Australian College of Nursing

the hive

#20 SUMMER 2017/18

DIABETES & OBESITY

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Australian College of Nursing

Exciting things coming in 2018!

We are starting the New Year off with a bang by launching a new and improved version of our online member engagement platform.

YOU'LL BE ABLE TO:

- Search our member directory
- Create a network of contacts
- Message members you are connected with
- Engage in online discussions
- Connect via video conferencing

and much more!

Naming competition

Since this new platform is all about our members we're giving you the chance to name your new online space!

Send your suggestion to marketing@acn.edu.au by 7/1/2018.

If your name receives the highest number of member votes you will win a $500 Coles Group & Myer gift card!

the hive

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DIABETES & OBESITY

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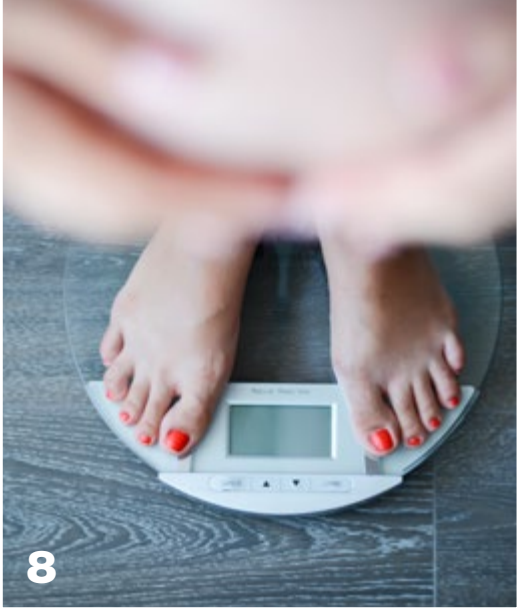
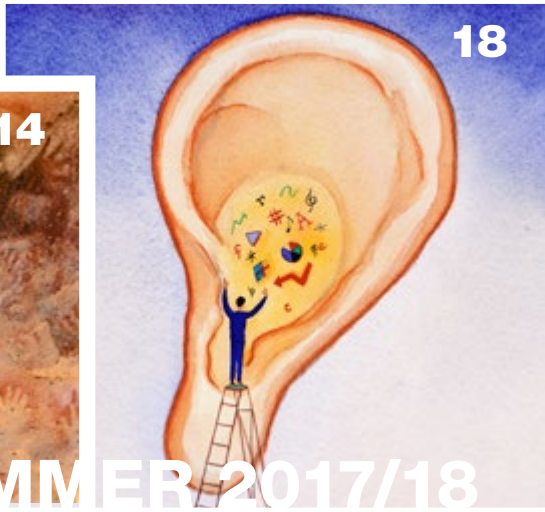
We love to see member submissions in *The Hive*. If you're interested in having your submission considered for publication, please see our guidelines and themes at **www.acn.edu.au/publications**.

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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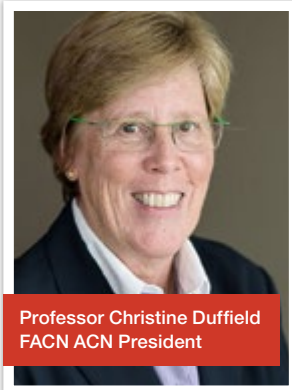

Professor Christine Duffield
FACN ACN President

President's report

The health of a country's citizens is critical for individuals' wellbeing, but also because a healthy and productive workforce contributes to economic growth. Healthy citizens live longer and cost the health system less.

It is no secret that the average age of the Australian population is increasing. We also know that the mortality rates of non-communicable diseases associated with ageing are projected to increase by 15% globally between 2010 and 2020 (World Health Organization (WHO), 2011). Diabetes alone accounted for 10% of all deaths in Australia in 2014 and mortality rates continue to rise significantly with age (Australian Institute of Health and Welfare (AIHW), 2017). Australians over 85 are three times as likely to die from diabetes than those aged 75–84 (AIHW, 2017).

Rates of overweight and obesity across the age spectrum are at pandemic levels. In Australia, an estimated 11.2 million adults and one million children were overweight or obese in 2014 (AIHW, 2016). Globally, more than 1.9 billion adults and 41 million children under the age of five were overweight or obese in that same year (WHO, 2016).

As we all know, excess body fat can have adverse metabolic effects on cholesterol, blood pressure, insulin resistance and triglycerides, leading to an increased risk of multiple chronic diseases, such as type 2 diabetes mellitus (WHO, 2011). Coronary heart disease and ischaemic stroke are other examples of non-communicable diseases that have a high correlation with the global prevalence of obesity (WHO, 2011; WHO, 2015).

Less well known is that the nursing workforce isn't particularly healthy. In recent work, Perry et al. (2016) found that despite nurses overall rating their health as good, very good or excellent health, 64.9% stated they had at least one chronic disease diagnosed (8.6% had pre-diabetes, diabetes or glucose intolerance) and few were symptom-free. Perhaps more alarming are the findings that 20% had hypertension or elevated blood pressure and more than 61% were overweight or obese.

These results are concerning given the reliance of the health system on nurses. Anything which impacts negatively on their health status will impact on service delivery; increase costs resulting from increased sick leave and turnover; and will exacerbate the projected shortage of nurses. Perry et al. (2017) also found nurses intending to leave work had more sick days, 'mental health days' and hospitalisations.

The poor health status of Australian nurses mirrors findings elsewhere in countries such as the United States (James et al., 2013) and the United Kingdom (Royal College of Physicians, 2015), where concerns have been expressed about the health of the nursing and health care workforce. Both countries have introduced initiatives to improve nurses' health and wellbeing.

This year, the National Health Service (NHS) in England introduced a £450million national incentive fund to improve the overall health of frontline staff (NHS England, 2016). Employers across the public and private sector have been allocated funding to promote healthy food options, introduce a number of physical activity schemes, improve access to physiotherapy services and facilitate mental health initiatives in the workplace (NHS England, 2016).

In the US, the American Nurses Association (ANA) has also taken decisive steps to promote health and wellbeing by declaring 2017 to be the *Year of the Healthy Nurse*. They are driving a number of activities that focus on key health, wellness and safety issues each month. Moreover, they are piloting a *Healthy Nurse, Healthy Nation™ Grand Challenge*, in an endeavour to encourage the nursing workforce to prioritise physical activity, sleep, nutrition, quality of life and safety (ANA, 2017).

This edition of *The Hive* highlights the rising burden of obesity and diabetes on health care systems nationally and globally. It features a number of articles that demonstrate the vital role of the nursing workforce in leading the prevention, management and coordinated care of these chronic, non-communicable diseases.

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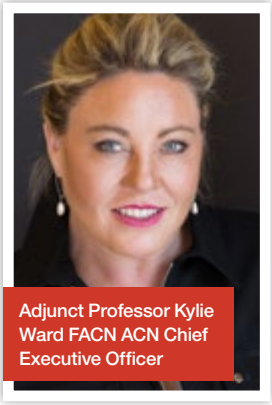


Adjunct Professor Kylie Ward FACN ACN Chief Executive Officer

Hello!

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

> **"The changing health profile of the global population has seen a significant upwards shift in the prevalence of obesity and diabetes worldwide..."**

The changing health profile of the global population has seen a significant upwards shift in the prevalence of obesity and diabetes worldwide.

In this edition of *The Hive*, we feature a number of thought-provoking articles that highlight how the nursing profession works to collectively reduce the widespread burden of these chronic and complex diseases.

As the backbone of our health and aged care system, nurses play an active role in chronic disease prevention and management. In her highly informative article, **Diabetes care and coordination**, **Patricia J Randell MACN**, outlines how nurses lead the provision of holistic, patient-centric care to enhance health outcomes in general practice.

The nursing workforce is well placed to drive the development and delivery of innovative models of care to reduce the rising incidence of chronic disease in our communities. **Suzanne Carroll MACN**, in her engaging editorial, **Are your neighbours making you unhealthy?**, explores how nurses are working to reverse social norms that influence lifestyle choices which can lead to obesity and diabetes.

The bi-directional relationship between diabetes and obesity is further explored by **Paula Hession MACN** in her highly engaging piece, **Diabesity**. Reflecting on her experiences as a registered nurse and credentialed diabetes educator, Paula accentuates the immense importance of compassion and respect in nursing practice towards those living with these critical health issues.

With a view towards 2018, I am pleased to announce the themes for the next four editions of *The Hive: Workplace Culture, Self-Care and Personal Empowerment, Diversity,* and *Our Future Workforce.*

These four themes will explore how we can foster the development of a highly skilled nursing workforce to meet the complex challenges facing our health care system today, and into the future.

I hope you enjoy the warm weather and this inspiring read.

NSW Nursing Informatics Joint Position Statement Launch

South Australian Nursing and Miwifery Leader Breakfast

Victorian Public Healthcare Awards

Telstra Business Women's Awards

Fiji nurse visit

FOUR ACN POLICY CHAPTERS LAUNCHED

ACN recently launched four new Policy Chapters in recognition of the constantly changing landscape of the provision of patient care and services within the Australian health and aged care system.

The aim of our new Policy Chapters is to provide opportunities for nursing leaders and experts to inform change and guide future directions through collaboration. The intent is to influence government and policy makers relating to reform required now and into the future.

Each Policy Chapter will facilitate face-to-face and virtual meetings throughout the year.

These will be determined by the Chapter Chair and Deputy Chair in consultation with ACN and be specific to the priorities of the Policy Chapter.

This may consist of forums, workshops and projects. The first planned meeting of Policy Chapter participants will be at our Policy Summit in Canberra on 20 April 2018.

Our four new Policy Chapters are:

- Workforce Sustainability
- Healthy Ageing
- Chronic Disease
- End of Life Care.

ANNUAL GENERAL MEETING AND BOARD ELECTION

On Monday 4 December, ACN held its Annual General Meeting at our Parramatta office.

This meeting provided Fellows and Members with an update on our activities and an overview of our successes during the past financial year.

At the AGM, all those in attendance received a copy of ACN's *Year in Review*. The *Year in Review* is a celebration of our progress, growth and accomplishment's throughout 2016–2017.

During this meeting, the newly elected ACN Board Directors were announced. We would like to congratulate Adjunct Professor Susanne Hawes FACN, David Plunkett FACN, Belynda Abbott FACN and Professor Linda Shields FACN who were elected to the ACN Board of Directors and to Ross M Lewin, our new Independent Director on being elected to the Board of Directors for the Australian College of Nursing.

Board performance is crucial to ensure growth and sustainability of ACN as the pre-eminent and national leader of the nursing profession. We are confident that all our new Directors will be strong advocates for ACN and raise the organisation's profile with government, consumers and across other health care professions.

Following the meeting, the Dean of the Faculty of Nursing and Midwifery (Sydney Nursing School) at the University of Sydney Professor Donna Waters FACN gave an inspiring presentation as our guest speaker.

REGION AND COI LEADERSHIP GROUPS ANNOUNCED

This December, ACN released the new Leadership Groups for our Regions and Communities of Interest (COIs).

The Leadership Groups now comprise of a Chair, Deputy Chair, Communication Coordinator and Secretariat Support for each Region and COI.

This revamped structure is in response to feedback from ACN's active membership. The changes are designed to enable the leadership duties to be shared, rather than led by one Key Contact as in our previous model, so that our Regions and COIs can continue to provide unique opportunities to connect with members who are located in a local area or share an area of practice.

Congratulations to all those who have been selected to lead engagement across our special interest and regional groups. To find out who will head your Region or COIs, please check our website: **https://www.acn.edu.au/regions-communities.**

INAUGURAL NATIONAL REGULATION SEMINAR AND DINNER

Bringing together leaders from across our profession and country, the National Regulation Seminar and Dinner was held on Wednesday 15 November at the Rydges Hotel in Melbourne.

This inaugural, sell-out event was co-hosted by ACN and the Nursing and Midwifery Board of Australia (NMBA).

The seminar featured a keynote presentation by the United States National Council of State Boards of Nursing (NCSBN) Chief Executive Officer Dr David Benton.

David was joined by the NMBA Chair, Associate Professor Lynette Cusack MACN, ACN President Professor Christine Duffield FACN, and Australian Health Practitioner Regulation Agency (AHPRA) Chief Executive Officer Martin Fletcher for a panel discussion.

This event provided all those in attendance with an opportunity to have their say on nursing regulation and enjoy networking with passionate nurse leaders working across our health and aged care system.

NURSES WELCOME FAIRER AND MORE EQUAL AUSTRALIA

ACN congratulates the Australian Parliament on the passage of same-sex marriage legislation, which stipulates that the right to marry in Australia will not be determined by sex or gender.

"ACN would like to acknowledge the determined effort of so many people who have long campaigned for greater equality. We extend our best wishes to same-sex couples who will now be able to marry from January 2018," said ACN CEO Adjunct Professor Kylie Ward FACN.

There is a clear link between mental health and equality. The passing of the same-sex marriage bill will help reduce discrimination and improve health outcomes for our LGBTIQ population.

