Australian College of Nursing

the hive

#19 SPRING 2017

RESPIRATORY DISEASE

TUBERCULOSIS
MY RUN IN WITH AN INFECTIOUS DISEASE

NEONATAL RESPIRATORY OUTCOMES
COMBATING CHRONIC LUNG DISEASE IN PREMATURELY BORN INFANTS

CYSTIC FIBROSIS
WHY HAVING CYSTIC FIBROSIS IS LIKE BEING AN ELITE ATHLETE

NEWS & VIEWS

ACN CEO RECOGNISED FOR CONTRIBUTION TO NURSING

ELECTION OF DIRECTORS AND ANNUAL GENERAL MEETING

COLLEGIAN CLIMBS THE JOURNAL RANKS

Australian College of Nursing

EMBRACE YOUR PASSION AND SPECIALISE WITH ACN

ACN'S GRADUATE CERTIFICATES

OVERVIEW

ACN offers a number of graduate certificate courses, enabling nursing professionals to gain the qualifications they need to specialise in their particular passions and skillsets within the health care industry.

FLEXIBLE LEARNING

ACN offers a flexible learning environment, with all of our graduate certificate courses and postgraduate units of study being available part-time, online and some units of study encompassing clinical placement experience.

FEE-HELP

FEE-HELP is a loan scheme that assists eligible fee-paying students with tuition fees. ACN is an approved FEE-HELP provider. FEE-HELP can be used for our graduate certificate courses, provided the student meets the necessary requirements.

Call: 1800 265 534

the hive

#19 SPRING 2017

RESPIRATORY DISEASE

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Editors
Sally Coen
Olivia Congdon
Karen Watts

Editorial Committee
Ruth DeSouza MACN
Kate Kunzelmann MACN
Elizabeth Matters FACN

Design
Nina Vesala
Emma Butz

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

Printing
Elect Printing, Canberra

Advertising
02 6283 3417
partnerships@acn.edu.au

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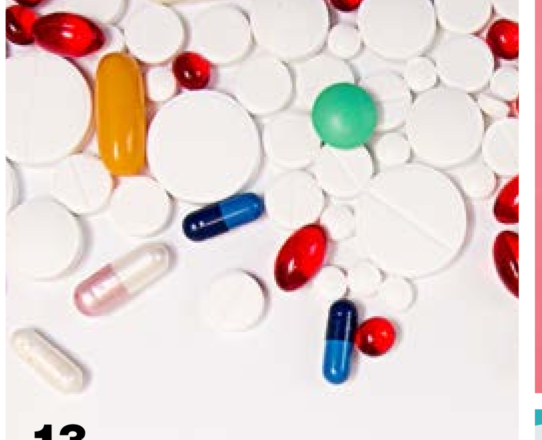
We love to see member submissions in *The Hive*. If you're interested in having your submission considered for publication, please see our guidelines and themes at **www.acn.edu.au/publications**.

For enquiries or to submit an article, please email **publications@acn.edu.au.**

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



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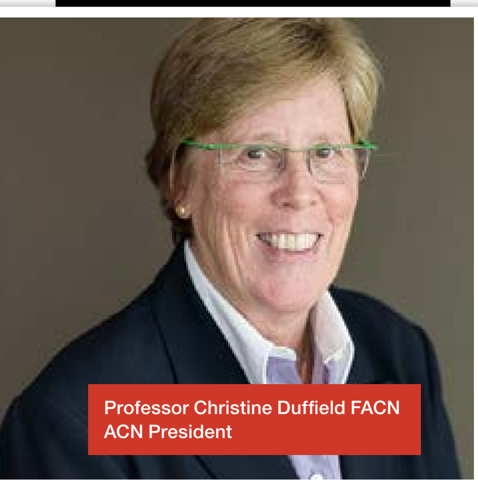
President's report



Professor Christine Duffield FACN
ACN President

The Australian College of Nursing is a 'newish' entity arising from a merger in 2012 of its two predecessor organisations.

Many of our membership is working or involved in one of the two most *dynamic* industries at the moment, health and higher education, so you understand the time and energy it takes to manage such a change. Belief systems are challenged, directions change, people come and go, new ideas emerge, some ideas get lost in the momentum of the moment only to re-emerge later, and eventually, a new organisation emerges.

Many of our longer standing Members and Fellows have commented that ACN in 2017 is a different organisation now than it was. It is likely to be a different organisation a year from now! This isn't unusual – we don't live in a vacuum and external conditions will always impact on an organisation. Success lies in our ability to adapt to new conditions, such as our changing membership.

As a membership organisation it is important that we know and understand those we represent. This is not an easy task given the diversity of the nursing workforce, not only in the variety of roles and specialties, but also, in our cultural diversity. Workforce sustainability is defined as having sufficient staff in the domestic context to meet health service demands (Little & Buchan, 2007). Australia has never achieved this (Duffield, 2015). We are an aging workforce – the average age of a nurse currently is 44.3, and 39.3% of nurses are over the age of 50 (Department of Health, 2016a; Department of Health, 2016b) and perhaps contemplating retirement. While the number of undergraduates entering nursing programmes is increasing, completion rates are declining (Department of Education and Training, 2014). As a consequence, we are heavily reliant on migration to meet the staffing shortfall, particularly of experienced nurses. It is estimated that 30% of nurses are born overseas (Ohr et al., 2010) making us a culturally diverse workforce. That said we are improving. The sustainability ratio increased from nearly 40% of nurses educated in Australia in 2003 to over 60% in 2013 (Duffield, 2015).

ACN's membership has grown by 9% this year and change is evident. While 32% of our members are aged 50–59, 40% are now under 49 years old and 20% are 39 years or less. We have experienced a 30% increase in male membership. Currently 56% have been members for five years or less and 41% were not members of our antecedent organisations. However, retention rates remain high with 2,963 members staying with ACN for over 10 years. While our Fellows still only comprise 8.5% of our membership, there are strategies in place to increase this number.

We have encouraged 1,111 undergraduate students to engage with us, with another 161 graduate nurses joining this year alone. We have 53 organisations which have affiliated with us, including our first Western Australian Affiliate, Edith Cowan University. While NSW has the largest number of members (30%) Queensland is increasing its membership very quickly (23.8%) and could overtake NSW if current growth rates continue.

In line with changing demographics, the way in which potential members find out about ACN has also changed. 269 members have joined through the internet, 139 through social media, 319 through universities and TAFEs and 471 members have joined because of a positive recommendation from colleagues or friends.

This edition of *The Hive* showcases the diversity of experience and expertise within our growing membership base. Through the theme, *Respiratory Disease*, we demonstrate the need for both our profession and organisation to continue to evolve to meet future demands facing our health care system.

MEMBERSHIP INCREASE

ACN has experienced a 9% increase in membership over the past twelve months

MALE MEMBERSHIP

During the past year, we have experienced a 30% increase in male membership

UNDERGRADUATE AND START-UP MEMBERS

We currently have 1,111 undergraduate and start-up members

ORGANISATIONAL AFFILIATION

We now have 53 Affiliate organisations across all four levels of our program

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Hello!

Welcome to the spring edition of the Australian College of Nursing's quarterly member magazine, *The Hive*.

At the forefront of care delivery and heart of our health care system, nurses are well placed to drive transformational change, shape future frameworks and lead improvements to tackle the rising burden of chronic disease in this country. Within this edition of *The Hive*, we feature a number of insightful articles that highlight how nurses collectively reduce the widespread impact of respiratory diseases within the Australian population.

Nurse-led management programs are an essential step in decreasing the mortality, morbidity and disability rates of respiratory diseases. In her highly informative piece, **Antibiotic stewardship – outcomes for COPD patients, Professor Colleen McGoldrick MACN** offers insights on how our profession can lead effective pulmonary rehabilitation, management and education with an adherence to therapeutic guidelines.

New technologies and treatments have facilitated a significant shift in the management of chronic respiratory diseases over time. In an engaging editorial, **A new clinical role for nurses – turn of the century advancements in pulmonary hypertension, Tara Hannon MACN** explains how technological advances have facilitated new models of care and enhanced respiratory outcomes for patients living with rare lung diseases.

As technology continues to advance and evolve health care delivery, it is important that we still remember to honour the origins of our profession. Giving a historical perspective on innovations in nursing practice, **Marilyn Gendek FACN** achieves this perfectly, taking readers on a fascinating journey through our professional history in her captivating piece, **The humble stethoscope – a historical approach**.

Utilising technology to finesse treatment regimes and improve respiratory health is a concept further explored by one of our nurse educators, **Trish Lowe MACN**, in her clinical update, **Neonatal respiratory outcomes – combating chronic lung disease in prematurely born infants**. Drawing on a wide body of empirical evidence, Trish describes the pathological processes that can impede foetal lung development and examines various nurse-led initiatives aimed at improving patient outcomes.

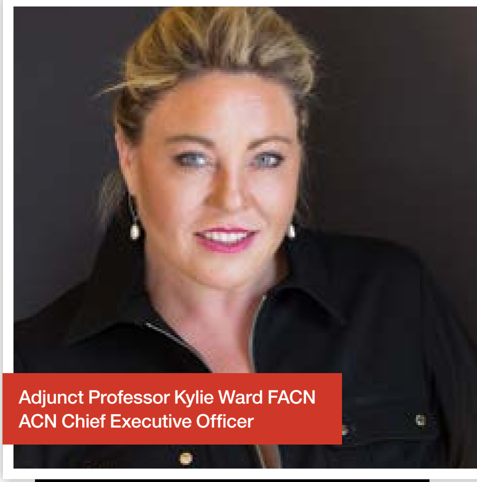
With the care and management of chronic conditions, it is important to not only focus on achieving optimal health outcomes but preserving quality of life. Reflecting on her experiences supporting a young patient coming to terms with a debilitating diagnosis, **Connie Kambanaros MACN**, outlines the immense importance of compassion and empathy within nursing practice in her beautifully honest self-reflection, **Caring for young adults with cystic fibrosis**.

The complexities of care for people living with this recessive, genetic condition is further touched on by **Felicity Finlayson MACN** in her fascinating comparative piece, **Cystic fibrosis – why having cystic fibros is like being an elite athlete**. Drawing upon her wealth of experience and expertise as a specialist nurse coordinator, Felicity provides a fascinating comparative analysis that provides readers with an interesting perspective on how to best support patients living with chronic conditions.

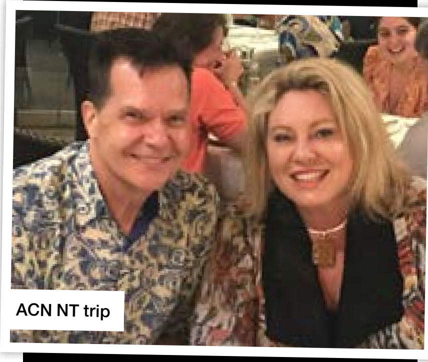
Effective communication is essential to build trust and support patients as they navigate the intricacies of our health care system. In her regular feature, **Nursing matters, Elizabeth Matters FACN**, discusses the value of incorporating foreign language acquisition into current education frameworks to enhance communications in an increasingly globalised society.

Building the capacity and capability of the nursing workforce to address the changing health profile of our population is further emphasised by **Alison Devitt MACN** in her engaging clinical research piece, **Nursing reflections on a pilot project – improving outcomes in chronic disease management using nurse-led home telemonitoring**. In her engaging research report, Alison outlines an innovative model of care aimed at enhancing the lives of Australians living with chronic and complex conditions.

I hope you enjoy the read and feel inspired by the power of our profession.



Adjunct Professor Kylie Ward FACN
ACN Chief Executive Officer



ACN NT trip

National Nursing Forum

Investiture of Fellows

ACN NEWS & VIEWS

COLLEGIAN CLIMBS THE JOURNAL RANKS

Recent academic journal rankings have placed ACN's *Collegian: The Australian Journal of Nursing Practice, Scholarship and Research* in a high position, compared to other journals in the same category.

Collegian has climbed from an impact factor of 1.122 to 1.398. This is an impressive increase, and demonstrates that *Collegian* articles are being frequently cited.

This measurement reflects the credibility and importance of the journal on the basis of the number of citations an average article receives.

ACN is very proud of this achievement and wishes to congratulate our Editor-in-Chief Professor Lisa McKenna FACN and team of editors, Melissa Bloomer FACN, Elizabeth Halcomb FACN, Eamon Merrick MACN, Jennifer Newton FACN, Jane Phillips MACN, Nicholas Ralph MACN and Michael Roche MACN. Thank you for your continuous efforts to create such a high quality publication.

All ACN Fellows and Members have electronic access to *Collegian*. Subscriptions include print and online access. Visit **www.collegianjournal.com** for more information.

ACN CEO RECOGNISED FOR CONTRIBUTION TO NURSING

On Friday 29 September, ACN CEO Adjunct Professor Kylie Ward FACN was presented with the 2017 Australian Capital Territory Telstra Business Women's Award for the *Purpose and Social Enterprise* category.

Kylie received this award as recognition for her invaluable contribution to our profession and tireless commitment to our organisation. This award was very well deserved and a tribute to all that she has achieved for nurses throughout her distinguished career.

The Telstra Business Women's Awards are an incredible opportunity to celebrate the professional accomplishments of dynamic and passionate women from across the business community. They provide a platform to empower women and place female role models into the spotlight.

The *Purpose and Social Enterprise* category specifically acknowledges female business leaders who strive to bring positive social or environmental change within our society.

Kylie was named the *Purpose and Social Enterprise* state-category winner because of her determination to drive change across the Australian health care system.

We would like to take this opportunity to congratulate Kylie on this significant professional achievement.

ELECTION OF DIRECTORS AND ANNUAL GENERAL MEETING

ACN is currently undertaking the bi-annual election process to appoint four Directors to the Board.

The newly elected Directors will be announced at the Annual General Meeting (AGM) on Monday 4 December at our Parramatta office at 4pm. The Chief Executive at the NSW Health Education and Training Institute Adjunct Professor Annette Solman FACN will be our guest speaker at this event.

Board performance is crucial to ensure growth and sustainability of ACN as the pre-eminent and national leader of the nursing profession. The Board provides the strategic oversight and direction to ensure that ACN continues to grow and develop, remains contemporary, enhances its reputation and continues to provide value to its members and to the broader nursing profession in accordance with the objects set out in our Constitution.

It is imperative that the Board collectively possesses an appropriate mix of skills, knowledge and experience to provide the strategic oversight required for an organisation the size and complexity of ACN. Directors must have a comprehensive understanding of their role in setting strategic directions, governance and financial matters. The Board must also reflect the composition of our membership in terms of age, gender, geographic location and experience.

We are seeking to elect an experienced skills-based Board which collectively has the governance skills and industry knowledge to lead ACN forward as an organisation. The professional skillset required of the Board will evolve in response to the challenges and opportunities ACN encounters in the market place. Board Directors are advocates for ACN who raise the organisation's profile with Government, consumers and other health care professions.

The ballot will close on Friday 24 November.

WA NURSING & MIDWIFERY LEADERS FORUM CREATES A PLATFORM FOR CHANGE

In June, ACN co-hosted the WA Nursing & Midwifery Leaders Forum with the WA Nursing and Midwifery Office.

The Forum provided a platform for nurse leaders from around the state to come together to discuss priorities for future health reform with the Deputy Premier, and Minister for Health and Mental Health, The Hon. Roger Cook MLA.

"We were pleased to have this opportunity to hear directly from the Minister and understand his aspirations for health care in Western Australia," ACN CEO Adjunct Professor Kylie Ward FACN said.

"The Minister's willingness to speak at the Forum showed he understands the important role nurses have in the delivery of health care," Adjunct Professor Ward said.

"I commend the Minister's commitment to working with nurse leaders to improve health outcomes for the people of Western Australia."

Adjunct Professor Ward was also a keynote speaker at the Forum. In her presentation, she discussed the importance of nurse leadership, as well as provided an update on ACN's reform agenda.

JOINT NURSING INFORMATICS POSITION STATEMENT

ACN recently released a Nursing Informatics Joint Position Statement with the Health Informatics Society of Australia (HISA) and its special interest group, Nursing Informatics Australia (NIA).

The position statement outlines that nurses have a unique leadership role in ensuring a digitally-enabled health system delivers on the promise of better health for all Australians. It argues that, as the largest single profession in the health care workforce, nurses need to be recognised and acknowledged for their enabling role in the digital health movement. The paper says that nurses have the potential to deliver better patient outcomes, as well as facilitate a better consumer and clinician experience.

This joint position statement is the first to affirm the role of nurses in digital health care at all levels and in all health settings. With seven key actions, it urges nurses and midwives to lead in decision-making, act as knowledge brokers, transform services and empower patients in self-care.

"This is an exciting time for nurses to lead the way and take advantage of advances in technology to both benefit the patient experience and maximise efficiencies in the workplace," ACN CEO Adjunct Professor Kylie Ward FACN said.

SUZIE HOITINK MACN SUPPORTS INDIGENOUS YOUTH IN NEW YORK CITY MARATHON

ACN is so proud that one of our exceptional members and keynote speakers from this year's National Nursing Forum, Suzie Hoitink MACN, has been selected as the Corporate Runner for the Indigenous Marathon Project Foundation.

As the corporate runner for this project, Suzie will be participating in the New York City Marathon along with 12 Indigenous young people later this year.

This annual project uses the marathon as a vehicle to promote healthy lifestyles to Aboriginal and Torres Strait Islander peoples. The project involves selecting a group of young Indigenous men and women to complete the New York City Marathon with just six months of training. It highlights the incredible natural talent that exists within this population, with the hope to one day unearth an Indigenous long distance running champion.

ACN would like to wish Suzie all the best in her role as the Corporate Runner and acknowledge her commitment to this important project.

ACN NEWS & VIEWS

ACN SNAPS

At ACN, we love getting out and about with our members and the wider nursing community! If you attend an ACN function or event, make sure you share your snaps with us through our social media platforms!

