How absolute polar are the extremes of my life? Sometimes it's hard to balance and keep perspective. When we run out of icy poles or we don't have the favourite flavour muesli bars and the kids meltdown, I can't very well say "you're hardly going to die because there's no icy poles Little Sally" – albeit true. Because for a child, no icy poles on a hot Australian summer afternoon is horrific news! The reality for an eight year old is not the same as mine – nor should it be. But to be honest, sometimes I struggle to keep that perspective. I love my children dearly and anything they're concerned about is a genuine concern to me. However, sometimes it's hard to maintain that same level of attention and compassion for a child sans icy pole, that just hours before, I gave to an elderly woman breaking in front of me, as she witnessed her husband of decades, descend into decline. Watching her tears fall as she acknowledges he is travelling along the cruel path so often casually labelled as the typical cancer trajectory. Perhaps the typical cancer tragedy is a more apt name. This living in two different worlds certainly isn't unique to palliative nursing but I do think it's often more amplified in this arena.

So is it all doom and gloom? Absolutely not. I've never counted my blessings more than I do now. We are privileged to share in moments of great beauty, moments of sheer victory and of course, moments of overwhelming humour. Nothing will pause pain like a smile. One family – one of the most unified and supportive families I have ever had the privilege of meeting – were staying together to support a loved one in her final days. The patient had to wear continence pads and was bedridden. The adult siblings attended to the personal care, and decided they also would wear continence pads for a short time to gain insight into the loss of dignity, control and comfort that continence aids can bring. They even "went" with the pad insitu. They all stated it felt very odd after decades of being toilet trained, to allow themselves to "go" while the pad was on, instead of going to the toilet. One of the siblings laughed as she told me the worst for her was the third time she "went" – as she forgot she no longer had the pad on!

"Thank goodness you're here!" Words that send chills down my spine and pump out buckets of adrenalin. You see, when you're at someone's door and their opening line is "thank goodness you're here", it's never followed by "because I've just made a huge double chocolate cake and have no-one to share it with", or "because I've just found out we have a long lost relative – multimillionaire – who's given us all these gorgeous clothes, near new, that won't fit us but happen to be your size!". No, it's usually something more like "because everything's a mess!", or "he's really bad, we had a terrible night", or "we need help!" And the "help" required can cover a multitude of needs. Medication advice, disease progression awareness, equipment to assist with transfers and activities of daily living, or urgent referrals to our occupational therapists, physiotherapists, dietitians, social workers, GPs, specialists, respite organisations and so on. It's bittersweet really, we're here because we can help – but we're here because you're dying. I call it the Mother Theresa Grim Reaper complex. To some, we represent help and comfort. For others, to put it bluntly, we are a stark reminder of death. I've actually had a patient's friend tell me I'm a nice lady but he hopes I never have to go to his house because that would mean he's dying. Yes, we all know in theory we are not immortal. We could be hit by a bus or choke on an apple tomorrow. But, when you've been given a diagnosis, told by medical experts that it's incurable, and someone has actually given an educated estimate of your remaining time, for some in that position, seeing a palliative care nurse is just too confronting. Pardon the expression, but our arrival on the scene sends a very clear message "sh*# just got real".

In the case of early referrals, we can offer so much practical, physical, emotional and spiritual support. For later referrals, sometimes we can still help make those final moments more comfortable. Sadly sometimes, though, and often with very late referrals, we can't do anything much at all. Yet even with early referrals, all the 'boxes ticked', conversations had, affairs in order and end of life care planning completed, a death doesn't always go to "plan". The only guarantee we have with death, is that we're going to have one. Confronting.

So as a palliative care nurse, all we can do is utilise our skills and knowledge, seek help from our colleagues, utilise the multidisciplinary team, liaise between the GPs and specialists, and most of all, listen to our patients and their families. We ask ourselves, what can we be doing to make this moment better? Sometimes it's not medication or equipment, sometimes it's just listening. What can we be doing to ensure this patient's wishes and dignity are respected (ethically and legally), to give the best chance of life in abundance right up until a peaceful death occurs? A death that ends the chapter of what was hopefully a life well lived but what is definitely a life now over.

We witness day in and day out that while someone may have taken their last breath, nothing can take away the love felt for that person. How true are these wise words in the bible - now these three remain – faith hope and love, and the greatest of these, is love.

LEADERSHIP AND ADVOCACY: DON'T FORGET THE NURSES

By Samantha Hoole

Nurse leadership is a complex and often evocative subject. Leadership in nursing is dynamic with a multitude of social, cultural and organisational challenges. We often read about ways of empowering nurse leaders and the importance of taking a stand as an individual entity within the health care profession; the importance of defining nursing as a standalone profession far removed and evolved from the role of "matron" or "doctor's handmaiden". Indeed, I remember one of my first subjects in my bachelor of nursing was foundations of nursing and history of nursing as a profession. It analysed, discussed and argued the sacrifices needed and strength shown by those who came before us. It exemplified how far we have come and what mountains we have moved to not only advocate for our patients, but to advocate for ourselves.