"ACN has always been a strong supporter of equality and the legalisation of same-sex marriage is exciting news for so many Australian families," Adjunct Professor Ward said.

MINI-FIELD OF WOMEN

On Tuesday 31 October, ACN showed our support for the many Australians affected by breast cancer and the dedicated nurses who care for them, by holding a Breast Cancer Network Australia Mini-Field of Women event in our Canberra and Sydney offices.

Mini-Field of Women events centre on an exhibition of 100 pink lady silhouettes planted in the ground or on display, and often include a simple ceremony.

The 100 silhouettes symbolise the more than 15,000 Australian women diagnosed with breast cancer and the more than 3,000 women who die from breast cancer each year.

Across both of our events, we displayed 200 silhouettes inscribed with messages of love and solidarity from our staff, Fellows, Members and the broader nursing community.

Staff dressed in pink and shared pink-coloured tasty treats in support of this important cause.

Together, we raised awareness about breast cancer and paid tribute to the thousands of people in our profession and community affected by this debilitating disease.

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

National Regulation Seminar and Dinner

ACN Annual General Meeting

Melbourne Nursing Informatics Joint Position Statement Launch

Metro South Health Community Nurses Network Symposium 2017

National Regulation Seminar and Dinner

Mini-Field of Women

National Regulation Seminar and Dinner

“ ACN has helped me grow as a professional and enhanced my nursing identify. ”

“ It’s my hub of professional information. ”

“ ACN has helped me to achieve my professional education and career goals. ”

FEBRUARY

4
WORLD CANCER DAY
An initiative that raises awareness of cancer to encourage its prevention, detection, and treatment.

6
INTERNATIONAL DAY OF ZERO TOLLERANCE FOR FEAMALE GENITAL MUTILATION
A public awareness campaign.

13
HEALTHY WEIGHT WEEK
An Australia-wide campaign aimed at helping people achieve and maintain a healthy weight.

14
VALENTINE'S DAY
A holiday that people celebrate with loved ones.

15
INTERNATIONAL CHILDHOOD CANCER DAY
A global collaborative campaign to raise awareness about childhood cancer.

20
WORLD DAY OF SOCIAL JUSTICE
A global campaign that supports efforts to ensure social well-being and justice for all.

MARCH

1
NATIONAL EPILEPSY MONTH
A month-long campaign aiming to raise awareness about epilepsy and seizures.

8
INTERNATIONAL WOMEN'S DAY
An international celebration of the social, economic, cultural and political achievements of women.

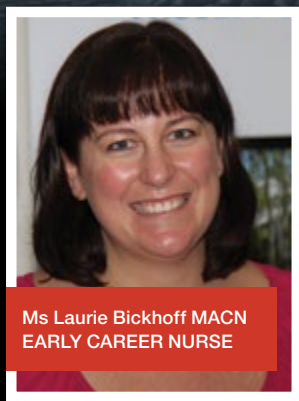
16
NATIONAL CLOSE THE GAP DAY
An annual event held to raise awareness of the Indigenous health crisis.

21
WORLD DOWN SYNDROME DAY
A celebration of the lives and achievements of people with Down syndrome.

21
AUSTRALIAN HEALTHCARE WEEK 2018
A two-day annual health care conference and exhibition based in Sydney.

24
WORLD TUBERCULOSIS DAY
A campaign that raises awareness about tuberculosis and efforts to eliminate the disease.

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**



Ms Laurie Bickhoff MACN
EARLY CAREER NURSE

> **“I have seen nurses go above and beyond to make sure the right equipment is sourced without the patient being left to feel embarrassed or burdensome.”**

OBESITY AND JUDGEMENT-FREE CARE

Caring for an obese patient can be challenging. I do not mean this in a negative way. However, it is important to acknowledge there are aspects of care which are more difficult. Depending on their reason for admission and level of independence, they may require care that is physically demanding for the nurse or specialised equipment that can be difficult to source. But do we give obese patients the same judgement-free care as that given to those suffering from a disease deemed unavoidable?

Consider the smoker admitted with bronchitis or a diabetic with poor glycaemic control now having complications, or an obese patient suffering a heart attack. One may argue they could all have taken action to prevent their current ailments. Their conditions may be viewed as preventable by health care professionals and hence they are deemed responsible for their own poor health.

I believe there is a degree of blame that can creep into our nursing care – the passing thought of, “you did this to yourself”. I base this belief off my personal experiences as a nurse, witnessing how obese patients are treated and talked about. I also base this off my personal experience as an obese person interacting with health care professionals as a patient.

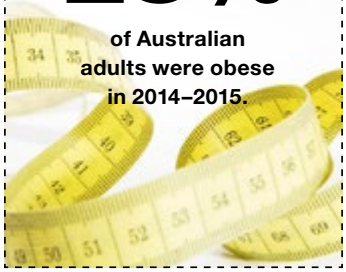
I have also seen the opposite. I have seen obese patients, thankfully more often than not, treated with the utmost respect and care. I have seen nurses go above and beyond to make sure the right equipment is sourced without the patient being left to feel embarrassed or burdensome.

To ensure we provide this level of care to all our patients it is essential we reflect on our own practice to check we are not unknowingly letting our personal beliefs impact our care. Furthermore, we must advocate for all patients to be treated with dignity and empathy, and speak up when we witness anything less. We also need to role-model this behaviour, for our colleagues, both within nursing and across all the health disciplines, and our students who absorb so much more than we realise from watching how we practice.

THINKSTOCK

FAST FACTS

28%
of Australian adults were obese in 2014–2015.



5%
of the burden of disease in Australia was attributable to overweight and obesity in 2011.

1 IN 4
Australian children were overweight or obese in 2014–2015.

1 IN 8
Indigenous Australian adults had diabetes in 2012–2013.

1.2 MILLION
Australian adults had diabetes in 2014–2015.

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Adjunct Professor
Cheyne Chalmers FACN
EXECUTIVE

THE ROLE OF THE NURSE LEADER IN OBESITY AND DIABETES

Recently I attended a health care length of service awards presentation and as I watched the procession of the long-standing employees walked proudly to the stage, I was struck by the awareness of how the physical demographic of our workforce has changed. As a leader who has always struggled with my weight, I am now representative of the population. In a Bogossian et al. paper in 2012, they identified 62% of the nursing workforce as being outside of the healthy weight range. When reflecting on the working life of nurses, Knutson and Van Cauter talk about the irrefutable evidence that now exists that describes a correlation between short sleep and higher body mass index (2008). The connection between obesity and diabetes is well known (Bostock-Cox, 2017) and as rates of obesity rise in the population so too, do the rates of metabolic syndrome and type 2 diabetes.

As nursing leaders, the workforce that we rely on is now potentially facing significant health issues. This is challenging my traditional thinking about my role and how I should support the team. Nurses often talk about the snacks they prepare to get themselves through the tough night shift, or the thank you chocolates they frequently get from grateful patients, their families or even their managers. I now believe as leaders we are required to have a greater focus on supporting the health and wellness of nurses in the workforce. This should include concern for physical wellbeing and considerations around diet, exercise and sleep.

I am being challenged to look at what opportunities exist around safer rostering to allow for better sleep patterns and initiatives, such as encouraging nurses to leave the ward during their breaks to undertake exercise or relaxation activities, as well as providing education around whole, nutritious food, moving away from the normal fatty carbohydrate-rich snacks that health professionals traditionally consume.

I have been on a personal journey of weight management and struggle with it every day, and the irony is, I understand the science behind obesity and diabetes. As a leader, I believe my role is to develop a healthy workplace, so nurses feel they are supported and able to make healthy decisions for their bodies and their lives.

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ARE YOUR NEIGHBOURS MAKING YOU UNHEALTHY?

When it comes to our health, where we live matters. Our family, friends, and even our neighbours may be making us unhealthy. Though we may not realise it, each of us is influenced by the attitudes and behaviours of those around us.

We are constantly surrounded by social norms, informing us as to how we should look and behave – and though many of these come from the people closest to us, they also come from our neighbours.

Social norms include two types, *injunctive* and *descriptive* norms (Cialdini, Reno & Kallgren, 1990). Injunctive norms describe what *ought to be done*; what is generally considered to be acceptable behaviour. On the other hand, descriptive norms describe what is typically done; what is normal. Both injunctive and descriptive norms influence our attitudes, beliefs and behaviours. Often injunctive and descriptive norms are similar, but sometimes they are not. We know we *ought* to eat healthy, be physically active, maintain a healthy weight, and not smoke, and most people would approve of these behaviours, yet many of us don't meet the appropriate health recommendations.

The injunctive and descriptive norms of our friends and families influence our own attitudes, beliefs and behaviours. We are more likely to be active, eat well, maintain a healthy weight, and not smoke if our family and friends are active, eat well, maintain a healthy weight and don't smoke (Christakis & Fowler, 2013). Recent research has found that we are also influenced by our neighbours' behaviours, whether they are our friends or not.

A series of studies using data collected for a 10-year adult cohort in Adelaide have found that individuals living in areas with a greater number of people who were overweight or obese, physically inactive, or with poor diets, had worsening cardiometabolic risk than individuals surrounded by residents with healthier body weight and behaviours (Carroll et al., 2016; Carroll et al., 2017). This was after accounting for other important factors related to health and health behaviours, including individual age, sex and socioeconomic status, and other residential features such as walkability and availability of healthy resources relating to diet and physical activity, and neighbourhood socioeconomic status.

Behavioural theories suggest we imitate the behaviours of others (Bandura, 1971, Rivis & Sheeran, 2003), while normative theories tell us that we use the attitudes and behaviours of others to inform appropriate behaviour (Cialdini, Reno & Kallgren, 1990). In areas with a greater number of overweight or obese people, a larger body size may become accepted as normal. This new normal may then reduce motivation to follow health recommendations regarding body size, diet and physical activity. Indeed, overweight individuals may not even realise they are overweight as their body size seems 'normal'. This obviously has important implications for population health, especially as more and more of the population become overweight and obese, driving the norm upwards with consequent increases in health cost to individuals and governments.

Overweight and obesity continues to rise in Australia, with almost two in three Australian adults currently overweight (AIHW, 2016). Of particular concern is that much of the rise in overweight and obesity is driven by increases in obesity rates, from 19% in 1995 to 28% in 2014–15. Overweight and obesity are major risk factors for cardiovascular disease, type 2 diabetes, musculoskeletal conditions, and some cancers. These risks increase as the excess weight increases (AIHW, 2016).

Suggestions that individuals lose their excess weight seem reasonable, yet substantial weight loss is very difficult and few individuals manage to maintain their weight-loss (Montesi et al., 2016). Moreover,

> **“The injunctive and descriptive norms of our friends and families influence our own attitudes, beliefs and behaviours.”**

fat stigmatisation and shaming is associated with adverse health effects, including mental health issues, negative coping strategies (e.g. binge eating and exercise avoidance), weight gain, and cardiometabolic risk (Papadopoulos & Brennan, 2015, Pearl et al., 2017, Sutin & Terracciano, 2013).

While there is a desperate need to denormalise overweight/obesity and reawaken awareness of what healthy looks like, this needs to be achieved while avoiding fat stigmatisation. These two aims are seemingly at odds. While we should continue to acknowledge the health risks of obesity, we can focus our attention on improving behaviours; a healthy diet and physical activity provide many more health benefits than simply controlling weight (Warburton, Nicol & Bredin, 2006; AIHW, 2017).

Currently most people do not get enough exercise or eat enough fruits and vegetables while they often consume too much fat and sugar. As individuals, we can focus on our own behaviours and set good examples for others, especially our children. But we also need policies that support healthy behaviours, ensuring adequate opportunities for healthy behaviours while reducing opportunities for unhealthy behaviours. We can all advocate for such policies.

The new normal relating to body weight and associated health behaviours is being transmitted to our children, along with the consequent increased risk of ill-health. Already, greater than one in four of our kids (27%) are overweight or obese. Surely we need to reassess what is being accepted as ‘normal’ – shouldn’t this be the healthy option?

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AUTHOR

SUZANNE CARROLL MACN

THINKSTOCK

INTERVIEW WITH AN EXPERT

Obesity prevention and management

*We interviewed one of our dynamic Fellows, Professor **Elizabeth Denney-Wilson FACN**, to find out about her career as an academic and researcher in the area of obesity prevention and management…*

Can you tell us a little bit about your background as an academic and researcher in the area of obesity prevention and management?

It all started nearly 20 years ago.

I did some work as a research assistant with Professor Louise Baur at the Children's Hospital at Westmead, looking at how we should define overweight and obesity in children. There was not a really strong consensus on this 20 years ago.

I got so interested in the topic that I asked her if she would consider taking me on as a PhD student and she agreed.

I was able to get some funding from the Ministry of Health to do a survey as a part of the *Schools Physical Activity and Nutrition Survey*. This involved getting blood samples from 500 teenagers who were in Year 10 at high schools in the Sydney metro area. I looked at the associations between their weight status and risk factors for diseases like type 2 diabetes, fatty liver and heart disease.