Remember to use our membership hashtag #ACNtribe

“Expanding my nursing horizon, seeing the bigger picture of the nursing profession, networking and inspiration will continue into my novice years.”
Suzanne Volejnikova-Wenger MACN

“Through organised conferences and meetings, I can network with, mentor, or be mentored by, nurses who may not be within my geographical or professional sphere.”
Sussan Pleunik FACN

Nursing and Midwifery Board of Australia Code of Conduct Launch

Community and Primary Health Care Nursing Week

ACN NT trip

ACN NT trip

Community and Primary Health Care Nursing Week

Policy workshop

ACN students

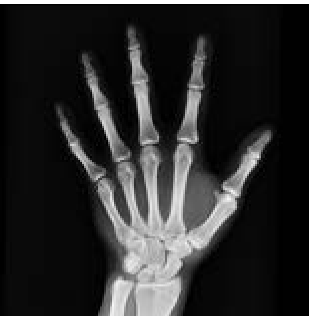
NOVEMBER

1

MOVEMBER
An annual campaign that encourages men to grow a moustache and raise funds for men's health.

8

INTERNATIONAL DAY OF RADIOLOGY
An annual event promoting the role of medical imaging in health care.



14

WORLD DIABETES DAY
An international event to raise awareness about diabetes.

16

WORLD PANCREATIC CANCER DAY
On this day communities around the world unite to raise global awareness of pancreatic cancer.

20

NATIONAL SKIN CANCER ACTION WEEK
This campaign urges Australians to take action to prevent skin cancer.

25

INTERNATIONAL DAY FOR THE ELIMINATION OF VIOLENCE AGAINST WOMEN
A day dedicated to ending violence against women and girls globally.

DECEMBER

1

WORLD AIDS DAY
A global initiative to raise awareness, fight prejudice and improve education about HIV and AIDS.

1

DECEMBEARD
A campaign that encourages men to grow a beard in December to raise awareness and funds for bowel cancer.

3

INTERNATIONAL DAY OF PERSONS WITH A DISABILITY
A national celebration of people with a disability.

5

INTERNATIONAL VOLUNTEER DAY
A day celebrating the difference volunteers make in their communities.

10

HUMAN RIGHTS DAY
The United Nations calls on everyone to stand up for someone else's human rights on this day every year.

25

CHRISTMAS DAY
ACN wishes you all a safe and happy festive season.

MORE Visit our website to see more upcoming events in Australia and around the world for the nursing and health professions: **www.acn.edu.au/events**

Making change happen

Ms Louisa Hope

Poster presentations

Welcome to country

From 21–23 August, ACN welcomed more than 450 attendees to our annual National Nursing Forum (NNF) at the Event Centre, The Star, Sydney.

The Forum was a massive success and incredible opportunity to celebrate our profession with all those in attendance. Through our theme, ***Make Change Happen***, we explored the creative ways that nurses can make a difference to individuals, communities and social determinates of health at a local, national and global level.

THE PROGRAM AND SPEAKERS

Opening with an enthralling welcome to country and closing with a surprise performance from the Queen of Rock and Roll, *Shelvis*, the Forum program sought to inform, inspire and entertain delegates through an impressive line-up of keynote presentations, concurrent sessions and masterclasses delivered by leaders in nursing, health and government.

Delegates heard from an impressive line-up of speakers, including the Australian Commission on Safety and Quality in Health Care CEO Adjunct Professor Debora Picone AM FACN (DLF), who spoke about nurses as leaders. An inspiring Oration was delivered by Dr Glenn Gardner FACN and the Commonwealth Chief Nurse and Midwifery Officer Adjunct Professor Debra Thoms FACN (DLF) gave the closing address, emphasising how we can make change happen across the nursing profession.

In addition to a variety of thought-provoking keynote presentations, delegates had the opportunity to view informative poster abstracts, hear from numerous concurrent presenters, participate in specialised masterclasses, and seek advice from senior nurse executives, clinicians and academics during our *Speed Leading: Speed Learning and Networking Session*. The *ACN Delegates Session* was also a highlight of the program and offered attendees an overview of current ACN activities and future plans.

Throughout the three-day program, ACN CEO Adjunct Professor Kylie Ward FACN and ACN Executive Director Anne Samuelson FACN kept proceedings on track as our Masters of Ceremonies. Kylie and Anne guided delegates through the event as we celebrated the energy, passion and innovation across all generations of nursing.

FEDERAL MINISTERS ADDRESS FORUM DELEGATES

ACN was honoured that Members of Federal Parliament addressed delegates at the National Nursing Forum. We were privileged to have the Deputy Leader of the Opposition, Deputy Leader of the Federal Parliamentary Labor Party, Shadow Minister for Education, Shadow Minister for Women, and the Federal Member for Sydney, The Hon. Tanya Plibersek MP, give a keynote presentation on the first day of the Forum. Minister Plibersek also participated in a lively panel discussion with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) CEO, Janine Mohamed, and Vice President of Health Informatics at Elsevier Clinical Solutions, Robert Nieves, facilitated by ACN CEO Adjunct Professor Kylie Ward FACN.

Inspiring change at the 2017 National Nursing Forum

CATSINaM CEO Ms Janine Mohamed, VP Health Informatics at Elsevier Clinical Solutions Mr Robert Nieves, Deputy Leader of the Opposition The Hon. Tanya Plibersek MP, ACN President Professor Christine Duffield FACN and ACN CEO Adjunct Professor Kylie Ward FACN

Commonwealth Chief Nurse and Midwifery Officer, Adjunct Professor Debra Thoms FACN (DLF)

The Federal Member for Flinders, Minister for Health and Minister for Sport, The Hon. Greg Hunt MP, also delivered a video address to delegates prior to the Oration on the first day. ACN was excited to be able to provide delegates with an opportunity to hear from leaders in government who can influence policy at the highest levels.

GALA DINNER

A special event at the 2017 National Nursing Forum, the Gala Dinner, offered delegates the chance to network with colleagues while enjoying a delicious three-course dinner and letting their hair down on the dance floor. The Gala Dinner included a moving speech delivered by Sydney siege survivor, Ms Louisa Hope, who inspired delegates with her positivity and journey.

NATIONAL NURSING EXECUTIVE GROUP

ACN was proud to host a meeting for the National Nursing Executive Group at the Forum. The meeting brought together nurse executives from across the country to engage in meaningful discussions about working to collaboratively progress the national nursing agenda.

The purpose of this group is to establish a clear strategic direction for the nursing profession, which is perfectly positioned to offer a powerful alternative voice in the debates that shape health care services and health care policy.

ACN GRADUATION CEREMONY

Following the closing plenary session at the National Nursing Forum, ACN held its inaugural Graduation Ceremony for more than 50 students who successfully completed our graduate certificate courses. We were honoured to have Associate Dean and Senior Lecturer Ms Sally Robertson FACN as our guest speaker at this event.

The ceremony was a special and auspicious occasion to acknowledge the hard work, commitment and achievements of all our graduates.

We look forward to welcoming you to the Gold Coast for next year's National Nursing Forum from 28–30 August 2018.

WITH THANKS TO THE SUPPORT OF OUR VALUED FORUM PARTNERS AND SPONSORS

Dr Glenn Elizabeth Gardner FACN

New nursing for a new generation health service

The National Nursing Forum Oration

ACN was honoured to have Dr Glenn Elizabeth Gardner RN PhD FACN HFACNP deliver the Oration at the 2017 National Nursing Forum.

Dr Glenn Gardner FACN is recently retired from the position of Professor of Nursing at the Queensland University of Technology. She has a distinguished reputation in nursing scholarship and her research activity has contributed to the applied, translational and theoretical aspects of nursing. Dr Gardner is recognised internationally for her research into advanced practice nursing and the practice and health service role of the nurse practitioner.

She has been the lead investigator on several landmark studies and has published extensively from this work in leading nursing journals. Dr Gardner has collaborated with nurse leaders and policy makers to provide a strong evidence base for nurse practitioner service development in Australia including foundation national standards for nurse practitioner education, regulation and practice. Her current research activity involves preparation of end user outputs from the final stages of a 10-year program of research that studied advanced practice nursing. Dr Gardner holds qualifications in nursing, sociology and education.

In her Oration, Dr Gardner spoke about new nursing for a new generation health service. She inspired delegates with her words and left them motivated to make change happen in their communities with her closing statement…

"We do at times rest on our laurels, confident in the fact that nursing is well regarded by the community. This is true. According to numerous polls, the public trusts us; we're seen as honest and ethical professionals. Trust is good, but it's not enough. It is memorable to most people that, when they are sick, vulnerable, alone in pain, sickness and fear, the person who is there to tend to them and their bodies – is a nurse. But our profession should demand more from the community than trust. We need the community to know that nursing is a solid and comprehensive clinical science. That we are agile, adaptive and innovative, and well equipped to address many of the pressures on health service. We must be loud and clear, proud and strong, about our profession.

So, to use a metaphor from the antiquity of nursing, we, you and I are the foot soldiers for the message about our profession. We are out and about, on the ground, in touch with the community through our patients, clients, their families and communities. We are in education, health service, health administration, clinical service and leadership roles. And we must speak about, and promote new nursing and its role in a reformed health service.

We must all – make change happen."

Delegates at our Gala Dinner

Delegate at our Speed Leading: Speed Learning and Networking Session

Together, we are stronger

Thanks to our Forum delegates!

ACN was excited to welcome a record-number of delegates to the National Nursing Forum this year. The Forum attracted nurses from across our membership, country and profession. It was an incredible opportunity for us to form meaningful relationships and valuable connections with so many incredible people who are working to make change happen throughout our health care system.

With over 450 attendees, the Forum was simply bustling with passion, energy and innovation. Thank you to all those who joined us and made the Forum such a success!

WHAT DID YOU ENJOY MOST ABOUT THE NATIONAL NURSING FORUM?

Hear from some of the amazing delegates who entered our Forum Facebook competition and provided feedback via the delegate survey...

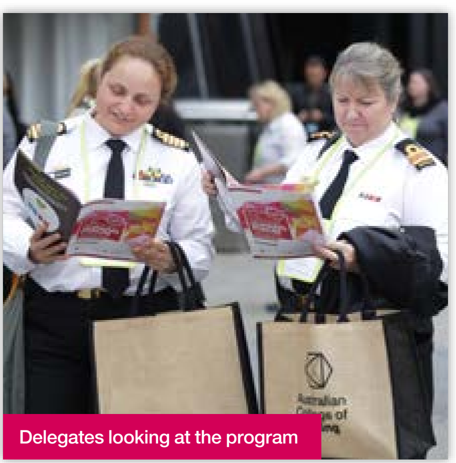
"I am loving the sense of collegiality, the comradery, and the shared learning that's going on here. I have too many favourite elements to list, but I know for sure that I'll be coming back again."

"The exchange of information and the opportunity to touch base with nursing leaders."

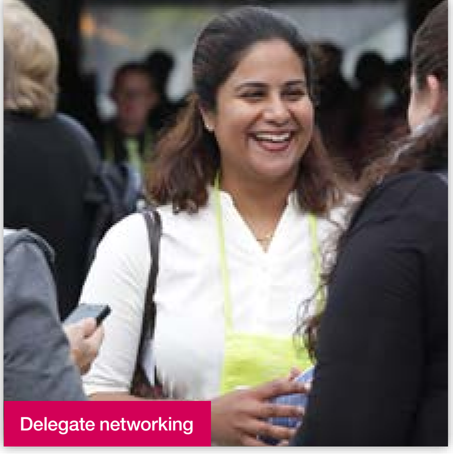
"The speed networking was an amazing opportunity to get advice from a range of different specialists. The masterclasses were also amazing!"

"I enjoy representing the Emerging Nurse Leadership program at the ACN National Nursing Forum."

"I have loved meeting with nursing leaders from across the country and hearing their insights on how to make change happen."

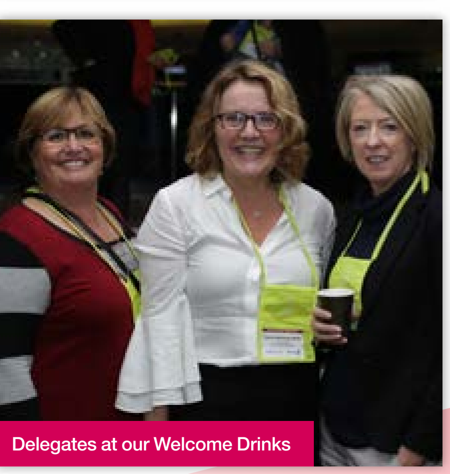


Delegates looking at the program



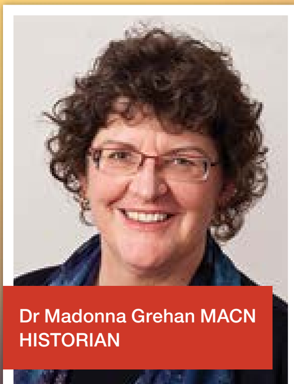
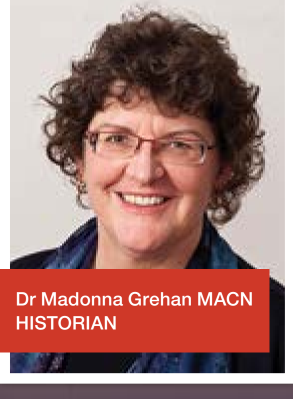
Delegate networking

Delegate at our Gala Dinner



Delegates at our Welcome Drinks

Delegates at our Gala Dinner

Dr Madonna Grehan MACN
HISTORIAN

OCCUPATIONALLY-DERIVED LUNG DISEASE

Occupationally-derived lung disease was the subject of a keynote address at a medical history conference in Melbourne recently. Dr Criena Fitzgerald, a historian and former nurse, drew on her 2016 book, *Turning Men into Stone: a Social and Medical History of Silicosis in Western Australia, 1890-1970*. As Fitzgerald argues, mining as an occupation was recognised as deleterious to lung health by the late 19th Century. Governments gradually instituted monitoring of miners' lung health as a public health measure. At the time, the concern was tuberculosis (TB), known to be highly communicable. TB was believed to proliferate in confined spaces where miners had only dank air to breathe. By the 1950s, TB was readily treatable. However, it took time for other more insidious diseases, such as silicosis and black lung, to be recognised as occupationally-derived.

With pressure from trade unions, and vigorous monitoring by public health departments, companies were forced to improve workers' conditions. Better ventilation systems became available for individuals and their working environments. Exposure to hazards was limited through shorter shifts, protective clothing, and so on. These interventions produced remarkable results. With no new cases of black lung identified in the mining industry by the 1980s, Australian authorities believed that this disease had been eradicated. Confidence was so high that government transferred responsibility for monitoring and reporting of miners' lung health to the companies that employed these workers.

Yet, in recent years, cases of black lung have re-surfaced in the Australian coal industry. Like many lung diseases, it's a debilitating and, ultimately, fatal condition for which there is no cure. And clearly, the assessment that black lung was eradicated was premature. Fitzgerald contends that black lung did not disappear at all but that complacency about old-fashioned diseases led to insufficient monitoring.

Textile manufacturing is another occupational environment where lungs are at risk. Finely-cut flecks of material, known as flock, escape during the milling process. Not necessarily visible, these flocks were inhaled by workers operating the massive industrial looms so redolent of England's manufacturing age. Today, the problem of flock inhalation persists in mass production of textiles. The former is associated with clothing manufacturing in South East Asia, the latter with vehicle manufacturing in which flock is glued on to surfaces. More recently, public health authorities have issued dire warnings about new waves of asbestosis and mesothelioma. This is because asbestos fibro sheeting was used extensively in house construction in Australia until the 1980s.

The symptoms of "overt" lung disease, including: silicosis, pneumoconiosis, asbestosis and mesothelioma, can be slow to manifest. And when they do manifest, the treatment might do little to arrest the condition. So when it comes to assessing lung health, respiratory rate remains a fundamental observation for nurses to undertake in all patients, even in people who are young, active, and healthy-looking. Mild shortness of breath, observed at rest, might be an early indicator of an, otherwise, silent disease.

iSTOCK

FAST FACTS

7 MILLION

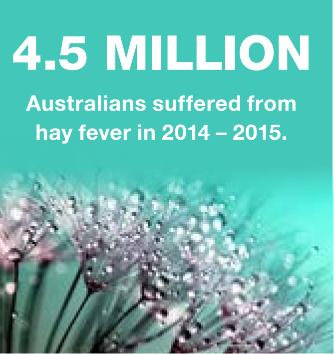
Australians reported having asthma and other chronic respiratory conditions in 2014 – 2015.

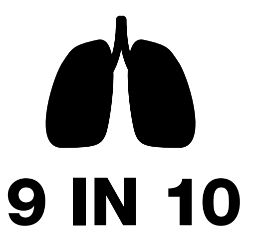
4.6%

of all deaths in Australia in 2014 were from chronic obstructive pulmonary disease.

4.5 MILLION

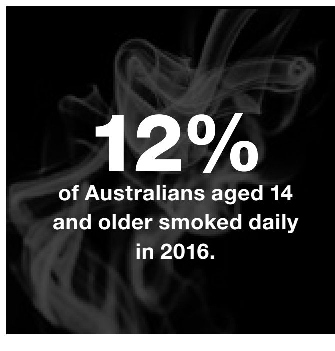
Australians suffered from hay fever in 2014 – 2015.





9 IN 10

Australians with chronic obstructive pulmonary disease reported having a least one other chronic condition in 2014 – 2015.



12%

of Australians aged 14 and older smoked daily in 2016.

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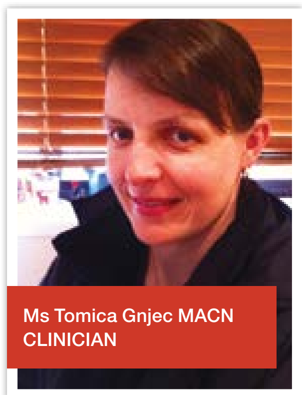
Australian Institute of Health and Welfare, 2017, *Smoking*, accessed 12 September 2017, < https://www.aihw.gov.au/reports-statistics/behaviours-risk-factors/smoking/overview >

WHEN YOU CAN'T BREATHE, NOTHING ELSE MATTERS


Ms Tomica Gnjec MACN
CLINICIAN

I am very fortunate to work with an incredible bunch of clinical and administrative staff in the frontline health arena. One particularly special staff member cleverly balances on the precarious tightrope of living with advanced chronic obstructive pulmonary disease (COPD). I admire her incredible resilience and strength in maintaining her numerous life "hats" including her role in a busy and unpredictable acute health setting. She often shares with me snippets of her life health journey – and recently mentioned pulmonary rehabilitation as a mainstay of ongoing management and its immense benefits.