Everywhere I look, read, and google search, there are myriad hands reaching out to assist nurses in developing their leadership skills. They explain the step-by-step "how to" of advancing the nursing profession, as well as their careers. They dictate what is expected of them as nurse leaders. Sadly, the one defining feature that seems to recur more strongly than any other is the expectations of nurse leaders from the health care organisation, from other health care professions, and from the patients we provide for. Rarely do I see what a nurse leader should be providing for the team they are working with and the nurses that they are hoping to lead. It seems that on a small community, ward based level, we have forgotten the importance of advocating for one another.

What do we as nurses crave from our leaders? Easy. All we ask for is a shared reality. I want you here with me, to see as I see, feel the strain and the stress of the coding patient, be with me for the exhilaration and satisfaction of a job well done regardless of the outcome. It's time to bring nurse leadership back to the nurses. While it may sound altruistic, we should be enabling our nursing leaders to advocate, empower and inspire our everyday nursing workforce to become the best that they can, both for our patients and for ourselves.

THE NEXUS OF NURSING LEADERSHIP AND PRACTICE DEVELOPMENT: REFLECTIONS FROM ACN'S MANAGEMENT EDUCATOR

By Leone Pike MACN

Before becoming the Management Educator at ACN, I spent a number of years working as a clinician, and then as a manager, predominately in the mental health and drug and alcohol space. Whilst in my current role, I became aware of the term 'practice development', which, as a concept, seemed to be sweeping across nursing in parts of the UK and much of NSW. I felt that I needed to find out what this phenomenon was.

My educational influences included the student centred approach of Rogers (Merriam & Caffarella 1999), the idea of emancipation through education, or 'transformative learning', and Friere and Mezirow's idea that individuals' schemas may change as they learn (Merriam & Caffarella 1999). When I undertook the Zinn (1983-1994) philosophy of adult education inventory, I found my style was pragmatic and eclectic: a mix of liberal, humanist, and a bit more behaviourist, than I would have imagined. I have always promoted the idea of assessing the learner's needs, using active learning, and that professional learning often needs to be vocationally relevant. I believe the deepest learning needs to occur on an emotional level.

The teaching I am involved in at ACN includes short and postgraduate courses in management. Content includes leadership and management, strategic planning, occupational health and safety, human resources and workforce development, financial management, team building, performance development, and quality and change management. Underlying themes throughout the courses include valuing staff and colleagues as individuals, appreciating their ideas and clinical skills, listening to and respecting patients and staff, respecting self, communication, leading by example, and building a culture of quality practice based on evidence. These themes are consistent with developing individuals and transformational leadership. I am committed to these ideas because I have seen them work.

It was from this background that I first heard about the practice development phenomenon. Words I was hearing around practice development included 'craft', 'quilting', 'crayons', 'coloured pencils' and 'stickers'. Not having a crafty bone in my body, I was somewhat sceptical, but I knew that I needed to know more, and so when the opportunity came up to attend a practice development workshop, I took it.

I found the workshop a little confusing at first. The facilitators seemed unable to define the concept of 'practice development', and there seemed to be almost a cat and mouse game of guessing what it was. As the day progressed, it seemed to me the ingredients for it were that it was person-centred, that it was inclusive of all staff and multidisciplinary, that it was localised, that it valued and respected everyone's work and input, and that it was essentially about improving and giving the best care.

After doing the workshop I felt that I needed to do a little more research and become a little more confident around notions of practice development. A definition I found on practice development from some respected proponents of the idea – McCormack et al. (2004) – is that it is:

> *A continuous process of improvement towards increased effectiveness in person-centered care. This is brought about by enabling health care teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic, rigorous, and continuous processes of emancipatory change that reflects the perspectives of both service users and providers.*

This definition seemed consistent with the ideas that I had gleaned from the workshop.

I then discovered that there was a division in the practice development concept: technical and emancipatory (Manley & McCormack 2003). As I understand this division, technical is about improving practice, whereas emancipatory is about improving and developing those staff involved. I accept that many may be horrified by my reductionist summary, but I am not sure that in the Australian health care context, exploring the nuances of the division would be either profitable or even legitimate. Friere's work (Allman 1999) on the emancipation of illiterate populations under a tyrannical government, who through learning to read, and then being able vote, gained autonomy, is the type of 'emancipatory' development that would be worth differentiating. Such a differentiation is not necessary in the context of most health care provision in Australia

“I found the workshop a little confusing at first. The facilitators seemed unable to define the concept of ‘practice development’, and there seemed to be almost a cat and mouse game of guessing what it was. As the day progressed, it seemed to me the ingredients for it were that it was person-centred, that it was inclusive of all staff and multidisciplinary, that it was localised, that it valued and respected everyone’s work and input, and that it was essentially about improving and giving the best care.”