I found that there was a really high prevalence of risk factors in the 15-year-old kids who were overweight and obese. They were kids who weren't seeking medical care or any treatment. They were just happy, regular teenagers but because of their excess weight, they had risk factors for chronic diseases that you'd normally expect to see in adults. So after that, as much as I really loved that kind of research, I thought, "What I really want to focus on is prevention."

I thought this because, with the continued prevalence of overweight and obesity, if we don't do something about prevention, then we are going to have so many people with chronic diseases like fatty liver and type 2 diabetes.

So I decided that the best place to research preventive care is primary health. It was at this point that I got really interested in the role of nurses in delivering preventative care.

Over the years, my research interest has taken a two-pronged approach.

I think nurses are really good at health promotion, and they have a real opportunity to live and breathe interventions that might encourage people to eat better or be more active, having an overall effect on their weight.

What role do you think nurse leaders have as advocates for our patients in terms of obesity prevention and management?

As nurses, we don't always realise that we are providing health promotion and the opportunities we have to offer suggestions to our patients. When we do become aware of this, we do it really well.

This is because we have really good, long-term relationships with people and they look to us for guidance. There is a lot of evidence to suggest that if health practitioners provide people with advice or suggestions around healthy eating and physical activity, they are much more likely to do something about their weight.

While they might not immediately change their diet or habits, nurses can plant the seed. If you are able to include just a little bit of health promotion into all your interactions with patients, then there's a real opportunity to get people at least thinking about behavioral change and taking the next step towards eating better and moving more.

Nurses can also help people to think about where they can go for more intensive assistance around weight management; whether this be allied health practitioners, like dietitians, or commercial providers, like *Weight Watchers*.

As nurses, we can be care navigators.

However, nurses themselves don't always prioritise their own wellbeing. Indeed, lots of nurses carry a bit of extra weight and don't eat well.

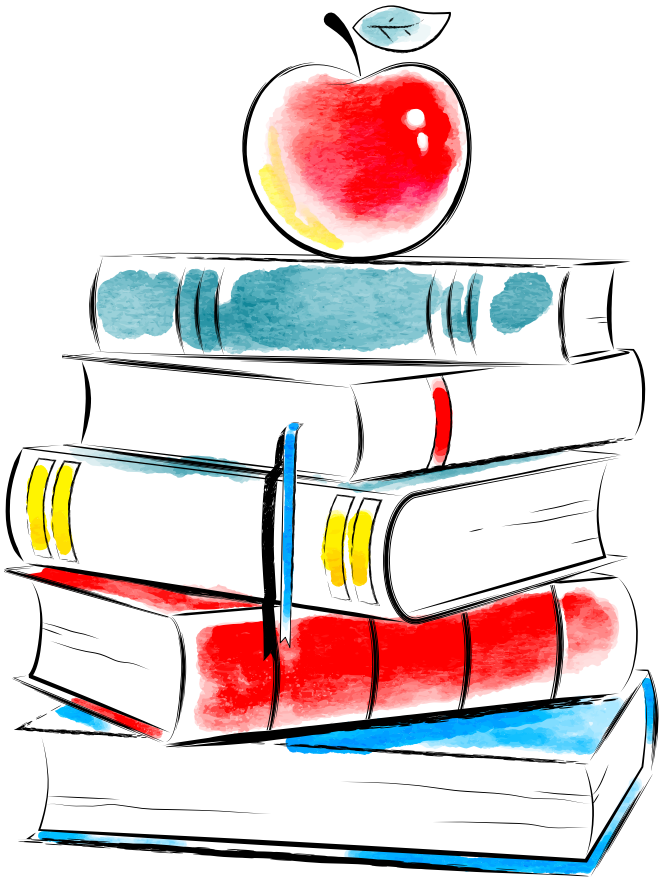
For example, nurses are less likely than the general public to eat the recommended serves of fruit and vegetables. So we need to work on our own diets and physical activity.

While nurses are quite busy and active at work, we often overestimate the level of physical activity and overcompensate in terms of eating too much.

As nurse leaders, we really need to be much more proactive in getting nurses to think about their own health and wellbeing. We need to get our employers to think about how they might support nurses in terms of healthy eating and physical activity programs which promote healthier lifestyles.

Would you say nurses are role models to our patients?

Whether we like it or not, we are role models. There's nothing you can do about it. So it is important that we do look after ourselves. You can't really look after other people, if you don't look after yourself.



> **“The healthier nurses are, the better they feel, and the longer they’ll be able to stay in the workforce.”**

Shift work and the high level of exhaustion that comes with that, as well as the environments that we work in, can make it extra challenging for nurses to be healthy and physically active. That’s why I think it’s important that nurse leaders promote and advocate on behalf of nurses to get management to invest in this issue.

Do you think more nurses should get involved in this area of research? If yes, how would you encourage them to do this?

There’s a 101 ways to look at research in this area. It’s a growing field and its certainly not going to go away in my lifetime or the lifetime of many nurses who are working today.

Hopefully, with all of the interventions that are now focused on prevention, we might see a levelling off. However, in the immediate future, we are going to see more and more people with diabetes and other complications of obesity. This could include anything from fatty liver to sore hips and legs.

So I would really encourage nurses to think about getting involved in this area of research. Even if you don’t want to initiate research yourself, I would encourage you to be a part of other people’s projects. In turn, this could provide you with your own research question, which you might really want to answer.

In terms of best practice and evidence-based care, we really need to understand the best way of engaging people in interventions that might help them drop some weight and be better versions of themselves.

We also need to develop an understanding of what nurses can do in terms of supporting themselves and each other with maintaining healthy lifestyles, so that they are able to continue in the profession for much longer – because we need you!

Why do you think it is important that research and action is undertaken in this area?

The prevalence of overweight and obesity is about two thirds of the population. We live in an environment where it is really easy to overeat. It’s challenging to be sufficiently physically active to counteract the amount of energy and nutrient poor food that is readily available.

It is really hard for people to know what they should be eating and what they can do to lose weight. As nurses, we see people so frequently and develop such good relationships, that we really should be at the forefront of preventative health care. Nurses who engage with preventative health, find they really enjoy it, and it becomes a core part of their role.

It just makes good sense for health promotion to be a part of our routine practice.

What drives your passion and interest in this particular area of research?

Research isn’t always easy, so you do have to be really passionate about it.

My passion lies in an understanding that if we take action and intervene early, we can really change lives. If we are able to help children to get onto a trajectory whereby they gain the right amount of weight and they grow at a healthy rate, we can really change their livelihood.

Kids who are overweight can get bullied, have physiological problems and develop elevated risk factors for chronic diseases. So if we can help kids to grow at a healthy rate, then we can not only change their lives but their whole family’s.

I just think that’s a really good reason to get up in the morning.

I’m also really passionate about nurses taking good care of themselves and recognising that their health and wellbeing should be a priority. The healthier nurses are, the better they feel, and the longer they’ll be able to stay in the workforce.

I would really encourage all nurses to put themselves at the centre of their work.

THINKSTOCK

DIABESITY

The perspectives of a registered nurse and credentialed diabetes educator

The global epidemics of both diabetes and obesity (dubbed *diabesity*) are well recognised as the most impacting health issues of our time. It has a profound social and economic impact.

The International Diabetes Federation estimates that there are 415 million people with diabetes, which equates to 8.8% of the world's population (2014).

In Australia, the Australian Bureau of Statistics (ABS) reports that 1.2 million people had diabetes in 2014–2015 (5.1% of population). Concurrently, the rate of obesity has doubled in the past 20 years (World Health Organisation, 2017), with a study published in *The Lancet* showing the global prevalence to be approximately 37% for men, 38% for women and alarmingly, 23% for children (Ng et al., 2014).

Australia is now ranked among the most obese nations in the world, with almost two out of three adults (63%) being either overweight (BMI>25) or obese (BMI>30) in 2014 (Australian Institute of Health and Welfare (AIHW)). Indigenous Australians are three times more likely to have type 2 diabetes and are also at a much greater risk of complications (AIHW, 2014).

Of grave importance is the rise in the incidence of type 2 diabetes in children linked to obesity levels. With 20%–50% of new onset diabetes cases diagnosed in children in the US now being type 2, it is likely that the trend will follow in Australia (Dabelea et al., 2014).

Obesity impacts the rising incidence of gestational diabetes, which increases the risk of profound untoward effects on the unborn foetus if the diabetes is not adequately addressed. There is also a legacy effect for the development of obesity and diabetes in children born to mothers with uncontrolled gestational diabetes.

Furthermore, obesity has been identified as a factor in the increased incidence of type 1 diabetes, which is also a growing trend, especially in children.

There is a bi-directional relationship between diabetes and overweight/obesity. Obesity impacts on the action of insulin, resulting in insulin resistance. In people who are genetically predisposed to beta cell damage, insulin resistance is the harbinger of impaired glucose tolerance and type 2 diabetes, gestational diabetes and in the development of type 1 diabetes.

Lifestyle is the main causative factor in the Australian obesity epidemic, largely due to sedentary behaviours and overconsumption of food. However, less well appreciated is that obesity itself is mostly due to a person's own pre-programmed weight control system.

Physiological changes also occur following weight gain that impact on an overweight/obese person's ability to feel satisfied. The altered physiological changes drive hunger and make weight loss/maintenance very difficult to sustain.

Diabetes can also have an impact on weight gain leading to a worsening effect of the disease. Various mechanisms, including the adverse effects of pharmacotherapy used to control blood glucose (insulin and sulphonylurea medication), the effects of hypoglycaemia, and the adverse effect of medications used to treat co-morbid conditions, such as mental health issues, all have a potential unwanted side effect on weight gain.

Diabetes is a complex physiological condition that has always been recognised as a chronic disease and managed appropriately. Obesity on the other hand has been viewed as a condition and side issue, and has not been supportively managed in our health system.

However, in 2013, the American Medical Association classified obesity as a disease state. Subsequently, in 2013, an Australian Committee was formed to establish clear management guidelines in the treatment of obesity. The committee recognised obesity as a "complex and multifactorial chronic disease…that requires long term management," (National Health and Medical Research Council (NHMRC), 2013).

The resulting *Australian Obesity Management Algorithm* (NHMRC, 2013) outlines clear guidelines for the management of obesity. The validation of a serious health issue will hopefully assist in the care of individuals whose lives are currently impacted by obesity, and more often than not, coupled with diabetes.

The aims of the guidelines are to:

1. Assist general practitioners (GPs) in treatment decisions for treating adults with obesity
2. Provide a practical clinical tool to guide the treatment of obesity in the primary care setting

There are four guiding principles for management outlined in the document:

1. Lifestyle interventions
2. Pharmacotherapy
3. Bariatric surgery
4. Weight loss strategies

The role of the credentialed diabetes educator (CDE) in the care of obese and diabetes-affected individuals is to support and educate the person within a multidisciplinary team. My work as a registered nurse CDE is within a private general practice.

The location of my practice is rural with my patients coming from varied education levels, heterogenous socio-economic groups and with some variation in ethnicity (approximately 5%), mostly from Southeast Asia.

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Almost all of my patients are overweight and a high proportion are clinically obese. I spend time with each person to elicit the difficulties experienced by them as an individual, and to incorporate a diabetes self-management education plan that specifically addresses their issues in self-management.

To be effective as an educator, I feel that a person-centred approach is of paramount importance. Harnessing my interpersonal skills in order to develop a relationship with my patient is crucial to the resulting care. I endeavour to create a relaxed interview style and I find myself drawing from my own life experiences and challenges (sometimes utilising appropriate self-disclosure), to enable me to fully understand my patient's perspective.

I try to use open ended questioning and the use of assessment tools, e.g. *The Problem Areas in Diabetes Assessment Tool*, to elicit the issues the people find difficult.

I have found that people are happy to open up about their lives, the impact of living with chronic disease and the struggles they face daily, once they feel valued and comfortable.

Struggling with everyday challenges (as parents, carers, spouses, workers) they somehow have to try to also manage blood glucose monitoring and medication, as well as routine visits to pathologists, GPs, specialists, allied health team members, etc.

Despite all this, in my experience, it is the constant decision-making with regard to food and diet, often with associated feelings of deprivation and guilt, that is of most concern to people with *diabesity*. There is a recurrent theme of perceived failure in an attempt to lose weight or prevent weight gain, and/or in trying to achieve target blood glucose levels.

This is often the most burdensome and impacting issue for those with diabetes and obesity.

Furthermore, people with *diabesity* often come with years of weight problems and psychological/psychosocial issues alongside their battle to strive for diabetes control.

There is a predominance of mental health issues co-existing in individuals with *diabesity*. Mental health issues are an independent risk factor for diabetes, and diabetes itself will impact the mental health of many people with *diabesity*.