I very much subscribe to the multimodal approach to health care issues – so what is this pulmonary rehabilitation or "pulmonary gym"? My colleague pointed me in the direction of the Lung Foundation, Australia – currently the only existing national charity dedicated to promoting and supporting individuals with lung disease. Pulmonary rehabilitation is described as a comprehensive education and exercise training program, which incorporates individual assessment and runs for up to eight weeks in a community setting (Lung Foundation, Australia, 2017). The ultimate goal is to decrease reported periods of breathlessness whilst increasing the individual's functional capacity in their everyday life (Lung Foundation, Australia, 2017).

Puhan et al. (2011) note that pulmonary rehabilitation has a significant clinical effect on individuals with COPD and is becoming a mainstay in the long-term management of patients with stable diseases. They also identified reduced hospital admissions, mortality rates and numbers requiring treatment, whilst individuals reported an improvement in quality of life (Puhan et al., 2011).

At whatever interface we meet these individuals – we can continue to explore and guide them in their awareness of various pulmonary support and advocacy organisations. This can only assist with improving their quality of life through a more sustainable and holistic management of their pulmonary disease.

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THE INFLUENZA VACCINE

Mr James Bonnamy MACN
ACADEMIC

Influenza, affectionately known as "the flu", is a highly contagious viral respiratory illness that is often dismissed as not being a serious illness. Most people recover after a few days, but for some people it can be fatal. Fortunately, influenza is a vaccine preventable illness. The first influenza vaccine was developed in 1938 and was used during World War II to protect the US military force (Hannoun, 2013). The methods used to develop the influenza vaccine were then used to successfully develop the polio vaccine in 1952.

In Australia, the current influenza vaccine is a quadrivalent vaccine that protects against four common strains of influenza. The influenza vaccine is available for anyone aged over six months. Despite being at the greatest risk for influenza, infants and children have the lowest rate of vaccination (Poehling, Edwards, & Weinberg, 2006). This places them at risk of severe influenza complications including secondary bacterial infections.

This year has seen a record number of influenza cases, with children and teenagers aged between 10–19 being among the hardest hit. Unfortunately, many general practitioners (GP) are incorrectly informing parents that children do not need to be vaccinated (Booker, 2017). Recently, Melbourne GP, John Piesse, was condemned for supporting the anti-vaccination movie *Vaxxed* and speaking out against the influenza vaccine for children (Choahan, 2017).

Many parents also incorrectly believe that the influenza vaccine is unsafe for children and that it can cause influenza or does not work. Nurses are well positioned to provide accurate advice regarding the safety and efficacy of the influenza vaccine. Given our involvement in all areas of health care, we must take this opportunity to provide factual information about vaccination to protect those most at risk of severe influenza disease.

There are myths aplenty regarding the influenza vaccine, including that people with an allergy to egg protein cannot be vaccinated or that the influenza vaccine is unsafe for pregnant women. Nurses must work to dispel these myths and should equip themselves with factual information to respond to any concerns about vaccination.

To help spread the facts, and not the flu, have a look at the following website: www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/ATAGI-advice-influenza-vaccines-providers

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Adjunct Professor
Cheyne Chalmers FACN
EXECUTIVE

THE ROLE OF THE NURSE LEADER IN RESPIRATORY DISEASE

Respiratory illness is a broad description that can be used to cover everything from childhood asthma, through to chronic end-stage lung disease. However, one core element is present in all cases and that is the inability to breathe freely. The fear that is experienced when you can't breathe is traumatic. How we respond as nurses in these situations is critical; showing patience, compassion, confidence and calmness are all essential elements of care required when working with people with respiratory disease.

This year, we have seen a significant increase in people with influenza; this usually puts pressure on emergency departments, general wards and intensive care units, as pneumonia can be a complication. Last year, Melbourne experienced the thunderstorm asthma anomaly, which caught us off guard and resulted in multiple ambulance calls in a very short period of time. As a system, we are often challenged by seasonal variations in health care presentations and at the heart of this is the ability to be flexible and respond with highly skilled nurses. As a leader and manager in that system, our role is to ensure we have a baseline of staff who are adequately skilled and experienced at all times to respond to these life-threatening challenges. We also need the ability to understand logistics, systems and processes that are required to respond, and then to lead the team with confidence and assurance, ensuring all is done to create an environment that produces the best possible outcomes.

As a nurse leader who has a background in respiratory nursing and who has cared for loved ones with this disease, I have immense empathy for the courage and sheer will it takes for people in this position to get up every day and keep on living. Your breath is your very life, and when you are robbed of the sensation to breathe easy, the toll on your whole being can be dramatic.

A person with chronic and end-stage respiratory disease often has many ingrained coping mechanisms, rituals and routines that ensure they can get through the day safely. When a person in this positon presents to a hospital setting they can provide many challenges to a busy nurse.

How can we slow ourselves down in our daily work to get all of our tasks and activities done before we get to go home and handover to the next shift?

> **"Your breath is your very life, and when you are robbed of the sensation to breathe easy, the toll on your whole being can be dramatic."**

ISTOCK

THE LATEST ON LUNG CANCER

Lung cancer is the fourth most commonly diagnosed invasive cancer in this country (Australian Institute of Health and Welfare (AIHW), 2011). It's mortality rates are higher than any other cancer, with only 13% of people surviving five years after diagnosis (AIHW, 2011). Over time, the rate of diagnosis has increased by 75% in females and decreased by 35% in males (AIHW, 2011).

There are a number of lifestyle, environmental and biomedical factors which can lead to lung cancer.

Smoking is the single largest cause of lung cancer in Australia. It has led to approximately 65% of lung cancers in females and 90% in males (AIHW, 2011). Compared with non-smokers, smokers are 10 times more likely to develop lung cancer (AIHW, 2011). Estimates suggest that living with a smoker also increases your chances of developing lung cancer by 20–30% (AIHW, 2011). Currently, one in six Australians smoke tobacco daily (AIHW, 2011).

Radon gas is the second leading risk factor for lung cancer around the world (AIHW, 2011). Radon gas is a naturally occurring radioactive gas released from the normal decay of uranium in rocks and soil.

Other causes of lung cancer include exposure to industrial and chemical carcinogens, air pollution, genetics and previous lung diseases.

THINKSTOCK

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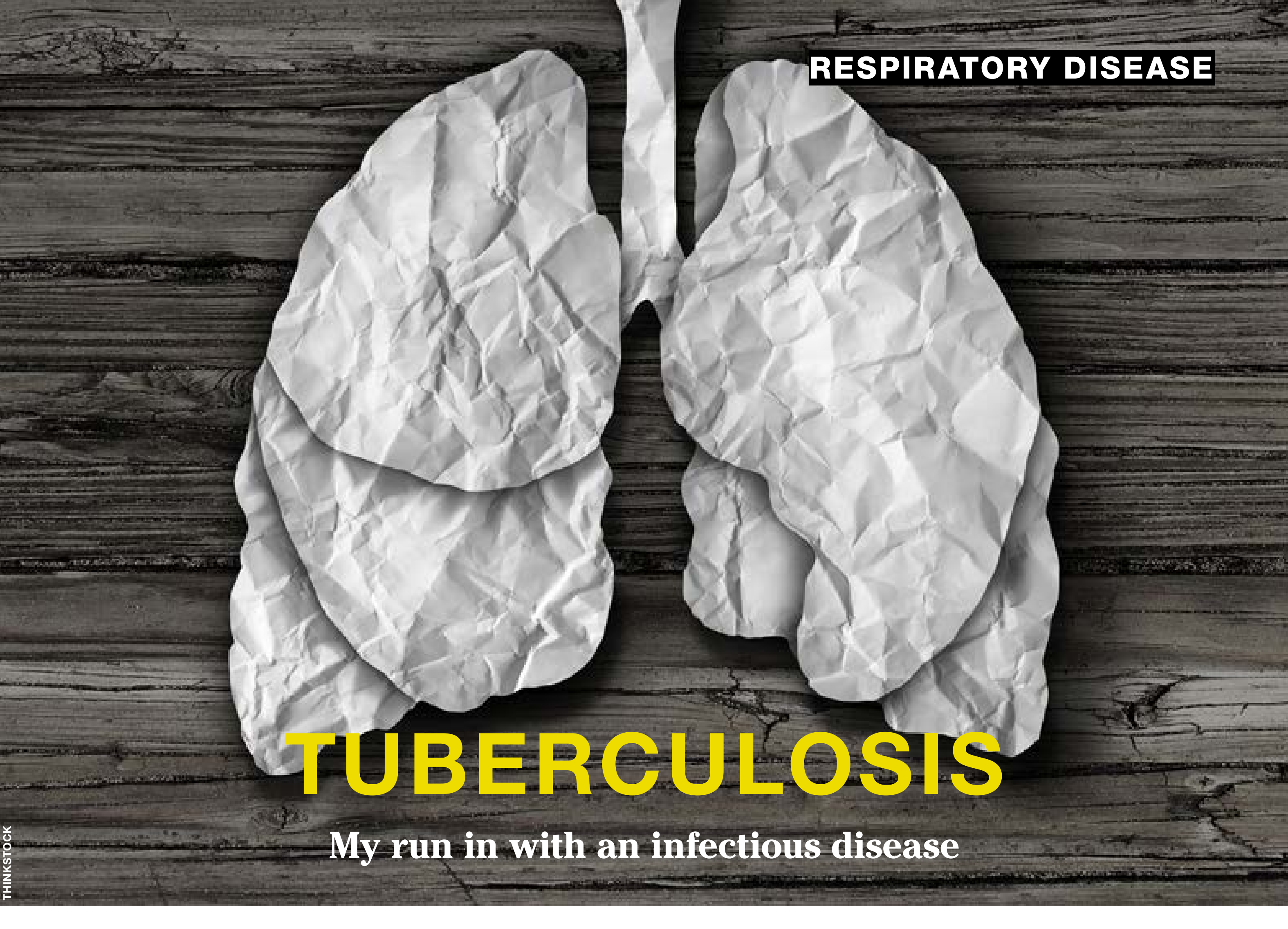
THINKSTOCK

TUBERCULOSIS

My run in with an infectious disease

> **“As a brand new nurse with no experience with respiratory patients I was now terrified.”**

The best way to scare a brand new graduate is to have a run in with an infectious disease. I arrived to work for a late shift, excited and jolly, as it was my second last shift before I had my first four day weekend and I was to fly to Sydney to see my sister and meet my one week old nephew. The shift went without a hitch and I was stoked. The only thing that was even a tiny bit odd was that I had an acute medical patient; I work on a surgical ward. But we have outliers all the time and I didn't think much of it. All I had left was an early shift the next day, with my flight that afternoon.

At 4:00am in the morning, I was lying awake with excitement for my first long weekend that was coming up and I received a text from one of my co-workers saying that the outlier patient had just been moved to a negative pressure room as they suspected he had tuberculosis (TB). My stomach dropped, the first thing I thought about was I couldn't see a newborn baby if I had been exposed to TB. I was going through everything I had done at work and if this patient had TB I was certain I would get it. As per the doctors' orders, I had completed deep breathing exercises, coughing and nebulizers with this patient; anything you can think of to help remove build up on the lungs, I had done. As a brand new nurse with no experience with respiratory patients I was now terrified.

TB isn't something that is overly known about these days and we are not required to be vaccinated against it as nurses in Australia anymore. When we apply for nursing positions, we are required to complete a skin test and chest x-ray to ensure we haven't already been exposed, but that's as fair as it goes.

If you ask my friends how they would describe me, a word that would be said fairly consistently would be dramatic. True to my nature, I was expecting to get to work for my early shift and be escorted to quarantine for extensive tests and all sorts of crazy things. Of course, I wasn't and no one had even spoken to me about it. I completed my shift like normal; well, until my anxiety drove me crazy. So I spoke to my head nurse, who had heard nothing about the case and directed me to infection control for further information. They were extremely helpful and calming, and although no diagnoses had been confirmed the risk of me contracting TB was very low, furthermore, passing it on to others was incredibly unlikely. TB in a healthy young adult such as myself is fairly minor; it is mainly an issue for those with impaired immune systems.

That 48 hours of anxiety and the unknown was awful. Looking back on it now it was also very funny, but I would prefer if I didn't have this type of scare again.

AUTHOR

JANE BORN (PSEUDONYM)

NEONATAL RESPIRATORY OUTCOMES

Combating chronic lung disease in prematurely born infants

Of the 310,330 live babies born in Australia in 2014, approximately 91% were born at term (37–41 weeks) and 9% were pre-term (before 37 completed weeks' gestation) (Australian Institute of Health and Welfare (AIHW) 2016, p. 4). Premature birth is associated with a range of adverse outcomes – most notably lung dysfunction – which has the potential to impact on the health of effected individuals throughout their lifespan (Carter, Granty & Carter, 2016, p. 921). As the survival rates of prematurely born infants continues to rise, interdisciplinary cooperation is being directed towards improving the quality of survivors' lives. This article describes the pathological processes leading to lung disease in prematurely born infants and some of the initiatives being implemented to enhance respiratory outcomes.

Foetal lung development commences at three weeks' gestation and occurs in stages (Blackburn, 2013, p. 311). By 24–26 weeks, terminal air sacs emerge as outpouching of the terminal bronchioles (Blackburn, 2013, p. 311). During this "saccular phase", the number of terminal sacs increase dramatically – from 240,000 at 24 weeks to four million at 32–36 weeks – as does lung surface area and volume (Blackburn, 2013, p. 311). It is at this stage that surfactant synthesis begins.

Surfactant is a phospholipid which reduces surface tension, the inspiratory force required to inflate the lungs and maintain residual functional capacity (Carlson, 2014, p. 364). Surfactant synthesis occurs in early gestation but escalates dramatically in the weeks preceding birth, to the highest level of any time in life (Carlson, 2014, p. 364). This process, along with respiratory movements in utero and the secretion of thyroid hormone and growth factors, prepares the infant for independent respiration (Carlson, 2014, p.364). The capacity for optimal gas exchange is enhanced, as developing blood vessels stretch the pulmonary epithelium, bringing pulmonary capillaries and alveolar surfaces into close proximity (Blackburn, 2013, p. 311).

Babies born prior to 30 weeks gestation are at risk of developing hyaline membrane disease, bronchopulmonary dysplasia and chronic lung disease. Hyaline membrane disease (HMD) occurs as a result of the pulmonary underdevelopment described and surfactant insufficiency (Carlson, 2014, p. 364). Due to linear lung development, the risk of HMD is inversely related to gestational age, with an incidence of 60% at 29 weeks, falling to 20% by 34 weeks gestation (Carlson 2014, p. 458). Broncho-pulmonary dysplasia (BPD) is a chronic lung disease first reported by Northway, Rosan and Porter, in 1967. It is a condition which develops as a result of barotrauma, following the mechanical ventilation and oxygen therapy used to treat respiratory distress and hyaline membrane disease, in premature infants (Davidson & Berkelhamer, 2017).

Respiratory Distress Syndrome (RDS) presents as rapid, labored breathing and sub-optimal oxygenation. It is best treated by the provision of minimally injurious respiratory support, early exogenous surfactant administration, the judicious use of supplementary oxygen and early closure of the patent ductus arteriosus (Carlson, 2014, p. 458; Davidson & Berkelhamer, 2017). As indicated, the condition is most commonly attributable to HMD. However, with sepsis, congenital cardiac disease and renal impairment, neurological and metabolic causes must be excluded as contributing causes (Gallacher, Hart & Kotecha, 2016, p. 32). Serial radiology and echocardiography are crucial to identify the underlying cause, and to direct and monitor treatment (Gallacher, Hart & Kotecha, 2016, p. 32).

Treating respiratory distress, paradoxically interferes with alveolarisation and vascularisation, leading to "arrested lung development" (Gardner, Enzman Hines & Nyp, 2016, p. 604). Therefore, the provision of minimally invasive respiratory support to maximise gas exchange, whilst protecting the developing lung tissue, is required (Gallacher, Hart & Kotecha, 2016, p. 32). Notwithstanding this awareness, chronic and recurring lung injury, alveolar haemorrhage, micro-atelectasis, hyper-expansion and oedema, continue to feature as pre-cursors to the development of chronic lung disease in prematurely born infants (Gardner Enzman Hines & Nyp, 2016, p. 604). Even during the post-acute phase, barotrauma, chronic inflammation and infection, further damage lung tissue (Gardner, Enzman Hines & Nyp, 2016, p. 604). Medications such as steroids and diuretics, feature heavily in treatment regimens and may be required to manage acute exacerbations of chronic conditions (Gallacher, Hart & Kotecha, 2016, p. 32).

The terms broncho-pulmonary dysplasia (BPD) and chronic lung disease (CLD) are often used interchangeably. However, BPD is only one of many conditions with the capacity to chronically impact on respiratory health. Others include pulmonary atresias, pneumonia, congenital heart disease and meconium aspiration syndrome (Gardner, Enzman Hines & Nyp, 2016, p. 603). Definitive diagnosis is made based upon an infant's requirement for supplemental oxygen at 28 days of life – and/or 36 weeks corrected gestational age – with the length of supplemental oxygen dependency, used to indicate disease severity (Gallacher, Hart & Kotecha, 2016, p. 34; Gardner, Enzman Hines & Nyp, 2016, p. 604). It is not uncommon for prematurely born infants to be discharged home on supplemental oxygen and to require regular hospitalisations for acute exacerbations of respiratory conditions, throughout infancy.

The increased survival rate of prematurely born babies has been attributed to: birth in hospital, maternal steroid administration, exogenous surfactant use, fewer days' mechanical ventilation (with associated reduction in risk of barotrauma), improved oxygenation and oxygen saturation targeting (Gardner, Enzman Hines & Nyp, 2016, p. 603). However, notwithstanding recent theoretical and technological advances, BPD remains the most common morbidity associated with prematurity. Incidence rates remain at approximately 40% for babies born at – or less than – 28 weeks' gestation (Carter, Granty & Carter 2016, p. 921).