(although some may argue that it may be useful for some Indigenous populations). To me, improving patient outcomes is the desired outcome of health care, and this involves improving the practice and those providing the service, and this usually requires a positive culture.

Further research revealed that the activities and strategies of practice development include action learning, high challenge with high support, values clarification, critical and 360 degree feedback, observation of care and clinical support (McCormack et al. 2004). All of these activities were consistent with ACN’s leadership and management education. A survey of ACN short course participants, for example, indicated that the important parts of practice development included in our courses were teamwork, valuing the skills of others, communication, and leadership style.

I could draw many parallels between the ideas embedded within ACN’s management education programs and those of practice development: values, clear goals, respect, communication, evidence, culture, teamwork and action learning. Indeed, it seemed to me that ‘practice development’ had wrapped up all the ingredients of progressive management and transformative leadership and given it a name.

I did note some critical comments on practice development, such as those from Thompson et al. (2008), who question whether it has been simply invented as an academic pursuit. I also note comments by Fenwick (2003) who explored the paradox of imposing emancipation: of ‘doing change to people’, suggesting that action learning could actually be oppressive.

Tensions I have noted in teaching management and leadership include the setting of standards, discipline within a ground-up and teamwork approach, quality and innovation when there may be risk takers or ‘mavericks’, localised routines and transferable knowledge, and of course the needs of the task and those of the people doing the task. Tensions as mentioned in practice development might be technical as opposed to emancipatory. A question which perhaps Fenwick may ask of practice development is whose agenda is it?

In the context of modern Australian health care, the agenda is improved quality of care for patients. The navigation of these tensions requires committed responsible leaders and managers who are able to provide clear guidelines and balance. Such managers and leaders both develop those who provide health care, and ensure the best possible care is given. It is often by developing those who provide the care that the best care is provided.

So, given both my theoretical and practical experiences with practice development, how do I feel about it? I think practice development is a name that wraps up a number of the ideas that I am committed to teaching in my courses. I think it provides some good structures for staff to work with, such as values clarification exercises, and action learning sets. It seems inclusive. It looks for best practice evidence but retains a local focus. The movement seems to recognise the need for mentoring, networks and the time that cultural change in a large bureaucracy takes. Maybe by having a name and being a movement, such a dynamic set of characteristics can be recognised and seem more legitimate.

Not much evaluation is available around practice development. I believe that this is because it is about a whole culture, just as I believe desirable leadership and management is about building a culture. There is the danger, as Thompson et al. (2003) point out, that some might over discuss the ideas without actually practicing them.

I applaud NSW Health for its vision to promote the ideas of practice development, with programs like ‘Take the lead’, ‘Essentials of Care’, and the ‘Reach’ program. The Garling report’s recommendation number 23 was already being implemented by such programs before it was even made. I note that the Take the Lead report featured a photograph of Ghandi and his quote “Be the change you want to be”. There is another famous line that, though its origins may be dubious, absolutely fits with Ghandi’s in this context of practice development: ‘Just do it’.

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THE POWER OF ONE

By Musette Healey

The power of one; that ability we all have to make a positive difference in the lives of others. Leadership is about making a difference to others and the environment. It is something we all need to be part of; it is not just for the elite few. Leadership has become something bigger than us. It has become the Holy Grail that only few achieve. It has become about changing the world, but what if leadership was not about all of those things. What if it was about 'lolly pop' moments and 'having each other's back'?

Lolly pop moments is a term used by Drew Dudley (2012) to describe the everyday things that you do, which to you, may be inconsequential, but which have an impact on others. They are the moments when someone says or does something that makes you feel your life is better. Dudley talks about an instance at university where he was giving out lolly pops and interacted with another student who was there for her first day. She was anxious and questioning whether she should be there or not. For him this interaction was insignificant, so insignificant that he does not remember it, but as he found out several years later, it was incredibly significant for her. How many times have you had an interaction with someone who has changed your life? Have you ever told that person?

I have been very fortunate to have worked with some incredible nurses who have demonstrated this everyday leadership that Dudley refers to. Think about the nurses you work with, who do you identify as a leader and why? Everyday leadership is about the little things that we do that make a difference in others' lives; it is about giving that lunchtime antibiotic for the colleague who has not yet been to morning tea; it is about the "thank you for a great shift" that you say as you walk off the ward at the end of a busy day. We do not know what is going on in someone else's head and our single action or words could be the thing that changes their thought process; their actions.