> **"People with diabetes and obesity deserve to be treated with respect and kindness, and need our active support and help."**

The Miles Study in 2016 reported a very high prevalence of psychological and emotional problems amongst the diabetes community with the most commonly reported problem area relating to "worrying about the future and the development of diabetes-related complications" (pg. 9). 17% of people surveyed in the Miles Study indicated that they had been diagnosed with mental health problems at some point in their life (2016).

It can be a very draining experience for a person with diabetes and obesity, more often than not leading to anxiety, depression and sometimes 'diabetes burnout'. This can then compound problems with an added trigger for emotional/psychological eating behaviours and poor self-management of diabetes.

Often people will report having experienced 'weight bias'. My patients open up about how they are treated at work, at social gatherings, by members of their family, and sadly, even experienced weight bias from within the health professions.

The 'body politic' often act as 'food police', apportioning blame to the individual with *diabesity* for 'failing' to reduce food intake and to make what they feel are appropriate choices, often with very little insight!

Dietary intervention in *diabesity* can be of great benefit, however, it needs to be carefully supervised, especially with regard to gestational diabetes, type 1 diabetes, and/or people with type 2 diabetes who are on insulin therapy or sulphonylurea medication.

Hypoglycaemia is an adverse effect of reduced energy diets in the presence of both aforementioned medications. In the presence of dietary intervention, it is imperative to closely monitor the elderly, those with renal disease and those taking warfarin therapy for any adverse effects. It is therefore recommended that people be referred to an accredited practicing dietician for dietary supervision and to a CDE to assist with issues surrounding titration of medication and insulin, as well as self-management of hypoglycaemia.

Diabesity is the most impacting health issue of our time. If we are to assist those who are struggling with the burden of this disease, then collectively as health professionals we need to actively respond. We need to utilise the prescribed management tools and affect change with clear, evidence-based strategies.

People with diabetes and obesity deserve to be treated with respect and kindness, and need our active support and help.

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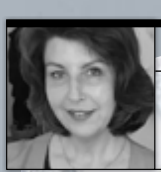

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THE ART OF LISTENING

Supporting people who live with diabetes and obesity

As you begin reading this piece let me first make a disclaimer. It will not contain clinical references or fancy graphs with beautifully gathered statistics. What it will contain is my real life experiences of supporting people with diabetes and obesity. It can be a struggle to control weight for many people whether they have diabetes or not. Many have eating patterns that have been entrenched from childhood and/or lifestyle habits that are affected by their everyday struggles.

JUST ANOTHER DAY AT THE OFFICE

The sun is shining; it's a perfect spring day. Jack waits to see me; he is on the doorstep as I arrive at work. I am greeted with his friendly smile and he asks if I have time to see him before he goes to Centrelink this morning. He is a 45-year-old Aboriginal man who has not been to our clinic for two years.

I overhear his discussions with the receptionist. He outlines that he has not seen anyone about his health in two years, as he has been out of town on family matters. Jack has type 2 diabetes and was diagnosed in 2012. He also tells reception he can't remember when he last had his tablets.

THE CONVERSATION

How did we start our meeting?

I told him it was good to see him again, and asked how he was going and what could we do for him today.

I can hear his despair at losing family members. I can hear his love for his family and country. He has had to move his family back to town and they are all here for better access to medical care. I could hear from his descriptions that his diabetes is a cause for concern; he knows it as well. I can hear that his wife is telling him he has to get well. Most importantly, it's totally clear his family need him now, more than ever.

He told me about his journey over the past few years. His family has been very unwell and sadly, a number of them have passed. Jack now describes himself as the 'all-rounder' support person. He used to have a job in town but stopped to become a full time carer for his nephew, wife, mother and older brother, who is now experiencing renal failure. They have all moved back to town to be closer to medical services. He has not been feeling so well lately. He is tired, moody at times, waking up to pass urine and craving cola.

"I just love my Coca-Cola."

Jack tells me his health is his main focus now, and his wife will help him. However, she has told him he has to help himself first.

The alarm bells are already ringing loudly in my head. I ask if it's okay to do a check of basic things, including blood pressure and blood glucose. He continues to talk to me throughout this examination. Among these observations, I find that his weight is 130kgs, BMI is 46, random blood glucose level is 20.0 mmol/L (no blood ketones), and HbA1c is 101 mmol/mol (11.4 %).

Some nurses may read this and will be shocked by such a high BGL. Take a deep breath, and calm down. This can be a regular occurrence at our service. It might also shock you to know that this can be successfully managed, without ambulance and hospital admission, and all the associated social impacts.

How I feel about what he is telling me, can impact on his care. Often the initial reaction to such a presentation is: I have to fix this! The first reaction can be to prescribe medications, give him a regime, encourage him to start dieting and exercise, refer him to a dietitian and exercise psychologist, tell him to come back for a review, etc.

Do you ever think this way? Do you ever think: we have to FIX THIS NOW! This is the place your brain can run to, when people like Jack first present. And while, yes, we need to set a pathway and priorities, there is one way to do it, and another way that will instantly turn Jack away from you and the clinic.

THE OUTCOME

Social and emotional wellbeing are paramount. Yes, he needs to make changes to help him lose weight and have improved diabetes control. But these changes have already started: focus on the positive.

Think about your response to a difficult situation: how do you feel about what you know?

I express to Jack how good it is that he is here to see us today. I ask him what his plans are with the family today and for the rest of the week. How does he feel about going back onto some medications today?

Look at the big picture: is there food security, is there appropriate housing, does he have transport? Link this in with a culturally-appropriate team.

Our service has a fantastic team of Indigenous health workers who know his family. If we help Jack with his home life and family, Jack will then be able to help himself. Jack is happy for our support worker to accompany him to Centrelink and help with housing questions. They also go to the 'friendly' chemist in town and make sure he starts back on his medications.

Our drop-in clinic is open every morning and Jack has expressed that he would like to come back each day for a checkup. We will provide transport.

There were a few missed appointments but his BGL came down nicely once he went back on his medications. After his family were linked in with support services, he was also keen to see the rest of our team. He has lost some weight, stopped drinking cola and his overall diet improved as the family settled.

> **“Effective communication is 20% what you know and 80% how you feel about what you know.”**
>
> **Emanuel James (Jim) Rohn (1930–2009)**

THE MORE YOU KNOW THE LESS YOU NEED TO SAY (JIM ROHN)

Before you can listen and support anyone about weight loss you need to think about how you feel about what you know. There are questions you need to ask yourself about how you feel about change.

Over my 42 years of nursing, I have meet colleagues who are brilliant and knowledgeable doctors and nurses. They quote endless evidence-based data about diabetes and how weight loss can improve long term outcomes, but many just don’t see the ‘big picture’ and look at the person holistically.

Yes, they know it all, but if we asked them to make changes in their own lives could they? How easy would it be? One of the most important tools a nurse can have is the ability to be able to have reflective practice. A true ‘internal’ reflective practice is where one not only looks at the task/communication/patient that takes place. They must also examine how they feel about what has occurred, and how many external factors influence someone to make positive change.

Lastly, if you are a diabetes educator, have you ever considered dropping ‘educator’ out of your title? Sometimes, people that need to make changes in their lives, don’t need an ‘educator’ – they need a nurse. Especially in the Indigenous community.

I found that patients repeatedly failed to attend appointments while I was an ‘educator’ but they do come to see me as a nurse. Why do patients come to see nurses? Because we listen to them.

AUTHOR

LEIGH SPOKES FACN

THINKSTOCK

MY ROLE AS A DIABETES EDUCATOR

The means to make a difference

> **“My role as a diabetes educator is to be a listener, encourager, persuader, advocate, health coach, teacher, and motivator.”**

I am a diabetes educator who works in both inner Melbourne and in the outer North West fringes of Melbourne, where new houses and shopping centres are popping up almost daily.

Most of my clients are obese, they are from lower socio-economic groups, many from migrant populations.

They work or commute long hours to work, spending nearly all their income on paying off massive mortgages, or trying to meet rent if they are not in public housing.

They often don’t have the time or the money to make healthy lifestyle choices.

It is such an easy thing to say: “Lose some weight.” But it is such a difficult thing to actually do.

No one wakes up in the morning suddenly obese.

Every person is different as to how they got there. Tackling obesity is a complex, multifaceted challenge.

With obesity comes the risk of developing diabetes, or difficulties in managing it. When someone is diagnosed with diabetes it can be a huge shock and often a lifelong challenge.

My role as a diabetes educator is to be a listener, encourager, persuader, advocate, health coach, teacher, and motivator. We work together on tackling living with diabetes, setting realistic goals, making manageable lifestyle changes, and reviewing the benefits of medication. But what is exciting now is we live in an era of new technology breakthroughs with smart phones, health applications, tracking devices, and flash glucose monitoring, making it easier to both motivate and support management of diabetes.

At the same time there are new medications and research breakthroughs around gut health, regulator hormones and achieving satiety that tackle both obesity and diabetes.

We have the means and technology to make a difference.

AUTHOR

EVELYN BOYCE MACN

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FIRST AUSTRALIANS

Diabetes and cultural safety in nursing

We know that diabetes is the most rapidly growing chronic illness in Australia and is often spoken of as reaching epidemic proportions. Diabetes is more highly present in socially disadvantaged groups, and most highly present amongst Aboriginal and Torres Strait Islander peoples who are overall more than three times as likely to experience the burdens of this illness than non-Indigenous Australians (Burrow et al., 2016). Historical, cultural and social factors deeply contribute to this unequal burden of illness, and its comorbidities and social consequences.

In her 2016 national address, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) CEO Janine Mohamed spoke of racism, poverty and dispossession as the core factors that impact upon these health outcomes of Aboriginal and Torres Strait Islander peoples. She also spoke of the core need for cultural safety amongst all health professions and their services, and the way in which Australia was, "lagging behind," in its progress towards cultural safety in health care. But understanding cultural safety and its progress requires the nursing profession, and its students and educators to develop new knowledge and new practices, and to reflect upon their own history.

Whilst undertaking my undergraduate degree in nursing, I was provided the opportunity to expand my knowledge concerning Aboriginal and Torres Strait Islander peoples' health care, through a dedicated unit of study, *Aboriginal and Torres Strait Islander people's health*. This unit provided foundations for cultural awareness, competence and safety within a health setting. During this journey, we were guided to think reflectively, to read the selected readings critically, and to deeply consider the perspectives and narratives from a range of speakers and writers who generously gave their storytelling, their truth-telling and their leadership towards cultural safety within the nursing profession. At the end of this unit of study we were asked to present a formal reflection, with recommendations for new graduate nurses as they enter a profession that is being challenged to hasten its journey towards cultural safety. This paper presents my reflection, with the goal of contributing to the nursing profession's awareness of cultural safety and the continuing steps we take towards responding to the enduring health inequalities of Aboriginal and Torres Strait Islander peoples.

LEARNING ABOUT CULTURAL SAFETY

Throughout the duration of this unit, I have witnessed personal growth in myself. I had entered this learning space with a foundation of knowledge presented to me through my own personal narrative. This unit has affirmed my initial thoughts surrounding the complexities and depth of Aboriginal and Torres Strait Islander peoples' culture. In addition, I gained insight into my own personal levels of knowledge and experiences, and the expansive quantity still to learn; a task I wholeheartedly accept. I can never fully know Aboriginal and Torres Strait Islander peoples' culture, or to the same depth as someone who lives this experience every day. But following the conclusion of this learning journey, my aspirations are to listen to more peoples' truths, and learn as much as I can, for as long as I can.

Moreover, this experience has developed my understanding of central concepts, such as cultural safety, decolonisation and institutional racism. I have learnt to draw deeply on the work of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and their definition of cultural safety (CATSINaM, 2013), which clearly identifies our professional responsibilities: to recognise racism and power imbalances, to acknowledge the past and present impacts of the dominant culture, and to explore the ways in which I as a nurse can address these processes within my practice and within health care services. I recognise that this is an ongoing process of development for me, and my profession.

Further, I have become increasingly aware of the history of the nursing profession in Australia, and the often untold ways that this profession injured and traumatised Aboriginal and Torres Strait Islander peoples and their communities (Forsyth, 2007). There have been cycles of institutionalised racism and by un-teaching nurses the 'white' prevailing discourses of nursing and health, we can begin to understand and develop empathy (Downing et al., 2011).

When I commenced my learning in this unit I felt I held cross-cultural awareness and knowledge firmly in my grasp. But this confidence was challenged by what I read and heard from my teachers. And so, I began to accumulate many questions about my competence and I felt anxiety. How deep could this learning process be? Will I be able to swim? How will I know where to go to learn more? But my teachers were strong and knowledgeable swimmers, and gave clarity to concerns, giving many directions and currents towards further learning and safe humility. As I progressed through this journey, I was awakened to the notion that one cannot hold knowledge of Aboriginal and Torres Strait Islander culture and history firmly in one's own hand.