Therefore, interdisciplinary cooperation is being targeted towards addressing the ongoing pulmonary, nutritional, pharmacological and neurodevelopmental requirements of effected infants (Davidson & Berkelhamer, 2017). Most notably, research has focussed upon refining methods of non-invasive respiratory support. For example, a new continuous positive airway pressure (CPAP) protocol developed in Canberra, named CICADA (CeasIng Cpap At standarD criteriA) has shown promising results.

Heath, Jeffery, Broom, Shadbolt and Todd (2016, p. 321) studied babies born at less than 30 weeks, over three distinct time periods, spanning January 2004 – December 2012. Their findings highlighted the benefits of ceasing CPAP altogether, when clinical stability was evident, rather than following a protocol of slow weaning. Study findings revealed significantly reduced CPAP duration, time to wean, oxygen duration and CLD rates (Heath Jeffrey et al., 2016, p. 321). Early cessation also expedited positive outcomes, such as the transition to full feeds and transfer from neonatal intensive care to the special care nursery (Heath Jeffrey et al., 2016, p. 321).

Post discharge outcomes associated with low birth weight and BPD have traditionally included: pulmonary hypertension, growth failure, recurrent hospitalisations, adverse neurological outcomes, low tone, early motor delay and cerebral palsy (Carter, Granty & Carter 2016, p. 921). As medical management results in increasing numbers of adult "survivors", it is possible that resultant pulmonary dysfunction, asthma-like symptoms and exercise intolerance may lead to significant long-term pulmonary sequalae and present a burden for patients, their families and the health system (Davidson & Berkelhamer, 2017). Therefore, any advancement in treatment protocols such as that described by Heath Jeffrey et al., (2016) are extremely encouraging and welcomed.

Almost 1:10 babies are born prematurely with ongoing lung dysfunction, impacting throughout the life span. As survival rates increase, the need to minimise lung damage and vigilantly avoid treatment regimens known to negatively impact on lung development, are required. One of the ways this can be achieved is by the employment of minimally injurious, non-invasive, respiratory support. To this end, interdisciplinary cooperation is being directed towards the finessing of treatment regimes to improve neonatal outcomes and the respiratory health of survivors.

THINKSTOCK

“As survival rates increase, the need to minimise lung damage and vigilantly avoid treatment regimens known to negatively impact on lung development, are required.”

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Editor's note: Trish designs and develops our Graduate Certificate in Neonatal Care. This graduate certificate will expand your knowledge and skills for the provision and coordination of evidenced-based care for the neonate and their family. Visit our website for more information.

AUTHOR

TRISH LOWE MACN,
ACN NURSE EDUCATOR

ANTIBIOTIC STEWARDSHIP

Outcomes for COPD patients

My passion in nursing has always been to improve the care of respiratory patients by assisting them through their own patient journey. In order to fulfil this dream, I worked to become a nurse practitioner (NP) in chronic disease management specialising in respiratory care, whilst I was a practice nurse in general practice in Queensland. My goal had always been to develop a NP-led respiratory clinic within the public system. The aim was to manage chronic obstructive pulmonary disease (COPD) patients as inpatients through to discharge and then follow up as an outpatient – this was a great passion for me. I hoped this would improve re-admission rates and better outcomes for the patients themselves. It would mean these patients could be referred directly to pulmonary rehabilitation for further management and education. In turn, this would encourage patient empowerment in their own care. Whilst in this role, it became apparent that the prescribing of antibiotics did not always fall within the antibiotic guidelines for COPD patients as outlined by the Therapeutic Guidelines (TG) (2014). Antibiotic stewardship at this time was becoming the "in topic". I seized the moment and began to observe the clinical practice around this, with a view to changing practice to improve the quality of life for these patients.

Adherence to antibiotic management guidelines has been shown to save lives and costs in many different health care settings (Wilke, Grube, & Bodmann, 2011; Hecker et al., 2014; Elemraid et al., 2014). Guidelines such as these allow better use of health resources and reduction of antibiotic drug resistance, which is not only highlighted in Australia but also present globally (Wilke et al., 2011).

It is important to select appropriate antibiotic regimens for patients especially with bacterial infections, as this can affect overall patient outcomes and have a huge knock-on effect. The management of antibiotics with patients with respiratory diseases still continues to be of concern worldwide. Adherence to antibiotic guidelines for exacerbations of COPD as noted by Fanning et al. (2014) is less than adequate.

COPD is a serious, progressive and disabling condition that limits airflow in the lungs. It includes emphysema and chronic bronchitis. People with COPD are often short of breath and may have frequent coughing. The condition mainly affects older people and its main cause is active smoking or exposure to smoking, although some people with COPD have never smoked in their lives (Australian Institute of Health and Welfare (AIHW), 2017). The health trajectory of patients with COPD rapidly declines after each exacerbation, so it is imperative to assist in keeping them well and out of hospital.

According to *Queensland Health* (2016), respiratory conditions totalled 8% of the overall causes of death in Queensland; equalling 2,372, of which 1,472 were specifically related to COPD. COPD is noted as one of the seven largest causes of lifestyle-related chronic disease burdens. According to AIHW statistics in 2014, COPD was the fifth leading cause of death in Australia. In that year, 7,025 people died from COPD (4.6% of all deaths).

The *COPD X Plan* (2016), formulated by the Australian Lung Foundation, which currently endorses the Therapeutic Guidelines (TG14), recommends *Doxycycline* or *Amoxicillin* oral as first line antibiotic therapy for exacerbation of chronic obstructive pulmonary disease. However, some studies demonstrate differing regimes across Australian hospitals (Robertson et al., 2002). Considerable deviation from the Therapeutic Guidelines for management of acute respiratory infections, in respect of antibiotic choice, can be seen as a problem not confined

> **“When antibiotics became industrially produced following World War II, our quality of life and our longevity improved enormously. No one thought bacteria were going to become resistant.”**
>
> **– BOONIE BASSLER 2017**

to only the regional areas of Queensland. There is a general trend to treat COPD as severe community acquired pneumonia irrespective of presentation. Similarly, there is a powerful drive to utilise intravenous broad spectrum third generation cephalosporin as the preferred, first line antibiotic irrespective of the TG (McGoldrick, Ulahannan & Krebs, 2016). Interestingly, the re-admission rate was highest for this cohort of patients who received intravenous ceftriaxone as an initial or secondary antibiotic (McGoldrick, Ulahannan & Krebs, 2016).

The importance of antibiotic stewardship at a local, national and global level is undoubted. However, achieving change in practice is challenging. As well as more education of prescribers about the value of antibiotic stewardship, education of those in management positions about the increased re-admission rate in patients not treated according to therapeutic guidelines recommendations may stimulate action. The message that deviation from antibiotic guidelines may increase re-admission, thereby leading to increased bed occupancy, which may impinge on other important activities, such as elective surgical admissions, could be a powerful change enabler in this climate.

Previous studies of barriers to physician adoption of guidelines have identified awareness, familiarity and agreement as the most common barriers. A previous randomised trial of provider education, computerised reminders/direct patient letters and a nurse facilitator showed the best results with a nurse facilitator. Delivering guidelines in computerised form has been shown to be superior to paper or a choice of paper/computerised. Hence, an optimum strategy may be the combination of a nurse champion with computerised prescribing guidelines specifically in the emergency department, as this is the first setting in which antibiotic therapy is usually commenced.

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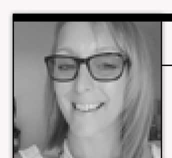

AUTHOR

PROFESSOR COLLEEN MCGOLDRICK FACN

THINKSTOCK

CARING FOR YOUNG ADULTS WITH CYSTIC FIBROSIS

A personal, reflective piece

I've always thought that nursing was about doing the tasks of clinical observation, reporting the normal values, documenting the haemodynamic, and providing the highest level of care, as if the patient were a member of my family – like my grandmother for example. How would you like your loved one to be cared for? Presumably, by the best nurse possible; ever-efficient, attentive and caring. Yet caring for young adults (those over the age of 18 and into their adulthood) with a chronic respiratory condition, in the adult acute care setting, is more than that; it's challenging, multifactorial and the issues that can arise can be confronting.

I work in an acute public hospital and have been there for over 10 years now. I work on a respiratory ward (with lots of sputum), specialising in caring for adults who have cystic fibrosis (CF), chronic obstructive airway disease (COPD), asthma, lung transplants and other critical respiratory issues. This article is a personal reflective piece on a particular experience of caring for someone with a chronic respiratory illness in their adulthood.

The experience that I am writing is about an adult patient who has cystic fibrosis. Generally, those with CF are diagnosed after birth or up to the age of one-years-old, and have been in the hospital setting since then. Their parents have been told that their child is unlikely to make it to the age of 30 but luckily, we have made plenty of advances in testing, such as gene isolation (research) physiotherapy treatment, medication and surgical intervention (lung transplants). These advances have given this group of patients a longer life expectancy than first thought over 25 years ago.

Yet, a key issue with these patients when they first come to the acute adult setting for the management of their CF, is compliance. This involves getting them to take responsibility for their own health; as they are now adults who can utilise services and access great care. Add to this, their maturity levels, mental health, education, work, lifestyle choices, body image issues, social status and their personal network with other patients in the CF community. This can be multifactorial and challenging to say the least but the rewarding thing is forming that nurse-patient relationship. With this in mind, it is important to remember that they are adults, who want to be heard and feel like they are in control of their health and life. This therapeutic relationship not only involves nurses but physiotherapists, dieticians and social workers. The following is an experience that I would like to share with you and what I learned from it.

The patient in this story, referred to here as KE, was a vibrant woman. She could also have an attitude and was rebellious in nature. KE was initially compliant when transitioning her management of CF from the children's hospital setting to the acute adult setting. However, as KE grew older, she wanted to experiment and experience life; she never wanted to be seen or known as, "the sick girl". So, she began to experiment with alcohol and illicit drugs; wanting to be involved in a life that was away from the hospital and do things that all her other friends were doing – like going out and meeting boys.

One day, KE sneaked some alcoholic drinks into the acute hospital. Whilst undergoing treatment, she shared a few drinks with another patient who was also admitted for CF management. They became way too rowdy, disturbing other patients, who subsequently complained. Therefore, KE and the other patient were discharged early, subsequently compromising both of their treatments.

The impact that this had on KE and her illness led her to have subsequent and more frequent admissions to hospital to manage her CF that year. This impacted on her mental health greatly and she was intermittently remorseful. KE had to not only deal with her own attitude to her health but had to confront this with the medical team, allied health staff and nurses. She was paranoid, thinking that the nursing staff were talking about her and this incident, as well as the doctors. She also had to deal with the remorse of how she influenced another patient to compromise their treatment. Did she make his/her health worse? This was a lot to think about and deal with. She was moody; isolating herself and participating in minimal chest physiotherapy. She even had a sign on her door that was abusive, saying something along the lines of, "Only the CF team, doctors and the nurse who is looking after me can enter this room, the rest of you can @#$^ off."

How confronting was this sign? I was offended greatly by it, as I had cared for KE on previous admissions that year. However, I knew that during this admission, she was in no mood for a "tough love" talk from a nurse who she had a good bond with. Eventually, after a few sessions with a psychologist, KE's attitude improved. We then started seeing her less frequently for subsequent years; assuming that she now had the maturity, mentality and compliance to manage her CF best at home, away from the constraints of the acute adult hospital setting.

> “We all want to be in a positive environment enhancing the best outcomes for our patients and be that efficient, attentive and caring nurse.”

During a scheduled admission a few years later, I managed to care for KE again and I can remember her asking me, “How bad was I during that admission”? She later told me that she was in a, “Bad place then”.

So tell me, how do you provide care to a young person who’s growing into their adulthood in a situation like that? How can you care for them like you would a loved one?

You do it in a way that is not patronising to them. Remembering that they are not children anymore and nurses are not their parents. Yes, they do have a chronic illness but it can be managed if they are compliant and committed to preserving the quality of life they want. You encourage them to be themselves, integrate what their beliefs are about their health and life into their care, communicate with them, ask them what they want to achieve from this admission and/or subsequent ones, use your resources effectively alongside the medical staff representing the patient and communicating their needs, and set appropriate boundaries. After all, we all want to be in a positive environment enhancing the best outcomes for our patients and be that efficient, attentive and caring nurse. We have a responsibility to care for all patients through all stages of their lives.

THINKSTOCK

AUTHOR

CONNIE KAMBANAROS
MACN

A NEW CLINICAL ROLE FOR NURSES

Turn of the century advancements in pulmonary hypertension

Breathlessness or dyspnoea is a common symptom of a variety of conditions, such as asthma, pneumonia and emphysema. However, one of the most serious causes of breathlessness, which is difficult to diagnose, is the rare lung disease known as pulmonary hypertension (PHT). Blasi (2010) reminds us of the importance of remaining vigilant for less common causes of unexplained breathlessness, so diseases such as PHT are not missed.

PHT is a rare but serious multifactorial group of disorders with no real cure and can affect people from any race, gender or age at any time. Simply, PHT is raised blood pressure in the pulmonary circuit, clinically defined as a resting elevation of the mean pulmonary artery pressure (mPaP) greater than 25 mmHg as assessed by a right heart catheter (Simonneau et al., 2009).

In its early stages, the symptoms can be subtle and non-specific. Breathlessness and fatigue may only be problematic with exertion, such as when walking up steep inclines, climbing stairs or even the simple task of wheeling out the refuse bin. Often this is not enough of a discomfort to prompt a patient to seek medical attention. Patients may interpret this breathlessness and fatigue as "normal" (Blasi, 2012).

What is enough to prompt a patient to seek a medical assessment is an escalation of symptoms, often accompanied by other symptoms such as ankle oedema, dry cough, and syncopal and presyncopal episodes (Doughty and Mainwood, 2001).

With disease progression, pressure in pulmonary arteries slowly increases, ultimately leading to the development of right heart failure. Respiratory tests investigating causes of a patient's breathlessness often include spirometry, arterial blood gas and chest x-rays, which are often normal and will miss PHT.

Patients may be prescribed inhaled medications commonly referred to as "puffers" erroneously. It is not until patients have had an echocardiogram and conformational right heart catheter that a diagnosis of PHT is made. Unless suspected, this can often have significant delays in diagnosis. Data from one study reported inappropriate or delayed therapy can be up to two years after onset of first symptoms (Rich et al., 1987, cited Strange, 2014, p.117). Early diagnosis and treatment is vital in managing this disease known for its rapidly progressive nature if left untreated.

HISTORY OF PHT

Prior to the development of heart catherisation in the 1930s, there were only occasional observational accounts that describe PHT, as we know it to be today.

The first was in 1891 when Ernst von Romberg noticed at autopsy, abnormal structural changes in the pulmonary vessels (Anderson et al., 2016). The second was in 1901 when Abel Ayera coined the term cardiao negro (black heart) for a syndrome characterised with breathlessness, coughing, cyanosis and abnormalities in the pulmonary vessels. Thirdly, David Dresdale in the 1950s, with the application of heart catherisation, found increased pulmonary artery pressure in patients that had neither lung nor heart problems (Foshat and Boroumand, 2016). PHT was seeing us but we were only just starting to see it.

The catalyst that would finally catapult PHT onto the global arena was in 1965 when there was a surge in the number of diagnosed cases of PHT-pulmonary arterial hypertension (PAH) caused by the appetite suppressant, *Aminox*. This epidemic prompted the World Health Organisation (WHO) to hold its first PHT symposium in 1973, a year after *Aminox* was withdrawn (Anderson et al., 2016). The purpose of this meeting was to gather the experts with knowledge and experience related to PHT.

25 years after the first meeting, the 1998 PHT symposium proposed the PHT classification system referred to as the Evian Classification, named after the location of the symposium. The Evian Classification established individual categories of PHT, where within groups there was shared pathological and clinical characteristics and therapeutic options. PHT being a single disease, five groups of disorders were identified as causing PHT (Simonneau et al., 2004).

The PHT symposium continues every five years and the classification is reassessed each time. Refinements are made reflecting the knowledge that has accumulated. The current classification is the Nice Classification that was updated in 2013 and will be reassessed in 2018 (see the Nice Classification here: http://www.pah-info.com/Classification_of_PH).

THINKSTOCK

PULMONARY ARTERIAL HYPERTENSION GROUP ONE

One of the most severe forms of PHT is Pulmonary Arterial Hypertension (PAH) Group One in the Nice Classification. PAH is a rare but devastating progressive disease that ultimately leads to right heart failure and death. The incidence of PAH is approximately 2.4 cases per million annually and it is more common in women that in men (Noel et al., 2017). Of the five classification of PHT, it is this group that has received the most research attention.

Knowledge of the exact trigger for PAH is still unknown but Matura (2011) suggests that there is the existence of a common pathway whereby structural and remodelling changes occur in the pulmonary vasculature.

These changes are thought to be a result of sustained increase in pulmonary pressures and pulmonary vascular resistance (PVR) from a combination of in situ thrombosis, pulmonary vasoconstriction and the remodelling of the vascular wall (Matura, 2011, p.269.)

PAH SPECIFIC THERAPY

The main treatment goal for PAH is to slow the progression of the disease (Doyle-Cox et al., 2016).

Current PAH therapies have been developed to target the three main pathways involved in the pathogenesis of PAH. These pathways and the therapies available include:

- Endothelin receptor antagonists: *Ambrisentan, Bosentan, and Macitentan*
- Prostacyclin: *Epoprostenol, Iloprost*
- Phosphodiesterase type 5 inhibitor: *Sildenafil and Tadalafil*

The number of medications available continues to grow at a rapid pace. The first medication was approved in Australia in 2004 and since that time, a further seven have been approved, with the recent approval of *Riociguat*, a novel therapeutic class of therapy.

Prior to the development of PAH-specific targeted therapies the average life expectancy was less than three years. The life expectancy today is around seven years (Gin-Sing, 2010).

The future looks positive because with greater research focus and interest, more medications are being developed. Combination therapy, involving one medication from each of the three pathways, is proving to be more effective in achieving treatment goals than single use therapy (Strange et al., 2013).

In Australia, patients can only receive one medication funded by the Pharmaceutical Benefit Scheme (PBS) at this current time. The PBS mandates the prescribing of PAH therapies to designated specialist centres only and there are strict patient criteria and conditions of eligibility. Only patients diagnosed with Group One PAH are eligible to receive therapy. Currently there are 60 specialised designated centres throughout Australia.