Leadership is not an individual endeavour. You cannot have a leader without followers, and you cannot have followers without a leader. Leadership, therefore, requires a team. There have been some interesting observations about leadership from the military, and there are lessons that we as nurses can learn from them regarding leadership. Nursing has a strong hierarchical structure similar to the military, and like the military we often work in teams, in high pressure, high stakes situations, where peoples' lives are at risk.

In a TED talk in 2011, General Stanley McChrystal, the former commander of the US and international forces in Afghanistan, spoke about what he has learnt about leadership through his military career. For me, the key messages from his talk were that we need to have a sense of shared purpose and consciousness despite the varied ages and skill sets of our teams. We need to listen and learn from each other; we need to be able to let each other "fail but not be a failure" (McChrystal, 2011). We need to build trust and faith in each other and foster relationships.

McChrystal (2011) says *"I came to believe that a leader isn't good because they're right; they're good because they're willing to learn and trust. This isn't easy stuff. It's not like that electronic abs machine where 15 minutes a month, you get washboard abs. And it isn't always fair. You can get knocked down and it hurts and it leaves scars. But if you're a leader, the people you've counted on will help you up. And if you're a leader, the people who count on you need you on your feet."*

So how do we develop this leadership in nursing? How do we all become leaders every day? Firstly, we need to recognise that we all have something to contribute regardless of age, ethnicity, education or experience; the Assistant in Nursing (AIN), the new graduate registered nurse, the Registered Nurse (RN) with 25yrs experience, all have something to offer. Unfortunately, horizontal violence is still active within our profession and it is like a virus that is easily spread and can undermine the health of the team and the leadership attempts of its members.

We need to have a shared sense of purpose within our ward/unit/practice and health facility and I would challenge you to extend this beyond the obvious of providing high quality care that leads to positive patient outcomes.

Within our units we need to foster relationships with each other, gain understanding and insight into what makes each other tick, what our strengths and weaknesses are, and build the trust and faith in each other and our abilities. We need to respect each other, listen and learn from each other and support each other, we need to 'have each other's back'. We need to build a team where we all have and take the opportunity to lead and we need to take the opportunities to acknowledge the 'lolly pop' moments regardless of how small they are.

Let us create a leadership movement in nursing that starts from the ground up, because we all have the power of one.

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REGIONAL ROUNDUP

On May 12 2015, many ACN members came together to celebrate International Nurses Day (IND). A number of ACN Regions, especially those in Queensland, made the most of the opportunity and encouraged member attendance at a number of local events, highlighted below.

QLD SOUTH REGION

Queensland South Region members experienced a wonderful dinner whilst sharing stories of nursing experiences. It brought much laughter. The brave whistleblower nurses of Campbelltown and Bundaberg were also honoured. Further, the group honoured Barbara Healey MACN who celebrated her 49th year in practice and is still going strong. The Key Contact Ilze Jaunberzins looks forward to seeing more of you on August 4 at the next ACN gathering, titled "What can the legacy of Vivian Bullwinkle teach us about resilience?"

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BRISBANE REGION

On IND in Brisbane, Region Key Contact Belynda Abbott attended the Royal Brisbane and Women's Hospital IND celebrations to spread the word about ACN. Belynda had many visitors to her wonderfully decorated table and was able to provide some wonderful giveaways and a raffle prize. Thank you Belynda for attending on behalf of ACN.

Belynda Abbott FACN
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QLD FAR NORTH REGION

ACN's Far North Queensland Region members celebrated by hosting two local breakfast events – one in Cairns and one in Townsville.

Cairns

Twelve nurses attended the IND ACN nurses breakfast in Cairns. The Rural Flying Doctor Service (RFDS) hosted the breakfast, which included a tasty continental mix of pastries, fruit, yoghurt and frittata. Katherine Isbister, RFDS flight nurse, gave a presentation on the history of RFDS, the sort of work they do in far north Queensland and the role of a flight nurse. RFDS Pilot Ben then showed participants around one of the aircrafts and flight nurse Caren Harrison explained how the nursing staff worked in the aircraft. Participants at the breakfast were from James Cook University, RFDS, TAFE, and private and public hospitals.

Townsville

More than a dozen nurses came together over breakfast in Townsville on International Nurses Day to celebrate who they are and what they do. An enjoyable morning of networking and socialising was had by all.

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Visit ACN's Engagement page on ACN's website www.acn.edu.au/regions to find out who the Key Contact is in your Region.

ACN MELBOURNE REGION LEADERSHIP GROUP: A NEW INITIATIVE

By Jennifer Newton FACN

This year in response to a call for interest, several members put their names forward to form a leadership group to assist in planning events and promoting ACN. I was delighted with the response and you can read a brief biography about this diverse and interesting group of members.