It was not a collection of pieces that you added to your basket of knowledge; a separate entity to one's life they are living. It was an ever lengthening and layering blanket, that entangled into your daily experience. By the conclusion of this unit, reflecting on my knowledge, I was full, I was overflowing, and yet I wanted more. This conclusion has shown me that I have only swum in the shallows of knowledge. I will never fully know Aboriginal or Torres Strait Islander peoples' culture and history. This initially provoked a sense of self-involved worry; the fear I would make a mistake. But this feeling was quickly subsided by my motivation to swim deeper, now independently. To listen to people's narratives, the many truths, and learn as much as I can.

WHAT IS CULTURAL SAFETY?

Over the course of this semester I have developed an understanding of the concept of cultural safety. Cultural safety is hard to define, as this concept itself is continuing to develop as we move towards post-colonisation. It is the collection of inter-relating ideas. It is the ability to externally and internally recognise one's own culture, and its effects on the lives of others. However, it is not this notion on its own. It also involves the recognition of racism, power inequalities within society, and privilege. Cultural safety can only be identified by those in our care, we cannot declare it. Moreover, it focuses on one's ability to listen to difference, and alter our care to difference.

I feel use of the term 'safety' can be misleading; it suggests that through the noted definition a person will feel safe. However, through the knowledge I have been gifted from this unit I am aware that intergenerational trauma, Aboriginal and Torres Strait Islander people's history, and the nature of institutionalised racism, may not allow this to be possible (Herring et al., 2013). It is a privileged attitude to believe that the implementation of this concept will allow all Aboriginal and Torres Strait Islander peoples to feel safe in such a one-dimensional, 'white' model of health care. Therefore, cultural safety in itself is continually changing as health systems develop and we change our perspectives and practices, through listening to those in our care.

RECOMMENDATIONS FOR NEW GRADUATE NURSES

I believe recommendations should be made to promote culturally safe practice in new graduate nurses within Australia. Throughout my tertiary education, the level of cultural competence I witnessed amongst my peers and educators was relatively low. As a student, you are placed into a nursing education discourse that suggests mentors and educators hold 'the knowledge'; the one truth. However, this discourse emerges from an extensive history of institutionalised racism within our places of learning and health care. It was not until the end of my second year that I realised how intensely racism was engrained in the nursing profession's history and dominant discourse. There is no one solution to solve this cyclical discrimination and cultural blindness. However, steps can be made to reduce this and progress towards cultural safety.

I recommend that more integrated culturally-safe education should be presented throughout the undergraduate curriculum, in addition to a specific unit dedicated to Aboriginal and Torres Strait Islander people's health. By un-teaching nursing students the 'white' health discourse, we can begin to understand context and develop cultural humility. This experience could highlight to nurses the racism within their workplace, provide skills and education on Aboriginal health care, and begin to see all truths as equal truths (Sherwood, 2013). Yet, I hesitate around this recommendation. How can we be sure that our education will be culturally safe – both in its teaching and its teaching contexts? Have all those who educate us travelled along a journey towards cultural safety?

I recommend that nursing students be enabled to undertake a clinical placement within an Aboriginal Medical Service or Torres Strait Islander Health Service. This cultural immersion is arguably the most effective way to learn about the 'being' of cultural safety, within communities and alongside health providers (Hart et al., 2015)

Yet I also hesitate again around this recommendation. Can we be certain that all students on placement would be humble, respectful, and culturally aware and competent? Would they all practice the reflection needed to further their understanding towards cultural safety. And what of the 'burden' upon Aboriginal and Torres Strait Islander health services? How could this cultural immersion be a reciprocated gift?

My thoughts as I complete this reflection draw me to the immediate need for further integrated, culturally safe education within undergraduate nursing curriculums. There must be a 'critical gaze' upon the education and socialisation of nursing students and their preparations to enter into complex health care systems that are overshadowed by history.

"…the water sands under our feet shift and move so often—the land to which we can reach out is often distant, unknown" Galarrwuy Yunupingu (Pearson, 2014, p. 4)

I acknowledge Bethne Hart, Miriam Cavanagh, Vicki Wade, Pauline Deweerd, Sophie Greig and Samantha Petric for their teachings.

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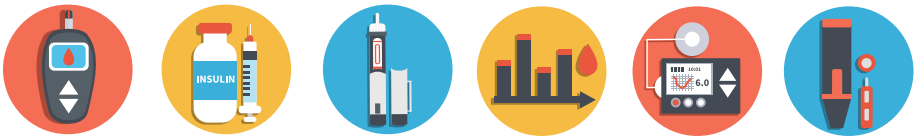
DIABETES CARE AND COORDINATION

Views from a chronic disease nurse



The coordination of diabetes care within general practice (GP) can be successfully managed by a practice nurse/chronic disease nurse. It is my belief that the most important factor in diabetes care coordination is how you communicate with your patient to get them to be proactive and empowered to manage their own disease.

I commenced my career in the UK, obtaining diplomas in diabetes care, coronary heart disease in the community, family planning and sexual health, asthma, and chronic obstructive pulmonary disease. During this time, I played an active role developing systems within my workplace and with other agencies.

I came to Australia in 2009, thinking I needed a career change. After working for 10 months at the Mater Hospital in Townsville on a surgical ward, I very quickly recognised that my heart and passion lay in general practice. I then worked with the Medicare Local for six years supporting general practice, as well as working in the afterhours clinic. During my last three years at the Medicare Local, I was the coordinator for the *Telehealth Diabetes Trial* in Townsville part-time and worked in general practice to keep my clinical skills up-to-date. I am still involved with a clinical trial study. I am also employed as the chronic disease nurse in general practice at the Health and Wellbeing North Ward in Townsville.

My role as a chronic disease nurse involves identifying areas of intervention for patients, which requires the expertise of other health services to help attain goals to manage their diabetes. I also provide strategies, support and health education, building a strong working relationship with my patients. It's wonderful to go out into the waiting room, and see patients beam and give you a little wave.

My passion lies in delivering a holistic, patient-centric approach to care. I believe that the fundamental basis of this model of care is communication. In this day and age, there are many different methods of communication readily available: letters, phone calls, telehealth and face-to-face interactions.

In my early days of coordinating diabetes care, I would touch base with acute diabetes nurses, endocrinologists, podiatrists, optometrists and dieticians regularly to discuss patients and how systems could be changed to improve care delivery at the local level. The end product was the ability to provide the necessary tools for patients to confidently navigate the health care system and provide support through their journey in managing their chronic disease. Correspondence letters were shared with me during this time. This gave me, as a coordinator, the opportunity to follow up if necessary but those were my yesteryears!

My level of experience, and with the use of the *GP Management Plan* as a template (a measurable method for Medicare to audit for billing), has placed me as the central pivot in coordinating care, regarding the recommendation of referrals and building strategies to achieve identified outcomes. I feel it is also my duty of care to find those buttons in each individual that induce a lifestyle change and produce improved health outcomes.

The critical part is to captivate the patient and show some interest, rather than just sending them off to the required allied health professionals. It's important to talk to them about their condition; as a diagnosis can be daunting and carry immense guilt. There are five nurse appointments a year that can be billed. I try to use these appointments as an opportunity to build solid relationships based on trust and respect with my patients, while drip feeding them information backed by evidence-based care. I find out what barriers they may be facing in managing their condition (work, travel arrangements, etc.) and problem-solve with them to overcome these barriers. There is always a way around it. Small changes to routine and a patient's thinking can produce huge beneficial health outcomes, empowering the patient to manage their own health and diabetes.

That all sounds wonderful when it works but it is not so easy when patients grasp on to inaccuracies.

Is it possible to forge those professional working relationships within the current structures of general practice in Australia? I'm not sure. I do feel that it would be beneficial to patient care and outcomes, if relationships could be forged with specific health services in order to provide a seamless, cohesive approach to chronic disease management.

Adopting a holistic approach that takes into consideration mental, physical and social health, enables me to offer support and education that is appropriate and facilitates increased chances of lifestyle change and disease management.

I have been a nurse for 33 years in the community. I have built my skills and knowledge base, resulting in a very fulfilling career as a generalist and care coordinator. I do not feel that practice nurses are given the recognition within Australia for their diverse work within general practice by governing bodies. If we are to deliver the chronic disease model of care in collaboration with other services using a team approach across multidisciplinary sectors, we all need to be working and communicating together to ensure quality, evidence-based care is received by all patients.

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PROFESSOR TRISHA DUNNING

Making a difference in diabetes education, practice and research

Professor Trisha Dunning AM FACN (DLF) is an inspiring nurse leader, researcher, mentor, credentialed diabetes educator, and Distinguished Life Fellow of ACN.

She is an internationally recognised leader in diabetes education, practice and research who has made an enormous and invaluable contribution to our profession and organisation.

During the course of her distinguished career, Professor Dunning has been a highly active member of the professional nursing community and held several senior leadership positions. She is currently the Chair in Nursing, Executive Director and Member of the Centre for Quality and Patient Safety Research at the School of Nursing and Midwifery within the Faculty of Health at Deakin University. Professor Dunning holds a joint appointment between the university and Barwon Health.

In this role, Professor Dunning provides strong clinical and research leadership to staff and postgraduate students. She heads and contributes to high-level research, collaborating with consumers and a wide range of industry experts to deliver sustainable research outputs and implement applied research to inform clinical services and practice.

Throughout her career, Professor Dunning has led and worked on numerous research projects, which have had a resounding, global impact on patient care, policy and nursing practice. This includes developing the revolutionary *Guidelines for Managing Diabetes at the End of Life*, establishing the *Guidelines for Managing Diabetes in Residential and Other Care Settings*, and leading research that resulted in the eventual establishment of an after-hours clinic at St Vincent's Hospital in Melbourne, specifically for young adults.

Professor Dunning has published a wide range of influential research and work during her career, including 300 peer-reviewed

publications, 14 books and 28 book chapters, as well as numerous research reports, invited papers, clinical guidelines, position statements, letters to the editor, invited editorials, research summaries, short stories and poetry. She has delivered a large number of conference presentations and reviewed abstracts, academic papers, research grants and journal submissions for her students.

Professor Dunning's commitment to our profession has also been largely defined by her membership, leadership and contribution to a number of professional bodies, boards, committees and expert groups both nationally and globally. Through committee and consultative work, she has made an invaluable contribution to policy at a local, national and international level. This has included as a consultant for the World Health Organisation to the Eastern Mediterranean Region Department of Nursing at the Ministry of Health in Kuwait, the President of the Australian Diabetes Educators Association, an international expert on the Diabetes Research Strategy at Bergen University College, Vice President of the International Diabetes Federation (IDF) and the Inaugural Chair of the IDF Diabetes Education Consultative Section. She is also on the editorial Board for several prestigious journals, and is the Editor-in-Chief of *The Global Journal of Health Sciences.*

Throughout her career and while working within the postgraduate diabetes education program at Deakin University, Professor Dunning has played a key role in building the next generation of nurse leaders. She has mentored and supervised a number of PhD, Masters and Honours students, co-authored articles with students for various publications, and delivered numerous workshops for fledgling researchers and clinicians. She has also helped establish and taught at the International Society for Paediatric Adolescent Diabetes Inaugural Annual Science School, as well as three other schools in Singapore, Slovenia and Poland.

Professor Dunning has a long and active history with ACN. She first joined the Royal College of Nursing, Australia (RCNA) in 1993 and was recognised with a Distinguished Life Fellowship in 2011. Over the years, Professor Dunning has made many important contributions to our organisation, sharing her expertise to inform our positions in the fields of ageing and research. This includes as part of our expert advisory group on ageing and as a reviewer for our academic journal, *Collegian*.

In recognition of her significant contributions to nursing, diabetes education, management and research, Professor Dunning has received various national and international accolades throughout her career, including a Member of the Order of Australia.

Recently, Professor Dunning was inducted into the International Nurse Researcher Hall of Fame at this years' Sigma Theta Tau International (STTI) Nurse Research Congress. She was inducted in recognition of her research, which has enhanced our profession and the people it serves. ACN would like to congratulate Professor Dunning on this enormous achievement and thank her for her incredible contribution to the nursing community.

THE EVOLUTION OF CREDENTIALED DIABETES EDUCATORS

In Australian society

WHY IS DIABETES EDUCATION IMPORTANT?

Around 1.7 million Australians have diabetes. This includes all types of diagnosed diabetes (1.2 million known and registered) as well as silent, undiagnosed type 2 diabetes (up to 500,000 estimated) (Diabetes Australia, 2015). Diabetes has been designated a national health priority area since 1997 (Australian Institute of Health and Welfare and Commonwealth Department of Health and Family Service, 1997) and a revised National Diabetes Strategy was developed by the Australian Government in 2016 (Commonwealth of Australia, 2015). Of the three main types of diabetes, type 2 diabetes accounts for 85–90% of all diabetes diagnoses and is expected to become the leading cause of disease burden in Australia by 2023 (Australian Institute of Health and Welfare, 2010).