THE PHT NURSE

We have seen the development of other types of specialist nursing roles in the care of patients with breast cancer, diabetes and asthma but only recently the PHT nurse. The majority of PHT nurses are attached to specialist teams at designated PHT centres in both public and private locations. Most of PHT care provided at these centres is outpatient based.

Essential to the role is an advanced nursing knowledge of PHT and the skill to make complex decisions, crucial in supporting, teaching and caring for both patients and their families.

Time is spent with patients and families helping them to understand the PHT disease process, recognising signs and symptoms of worsening, self-monitoring and discussing the various treatment options.

PAH-specific therapy requires patients to have ongoing monitoring mainly though outpatient appointments with telephone support. The more complex PAH therapies, like inhaled or intravenous therapies, require substantial time teaching patients and carers about how to self-deliver these medications using aerosol or intravenous delivery.

PHT nurses educate other nursing colleagues who are usually unfamiliar with this rare disease and its complex therapy. Patients with PAH from time to time will require hospital admission for acute care and for many nurses this may be their first time caring for a patient with PHT. This can be quite a daunting and challenging experience. The PHT nurse is a point of reference and a vital link for frontline nurses working in partnership with collaborative patient care.

With the complexity of this disease coupled with the changing regulatory PBS requirements, the PHT nurse is proving to be invaluable and essential in the delivery of high quality nursing care. This new role will continue to expand and develop keeping abreast with medical advances in PHT.

CONCLUSION

PHT is a rare, complex and multifactorial disorder, which has a devastating impact on a person's quality of life. PHT has witnessed major advances since the turn of the century and now commands global attention, and significant interest and awareness continues too.

Continually being challenged by a prognosis that remains poor, the future still looks promising, and further treatments and drug pathways are on the horizon.

The PHT nurse has a key role in supporting and caring for patients with PHT and their families, and this role will continue to expand and be recognised as new nursing specialist role.

Unexplained breathlessness must always be investigated and the possible diagnosis of the rare lung disease of PHT must always be considered.

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AUTHOR

TARA HANNON MACN

CYSTIC FIBROSIS

Why having cystic fibrosis is like being an elite athlete

People who have cystic fibrosis (CF) have inherited two copies of a gene mutation located on Chromosome 7. This is where a protein cystic fibrosis transmembrane conductor (CFTR) is coded, on the DNA. CFTR protein forms a channel that is responsible for the transport of sodium and chloride across cell epithelial membranes. Water follows these ions, so if ion transport is suboptimal or absent, so is water at the cell surface. Thus organ function can be impaired.

In people with cystic fibrosis, the lungs are vulnerable to infection and gut function is not normal. Most males have bilateral absence of the vas deferens. CF is the most common lethal, genetic disease in Caucasians (MacKenzie et al., 2006).

To stay well with CF requires a daily regimen of physical and pharmacological therapies starting at the time of diagnosis. It can be a challenge to try and do all the treatments required to prevent disease progression. The burden of the treatments could be likened to the training demands experienced by elite athletes (EA).

GENETICS

The genetics of CF are as complex as the genetics of physical performance. There are more than 170 genes associated with performance or fitness phenotypes in humans, the CFTR gene being one of these (Rankinen et al., 2002). Exercise testing in people with CF has shown that there is an association between the number and quality of functional CFTR channels and peak anaerobic power (Selvandurai et al., 2002).

In people with CF, as in athletes, the efficiency of ion transport across the epithelial cell wall is the product of both quantity and quality of the CFTR channel on the cell surface. There are over 1,000 CF gene mutations. Genetic variations in CFTR channel function translates into many different cystic fibrosis phenotypes with different organ systems being affected more or less in each individual (Zielenski, 2000).

FUN FACT: there are no fitness or performance genes located on the Y chromosome (Rankinen et al., 2002).

THE GOAL

Now you have the genes, what do you do with them?

Having CF and being an elite athlete requires commitment to strive to achieve a goal.

The goal of the elite athlete is clear; to strive to achieve his/her/teams best possible performance at the highest level of competition. This involves paying attention to avoiding and treating complications/injuries.

The goal for people with CF is for long-term survival to enable the achievement of smaller life-affirming goals which, in turn, provide the impetus and motivation to keep doing whatever is required to stay as healthy as possible. The stakes are high for people with CF because it isn't just about survival; it is about symptom-free survival.

The development of new disease modifier therapies targeting specific genetic mutations, has the potential to dramatically reduce morbidity and improve survival (Vertex Pharmaceuticals Incorporated, 2017).

FUN FACT: the rate of improvement of CF life expectancy exceeds that of the general population in many economically developed countries (Hurley et al., 2014).

WORKING TOWARDS THE GOAL AND DOING WHAT IT TAKES

Elite athletes have a daily schedule that involves multiple sessions of various activities aimed at optimising competitive ability. Frequent testing and assessment is performed to ensure the training program is constantly being individualised to that athlete. Interruptions or failure to stick to the program will affect performance and success.

A person with CF commits to a regular routine that can include a number of different treatments many times per day or less regularly, as required. The components of the treatment regime vary with phenotype and disease severity (Cystic Fibrosis Australia, 2008). Constant monitoring of lung function, weight and regular screening for development of co-morbidities are required to inform the treatment plan.

THE IMPACT OF TREATMENT AND TRAINING ON THE BARE NECESSITIES: SLEEPING, EATING, WORK AND STUDY

Sleep quantity and quality is known to be suboptimal in elite athletes. A systematic review looked at the evidence for elite sport to degrade sleep quality. Pooled sleep quality data indicated high levels of sleep disturbance with three main causes; training, travel and competition. Many athletes exhibit traits of perfectionism, however, sleep disruption can occur as a result of the associated performance anxiety (Gupta et al., 2017).

Sleep disturbance has been shown in studies in children with CF (Vandeleur et al., 2017). Sleep disturbance in adults with CF often occurs as a result of shortened availability of sleep time due to treatments, coughing and disease progression-related anxieties. With CF, poor sleep impacts on sleep hygiene, capacity to participate in self-care and more broadly on social engagement, concentration and activities of daily living.

Good quality, energy rich nutrition is essential for athletes. Eating and drinking for athletes that train and compete at an elite level is carefully prescribed depending on the stage of preparation and the type of event. Body composition, integrity of the musculoskeletal system, flexibility, strength and total body hydration and glycogen stores are monitored constantly during training phases, competition and in the recovery period.

> “The burden of the treatments could be likened to the training demands experienced by elite athletes.”

While maldigestion, the most frequent issue affecting nutrition in CF, is not often experienced by elite athletes, attention to detail is just as essential in managing CF because higher body mass index is associated with improvements in lung function (Stephenson et al., 2013).

Maldigestion occurs in 85–90% of people with CF, so recommended daily intakes (RDI) for the normal population do not apply. In CF, 110-120% of RDIs are recommended.

Resting energy expenditure is 5–30% higher and recommended energy intake is 50% higher, than the non-CF population. The thirst response in CF can be dulled due to the change of serum osmolality and cannot be relied on to prompt people with CF to adequately replace fluids by drinking water alone in hot climates or after intensive exercise. Also, titration of pancreatic enzyme replacement therapy, plus insulin for those with CF-related diabetes, is a recurrent task that requires time, effort and attention to detail (Australasian Clinical Practice Guidelines for Nutrition in Cystic Fibrosis, 2006).

Interestingly, two of the aims of the International Olympic Committee (IOC) Nutrition Guidelines for Athletes could equally well be applied in CF:

- Choosing targets that are achievable and sustainable in view of your genetic blueprint
- Allowing enough time for the targets to be achieved with sensible changes to nutrition and training (Medical and Scientific Commission of the International Olympic Committee, 2016).

WHAT ABOUT TIME MANAGEMENT AND STICKING TO THE PROGRAM?

With CF, it is well documented that adherence to therapies varies. Studies indicate that people with CF undertake 50% (35–75%) of prescribed treatments and poor adherence is associated with increased probability of an exacerbation after controlling for disease severity and regimen complexity (Eakin et al., 2013). Finding time to do normal life activities can be difficult between treatments.

Estimates of daily time devoted to taking oral and inhaled medications, airway clearance and exercise range from zero to several hours a day. When undertaking a program of intravenous antibiotics at home, that time commitment escalates to six hours or more.

The importance of balancing life goals and health goals is supported within paediatric hospitals to keep children with chronic illness engaged in their studies. After school, it can be challenging for young people and adults to balance their time between study, work and treatments.

Recent media reports have shown there is a considerable psychological impact on athletes not adequately prepared for life after sport.

Elite athletes in Australia have access to the Australian Institute of Sport Personal Excellence Program. This collaboration with many universities provides unique study programs for individuals undertaking tertiary study while training and competing.

People with CF share the same challenges in balancing the time taken to pay attention to their condition and that required to undertake vocational training, often without the benefit of formal university programs and workplaces that support this level of commitment.

THINKSTOCK

SUPPORT TEAM

EA/CF

FAMILY

COACH/DR
Responsible for goal setting, assessment, setting the program, monitoring and modifying the program.

ASSISTANT COACHES AND TRAINERS/CF SPECIALIST NURSES
The "go to" people on the ground who know the person and their individual concerns, so they can triage new issues, encourage and advocate.

PSYCHOLOGIST
Assessment, monitoring and implementing strategies to optimise mood, minimise barriers to participation and achievement.

DIETICIAN
Devises appropriate nutrition plan to achieve agreed goals, monitors weight and body composition, and individualises diet and supplements.

PHYSIOTHERAPIST
Assess fitness, musculoskeletal integrity, advice and education around injury prevention and treatment regimes.

PSYCHOLOGICAL DETERMINANTS OF SUCCESS

A systematic review of psychology in elite endurance athletes concluded that practical psychological interventions such as imagery, self-talk and goal-setting have positive effects on performance. Verbal encouragement and head-to-head competition sustain positivity (McCormick et al., 2015). Mental fatigue has the reverse affect.

In CF, factors shown to increase adherence to therapies which ultimately reduce rate of physiological decline include resilience, optimism and family cohesion/coping/collaboration. Psychological interventions are being used to improve adherence and include cognitive behavioural therapy and self-hypnosis. Other strategies are also being studied (Goldbeck et al., 2015). Mindfulness and relaxation can be used to treat sleep problems, reduce anxiety and depression in people with CF and EAs.

THE NEED FOR A SUPPORT TEAM!

To cope with the demands made on them to perform at their best, people with CF and EAs need, and should have access to, a team of appropriately qualified and experienced people that convey and support the expectations required to achieve this goal.

Essential elements include: Family engagement, involvement and collaboration.

Formula for collaboration = (Engaging + Connection) x number of consultations

There are many similarities between the training regime that EAs undertake and the demands required to minimise the morbidity and mortality associated with having CF. With commitment and the help of their support team both can be winners!

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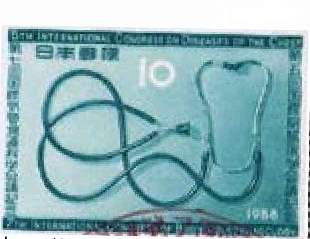
AUTHOR

FELICITY FINLAYSON MACN

THE HUMBLE STETHOSCOPE

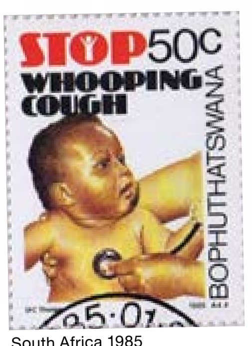
A historial approach

British Virgin Islands 1983



Japan 1958

South Africa 1999



South Africa 1985

Australia 2010

How can you tell the difference between a nurse and a doctor? If you believe some television dramas, the humble stethoscope is the defining factor. The doctors wear them, and the nurses do not – apparently. This very issue raised considerable media attention in 2015 when certain American celebrities alerted the public to their ignorance when they mocked Miss Colorado – a registered nurse – for wearing a stethoscope during her pitch for the Miss America Crown (Cipriano, 2015). They missed the point of her dialogue about her talent as a nurse – aided by a stethoscope.

The purpose of the stethoscope is for performing auscultation and is concomitant with breath, heart and bowel sounds from the foetus until death. An essential tool for nurses as well as other health care professionals, its origins date from 1816. The invention of the stethoscope is attributed to French doctor Rene Theophile-Hyacinthe Laënnec (1781–1826) who was motivated by problems associated with the then procedure for auscultation, such as ear to chest (and other too intimate places), as well as the need to improve listening quality and diagnostic accuracy (JAMA Revisited, 2016; Dickson, 2017; Harbison, 2017). So, necessity being the mother of invention, Laënnec first used sheets of paper rolled into a cylinder to create a listening device for heart sounds. This led to his construction of an instrument consisting of a monaural wooden tube which he named a stethoscope – from the Greek stethos (chest) and scopos (examination) (South Australian Medical Heritage Society, n/d). As a result, Laënnec was able to describe a new set of sounds such as wheezes and crackles.

The stethoscope was slow to be accepted. By the 1850s, development of the binaural rubber-tubed stethoscope improved on Laënnec's design. Variations started to appear in the 1860s and gradually, by the early 1900s, the stethoscope had become a commonly used doctor's diagnostic tool (Gluckman, 1996). It just took a little longer for nurses to be permitted to use it routinely – in collaboration with the sphygmomanometer (Wytenbroek, 2016). How many of you remember first using a stethoscope when learning to monitor blood pressure – the old way – and wondering what it was you were supposed to hear?

While auscultation continues to evolve in this world of advancing technology, it is still a necessary skill for nurses which requires technical proficiency. From cheap basic varieties in a range of colours, to expensive specialist ones in black, the humble stethoscope doesn't require a power source, doesn't require WIFI, and by its very design is one conduit for connecting nurses to patients to improve outcomes.

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AUTHOR

MARILYN GENDEK FACN

NURSING REFLECTIONS ON A PILOT PROJECT

Improving outcomes in chronic disease management using nurse-led home telemonitoring

"The telemonitoring nurse has become one of the pillars of my health, along with my general practitioner (GP) and cardiac nurse," said Ron during an interview about his experiences participating in a six-month, nurse-led home telemonitoring trial.

Ron is a 52-year-old man living with multiple chronic conditions: congestive heart failure, hypertension, chronic obstructive pulmonary disease and an anxiety disorder. Electronically recorded measurements of his BP, weight, Sp02, HR and one-lead ECG along with answers to questions about his symptoms are transmitted daily from his home to the nurse telemonitoring hub. The telemonitoring nurse then interprets the readings and responds further if required. If all is well, no further action is taken. Any readings that register outside Ron's normal range prompt a follow up call for further assessment. Sometimes, all Ron needs is some health coaching. Occasionally consultation with his wider health care team is needed.

Ron was referred to the telemonitoring nurse by a hospital-based GP as his multiple chronic conditions impacted on each other resulting in frequent, unplanned hospital presentations. Later, Ron reported that prior to participating in the telemonitoring program he had a relatively low level of awareness about managing his multiple conditions and this led to him experiencing considerable anxiety. After six months of taking his telemonitoring readings on a daily basis, Ron showed significant improvement in self-management and health literacy with a subsequent reduction in anxiety, reduced social isolation and fewer hospital presentations. Most importantly for Ron was the impact on his quality of life. For the first time in many years he had the confidence to travel interstate to visit his son knowing that he could manage his health effectively while he was away.

Ron is but one of 25 participants over the age of 50 years living with at least one chronic condition in rural NSW who participated in this nurse-led trial. The benefits of telemonitoring were most noticeable in participants whose chronic disease/s were more severe and in those who initially demonstrated a limited ability to effectively self-manage. These participants felt that the improvements to their capacity to manage their health issues more effectively were largely a result of the partnership they had formed with their trusted telemonitoring nurse, who they knew they could contact when needed. Ultimately, this helped them to both recognise and appropriately manage their symptoms and seek medical attention in a much timelier manner than when they observed indications of an acute exacerbation. An additional benefit for several participants occurred when the telemonitoring data collected enabled the nurse to advocate for adjustments to their prescribed treatments (Burmeister et al., 2016).