Kalpana Raghunathan is an RN and MACN. She currently works as a Consultant, Education and Training (Strategy, Design and Development). Kalpana has extensive experience in education and training strategy and development, having had leadership roles in vocational education. She has developed and managed health and community services qualifications for national training providers and specialises in designing educational programs for differentiated instructional settings, different learning environments and change management in education programs. Kalpana has a particular interest in learner preferences and education and training strategy in vocational education and workplace learning.

Donna Watmuff, FCHSM, CHE, FACN has international experience and perspectives in adult health education, human resources management, health care sales and marketing, residential aged care services and quality auditing services for community health care organisations. This includes in unionised and non-unionised private, not-for-profit, charitable and public sector environments. Cross-functional operational expertise has been gained in these fields in California, USA, and Australia, augmented by a life-long dedication to continuing professional development. Donna is a Fellow of ACN and is active in professional volunteerism, serving on ACN's national Community and Primary Health Care Nursing Community of Interest Advisory Committee. She is a Fellow of the Australasian College of Health Service Management (ACHSM) and serves on the Australasian College of Health Service Management, Victorian Branch, Education Working Group and was the recipient of the Claude Frencham Award, 2013, for significant contributions to the aims of the College.

Kylie Mayo is part of the pioneering group of clinicians who first introduced formal clinical networks into the Australian environment. Kylie is recognised as a leader in clinical engagement across the country. She has over 30 years' clinical, policy and administrative experience. Kylie has been providing advice to both government and nongovernment clients for over 15 years and has been involved in projects covering the configuration of surgical services, strategic service planning, development of models of care, transition planning for primary health care organisations and Local Hospital Networks, clinical and corporate governance, eHealth, development of business case components for new and replacement hospital builds, and ICT investment. Kylie has significant experience in recognising clinical commissioning requirements, issues and risks within complex and highly visible projects including new hospital builds and state-wide ICT deployments.

Meg Pollock is a recently registered nurse who just finished her graduate year at a large inner Melbourne private hospital. She currently works on a cardio-thoracic/vascular surgical floor and is undertaking her honours degree at Deakin University. Her topic is the patient experience of medication management, focusing on the difference between electronic and paper systems. She joined the ACN Melbourne Region leadership group to gain a better understanding of nursing issues in Melbourne and to gain experience working with more experienced nurses. She hopes to provide the junior nurse's perspective on issues facing the nursing profession.

Nyree Taylor is a Registered Nurse with experience working in clinical nursing and research. She has assisted professors and research teams design and develop studies for nursing practice. One of the core principles of working with teams is the importance of a team-based approach, and Nyree thrives on opportunities to work with people discovering new opportunities, new solutions, and improvements to enhance patient care. Her research areas include: facilitating clinical communication, evaluating technology for nursing care, gerontological online learning modules for cancer nurses and cancer survivorship education strategies.

Christine Smith RN MSc (Michigan) is a Fellow and current Director of ACN. She was a member of the Unification Committee to unite the Royal College of Nursing, Australia and The College of Nursing. She has practiced nursing for over 40 years in Australia, the USA, and England, and worked and consulted in organisations in the areas of health service planning, education and professional development since 1995. Between 1986 and 1995, Christine held senior appointments in hospitals in NSW and Victoria, including Deputy Director of Nursing from 1988-1995. From 1993 to 1995 Christine was involved in the development of a model of care based on the concept of Patient Focused Care, and the concurrent redevelopment of a major hospital in Melbourne.

We evidently have a very interesting and diverse range of members who are assisting in raising the profile of our Region.

Watch out for updates in the ACN eNewsletter for our planned events. In particular, in late October there will be the annual Gertrude Berger Oration and symposium which will have a focus on technology and the nurse.

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ACN Melbourne Region Key contact

THOUGHTS ON LEADERSHIP: INTERVIEWS WITH COI KEY CONTACTS

For this issue of The Hive, where the theme is 'Supporting our Nurse Leaders', ACN asked a number of Key Contacts from the ACN Communities of Interest (COI) to tell us a bit about their leadership journeys and experiences, including challenges, opportunities, and advice for aspiring nurse leaders. COIs are groups of ACN members who share a similar area of practice or professional interest. They provide opportunities for members to enhance their knowledge and keep up-to-date with the latest news and research findings, examples of best practice, and major policy developments. They also allow members to engage in a networking capacity with other members who share their area of professional interest. Each COI has a Key Contact who liaises with members and ACN. To find out how you can be part of an ACN COI, please visit the Engagement page of the ACN website or email engagement@acn.edu.au for more information.

DR CATRIONA BOOKER FACN

ACN Key Contact Leadership & Management COI

What motivated you to move into a nurse leadership role? Did you always envision working in leadership?

While my first two children were very young, I chose to work night shift as it suited my life commitments at that time. On reflection, while leadership was not a strong focus in those early days, I always held a passion for nursing as a developing profession, and felt strongly about having a voice. As a result, leadership and relevant roles did not become a focus in my career until my home commitments were less dependent on my time.