Diabetes is responsible for a reduced quality of life, disability and morbidity (Australian Institute of Health and Welfare, 2005). The AIHW (2010) reports that the most common comorbidities are cardiovascular disease (60%), disability (56%), depression (19%) and vision impairment (7%). In research commissioned by the Australian Diabetes Educators Association (ADEA), diabetes was linked to increased hospitalisation rates and higher mortality (Pekarsky, 2010). Diabetes Australia estimates the total annual cost impact of diabetes in Australia is $14.6 billion (Diabetes Australia, 2015).

Although research is limited, some research has found that diabetes education has reduced health service utilisation in the year following diabetes education that included fewer hospital admissions and physician visits (Balamurugan et al., 2006). Pezzullo (2014) identified that “translating the disease impact parameters (frequency of hospital admission, emergency presentation, general practice visits, comorbidities) from the literature search into their current Australian costs, diabetes education may prevent up to $2,827 per patient, per annum”. For the annual costs of credentialed diabetes educators (CDEs) per patient of $173, this represents a benefit cost ratio (BCR) of 16.3 to 1. Thus, CDEs will reduce health care costs through a reduction in need for services (Pezzullo, 2014).

CREDENTIALED DIABETES EDUCATORS IN AUSTRALIA

The majority of CDEs in Australia are registered nurses (85%), which is unsurprising given the history of CDEs. The original specialist educator role was mainly held by nurses, and in some countries, such as New Zealand and the United Kingdom, they still are the primary health professional diabetes educator.

The most frequently documented historical beginnings of diabetes educators arises from the United States and the “travelling” nurse established by the American physician Dr Joslin. Prior to the availability of insulin in the 1920s, treatment of choice was diet. With the availability of treatment with insulin, and progress in science and technology, the person with diabetes required an even greater knowledge of the management of their condition.

Recognising the significance of education for people with diabetes in promoting wellbeing, together with the emerging nurse specialist movement, it was only a matter of time before the diabetes nurse specialist developed. The broad scope of the nurse specialist as primary provider made significant inroads to the outcomes of the community of people diagnosed with diabetes. As shown in a study by Jordan and Schipp in 1971, it was considered that specialist nurses upgraded the health of patients in primary care with this chronic condition. Specialist nurses educating and monitoring patients resulted in better self-management and reduced hospitalisation (Shipp & Jordan, 1971).

The evolution of specialist credentialing took the role of the nurse specialist in diabetes care another step further. By the early 1970s, the American Nurses Association were credentialing the first specialist nurses in that country. Australian nurses embraced the American model. In 1984, Lesley Cusworth, President of ADEA at that time, highlighted that a decade earlier, care was mostly focused on those dependent on insulin; and diabetes education was limited, being basically delivered by overworked medical practitioners, nurses and dietitians who were rushed, and besieged diabetes organisations (Cusworth, 1984). It was in 1974 that the first outpatient’s diabetes education centre was established. Located at the Royal Newcastle Hospital, the significant reduction in hospitalisation over three years was linked to diabetes education (Cusworth, 1984).

ADEA was established in 1982 with one aim being to work, "towards upgrading, standardising, and evaluating, diabetes care", and on developing recognised training courses for diabetes educators (Cusworth, 1984). The early multidisciplinary membership of ADEA at this time reflected the progress in the management of diabetes, and recognition that people with diabetes had various needs and live in a diversity of locations. Today, patient-centred care and patient goals are foremost, requiring an inter-professional team approach. Thus, while the majority of CDEs under the auspices of ADEA, are nurses, the membership consists of dietitians, pharmacists, podiatrists, exercise physiologists, physiotherapists and direct-entry midwives.

ADEA commenced the credentialing of health professional diabetes educators in 1986.

BECOMING A CDE

The ADEA Board reviews applications for eligibility from health discipline national bodies and if approved members of that discipline can undertake the credentialing program, which includes seven steps:

1. Complete a Graduate Certificate in Diabetes Education
2. 1,000 hours practice in diabetes education/management
3. Completion of ADEA mentoring program (6 months)
4. 20 hours diabetes specific professional development (CPD)
5. Reflection and development of learning goals
6. Current CV
7. Referees report completed by an appropriate supervisor/manager, addressing the *ADEA National Competencies for Credentialed Diabetes Educators* (Australian Diabetes Educators Association, 2017)

THE ROLE OF CREDENTIALED DIABETES EDUCATORS IN THE CURRENT HEALTH SYSTEM

People with diabetes and their families or carers may see a health professional up to four times a year regarding their diabetes management. The rest of the year the person with diabetes is required to self-manage their condition and problem solve day-to-day. CDEs provide diabetes self-management education to people with diabetes and pre-diabetes, their support persons and carers, and their community that focuses on:

- facilitating an understanding of the condition
- facilitating an understanding of the risks and benefits of lifestyle choices and treatment options
- supporting people to make informed choices
- supporting problem solving
- facilitating active collaboration with the health care team to improve clinical outcomes, health status, and quality of life
- supporting implementation, maintenance and change of health behaviours as required.

As well as assisting in the management of diabetes, CDEs also support and provide advice to other health professionals, and work in a multidisciplinary team. The role has evolved over time and will continue to evolve. The current role and scope of practice is likely to include:

- management of diabetes within a multidisciplinary team
- community education and health promotion programs
- provision of healthy lifestyle advice, including basic nutrition and physical activity

> **“Of the three main types of diabetes, type 2 diabetes accounts for 85–90% of all diabetes diagnoses and is expected to become the leading cause of disease burden in Australia by 2023.”**

- consideration of psychosocial factors, their impact on self-management and how to address these factors
- education on the relationship between diabetes and other health conditions and how to prevent, recognise and treat short term and long term complications
- education regarding individualised structured blood glucose monitoring regimens to assess the effectiveness of lifestyle and/or medication interventions
- education in the role, options, safe use, side effects and storage of diabetes medications
- education regarding how to prevent, identify and treat hypoglycaemia (low blood glucose levels)
- education regarding how to prevent, identify and treat hyperglycaemia (high blood glucose levels), including developing a sick day care plan and managing sick days
- initiation of referrals to medical practitioners or nurse practitioners to optimise medication regimens if required
- education and evaluation of knowledge and skills regarding injecting glucose lowering medicines
- regular re-evaluation of the person with diabetes and/or their carers self-management knowledge, skills and strategies over the continuum of diabetes care
- input into policy and procedures relating to all aspects of diabetes education, management and care.

Medicare item numbers are available to CDEs for individual and group services under the Medicare Chronic Disease Management item: CDEs can access payments through services to veterans through the Department of Veterans Affairs (DVA) and can register people with diabetes onto the National Diabetes Services Scheme (NDSS).

Diabetes self-management education is structured, comprehensive, collaborative and ongoing, and includes:

- an individualised psychosocial, clinical and cognitive assessment of the person with diabetes or pre-diabetes and/or their care givers
- formulation of an education plan including collaboratively-identified behavioural goals based on agreed clinical goals
- implementation of the plan based on evidence-based principles of teaching-learning and behaviour change theory
- evaluation to assess the person’s attainment of self-management goals and progress
- documentation of all encounters.

Structured education ensures particular information is provided that has been deemed essential for the self-management of diabetes and pre-diabetes, and that national standards of diabetes education are being met in accordance with the *ADEA National Standards of Practice for Credentialled Diabetes Educators* and *ADEA National Standards for Diabetes Education Programs* (Australian Diabetes Educators Association, 2014). Structured education allows for correct processes being followed, evidence-based best practice being implemented and reviews being made through continuous quality improvement.

CONCLUSION

Many CDEs in Australia who are credentialed, remain credentialed for many years, even decades, because they find great satisfaction in the autonomy of working to their strength in diabetes education.

EDITOR’S NOTE:
ACN and ADEA are delivering a suite of CPD on diabetes in 2018

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96% of nurses say UpToDate® helps them improve patient care[1]

Nurses are on the front line of patient care and play an important role in making point of care decisions, delivering safe and effective drug therapy and educating patients. But with the busyness of work and life, it's hard to keep up-to-date with clinical knowledge and information.

UpToDate® is a clinical decision support (CDS) that covers more than 24 clinical specialties and is used in almost 80% of Australian hospitals and health care facilities to help health care professionals make better clinical decisions based on the latest evidence.

The CDS includes a number of features tailor-made for Australian nurses, including a drug reference and interactions tool (with 5,800 unique drug entries), more than 170 medical calculators and 1,500 patient education topics, which can be distributed directly to patients.

A recent survey[2] of nurses using UpToDate in hospitals and health care clinics in the US showed that nurses were using the tool several times a week and were finding it beneficial across a number of different areas:

- 96% agreed UpToDate helped them improve patient care
- 82% used UpToDate to find information about a specific drug
- 69% used UpToDate to educate their patients
- 62% used UpToDate to find information about a procedure

The survey demonstrated the benefit of nurses using UpToDate to make evidence-based decisions relating to patient care, drug therapy and education.

UpToDate is developed by more than 6,300 physician authors, editors and peer reviewers, who use a rigorous editorial process to synthesise the most recent medical information into trusted and actionable recommendations. More than 80 research studies confirm widespread international use of UpToDate and its association with improved patient outcomes.

Nurses report that using UpToDate increases their clinical knowledge by broadening their understanding of treatments and conditions, while supporting their role in educating and engaging a patient and their family.

With thousands of detailed drug references and a separate drug interaction resource, known as Lexicomp®, UpToDate minimises drug risks and increases patient safety. It also advances nurses' understanding of medications and side effects.

Additionally, there are more than 1,500 evidence-based patient education topics within UpToDate, designed to promote informed patient decision-making and improved patient education. These easy-to-understand information materials – which include graphics and charts – can be printed out or emailed to patients for further reading at home.

UpToDate is designed to save nurses time by providing quick access to clinical answers and information, with additional links to treatment recommendations, drugs, graphics, original evidence, and more. It also gives nurses access to current, evidence-based recommendations for care along with the ability to redeem CE and CPD credits[3].

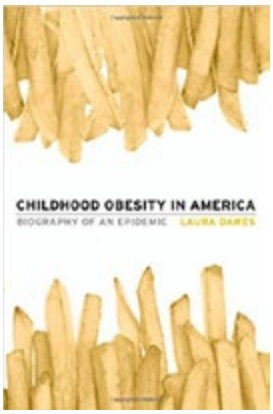
If you would like to learn more about how UpToDate can keep your clinical knowledge current while helping you to educate and engage with your patients, download our starter kit: https://go.wolterskluwer.com/ACN-EBM-Nursing.html

1. UpToDate Survey Results, August 2011 to July 2012, N=2,895

2. Bonis, P, Francis, E, Damaske, J. Nurses' information needs: a multicenter survey 2009; UpToDate Inc., Waltham, MA

3. The full list of societies or associations that recognise UpToDate as a CME/CE/CPD resource

NOVEL THOUGHTS



CHILDHOOD OBESITY IN AMERICA: BIOGRAPHY OF AN EPIDEMIC

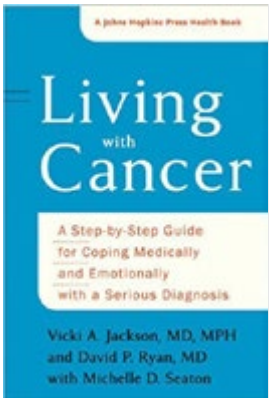
Author: Laura Dawes
Publisher: Harvard University Press
Published: 2014
Reviewer: Marilyn Gendek FACN

There was time when being obese not only had the potential for employment in a travelling 'freak' show but also to be newsworthy. The Adelaide newspaper, *News*, reported on Barney Worth who at 40 stone (or 254 kilos) was claimed to be "the fattest man ever admitted to Royal Prince Alfred Hospital." Barney was 26 years old and worked with a circus. He had to carry his own bed around with him as hotels could not cater for his needs.

In the introduction to, *Childhood Obesity in America: Biography of an Epidemic*, Laura Dawes cites the example of a 174lb (79 kilos) nine-year-old boy in 1896 who was also treated as a celebrity.

Childhood obesity was not seen to be common and there was less concern that a 'plump' child may be at risk of other illnesses later in life. Today obesity is commonly described as an epidemic. The content of Dawes presentation of childhood obesity in America takes us mainly through the 20th and 21st Century providing a picture of the progression of science, technology, knowledge and attitudes and how these have shaped where we are today. The chapters have been organised into three sections on this basis – measurement and diagnosis, causes and treats, and the epidemic. Dawes has offered a book on a very topical subject that is well researched, interesting, and in a style that is easy to read.

Dawes is a freelance historian of medicine, researcher and writer. She holds a PhD from Harvard University and is based in Canberra.