In 2016, a Commonwealth Scientific and Industrial Research Organisation (CSIRO) home telemonitoring research trial in which a nurse care coordinator managed a group of 100 chronically ill patients, reported similar findings. Importantly, these researchers were also able to demonstrate reduced costs overall, as a result of:

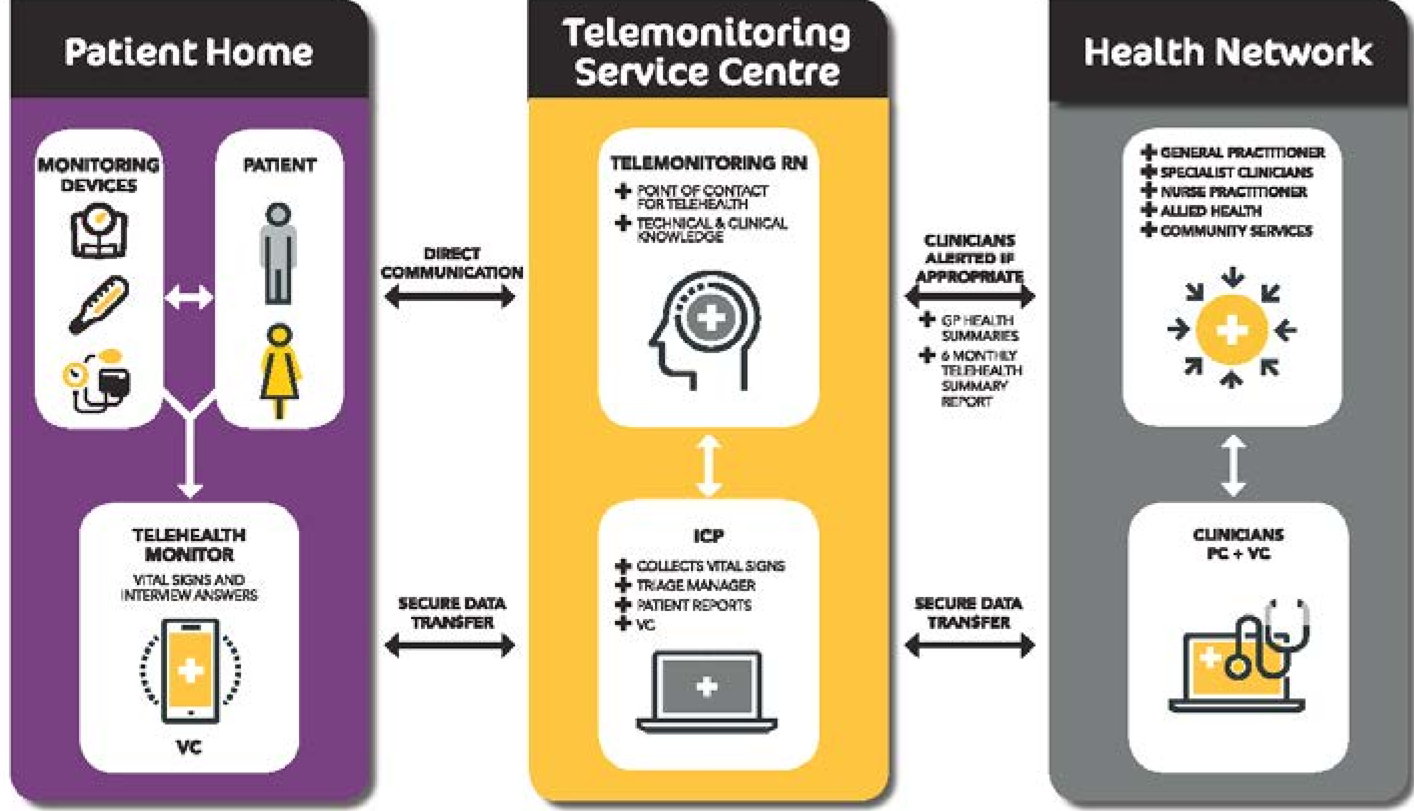
- Clinicians receiving early warning of deterioration enabling early intervention
- Improved self-management
- Reduction in unplanned hospital admissions
- Reduction in length of hospital stay (Celler et al., 2016, p. 17)

The emerging evidence demonstrating the multiple benefits of home telemonitoring, as described in the CSIRO trial and in this study, is beginning to influence Australia's health care strategies. Last year in NSW, the Ministry of Health (2016) released a telehealth framework and implementation strategy for 2016-2021. This has exciting implications for nursing as a profession, with opportunities to contribute to advances in health care delivery.

Although home telemonitoring is well-established in countries such as the US, it is still in its infancy in Australia. There is much to be done to perfect the use of this technology to enable effective integration within the wider health system. Our nursing team involved in Ron's care and that of the other participants in the study, have learned much from this pilot project. I have chosen five particularly pertinent learning points that I would like to share with you.

1. The telemonitoring nurse as clinical care coordinator was critical to the success of the service. The nurse-led home telemonitoring model used in this trial and which is visually depicted (see image), shows the centrality of the nurse in assessment, education of patients and referral to other members of the health team, including the patients' GP and a range of community service providers. In this model, the nurse acts as a gateway for the collection and sharing of information, as well as a central point of contact for the patient and health team.

2. For a nurse to successfully undertake the telemonitoring role it requires the capacity for advanced nursing practice in the care of people with complex health care needs. Some of the specific capabilities needed include: well-developed interpersonal communication skills; an ability to work collaboratively with patients, carers and the interprofessional health team; health coaching skills; high assessment confidence and; a well-developed capacity for clinical reasoning in combination with confidence in the use of telemonitoring technology. These requirements are consistent with previous research identifying the competencies required for nursing telehealth activities (Van Houwelingen et al., 2016).



3. In this trial, a frustrating barrier to effective interprofessional collaboration occurred when GP participation was poor. Previous studies that showed GPs' scepticism and reluctance to participate in similar activities related to personal barriers, reimbursement barriers and clinical workflow barriers (Brooks et al., 2013; Wade et al., 2014). Optimal outcomes in telehealth occur when services are delivered as part of team care and when there is effective communication between the team (NSW Agency for Clinical Innovation, 2015). We need to discover ways to both increase involvement of GPs and other health providers and to develop effective collaborative relationships.

4. Implementation of telemonitoring is newly emerging as part of health care service delivery in Australia. Forming a "community of practice" for health professionals involved in this area of health care will assist cross-organisational learning, facilitate sharing of solutions for common problems and enable development of health care policies and clinical practice guidelines specific to this evolving area of practice (Wade et al., 2016).

5. Current telemonitoring technology relies heavily on interpretation of vital signs for assessment of the person. A reliance on vital signs alone as indicators of a deteriorating patient has been shown to produce suboptimal outcomes (Chua & Liaw, 2015).

Multiple opportunities exist for experienced nurses to actively engage with designers of telemonitoring technology. Combining the assessment capacity of current technology with nursing processes is one of many ways in which the functionality of these technologies could be significantly improved.

At a time when the health care profession is being increasingly challenged by the complexities of a growing number of people living with multiple chronic conditions, home telemonitoring led by nurses in advanced clinical care coordinator roles is being recognised as an approach that improves patient outcomes (CSIRO, 2016). This model of care offers financial savings to the health care budget. However, if it is to find a sustainable place in Australia's health care system, financial support from the government (e.g. with Medicare Benefits Schedule items specific for the needs of telemonitoring services) will be required. Nursing, as the largest group of health professionals, is well placed to advocate for these changes. May Ron's words be a challenge for us to embrace technology, as we herald the way to an improved quality of life and a better health care experience for people living with chronic and complex conditions.

Note: participant name has been changed for the sake of anonymity.

Acknowledgements: Associate Professor Rachel Rossiter

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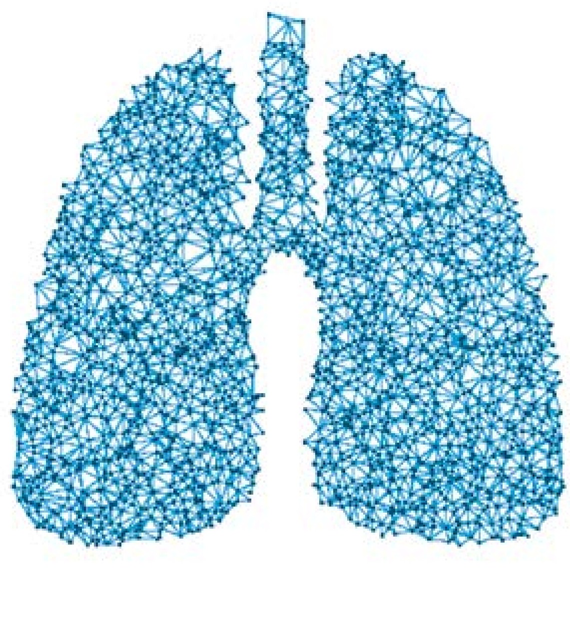
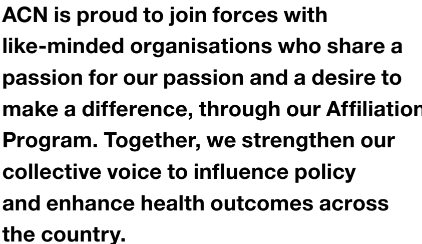
AUTHOR

ALISON DEVITT MACN



OUR BRONZE AFFILIATE

Thoracic Society of Australia and New Zealand



ACN is proud to join forces with like-minded organisations who share a passion for our passion and a desire to make a difference, through our Affiliation Program. Together, we strengthen our collective voice to influence policy and enhance health outcomes across the country.

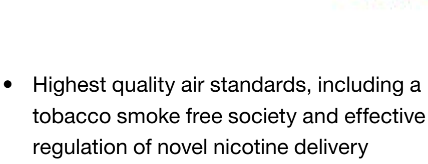
Affiliation packages are available in four levels (Platinum, Gold, Silver and Bronze) with each providing a comprehensive suite of benefits and services to support our Affiliate's staff in their professional practice and develop their leadership ability by connecting with nurse leaders. The program is open to every organisation that employs nurses or has nurse members.

Meet one of our Bronze Affiliates, The Thoracic Society of Australia and New Zealand, who is committed to supporting nurses in reducing the burden of respiratory disease in our population…

The Thoracic Society of Australia and New Zealand (TSANZ) holds a vital place in the medical community as the leading organisation representing respiratory health professionals.

The TSANZ is committed to serving the professional needs of its members by improving knowledge and understanding of lung disease, with the ultimate goal of preventing respiratory illness through research and health promotion, and improving health care for people living with respiratory illness. TSANZ exists to promote the:

- Highest quality and standards of patient care
- Development and application of knowledge about respiratory health and disease



- Highest quality air standards, including a tobacco smoke free society and effective regulation of novel nicotine delivery systems

The origins of the TSANZ date back to the 1950s. TSANZ grew out of the Laennec Society, named after René Laennec. The Laennec Society was established in 1952 as a result of the tuberculosis epidemic in Australia. In 1960 the name Australian Thoracic Society was adopted at a meeting with an assemblage of just 16 members, and much of the Society's mission and branch-like structure was decided at this inaugural meeting. In 1988 the Thoracic Society of Australia and the Thoracic Society of New Zealand were amalgamated into the TSANZ.

TSANZ's seven branches span Australia and New Zealand and are the primary point of contact for members.

Within the TSANZ, there are 17 different Special Interest Groups (SIGs), one of which is the Respiratory Nurses SIG.

The Respiratory Nurses SIG is run by a Convenor and Deputy Convenor from Australia and New Zealand. The current convenors are Karen Royals, Deborah Box, Rebecca Disler MACN and Jenny McWha, and they work tirelessly to keep SIG members up-to-date with education and networking opportunities and awards around Australia and New Zealand via a monthly SIG newsletter, advocate for nursing issues and represent nurses in decision-making processes as well as build the membership.

Nurses play an active part in the activities and offices of the Society. Respiratory Nurses SIG Australian Deputy Convenor Rebecca Disler MACN is also Deputy Convenor of the Evidence-Based Medicine & Practice SIG and the Nurse Representative on the VIC Branch Executive Committee of the TSANZ; whilst Respiratory Nurses SIG NZ Convenor Deborah Box is the NZ Branch Secretary. Respiratory Nurse SIG Australian Convenor Karen Royals serves on the Clinical Care & Resources Sub-Committee of the Board, responsible for the oversight and approval processes for TSANZ clinical guidance documents. Karen is also a member of the Local Organising Committee. Nurse member Mary Roberts, who is well known to many respiratory nurses, is a founding member and current Deputy Convenor of TSANZ's newest SIG, the Symptom Support & Palliative Care SIG. In addition to these nurses, a number of other nurse members are represented on each of the sub-committees of the Board and regularly present in respiratory training programs for a range of health professionals. Through active engagement with the Society, which is highly valued and encouraged, nurses help to establish the strategic direction and activities of their professional body.

TSANZ is a leading developer of clinical resources and guidelines which can be accessed at www.thoracic.org.au/journal. The TSANZ administers more than $1 million in research funding, and respiratory research grants are available to nurse members along with dedicated nurse awards to support nursing research and career development. TSANZ Chief Executive Officer Tanya Buchanan MACN, herself a former registered nurse, and the TSANZ Board recognise the importance of multi-disciplinary research and governance in achieving the TSANZ mission and the important role respiratory nurses play in achieving this goal.

The Australian Defence Force

An interview with Nursing Officer, Lieutenant Colonel Toni Bushby

Lieutenant Colonel Toni Bushby is head of the Royal Australian Army Nursing Corps (RAANC) in the Australian Army. She says the opportunities for professional and personal growth are what attracted her to the Army, and it's what keeps her excited to come to work every day after 21 years.

What convinced you to take the role of Nursing Officer in the Army?

My Dad was in the Army, so I was aware of the many opportunities available in the Australian Defence Force. I grew up in about 11 different places around Australia and the world, and I knew that if I joined the Army I could travel for work and not have to change employers. I also liked the idea of helping people in different environments.

What sort of training and professional development have you undertaken throughout your career?

The Army is very much focussed on continuous professional development, particularly in my line of work. You are encouraged to identify the areas you are interested in and pursue that. I have completed a Grad Certificate in Emergency Nursing, Grad Certificate in Pre-Hospital Care, a Grad Diploma in Vocational Education and Training, and a Masters in Health Management. I was able to do these with the assistance of Defence or through the Defence Assisted Study Scheme.

How does nursing in the Army differ from being a Registered General Nurse?

The Australian Army employs Registered General Nurses, just like any hospital or general practice. Nursing in the Army differs in that you primarily work in deployable health units. This means you and your unit can be deployed into combat zones or peace keeping missions to provide primary health care and immediate resuscitation in a pre-hospital setting. We are also required to undertake the Specialist Service Officer Course through the Royal Military College Duntroon, where officers learn the fundamental knowledge of command, leadership and management, unit and personnel administration, basic military skills and the ideals of officer behaviour.

Can you tell us a bit about how your role differs on deployment from working within a base environment?

You're routinely exposed to primary health care on base, with the odd trauma. You also know that you are ultimately supported by the Australian health care system should you need it.

On deployment it's 24/7, and you're not only dealing with the deployed force but with critically injured civilians.

On deployment, there isn't necessarily the back up to deal with issues in the situation you're in. Whether it's in a tactical situation, where you can't evacuate people until it's safe, or the weather is bad, you are often out of your comfort zone.

Is the equipment you use on deployment different to what you use on base? And how does it compare with what you would have access to as a civilian nurse?

There are a lot of similarities between civilian and military hospital equipment, however military equipment is far more robust to handle field conditions.

You could be in the back of a helicopter in pitch black with night vision goggles and working on a patient and your equipment can fail or run out of battery power because you are out longer than you thought you were going to be. That's when all your training comes in and you have to be able to rely on your ability to assess and manage the patient using your assessment skills alone. So it's far more challenging than a normal environment.

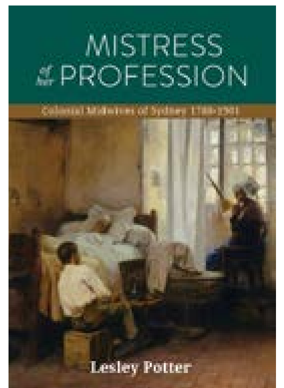
What would you say to someone who is interested in joining the Army as a Nurse?

Keep in mind why you want to join. If you want a challenging and rewarding career, one in which you can meet and help a range of different people and make a real difference, then embrace the Army life and learn everything you can. The skills you will be practicing and the experiences you'll be exposed to, you won't get anywhere else. If you don't take yourself out of your comfort zone, you'll miss wonderful opportunities.

As a nurse in the Army I'm part of a unit, which makes me part of something bigger. I don't believe you have that in a normal nursing role and that's what makes me feel like an incredibly valued member of a team. I have formed life-long friends and have been part of something positive in people's lives. I am incredibly proud to say I'm in the Army.

To find out more about health roles available in the Australian Defence Force, visit defencejobs.gov.au or call 13 19 01

NOVEL THOUGHTS



MISTRESS OF HER PROFESSION

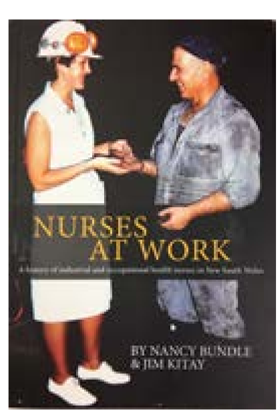
Author: Dr Lesley Potter MACN
Publisher: Anchor Books
Published: 2017
Reviewer: ACN Publications Officer Olivia Congdon

Mistress of her Profession: Colonial Midwives of Sydney, 1788–1901 is a true pleasure to read. This book takes the reader on a journey through the development of the nursing and midwifery professions in New South Wales during the 19th Century, particularly in terms of education and training. Whilst this book focuses on New South Wales midwives, it is a reflection of the attitudes and actions of many Australians, during this time. Dr Lesley Potter's MACN well-researched facts are brought to light with contemporary analysis and illuminating case studies, some of which are inspirational, others of which are devastating.

A former midwife herself, it is evident that Lesley has great admiration for the midwives she writes about, who have rarely been given the accolades they deserve throughout history, due to their lack of documented presence in the primary records.

Strong themes of gender equality, and the importance of education, training and evidence-based practice in nursing and midwifery are evident throughout. This is an eloquently written book, which fills a gap in Australian history. It certainly has relevance to all nurses and midwives today.

www.anchorbooksaustralia.com.au/product/mistress-of-her-profession1/



NURSES AT WORK

Author: Nancy Bundle AM FACN and Jim Kitay
Publisher: NSW Nurses and Midwives Association
Published: 2017
Reviewer: ACN Publications Officer Olivia Congdon

Nurses at Work is a fascinating history of industrial and occupational health nurses in New South Wales. The book delves into the story of nurses working from 1911 onwards, who were employed to protect and maintain workers' health. Nancy Bundle AM FACN worked in this specialty for many decades and her first-hand knowledge, alongside her expert research skills and Jim Kitay's refreshing sociological perspective, adds depth and interest to the book.

In *Nurses at Work*, industrial nursing is broken down into three periods: 1911–1939 (when nurses were appointed to industry by the welfare movement), 1940–1959 (when emergency legislation compelled dangerous industries to employ a nurse) and 1960 onwards (when the role changed to focus on injury prevention and also when numbers declined).

Particularly enjoyable aspects of the book include the supplementary stories of notable individual nurses, as well as the inclusion of a number of photographs, which help to paint a holistic picture of the time. The authors should be congratulated on the way they've put together a comprehensive and highly valuable history on the changing nature of industrial nursing and the profession.

www.nswnma.asn.au/history-of-occupational-health-nurses/

THE LIFE AND TIMES OF ROYAL PRINCE ALFRED HOSPITAL

Author: Muriel Doherty edited by R.L Russell AO FACN
Publisher: New South Wales College of Nursing
Published: 1996
Reviewer: ACN Publications Lead Sally Coen

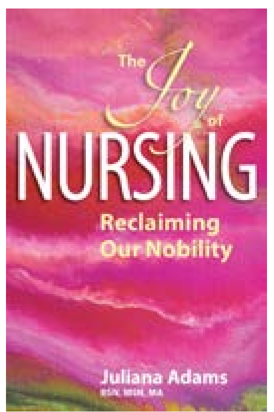
The Life and Times of Royal Prince Alfred Hospital is a unique, historical masterpiece that enlightens readers to the conditions and patterns of health care at this historical institution. Published posthumously, this fascinating, edited autobiography takes readers on an important journey into our professional past through the eyes of an eminent nurse, Muriel Doherty.