While I always felt committed to the profession, leadership opportunities initially 'tapped on my door' rather than me gainfully seeking them. On one of those night shifts, I received a call from the then Assistant Nursing Director for Education. The reason for her call was to ask if I was interested in acting in the midwifery educator role due to a gap in the current workforce.

This potential transition meant that I would be transferring to permanent day shift for the time of the secondment; something that diverged from my family plans. My focus had been on balancing home life with a young family and work. This offer stimulated my passion. I was quite flattered to be invited to take on the leadership role and yet quite nervous about my ability to meet the challenges this role would bring. In addition to a Certificate in General Nursing and Midwifery, I had undertaken a postgraduate degree in Nursing, and a Certificate in Mental Health. This study afforded me additional skills and knowledge, as well as a small measure of confidence.

In summary, I didn't make my transition to a leadership role through a planned process, but rather a prompt from another nurse leader. It provided an opportunity which I am very grateful for and it certainly initiated enthusiasm and motivation to continue on a planned career path. I am now an Assistant Nursing Director for Education within a large tertiary and quaternary hospital with some health and hospital responsibilities. This initially unplanned path has afforded me numerous professional opportunities. Since my first opportunity, I have been far more 'strategic' in determining my career direction.

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

It certainly would have been of benefit in my early career to be more aware of the organisational and professional structure, and the variety of available career paths. Professional organisations are essential to support awareness of professional development and networking opportunities.

From someone who did not plan their early career, ACN does provide opportunities on a 'platter' to support development as a professional. These can be accessed through the National Forums, access to regular magazines, and opportunities to review professional documents which influence nursing practice. In short, each nurse, regardless of their classification, has an opportunity to have a voice in the profession, and to grow from the experience. This professional group works hard to engage its members.

What are some of the challenges you face as the leader of your COI?

There is often a perception that if you have been a clinician for a significant time and are successful in that stream, then you can transfer to a leadership position with no formal support or preparation. Some well-resourced facilities offer a mentorship support network, however evaluation of the effectiveness of this support from a return on investment is difficult to quantify.

I also believe that many in leadership positions are challenged with bureaucratic processes which tend to stymie progress, creativity and innovation. Similarly, the economic environment dictates that financial integrity will also place boundaries or limits on the diversity of what can be progressed.

What are your goals for your COI?

Have a growing membership of nurses and midwives who contribute to:

- the fabric of leadership programs to support professional development
- a lead role on the design and development of a national mentoring program for nurses and midwives

- development of career pathways
- the political ACN voice for nursing profession issues

What are the biggest obstacles for nurse leaders in the Australian health care system?

Development and maintenance of a capable and competent workforce

How do you see nurses progressing change most effectively?

Collaborate with the professions with the intention of speaking as one voice. We are more powerful as a professional voice

Communicate effectively and broadly both within and externally to the profession

Enhance Industry and Academic partnerships

What is the best way for new/graduate nurses to move/expose themselves to leadership roles?

Consolidation of skills and knowledge is critical. I believe that once the basic skills and knowledge are confidently achieved, then it is a progressive step to increase complexity of skills and knowledge. Accessing professional supports through professional bodies is important and of great value if you have synergy with your mentor. Additionally, continuing to undertake programs to gain professional academic credit is vital.

What is the biggest misconception of nurse leaders?

That leadership and management is the same skill

ELIZABETH HANNA FACN

ACN Key Contact Climate and Health COI

What motivated you to move into a nurse leadership role, and specifically the COI role?

As I have done throughout my career, I identified a need, chose the areas that match my skill set and interest, and matched them with my availability.

Did you always envision working in leadership?

It has been a natural progression from very early in my nursing career. I have always been happy to assume responsibility when asked to do so. Nowadays, at this later stage of my career, I offer when I'm able to.

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

I engage ACN with the mindset that 'the more you put in, the more you get out. By that I mean in terms of personal growth, awareness of the key issues facing your profession, professional concerns, and job satisfaction. You get to the heart of what underpins health in Australia; where the real challenges lay, what needs to be done, and where it is all going awry. And what can I do to make a difference? Other benefits include connecting with other people passionate about your area.

What are some of the challenges you face as the leader of your COI?

My limited time, as I am already busy doing similar volunteer work for other health organisations, e.g. CAHA, PHAA and a few government committees, e.g. the NHMRC, Department of Health etc.

Lack of members wanting to assume active duties. To be fair though, most are working outside the area of climate change, so they do not feel as though they have the 'authority or knowledge', which is what I am happy to offer, including courses.

What are your goals for your COI?

- For me to devote more time to it
- To reinvigorate it
- Attract more helpers to assist in running activities, and spreading information, so that it grows into a strong active group that can eventually be self-sustaining
- In five years' time, for there to be hundreds of active members of nurses, whose roles are clearly delineated as climate change nurses

What are the biggest obstacles for nurse leaders in the Australian health care system?