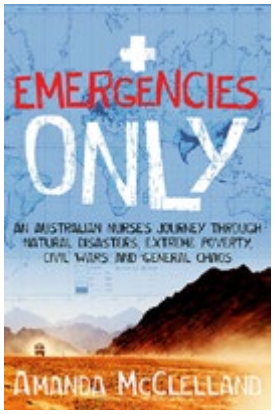


LIVING WITH CANCER: A STEP-BY-STEP GUIDE FOR COPING MEDICALLY AND EMOTIONALLY WITH A SERIOUS DIAGNOSIS

Author: Vicki A Jackson, David P Ryan and Michelle D Seaton
Publisher: Johns Hopkins University Press
Published: 2017
Reviewer: ACN Publications Lead Sally Coen

Living with Cancer: A Step-by-Step Guide for Coping Medically and Emotionally with a Serious Diagnosis, is an essential read for any nurse working in oncology or palliative care. While this book is a self-help guide for health care consumers, it also provides health care professionals with an enhanced understanding of the day-to-day struggles their patients experience following a terminal diagnosis.

Each chapter delves into a different issue that people living with cancer face as they navigate the intricacies of our health care system and the turbulent waters of a debilitating cancer diagnosis. Giving a unique insight into the emotional and physiological aspects of this disease, the authors provide useful tips and strategies to help nurses better understand the needs of their patients. Brimming with stories that outline unique patient experiences, *Living with Cancer*, is a valuable learning resource, which will simultaneously tug at your heart strings.



EMERGENCIES ONLY

Author: Amanda McClelland
Publisher: Allen and Unwin
Published: 2017
Reviewer: ACN Publications Officer Olivia Congdon

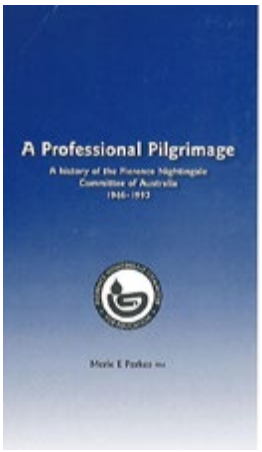
Emergencies Only is the autobiography of an extraordinary Australian Red Cross nurse and Florence Nightingale Medal awardee, Amanda McClelland. Her work at the forefront of the globe's most intense medical emergencies is documented in this gripping and eye-opening book. The pages within this new-release detail the human stories behind natural disasters, war, extreme poverty and disease epidemics.

Dip into this book if you are curious as to what it would be like to respond to the Ebola outbreak in West Africa, work in the most remote Indigenous communities in Australia's top-end or in communities in Papua New Guinea, which are rebuilding after the devastation of a cyclone. The author's insights and observations are truly enlightening.

Despite the fact that McClelland follows trauma and tragedy, *Emergencies Only* is written with optimism and heart. She demonstrates how health care providers and nurses are the steady shining lights in the midst of the world's darkest days.

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



A PROFESSIONAL PILGRIMAGE: A HISTORY OF THE FLORENCE NIGHTINGALE COMMITTEE OF AUSTRALIA 1946–1993

Author: Merle E Parkes AM
Publisher: The New South Wales College of Nursing
Published: 2002
Reviewer: ACN Manager Corporate Support, Karen Dansey

The words "Florence Nightingale," are synonymous with nursing.

From the international origins of England in 1934, the National Florence Nightingale Memorial Committee of Australia was established in 1946. It endured for a period of nearly 50 years in a landscape where nursing education and opportunities were not what they are today. The committee was made up of a group of remarkable people who had the vision, commitment, determination and motivation to reform nursing education. These individuals were the early nurse leaders.

They identified the need to provide the profession with the tools to progress and shape the future of nursing and nursing education. The committee provided the financial means for those so honoured, to be able to travel overseas on a travelling scholarship for advanced nursing education and qualifications not available in Australia at the time. One of the recipients of these scholarships was the author of this book, Merle Parkes AM, who was awarded the scholarship in 1955.

This book is a fitting tribute in recognising and acknowledging the hard work and dedication by the members of the National Florence Nightingale Memorial Committee of Australia and the state branches, the challenges they faced and overcame, and the legacy that continues today.

NOT YOUR AVERAGE NURSE

Author: Maggie Groff
Publisher: Random House Australia
Published: 2017
Reviewer: ACN Publications Officer Olivia Congdon

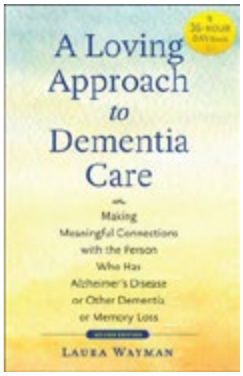
This absorbing memoir of a young nurse in the 1970s to 1980s, working in London, is a vivid and charming book. Award-winning author Maggie Groff takes her readers through the ups and downs of her nursing training and career in a sharp and witty manner.

You will read of her exploits with friends and colleagues, stories from patients, her mistakes (from tiny to calamitous) and exciting travels abroad.

Those currently working in the profession will be interested in how Groff and her peers fought for many of the rights women and nurses have today. Their determined approach is an inspiration for the battles our profession is still facing.

Along with the nostalgia of 70s/80s pop culture, the diversity of the author's experiences and the history-lesson of politics at the time, this memoir has beautiful moments of friendship and compassion, which remind us about what life – and the nature of nursing – is really about.

Larger than life, and bursting at the seams with relatable moments, *Not your Average Nurse* is a joy to read.



A LOVING APPROACH TO DEMENTIA CARE

Author: Laura Wayman
Publisher: Johns Hopkins University Press
Published: 2013
Reviewer: ACN Publications Lead Sally Coen

This beautifully written, emotionally stimulating book takes readers on an inspiring journey through the depths of dementia care. Reflecting on her extensive experiences and expertise as a personal carer and dementia-care consultant, Laura Wayman provides meaningful insights on the everyday realities for people living with this debilitating disease.

Emphasising the importance of compassion, care and love in nursing practice, Ms Wayman outlines the enormous difference nurses can make in the lives of their patients. Within each chapter of this book, she reflects on a different personal experience, which had a resounding impact on her practice and deepened her understanding of the complexities of dementia care. Interweaving touching personal antidotes with a myriad of hard-hitting facts, this book provides readers with easily digestible information about dementia and the experiences of people living with it.

With an increasingly aging population and rising incidence of dementia, this book is a must-read for all current, emerging and future nurse leaders interested in expanding their clinical knowledge and professional understanding in this growing area of practice.

Nursing matters

“Where can mid-career and senior nurses turn for guidance?”

Throughout 2017, I have had the pleasure of participating in the ACN Mentoring programs and have loved the opportunity to talk nursing with some inspiring early career nurses just raring to get into all that this profession has to offer. It reminded me what fun it is to talk with other motivated nurses about our craft. It also made me realise that, despite my recurring feeling that there is still so much that I don’t know about nursing, there is plenty that I can share which can prove thought-provoking and useful to one of my colleagues.

Mentoring and network building are seen as core skills in the making of any successful career. Students are regularly encouraged to seek out the advice of more senior colleagues as they make their way through their course and enter the first few years in practice. As a former clinical nurse educator and an active ACN member, I have been impressed with the resources, thought and effort which go into developing structured mentoring programs for our early career colleagues. I would say, anecdotally, that most nurses entering a new professional area have access to really excellent guidance and support during the first couple of years. There is an abundance of formal and informal meetings, preceptorship programs, buddy systems and educational opportunities. More senior nurses often promote opportunities for their junior colleagues when it comes to time observing in theatre or participation in other educational experiences. An early career nurse with drive and a curiosity about the profession can find many places to seek support. My question is: what happens after this period is over? Where can mid-career and senior nurses turn for guidance?

It is my observation that the further one proceeds along a certain speciality path, the more entrenched one gets. We spend a lot of time in the early years acquiring specialist knowledge and skills which make us a valuable resource to our team. The result is we carry more supervisory ability and cannot be as easily spared to attend career building sessions, help out on other wards or go and watch a new procedure just because it is ‘interesting’. We enter a certain level of comfort which is a welcome relief after the stress of the novice period. We hone our skills in the areas of our training which are most relevant to what we do, while often abandoning those skills which we once learnt but now never use. After a while, a certain feeling of dread arises if we happen to be thrust onto an unfamiliar ward or confronted with an outlier patient because, after a certain point, it feels a bit shameful to admit that we do not feel confident, lack skills and need the advice of our colleagues.

If everyone was satisfied to pick just one skillset and stay with it forever, then perhaps things would be simpler. The problem is that it is not good for us and it is not good for our patients. We need the challenge and the novelty of the new but we need to lose the idea that mentoring and seeking out a new path are only for the ‘juniors’. Over and over again, I have had private talks with other experienced colleagues who admitted

that they would love to try a totally different speciality, move into research, learn how to speak more confidently in public or receive revision on something which they are 'supposed' to know how to do. However, when encouraged to actually put these plans into action, there are barriers along the way which are different to those which confront entry level nurses.

While it is accepted that a junior nurse can always benefit from learning 'something', however broad, senior nurses who ask to use their study leave to pursue a career building opportunity in an area outside their day-to-day speciality are often told that their selection is irrelevant to the needs of the ward and their request is denied. Unlike a junior nurse who is encouraged to 'always ask', many senior nurses avoid situations where they are confronted with new and unfamiliar tasks because if they admit that they cannot do something they fear annoyance, loss of standing and judgement. As junior nurses rotate round specialties and engage in further study, the range of colleagues encountered remains diverse but the longer we stay in our familiar zone, the less opportunity we have to meet colleagues unconnected with it. There are many benefits to working with an established, close-knit group of colleagues, many of whom we may consider friends but, sometimes, we need the opportunity to talk and learn from a colleague outside our immediate circle in order to gain exposure to new ideas and directions.

This is not to say that it is impossible for senior nurses to find opportunities to engage in mentoring in the wider nursing community, if they are determined to do so. Indeed, over the last ten years, I have been guided and accompanied by many colleagues who took time to listen, discuss and debate professional issues with me, which I find important and interesting. Great things can come out of these informal and spontaneous instances of mentoring but I feel that for many nurses, such opportunities are hard to find. I believe that, as a profession, we could develop more formal mentoring projects, which allow experienced nurses to feel heard and supported in their personal career goals.

Our field is incredibly wide and diverse yet many good nurses find themselves stuck in a rut from time to time and need a change of scene to rediscover their passion. Trying to take a new path when there is more to lose requires a different sort of bravery from that required at the beginning of a professional life. It is no less deserving of support strategies. As we all look to 2018 and reflect on our own career goals and direction, it seems like a perfect time to ask how mentoring can be made a meaningful part of every nurse's professional reality.

AUTHOR

ELIZABETH MATTERS FACN

THINKSTOCK

TOP10

Ways nurses make Christmas merrier

ACN staff and members joining together for Christmas celebrations

1

VISIT THE NORTH POLE

Many nurses working with children over the holidays bring the magic of Santa's village to clinical settings. From setting up Santa's workshop at the nurse's station to donning a pair of reindeer antlers, these dedicated professionals go out of their way to make our littlest patients feel far away from the realities of the world.

2

HOST A CHRISTMAS FEAST

While brandied eggnog and pork crackling may be off the table for some patients, nurses often pull out all the stops to bring the joys of Christmas dinner to those in need. No matter what's on the menu, these amazing men and women put in an extra special effort to emulate a traditional Christmas feast for their patients.

6

DECK THE WARDS

In health care settings across the country, nurses deck the wards with boughs of holly, bringing Christmas cheer to clinical environments. Using decorations to create a festive atmosphere, these devoted nursing professional's embrace the holidays in our hospitals.

7

SPREAD THE SILLY SEASON

While serious about delivering high quality care, some nurses also dispense a dose of fun and silliness to lighten spirits in our hospitals. These passionate nurses have fun with their patients and each other, bringing the silly season to their wards.

Every year, nurses across our country and profession work tirelessly to provide high quality health care to Australians in need throughout the holiday period.

Not only do these dedicated professionals sacrifice precious time with their loved ones, many go above and beyond their position descriptions to bring festive cheer to those in their care.

Here are just 10 ways that nurses make patients feel special during the holiday season…

3

BRING THE COMFORTS OF HOME

During the festive season, many nurse's work hard to bring the comforts of home to patients spending the holidays in hospital. From hanging much-loved Santa's stockings around the ward to upholding a special family tradition, these incredible professionals go above and beyond to make our hospitals feel like home.

4

MAKE IT SNOW

While we can only dream of a white Christmas here in Australia, many dedicated nurses work to transform clinical environments into winter wonderlands during the festive season. Determined to bring the holidays to our hospitals, these nurses use a touch of creativity and imagination to make it snow for our patients.

5

GO CHRISTMAS CAROLLING

While not all of us can hit the high notes with the likes of Michael Bublé or Bing Crosby, many nurses test out their vocal chords in an effort to bring the silly season to their patients. From holding a Christmas concert to carollers visiting the wards, music is a great way to get into the holiday spirit.

8

THROW ON SOME CHRISTMAS THREADS

Nothing feels more festive than dressing up to do your rounds in a tacky Christmas sweater or your classic Santa hat. For many nurses, dressing up is a great way to engage with patients of all ages during the holiday season.

9

HAVE A MOVIE MARATHON

Binge watching all the Christmas movie classics is a great way for patients to escape their current situation and enjoy the holidays. Despite their often-hectic work schedules, many nurses will still take the time to watch a few minutes of *The Grinch* or *Love Actually* with their patients, bringing them comfort and company.