Drawing upon a collection of historical documents, memorabilia and correspondence, Doherty paints a picture of the changing conditions for nurses at the *Prince Alfred Hospital*. Her historical timeline covers the earliest years of the hospital, from the early 1880s up to 1920. Through her meticulous editing, R.L Russell AO FACN beautifully preserves this inspiring story, which will undoubtedly be of great interest to the nurses of today.

https://shop.acn.edu.au/

A COLLECTION OF NURSING BOOK REVIEWS

If you would like to submit a nursing book or film review for publication in an upcoming edition of *The Hive*, please email us at publications@acn.edu.au



THE JOY OF NURSING – RECLAIMING OUR NOBILITY

Author: Juliana Adams
Publisher: Steamboat Springs Publishing
Date of Publication: 2016
Reviewer: ACN Publications Lead Sally Coen

This beautifully raw, uplifting and at times, heart-wrenching personal account of a nurses' journey from novice to expert is a wonderful reminder of the unique joy and privilege of being a nurse.

Reflecting on her journey from a new graduate nurse to an experienced professional, Juliana Adams shares her stories, her insights and her dedication to the nursing profession. The immense importance of nurse leadership in overcoming challenges and barriers to delivering high quality care is a reoccurring thread throughout the text. The honour of being a part of some of the most joyous and difficult times of another's life, is also a common theme in Juliana's stories.

This book is both reinvigorating and refreshing – it will make you cry, it will make you laugh and most of all, it will make you feel. A must-read for anyone thinking of joining this highly rewarding profession or an experienced professional looking to rekindle their love for nursing.

www.amazon.com/Joy-Nursing-Reclaiming-Our-Nobility/dp/0997200308

AUSTRALIA'S CONTROVERSIAL MATRON

Author: Judith Godden FACN (Hon)
Publisher: Australian College of Nursing
Published: 2011
Reviewer: ACN Publications Lead Sally Coen

An enthralling read and celebration of the life of a truly transformational nurse leader, *Australia's controversial matron: Gwen Burbidge and nursing reform*, takes readers on an exciting journey through our professional history. This refreshingly honest and utterly absorbing biography details the complex challenges facing our profession against the backdrop of World War II during the 20th Century.

Interweaving compelling prose with historical narrative, Judith Godden FACN (Hon) illustrates how one nurse's tenancy and determination to make a difference changed the course of nursing. She paints a picture of the barriers nurses faced receiving appropriate education, training and regulation, as we struggled to establish ourselves as a legitimate profession in the medical world.

Paying tribute to our professional past, this novel shines the light on a feisty, spirited and truly inspirational woman who paved the way for the nurses of today. It shows us how her legacy lives on in us all, as we continue to strive for change to enhance health care outcomes across the country.

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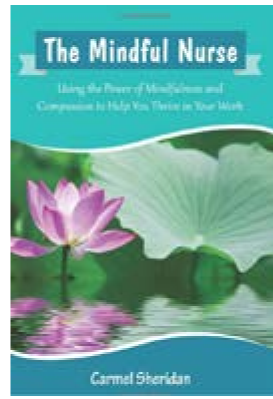

THE MINDFUL NURSE

Author: Carmel Sheriden
Publisher: Rivertime Press
Published: 2016
Reviewer: ACN Publications Lead Sally Coen

A much-needed and well-written guide to help care for the caregiver, this book teaches mindfulness and compassion practices to lessen stress, increase job satisfaction and enhance relationships within the nursing profession.

In her highly informative text, Carmel Sheriden outlines a new understanding of everyday mindfulness and compassion, while outlining how this can be achieved and maintained within stressful work environments.

With a focus on the incidence of compassion fatigue in the nursing and health professions, Carmel explains how we can nurture others without depleting ourselves. Using a gentle approach and a touch of good humour, she relates mindfulness practices to both a personal and professional context.

An easy read that flawlessly interlaces real-life scenarios with theory, this is a book to which all nurse can relate. I would highly recommend *The Mindful Nurse*, to any of you who are looking to increase your ability to handle stressful situations in the workplace.

www.amazon.com/Mindful-Nurse-Mindfulness-Compassion-Thrive/dp/0993324525

Nursing matters

Foreign language learning – a requirement in nursing training?

It is a universal nursing truth that communication is the key to success in our profession. It is simply impossible to create the therapeutic trust required to perform nursing work without it. Yet should we take this commitment to excellence in communication one step further and incorporate foreign language acquisition and intercultural communication into core nursing training?

In Australia, 26% of the population is born overseas and 21% of the population uses a language other than English at home, yet in 2016 only 12% of Australian high school students studied a language other than English for their final school examination (Australian Bureau of Statistics, 2017). The only compulsory language study is one year in early high school, and that doesn't take you far.

My question to the nurses of Australia is: how do nurses care for our multicultural community if we haven't learned a foreign language meaningfully ourselves? Well, we know what happens…we make up flash cards with pictograms and we enlist support staff and family members to help. We speak our own language very loudly even when the patient doesn't understand and we mime. When it is really, really, serious, we get an interpreter to come and translate what the doctor needs to say. Nursing a patient through a significant language barrier is a really challenging situation. Now that I have experienced life in a non-English speaking country myself, I think we as a profession could make it an aim to prepare ourselves better for this situation in Australia.

Here in Frankfurt, Germany, where I am currently working, foreign language confrontation is a part of everyday life. The city has representatives from more than 180 nations living here. Many are expatriate business people, newly arrived immigrants or refugees, and citizens from other European Union lands (Frankfurt.de, 2017). Frankfurt is a particularly multicultural town but around 33% of Germany's total population is comprised of people who are either foreigners or citizens with an immigrant background (Destatis, 2017).

Nurses, not just in Frankfurt but anywhere in Germany, have already completed between six and eight years of foreign language study when they enter their nursing training. The majority have studied English all that time. Depending on which school they went to, they may have also studied a second language. In addition, once they enter their nursing training program, they are normally required to do compulsory units on industry specific communication in a second language, usually English. The result is that an anxious, non-German patient heading into a German-speaking hospital will find a team of nursing staff who can care for them in German, English or perhaps their own native tongue.

Of course, I am the first to admit that knowledge of the German language is not going to make me a proficient communicator in Mandarin or Arabic or Swahili. I realise that Australians could argue that it is a waste of time and energy to learn other languages when the "whole world" learns and speaks a bit of English. I also acknowledge that there are universities already offering courses with the option to combine foreign language study with a nursing program and there is great work already being done by our colleagues in highly multicultural areas of Australia who already work in two or more languages and make health care as accessible as they can to their diverse local population. I would still maintain, however, that all nurses would benefit from gaining some basic competence in a second language. You may like to consider the following:

Learning a language is not about new words, it is about a new worldview. You realise pretty quickly that other cultural groups truly see the world in a different way. For example, in German, one shows respect and politeness by referring to everyone outside family and friends who is over the age of about 16 as Mr or Ms X. To decide to show warmth and friendliness by referring to a person by their first name or, worse, by a nickname or term of endearment in a professional context would be belittling and highly offensive. German is not the only language where this occurs and, by having experienced this once through learning German, this knowledge encourages me to check more thoroughly how a non-english speaking background (NESB) patient would prefer to be addressed.

Different languages refer to different emotions and illness phenomena in completely different ways. In English, we experience extreme disappointment as "heartbreak" or we might have "something on our mind" or view an inconvenience as "a pain in the neck". In all cases, another fluent English speaker would know what we meant. In other cultures, feelings of distress, anxiety and depression are associated variously with the lungs, kidneys, liver, abdomen and so on (Drapeau, Marchand & Beaulieu-Prevost, 2012). Having come across these sorts of difference in one language makes one more alert to the possible misunderstandings that may occur when using "turns of phrase" with non-native speakers.

Life outside your own language can be really unenjoyable. Occasionally on holidays, you might have had a situation where the service people did not speak good English, leading to disastrous but funny stories involving hotel mix ups and strange meals. Imagine if this was your everyday life! Living in a foreign country where every communication is an effort can be exhausting, frustrating and anxiety inducing. It is tiring to have to plan every communication; it is frustrating to miss opportunities because you didn't fully understand; it is demoralising when someone speaks down to you in a way they

could never have done if you had had the vocabulary to assert yourself properly. It is scary to think that, in a critical situation, those around you might not understand what you had to say or would not take you seriously because you used words clumsily. All these issues are true in someone who is well, but to have to work for your words when ill, is another matter altogether.

Language can change your personality. While I am a vociferous communicator in my mother tongue and relish the use of language to make my point, I find my personality changes somewhat in German. I am less confident, less assertive and willing to accept more even when the result is not something I want. I avoid situations which I wouldn't think twice about in English, such as ringing an organisation with an enquiry or responding quickly to a business email. I fear that people will not respect me when they hear my accent and, if someone is rude or having a bad day, I assume it is my lack of linguistic competence which has offended them. The busy, stressed atmosphere in hospitals is bamboozling even to those who understand everything around them but imagine the anxiety created in those who can't. If we are to build the trust and compassion which we value so highly in our therapeutic relationships, we have to talk about this problem and train all nurses to truly empathise with the challenges involved.

Nurses are advocates for their patients and create health through holistic assessment, empathy and, above all other things, meaningful communication, yet it seems that when it comes to NESB patients, we could try harder as a profession to bridge the divide. We could ensure that we include the topic of intercultural communication and foreign languages in our courses in more depth. We could promote the learning of even the rudiments of a second language through recognition, incentives and rewards as often occurs in the hospitality and travel industry.

> "Learning a language is not about new words, it is about a new worldview."

We could see severe communication problems with a NESB patient as a risk situation, which needs nursing identification and intervention by the entire team in a proactive and ongoing way. We don't expect a vision-impaired person to cope in a new and unfamiliar environment without orientation, aids and appropriate strategies. Why do we sometimes see a language barrier as an issue that the patient or their family should have to solve themselves in a situation of illness and distress? Why do we get frustrated and resentful that someone cannot speak our language when we can't speak theirs? I think we can do more and I think that in a country such as Australia, it should be a priority. Pamphlets and flashcards can help us provide information but they can't demonstrate empathy or help us as carers to appreciate how the world looks from another angle. The best way is to experience a little of the challenges ourselves.

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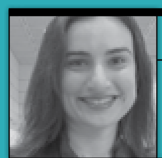

AUTHOR

ELIZABETH MATTERS FACN

THINKSTOCK

Community & Primary Health Care Nursing Week

Community and primary health care nurses make an invaluable contribution to our society. However, this is not well recognised by politicians and the general public.

Community and Primary Health Care Nursing Week is an annual ACN initiative aimed at raising awareness of this important area of nursing practice.

This year, Community and Primary Health Care Nursing Week was held from Monday 18 to Sunday 24 September.

As a part of this important campaign, ACN published an eBook filled with more than 40 stories that explored why community and primary health care nursing is vital to the health and wellbeing of our society. 44 celebrations were also held across the country and throughout the week in support of this campaign.

ACN would like to thank all those who contributed to Community and Primary Health Care Nursing Week this year. We also wish to acknowledge our Official Partner, Regal Home Health.

TOP 10

Places where you might find community and primary health care nurses

1 BEHIND PRISON WALLS

In correctional facilities across the country, nurses provide ongoing, high-quality care to some of society's most hardened patients. Each and every day, these committed professionals go behind prison walls to attend to the physical and mental health needs of our incarcerated population.

2 AT YOUR DOOR STEP

Bringing high-quality care to your door step, many community nurses cross the threshold into our home lives through in-house health services. Whether it is management of chronic conditions or palliative care, these incredible nurses look after Australians in the comfort of their own homes.

6 IN DETENTION

Many committed nurses work within detention centres and migrant health services providing culturally sensitive care to refugees and asylum seekers. These nurses practice in environments of considerable medical, cultural and social complexity, supporting members of numerous ethnic and cultural groups.

7 DURING YOUR FINAL MOMENTS

A source of solace during our final days, nurses can be found working in palliative care settings in every state and territory. These devoted health care professionals provide comfort, compassion and care during some of the most challenging moments of our lives.

Community and primary health care nurses work in a broad range of service delivery settings in metropolitan, rural and remote areas throughout Australia. These registered nurses, enrolled nurses and nurse practitioners have an expansive scope of practice and provide care across all levels of our health care system.

Here are just 10 places where you might find community and primary health care nurses making a difference across the country…

THINKSTOCK

3

ON THE STREETS

Hitting the streets and working in homeless outreach centres throughout the country, nurses provide much-needed care to Australians sleeping rough. These passionate nurses play a key role in restoring hope and dignity in the lives of people experiencing homelessness and poverty.

4

IN THE CLASSROOM

Bringing their professional expertise from the ward to the playground, nurses provide essential health care services throughout all levels of our educational system. From health promotion to management of chronic conditions, school nurses help ensure that our up-and-coming generations have the greatest chance of positive health outcomes at the earliest instances in life.

5

IN REHAB

Many inspiring nurses work in rehabilitation outpatient facilities and specialty centres, working to tirelessly improve quality of life for individuals with an injury, disability or chronic illness. Determined to help patients attain or maintain maximum function, these nurses make a meaningful contribution to our communities.

8

IN INDIGENOUS COMMUNITIES

Nurses work across numerous Indigenous health services dedicated to improving access, care and health outcomes for our nation's first peoples. This special group of nursing professionals work to close the gap on health inequalities for the Indigenous Australian population.

9

AT YOUR GP'S OFFICE

Often the first point of contact with our health care system, nurses are key members of multidisciplinary primary health care team's in general practice (GP). From diagnostic services to management of clinical care systems, nurses help meet local population health needs within the GP setting.

10

IN YOUR WORKPLACE

Occupational health nurses ensure safe working environments and provide essential health care services to the Australian workforce. From advising employers on first aid requirements to carrying out health monitoring checks, these exceptional nurses work tirelessly to improve the health and safety of our workplaces.

ADVERTORIAL

It takes a village

Few diseases are as isolating as dementia. Losing a sense of your life story and, finally, yourself, can make health, happiness and connection seem out of reach.

HESTA has invested $19 million through its Social Impact Investment Trust to finance Korongee, a cutting edge Australia-first village designed to maintain a sense of self, home and community for people living with dementia.

As the second leading cause of death in Australia today (Dementia Australia, 2017), dementia is a growing public health challenge. Unless a medical breakthrough is made, by 2056, more than 1.1 million Australians, and those who care for them, are expected to face it (Alzheimer's South Australia, 2017).

"The demand for dementia care across Australia is outstripping the available supply of services and facilities," HESTA CEO Debby Blakey says.

"This investment will help provide a world-class facility for the local community and benefits our members by earning a return, while also piloting a model for investing in aged care that could attract other large investors to this space."

Korongee is a partnership between HESTA, not-for-profit aged care provider Glenview, Social Ventures Australia (SVA) who manage HESTA's Social Impact Investment Trust, and the Commonwealth Government. It's the single biggest investment to date by the Trust, which is Australia's largest social impact investment fund.

FEELING TRULY AT HOME

Taking its cues from the Netherlands' successful De Hogeweyk village model, the village in Glenorchy, Tasmania will consist of 15 homes within a small town complete with streets, a supermarket, cinema, café, beauty salon and gardens.

Each household will match residents with similar interests and life experiences, so they can feel truly at home. That sense of continuity will flow through to the village's design, based on a typical Tasmanian streetscape that allows residents to wander freely and safely with support from health professionals acting as 'home makers'.

The project is the latest addition to HESTA's impact investing program, which aims to deliver both a return for our members and a measurable positive impact in the community. The program invests in areas of urgent need, such as social and affordable housing and now, person-centred aged care.

PARTNERS IN AGED CARE'S EVOLUTION

Ms Blakey says this investment in Korongee is a fantastic example of collaboration between HESTA and the health and community sector.

"We heard about the great work Glenview was doing and, because HESTA has a specific focus on identifying investment opportunities in our sector, we were able to explore how we could support this fantastic project," she confirms.

The collaboration has been welcomed warmly by Glenview CEO Lucy O'Flaherty, who shares this vision for healthier, happier ageing.

"Korongee's design will make it possible for residents living with dementia to walk around the village and participate in everyday life decisions, which are presently not available to those in dementia care," Ms Flaherty explains.

"It has been shown that residents at the De Hogeweyk dementia village live longer, eat better and take fewer medications and we hope to see similar transformative health benefits at Korongee."

> "The demand for dementia care across Australia is outstripping the available supply of services and facilities."

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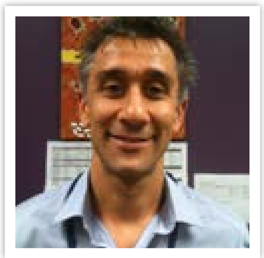
ACN grants and awards

Meet our successful 2017 recipients!

PRINCIPAL INVESTOR KATE CURTIS MACN AND CO-INVESTOR BELINDA MUNROE
COLLEGE CONSORTIUM RESEARCH GRANT

Professor Kate Curtis MACN and Dr Belinda Munroe are the emergency clinical nurse consultants for the Illawarra Shoalhaven Local Health District. Kate is also a professor of trauma and emergency nursing at the University of Sydney, where she oversees a program of emergency and trauma research.

Kate and Belinda are passionate about mentoring clinicians to conduct research and translate research into practice, and improving the way we deliver care to patients and their families. The ACN College Consortium Research Grant will be used to implement and evaluate the first ever evidence-based emergency nursing assessment framework called, HIRAID (History, Identify Red flags, Assessment, Interventions, Diagnostics, reassessment and communication). Research is needed in this area because there are about 9,500 emergency-related adverse events in NSW each year alone. Implementing HIRAID has the potential to significantly improve the completeness and efficiency of patient assessment, communication and decision-making for the 7.4 million patients that attend Australian emergency departments each year.