I am not in a position to comment specifically, but I expect they probably relate to many nurses still operating under the self-imposed boundaries of what they are allowed to do, i.e. scope limitations, rather than stretching those boundaries, expanding their knowledge and skill set. As in my own career, and those of many of my training group and Nsg colleagues, we have diversified. I do my thing, which includes teaching in the ANU Medical School program, and supervising the PhDs of Obstetricians, Public Health Physicians and Anaesthetists. One buddy is a Coroner in Vic, another is the CEO of major hospitals, and Professors of Public health - all showing that nurses can be leaders throughout all areas of the Health sector. We just need to reach out and go for it. As for obstacles, I expect that funding shortfalls are a killer, which is stretching/limiting the quality of care able to be provided. I also think that there has been a shift away from actual 'caring', which admittedly, must be hard to maintain when nurses are systematically quashed.

How do you see nurses progressing change most effectively?

By being committed and passionate. By caring about the health of Australians, as if everyone were their own sister/brother/mother/child. And by caring about their profession and the regard it is held in by the public, fellow health practitioners, and decision makers. When we have a critical mass of nurses who care and are passionate about making a difference, it happens. But opportunity will not come and seek us out if we hide under a rock, or try to do as little as we can get away with. It takes effort, drive, and commitment.

What is the best way for new/graduate nurses to move/expose themselves to leadership roles?

First by gaining clinical mastery of their chosen area, moving across areas to find their niche, and broadening their skill set. I doubt it is possible to have genuine leadership without a strong clinical background, and indeed a solid understanding of life 'on the shop floor' in the wards, in the clinics, and in the community, i.e. 'at the coal face'. They need to understand nursing and the issues first. They should be on the constant lookout for ways to make 'it' better - to improve the health system. That may include offering to assume responsibility on committees, offering ideas, and doing extra study. Be keen. This goes back to the scenario of getting back what you put in, i.e. those intangible benefits of having a deep understanding, and the ability to articulate the key issues and offer solutions. Growth towards leadership competence (not merely landing a gig) is a brick by brick effort, and never lose sight of the fact that leadership is about others, not the self.

What is the biggest misconception of nurse leaders?

Hmm, interesting question. I think the biggest one I have witnessed in operation is a misconception that nurses are stupid, and sometimes petty, and therefore cannot apply themselves to bigger problems, or to be really effective in dealing with them: the 'just a nurse' syndrome, which implies hiding under a rock, awaiting permission to clean up a doctor's mess, and being grateful for the opportunity to be a doctor's hand maiden.

KATE PARTINGTON MACN

ACN Key Contact Community and Primary Health Care COI

What motivated you to move into a nurse leadership role? Did you always envision working in leadership?

I completed my Registered Nurse training via the hospital system in 1983. During my first clinical ward experience as a preliminary training school (PTS) student I remember encountering a Charge Sister who devoured nursing students! Even as an early career nurse I felt incensed by this behaviour and felt that there must be a better way of nurturing and supporting nurses at all levels so that patient/client outcomes would be optimal.

I progressed on to CNS in my chosen speciality of community health nursing, intermittently acted in Nursing Unit Manager (NUM) roles, and then undertook a Nurse Educator role. As I was progressing through my career it became evident to me that those up the hierarchy were often there by sheer time in the position (through longevity or acting opportunities), and were not necessarily equipped with the skills either to manage or to lead. I decided that if I was serious about developing into a good nurse leader then I had a responsibility to complete extra studies.

I completed a Bachelor of Business, majoring in Human Resource Management, to prepare me to manage and lead nurses. I was subsequently appointed NUM of a Community Health Nursing Team. I more recently completed a Master of Nursing to further consolidate my formal learning in nurse leadership. No specific Master's program existed in nurse leadership so I chose subjects which aligned with my interests in effective leadership and management. I am now working with a Local Health District (LHD) as a Nurse Manager in Community Aged Care and am responsible for a number of teams consisting of nurses and other health professionals.

How does membership with a professional organisation – ACN - enhance your professional experience?

Membership of a professional organisation such as ACN enables me to keep current with developments in nursing. To quote Harry S Truman: "Not all readers are leaders but all leaders are readers". ACN material helps ensure that I keep abreast of current happenings in the nursing world which is imperative for being able to influence future directions in health care. In addition, attending the ACN Annual Nursing Forum provides up-to-date information and also enables networking opportunities with other nurses across all career stages.

What are some of the challenges you face as the leader of your COI?

I commenced as Key Contact for the Community & Primary Health Care (C&PHC) Community of Interest (COI) earlier this year. My motivation for taking on the role was that I believe strongly in the importance of Community & Primary Health Care Nursing.

It provides a quality, safe and economically sustainable way to deliver health care in an era of rapidly expanding consumer choice and finite health dollars.

What are your goals for your COI?

Our current focus is growing the profile of Community and Primary Health nurses who have struggled to have a voice in political spheres. Medical practitioners currently dominate public debate in this area, but I feel there is a valid role and opportunity for nurses to push for greater reform and lead the change. Nurses however first need to be visible to enable them to successfully influence.

What are the biggest obstacles for nurse leaders in the Australian health care system?

Firstly, the biggest obstacles are nurse leaders themselves being reluctant to lead change. Too often nurse leaders are the reactionaries rather than the revolutionaries. Secondly, an entrenched culture (within and external to health) which defaults to our medical colleagues as the source of greatest knowledge of our health system. Nurses and other health professionals have much to contribute, especially with respect to Community & Primary Health Care.

How do you see nurses progressing change most effectively?

I think nurse leaders have to become more politically savvy and start engaging more directly with the consumers of health to establish and lead the change that is needed.

What is the best way for new/graduate nurses to move/expose themselves to leadership roles?

I believe that I have always taken every opportunity to develop myself both personally and professionally. I believe in maintaining good professional boundaries and ensuring a balance in my life. Early career nurses should seek out opportunities; be smart about positioning themselves for opportunities; and be prepared to move out of their perceived comfort zone.

What is the biggest misconception of nurse leaders?

The biggest misconception of nurse leaders is that they can singularly effect change. Nurse leaders need to be collaborative, utilise others' expertise and value the input from all levels within nursing. Together we can make a difference.

SUSAN WILLIAMS MACN AND SALLY-ANNE WHERRY MACN

ACN Key Contacts Movement Disorders and Parkinson's COI

What motivated you to move into a nurse leadership role? Did you always envision working in leadership?

Sally-Anne and I are both very passionate about our chosen area of nursing expertise: Parkinson's disease and movement disorders. We are very fortunate to work with many other nurses who want to see Parkinson's disease nursing as a burgeoning specialty. Ultimately we aim to improve services to, and the care of, our wonderful patients, and to support other nurses in creating the vision we share of a country where all people living with Parkinson's have access to the services they need.

How does membership with a professional organisation – ACN - enhance your professional experience?

The ACN provides a forum around which to gather. Nurses don't need to work in isolation. It can be just as isolating working in a city tertiary hospital as in a rural setting. Nurses are responsible for creating themselves a professional network and pulling from resources available to them. By being part of the ACN, you have the ability to interact and network with other like-minded nurses. They may not be down the hall, but they are on the end of an email or the phone. You also have the ability to reach out and nurture others, help them to develop their interest into a speciality like ours.

What are some of the challenges you face as the leader of your COI?

Our time is given to the organisation and so it often competes with other pressing issues, such as work or home. As the Movement Disorder and Parkinson's disease (MDPD) Community of Interest, we have a diverse group, from ward and community nurses with an interest in the area, to specialists and academics. Catering for that breadth of nurses is challenging in the extreme, especially given our limited time.

What are your goals for your COI?

We would love for the MDPD COI to be a resource for nurses caring for patients with Parkinson's disease or a Movement Disorder. We realise how specialised this area is and feel privileged to be able to dedicate ourselves to such a niche area. But the truth is our patients access health care in many different ways. We would love our patients to meet informed nurses in all aspects of their care, be it their general practice nurse, the ward nurse caring for them post-surgery, their community nurse or the RN in the nursing home. It is also a way for the next generation of Parkinson's specialist nurses to learn, evolve and be mentored.

What are the biggest obstacles for nurse leaders in the Australian health care system?

Nurses often underestimate the power of their voice to make change. We are prepared to speak up for our patients individually, in our place of work, on our eight hour shift. We will advocate for services at home, medications on time, access to treatments, medical reviews. If we can extend this voice to include lobbying for change on a larger political landscape then we have the power to make a real difference for our patients. We may doubt ourselves and assume our voices are not important. They are.

How do you see nurses progressing change most effectively?

Keep chipping away at your goals, and don't do it on your own. Keep learning, keep collaborating.

What is the best way for new/graduate nurses to move/expose themselves to leadership roles?

New nurses come at things with fresh eyes and the passion of youth. These guys are the ones with the passion and energy to get things done. Those of us who have been around for a while get tired, but we have learnt from our experience and are hopefully wiser for it. So put your hand up for opportunities to contribute to the projects going on where you work. Partnering the energy and passion with the wisdom and experience makes for a remarkable team.

What is the biggest misconception of nurse leaders?

Leaders are often seen as special or amazing people. Usually they are really like Sally-Anne and I, nurses just willing to have a crack at it. Think big, start small. Nursing leaders aren't always managers, they are people whose passion leads them to extraordinary efforts.

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