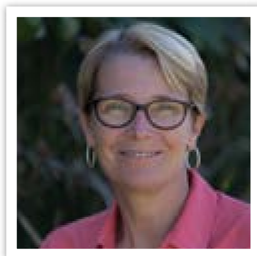


MARK SHAH
OLLIE SCHOLLIE NURSE PRACTITIONER SCHOLARSHIP

Mark Shah is a nurse practitioner specialising in the management of diabetes. His current work involves managing the emerging problem of childhood type 2 diabetes. His endorsement of nurse practitioners occurred 11 years ago and he is concerned about the lack of progress in the prevention of some chronic diseases. He is currently Co-Lead of the Diabetes and Endocrine Health Network, working closely with all health services and community members to improve diabetes care and services across Western Australia. He will use the Ollie Schollie Nurse Practitioner Scholarship to visit major US Diabetes Clinical Trial centres and the ADA Conference to learn about novel diabetes therapy.

VICTORIA CARROLL MACN
SUL STUART FRASER MEMORIAL SCHOLARSHIP

Victoria Carroll MACN is a clinical nurse in anaesthetics working at the Western Hospital. She has spent the majority of her nursing career within the perioperative environment and looks forward to continuing her future career within this specialty area. She enjoys mentoring and teaching new health care professionals and highlighting the importance of patient advocacy during the perioperative process. She is very thankful to be offered the Sul Stuart Fraser Memorial Scholarship for 2017, which she has used to enrol in a perioperative certificate. This updated research and education, will ensure that her nursing care delivery is evidenced-based and promotes best patient outcomes.



JACQUELINE PEET MACN
MARGARET Y WINNING SCHOLARSHIP

Jacqueline Peet MACN first graduated in 1989 from the University of Technology, Sydney and completed a graduate program at Royal North Shore Hospital. Within a year, she had married and moved to Brisbane to work at The Prince Charles Hospital in intensive care. Her employment and studies continued in areas, such as midwifery and operating theatres. These areas initiated an underlying interest in patient assessment practice and person-centred care, which developed after completing a research scholarship at the Queensland University of Technology (QUT). Her research is a collaborative project with QUT and Mater Private Hospital, Brisbane. The scholarship funds will support a presentation at the International Practice Development Collaboration conference in Switzerland (2018), as well as the purchasing of research materials.

ACN extends our thanks to our Grants and Awards Committee for their expertise and taking the time to assess all the applications.

Australian College of Nursing

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Our tribe

The latest membership news, activities and developments

At ACN, our Fellows and Members are the heart of our organisation and we are committed to supporting them to be the best they can be. Here's an update of what's been happening...

ENGAGEMENT RESTRUCTURE

Recently, ACN was pleased to announce some exciting new changes to our engagement structures:

- We will be tweaking our membership Regions based on their level of activity. We have started by condensing our NSW Regions and will monitor regional engagement to make further adjustments. Each of you have been allocated into one of the Regions automatically based on your post code, but can change this at any time by contacting us.
- ACN will continue to expand our 18 COIs to facilitate discussions about a range of topical issues affecting our profession. We have recently launched a new Military Nursing COI.
- We are changing the way our Regions and COIs are governed. Each group will now be led by a Chair, Deputy Chair, Communication Coordinator and Secretariat Support. These leaders will be profiled via our publications and rewarded for their commitment through a range of benefits.

POLICY CHAPTERS

ACN have established four Policy Chapters in recognition of the constantly changing landscape for the provision of patient care and services within the Australian health care system. These Policy Chapters are *Healthy Ageing*, *End of Life Care, Chronic Disease* and *Workforce Sustainability.*

It is our intent to establish Policy Chapters for identified areas across our profession, drawing on the skills and expertise of our membership and external stakeholders. The aim of our Policy Chapters is to provide opportunities for Fellows and Members to inform change and guide future directions for our organisation and profession.

Watch this space for more exciting announcements about our Policy Chapters.

NEW REPRESENTATION CHARTER

On 19 June 2017, the Board approved a new Representation Charter for ACN that provides clear guidance as to the responsibilities of Fellows and Members who are representing us in an official capacity. By developing the Charter, we are ensuring that the voice of the nursing profession is collectively strengthened through a consistent, disciplined approach that can increase influence in policy making decision processes.

PROFESSIONAL PORTFOLIO

Members can now use the ACN Professional Portfolio to track all of their Continuing Professional Development (CPD) activities in one place. This will save you from scrambling to pull together a year's worth of learning and achievements come registration renewal time!

Congratulations

Have you ever wondered what FACN stands for?

FACN is a highly regarded post nominal title indicating that a significant leader within our profession has been inducted as a Fellow of the Australian College of Nursing.

Fellowship of ACN is a prestigious member status, awarded in recognition of significant professional achievements and continuing commitment to our organisation. Fellows may be awarded a Distinguished Life Fellowship (DLF) in acknowledgment of their accomplishments.

Our DLFs and Fellows are given priority to key ACN events and high level representation opportunities.

Recently, we were excited to invest four new Fellows and a Distinguished Life Fellow.

If you or someone you know would be interested in becoming a Fellow of ACN, head to our website and find out how you can apply: www.acn.edu.au/fellowship

ADJUNCT ASSOCIATE PROFESSOR LYDIA DENNETT FACN

SA Health, Chief Nurse and Midwifery Officer

Lydia trained as an intensive care nurse before immigrating to Australia from London. She has extensive experience within both private and public health sectors, and has previously spent a number of years working in Victoria at Alfred Health, The Royal Children's Hospital, Melbourne Private Hospital and Western Health as a clinician, and for the last 15 years, in senior management and executive roles.

In her current role as the Chief Nurse and Midwifery Officer for SA Health, Lydia has the responsibility of providing professional leadership, as well as providing advice and direction on a diverse range of nursing and midwifery issues. Lydia has a strong commitment to ensuring continuing education and professional development of nurses and midwives.

Lydia has been a member of ACN for 17 years and has worked closely with us during this time. More recently, Lydia, in collaboration with colleagues, has worked with ACN to create the newly established National Nursing Executive Group.

Lydia holds a Master's Degree in Business Management, is an Adjunct Associate Professor with the University of South Australia and has been a surveyor for the Australian Council on Healthcare Standards since 2005.

MS LEANNE SMITH FACN, ACN BOARD DIRECTOR

Pindara Private Hospital, Enrolled Nurse, Advanced Practice

Leanne is currently employed as an advanced skill enrolled nurse at the Gold Coast University Hospital and works in acute inpatient mental health. Having originally completed a hospital-based enrolled nurse course, Leanne has continued her education by completing Advanced Diplomas from ACN, a Bachelor Degree of Social Science and a Graduate Certificate in Mental Health Practice from the University of New England.

Leanne is a Director on the ACN Board and a member of the Governance and Academic Standards Committee. Previously Leanne has been a member of the Nursing and Midwifery Board of Queensland Registration Committee, and the Queensland Nursing Council Board of Directors Education Committee and Peer Review Panel. Having had many opportunities to fulfil expert panel and committee positions at both state and national levels, Leanne has gained invaluable experience and the knowledge required to represent enrolled nurses at the highest level.

Leanne has a solid commitment to nursing and the professional status of the enrolled nurse. She believes that with a combination of the current education system and the diversity in extensive clinical practice, enrolled nurses will achieve a higher level of professional status, clinical practice satisfaction and be able to enjoy working to the full extent of the enrolled nurse scope of practice.

to our new Fellows

ADJUNCT ASSOCIATE PROFESSOR NAOMI DOBROFF FACN

Monash Health, Chief Nursing Information Officer (CNIO)

Naomi is a registered nurse, has a Master's Degree in Public Health and was awarded an Adjunct Associate Professorship within the School of Nursing and Midwifery at Deakin University in 2016.

Naomi has over 20 years of nursing and health care experience, initially focused on clinical nursing in areas of acute medicine, orthopaedics, rehabilitation, palliative care and indigenous health. Since 2004, Naomi has worked in senior administrative roles; including informatics, management, policy, project and leadership roles within major public health services.

In her current role as CNIO at Monash Health, Naomi is the health care executive responsible for leading and advocating for nurses and midwives in the appropriate implementation of clinical information systems that affect the provision of care to Monash Health patients. In this role, she is responsible for leading change in the digitisation of health care practice and processes for over 7,000 nurses and midwives.

Naomi has been a member of ACN since 1998 and over this time, has been an active contributor and advocate for us. In 2016, Naomi approached ACN to form a Nursing Informatics Community of Interest. This was due to the rapidly expanding role of nursing informatics within Australia. It was also after the formation of the Australian Chief Nursing Informatics Officer Collaborative, where the collaborative decided to align professionally to ACN; a position Naomi advocated.

MS YVONNE MCKINLAY FACN

General Practice Cremorne, Practice Manager

Yvonne commenced her nurse training in 1982 at Withington Hospital in Manchester. She graduated in 1985 and then went to work at the Christie Hospital in Manchester where she specialised in oncology nursing. Yvonne commenced at Royal Prince Alfred Hospital in March 1988, as a chemotherapy nurse and fulfilled her dream of working in the melanoma unit with Professor Stephens.

In 1989, Yvonne commenced at the Prince of Wales Hospital in Randwick as nursing unit manager for radiotherapy. Her career progressed rapidly and she held various management roles during her 12 year tenure at the Price of Wales Hospital.

In 2003, Yvonne joined the Northern Sydney Area Health Service where she was the coordinator for nursing career development and marketing. During this time, Yvonne launched the professional practice portfolio on behalf of area nursing, which was not mandatory back in 2004 but has since become so. Yvonne then left the public health system and went to work in the primary health care sector in 2009 and is now the Practice Manager of General Practice Cremorne.

Yvonne has been actively engaged with ACN and its predecessor organisations during her 20 years of membership. Since her hospital-based training, she has completed a Bachelor of Nursing, Graduate Certificate in Human Resource Management and a Masters of Business Administration. Yvonne enjoys promoting the profession and ACN, and continues to look for opportunities to improve patient care.

JUDITH MEPPEM PSM FACN (DLF)

Nursing, Midwifery and Health Care Consultant

Judith's extensive and exceptional career in nursing practice and administration has seen her play an important role in the New South Wales nursing community and subsequently accumulate many deserving accolades over this time.

She was the NSW Chief Nursing Officer for 12 years until 2002, where she aptly provided the professional interface between the Minister, Director-General, the Health Department and the public, private and academic sectors of the nursing profession.

After finishing her role as NSW Chief Nursing Officer, she was awarded a NSW Public Service Medal in the 2003 Australia Day Honours for outstanding public service to nursing administration.

Judith has frontline experience as a registered nurse, registered midwife, nursing unit manager, assistant director of nursing, deputy director of nursing, teaching hospital director of nursing and area director of nursing. She has worked in a mix of metropolitan and rural clinical settings throughout her distinguished career in areas including Moree, Newcastle, throughout Western Sydney and on the Northern Beaches of Sydney.

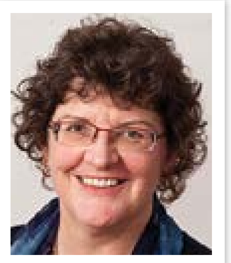
Judith has been a longstanding and highly supportive member of ACN and its predecessor organisation, The College of Nursing (TCoN) after joining in 1974. Five years later in 1979 Judith was invested as a Fellow. Additionally, she provided the 51st Oration for The College of Nursing in 2003.

Judith currently shares her wealth of knowledge through project management and consultancy services with a number of health care organisations, including ACN.

SHARE YOUR STORY WITH US

Thank you to all of our wonderful Fellows and Members who contributed to the 2017 spring edition of *The Hive*.

Thank you to all of our authors!



MADONNA GREHAN MACN

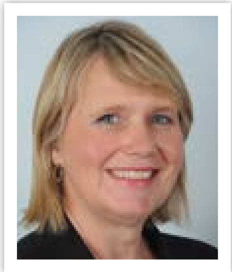
Occupationally-derived lung disease

JAMES BONNAMY MACN

The influenza vaccine

TOMICA GNJEC MACN

When you can't breathe, nothing else matters

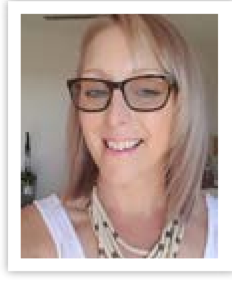


ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

The role of the nurse leader in respiratory disease

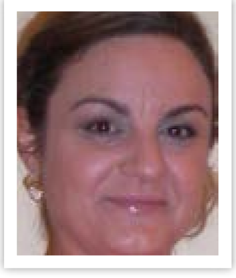
TRISH LOWE MACN

Neonatal respiratory outcomes



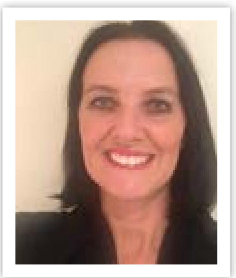
PROFESSOR COLLEEN MCGOLDRICK MACN

Antibiotic stewardship



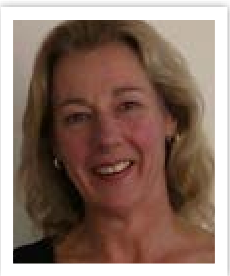
CONNIE KAMBANAROS MACN

Caring for young adults with cystic fibrosis



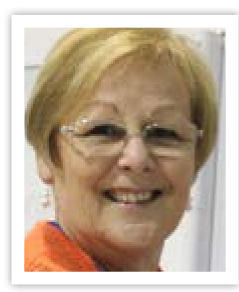
TARA HANNON MACN

A new clinical role for nurses



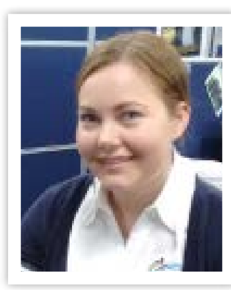
FELICITY FINLAYSON MACN

Cystic fibrosis



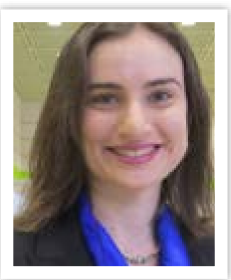
MARILYN GENDEK FACN

The humble stethoscope



ALISON DEVITT MACN

Nursing reflections on a pilot project



ELIZABETH MATTERS FACN

Nursing matters

ACN would also like to thank the author of *Tuberculosis*, who has chosen to remain anonymous. Furthermore, we would like to acknowledge our Bronze Affiliate, The Thoracic Society of Australia and New Zealand, for their valuable contribution to this publication.

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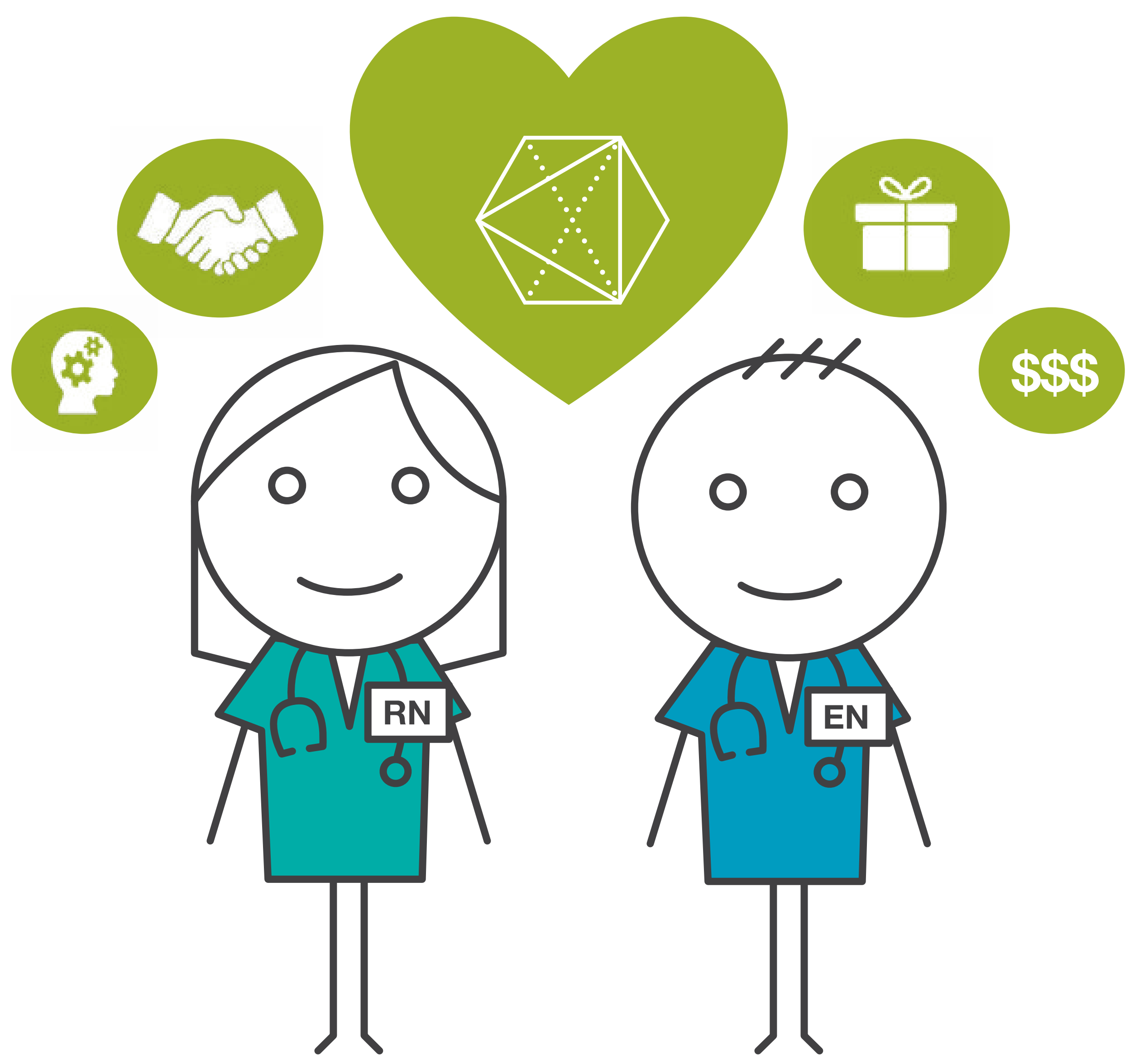

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