10

GIVE THE GIFT OF TIME

Christmas can be a very lonely time for patients who are far away from home and loved ones. Sometimes, the greatest gift nurses give is quality time with those who need it most during the festive season.

A lifetime of advocacy

A tribute to Lee Thomas MACN

"Lee Thomas has been the Federal Secretary for the Australian Nursing and Midwifery Federation (ANMF) for almost a decade, and has spent around 20 years working for the ANMF. As a formidable leader of our profession, Lee has dedicated her career to fighting for equality for nurses and midwives. We appreciate her advocacy, leadership and friendship over the years and wish her all the best for her future endeavours in her new career in law."

– ACN PRESIDENT PROFESSOR **CHRISTINE DUFFIELD** FACN
AND ACN CEO ADJUNCT PROFESSOR **KYLIE WARD** FACN

Lee Thomas MACN is about to embark on a career change to pursue her love for law, so ACN Publications Lead Sally Coen caught up with her recently to reflect on Lee's successful and lengthy career in the nursing profession.

Why did you decide to pursue a career in nursing and midwifery?

It's a bit of a funny story actually. When I was in Year 9 in high school one of our teachers told us that in the next year, Year 10, we would be required to do work experience. So, she handed us a sheet of paper and asked us to write down our top three work choices.

Now, I actually always wanted to be a hairdresser. But my mother was absolutely dead against it. I never really understood why, until later.

So I thought, "Oh well, I can't put hairdressing down, what am I going to write?"

I ended up writing down nursing and teaching. I don't think I even put down a third option.

When it came to the next year and we got our work experience invitations, I scored a 50-bed nursing home very close to the school. I went there for a week and I really enjoyed it; I just loved it.

We weren't doing too much hands-on stuff but I thought, "You know? I think this could be interesting. Maybe hairdressing's not for me."

Then, in Year 11, the same thing happened. We had to make a choice and I only made one: nursing. I was fortunate enough to get two weeks' work experience at the Children's Hospital in Adelaide and I really enjoyed it. My mind was made up.

In the 70s – early 80s, you had to wait three years after finishing your education before starting your general training. So in that three-year period, I worked at a nursing home full-time as a personal care assistant. This was the same home where I completed my work experience in Year 10.

And I loved it. I really, really enjoyed it. I think I learned a lot about basic care and I was taught these skills by the registered and enrolled nurses that I worked with. And the rest, is history almost. I went and completed my general education at Queen Elizabeth Hospital in Adelaide. I worked my graduate year and after that, completed my midwifery education at the Queen Victoria Hospital in Rose Park in Adelaide. I got my Bachelor of Nursing, and worked in public and private hospitals as a midwife up until 1997.

I had moved into management positions by this stage and in 1997, the union were advertising for a temporary nine-month contract position for an organiser. I had always been an active union member and had been a member basically since I started my training.

So I thought, "Oh that might be interesting." But I didn't think too much more about it.

Until the organiser who was at the hospital where I worked rang me and said, "Why don't you think about applying?"

So I applied for that nine-month position, and here I am 20 years later. The Federal Secretary of the union. I've had an amazing 20 years with the union but I'll go back to the hairdresser story….

My mother was so relieved when I told her that I was going to be a nurse.

When I said to her, "I really don't understand why I can't be a hairdresser?"

She said, "Dear, you would be on your feet all day!"

And I remember I looked at her and thought, "Yeah right, and I'm not going to be doing that? Because as a nurse you run the minute you get on the ward till the minute you finish your shift."

So I said to her, "But I'm going to be on my feet all day in nursing."

And she said to me, "It's different; it's different dear."

So that was the end of my hairdressing story and the start of my career.

What has been a notable learning experience during your career?

I can remember the first time I had to give an injection. In training school I'd only practiced on an orange.

He was a young man, terrified of needles (I wish they'd told me that) and as I put the needle into his bottom, he leapt across the bed. Of course, the needle came out.

It was very hard work – but it was good work. It still is good work. We were busy and while I'm very certain that this wasn't the best way to learn, it was all we had back then. Now we've moved onto a much better theory-into-practice, evidence-based education.

What are some of the highlights of your career and what is your proudest achievement?

Certainly my first election as the Bryant Secretary. It was a contested election, and I was pretty proud that I won. Then, when I came to the national office of the Assistant Federal Secretary and then the Federal Secretary; I was very proud, very humbled, very privileged to be in these positions working with our members, every day, to make sure that their lives were better and to make sure that they can deliver the best they possibly can in terms of care and outcomes for the people that they look after.

What has driven you to dedicate your life to fighting for the rights of and equality for, nurses and midwives?

Probably because I was a nurse and a midwife, and we had to fight for everything we got.

I also think I've got a healthy dose of social justice. I'm definitely on the side of the underdog. I think fighting for our conditions and fighting for the community is just so important. It's something that I've probably learnt from my parents to be honest. But I've just taken that to a whole new level.

Do you think nurses and midwives are still underdogs?

I think we've changed it but I do think because it's a 92% female-dominated profession, we still have an issue in terms of pay. I do think the issue around female equality is something that nurses suffer from but our union on behalf of nurses and midwives has made enormous gains over the years, there's no doubt about it.

What have you found most rewarding about being the Federal Secretary of the Australian Nursing and Midwifery Federation?

For me, my passion is about working with our members and advocating for them at the highest level.

What advice do you have for nurses and midwives aspiring to leadership roles?

I'm not sure that people aspire to leadership. I think, as women, sometimes we're identified as leaders. It's almost, serendipitous. I think my start with the union was serendipitous.

Having said that, I think that we should aspire to leadership roles. I think too few women aspire to leadership. It is not an easy road – there is no doubt about it. I have been offered opportunities over my lifetime that are invaluable but sometimes, you have to go out and make those opportunities for yourself. If you want to be a leader and you've got the qualities to be a leader, then you should look for those opportunities, and make those opportunities if you have to.

You should go for it. But don't think that it's going to be an easy ride, because it's not. It is, however, very rewarding and extremely fulfilling. It is vitally important that women continue to step up into leadership positions.

What's driven you to pursue law?

Again, I think in some respects, it was serendipitous. I moved to Canberra to take up the national role and felt the time was right for more study. I'd obviously already been advocating for nurses, for patients and for people. Through the union, we had helped people in terms of their disciplinary proceedings or advocated for them in terms of their employers when they were in a bit of strife.

So law seemed like a natural progression. Although I'm very clear that I never thought that I would practice law.

It's really just been over the last couple of years, that I've thought, "Actually? I do want to give this a go."

I've been with the union for 20 years and I'm really clear that, like all things, union leadership needs to be refreshed. I've got great people around me and it's my time. It's the right time for me to move on.

I will have finished my degree in a few weeks. I start my Graduate Diploma of Legal Practice in December this year and I hope to be admitted as a legal practitioner by April next year.

Is there a particular type of law that you are interested in?

My passion is criminal defense, but like all graduates and at my age (I'm no spring chicken), while I'm going to try to get a job in that area, frankly, I'm going to take a job in law wherever I can. For the first two years you have to work under the supervision of an unrestricted legal practitioner, so you've got a period of internship almost where you're restricted in practice.

My passion lies in criminal defense and to that end, I have done a little bit of work in that area. Most recently, on a Saturday morning in the bail courts in the ACT. This has been a learning experience and fabulous opportunity. You see some very sad things and people that really need your help. People who have been on the wrong wide of the law, ended up in the cells overnight and are looking for bail on a Saturday morning. So that's been an invaluable experience.

So it sounds like some of the things that first drew you to nursing is also what drew you to law?

I think definitely the advocacy. This will be my third career in my professional life and it's a very, very, strong theme throughout all three industries. It's always been a part of my DNA. That's what I want to do and I'm apparently, reasonably good at it.

Apparently.

No butts about it

Tobacco use is a leading cause of disease and death globally, a fact many HESTA members confront daily in caring for our community. This is one of the reasons we're proud to have excluded companies that produce cigarettes and tobacco products from our own investment portfolios since 2013.

And now we're urging other investors to follow suit — for the health of our community and of your super — by signing a world-first Investor Statement on Tobacco.

"Many of our members work in hospitals and health settings across Australia, where tobacco-related illness clearly increases pressure on service availability and to the health system overall," HESTA CEO Debby Blakey points out.

"As the national fund dedicated to health and community services, it's vitally important that we raise awareness of this issue.

"We're committed to responsibly investing our members' super savings by being a careful long-term steward of their investments."

"By excluding tobacco and signing the investor statement we aim to make a positive impact on the world our members will retire into."

Released to mark 2017 World No Tobacco Day, the statement was supported by the United Nations-backed organisation Principles for Responsible Investment — a global leader in their field.

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Nursing history

150th anniversary of a milestone in Australian nursing

2018 promises to be another year full of anniversaries to commemorate. Not least of all will be the centenary of the cessation of WWI hostilities. But the year also brings a nursing anniversary – the arrival of the first Nightingale nurses in the colony of NSW.

Nurses who enlisted in the Australian Army Nursing Service (AANS) in WWI, had to be a trained nurse and have passed the exam of the Australian Trained Nurses Association (ATNA) or the VTNA (Rae, 2015). These pre-requisite developments reflected a flourishing and organised profession, which had grown and spread across the country. It had built on the Nightingale model of nursing, which was introduced over 40 years earlier.

Prior to the arrival of the Nightingale nurses, there was no organised system for general nurse training in the colony and standards of care were inadequate (Russell, 1990). The only trained nurses in Sydney were a small group of Sisters of Charity, but they were limited in their capacity and by religious and political influences (Nelson, 2001). Consequently, in response to reports on conditions and community dissatisfaction, the Colonial Secretary, Henry Parkes, contacted Florence Nightingale requesting trained nurses for the Sydney Infirmary and Dispensary (Russell, 1990). The plan was to improve the care at the Infirmary and establish a training school based on the Nightingale model.

The Nightingale Training School at St Thomas' Hospital in London had been in existence for six years. In response, Miss Nightingale agreed, and Miss Lucy Osburn was selected as the Lady Superintendent to lead a group of five head nurses chosen from the first class register of the school – Mary Barker, Eliza Blundell, Annie Miller, Haldane Turriff, and Bessie Chant (MacDonnell, 1970).

These first Nightingale nurses set foot on Australian soil on 5 March 1868. Their imminent arrival and importance was noted in the *Sydney Morning Herald* (1868) three days earlier:

…through the kindness of the Hon Colonial Secretary, and the liberality of the Government, … a Lady Superintendent and five trained nurses …may be expected to arrive in Sydney in a few days. … Each member has been selected and trained by the matron of the Nightingale Training Institution in accordance with instructions written by Miss Nightingale, who has spared no trouble to make herself acquainted with details and requirements of the Sydney Infirmary, as a hospital and training establishment (March 2, p. 3).

Lucy Osburn held the position of Lady Superintendent until her resignation in November 1884. The story of her difficulties and controversies during this time has been well documented including – opposition, politics, fractious relationships, nurses' love affairs, a building that was unsatisfactory, and a Royal Commission (Godden, 2006; Nelson, 2001; Brodsky, 1968). While not all went smoothly, approximately 153 nurses were trained under Lucy Osburn's supervision and helped, "the new occupation in Australia of secular, hospital-trained nurses," (Godden, 2008, p. 30) spread with the diaspora of graduates. Some of the nurses who accompanied Lucy Osburn also made their mark. For example, Haldane Tariff became the first matron of the Alfred Hospital in Melbourne in 1871.

Five months after her resignation, Lucy Osburn sailed back to England. Never returning to Australia, although this was intended (Godden, 2006), she died on 22 December 1891. The cause of her death was diabetes.

5 March 1868 – the landfall of Lucy Osburn and her band of Nightingale Sisters.

A day to remember (Bodsky,1968, p.13).

While the profession has advanced, on 5 March 2018, the 150th anniversary of the arrival of Lucy Osburn, a special stamp and envelope will be issued by Australia Post to commemorate the contribution of this history and modern nursing in Australia.

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AUTHOR

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Handing down traditions

Acculturation in nursing

> **“The culture of nursing ought to be centred upon compassion.”**

INTRODUCTION

The topic I am writing about is ephemeral and difficult to name. It is *something* that happens albeit unconsciously to all of us who enter the nursing profession. It is *something* that those on the inside recognise, feel and appreciate but which is not so easily recognised, appreciated or understood by those on the outside. It is *something* we have imbibed, *something* that is instilled into us – tradition! The Jewish people know it well. Remember *Fiddler on the Roof* and the song of Tevye the milkman, *Tradition*? The word is derived from the Latin, traditio, meaning to hand on or to hand over. The persistence of a tradition is said to arise out of attachment to things past, to past societies, to past beliefs and perceptions or to persons who lived in the past (Edward, 1971).

ACCULTURATION

The process by which tradition is “handed down” is called *acculturation* or socialisation, in other words, the acquiring of values, norms, ways of behaving and embodying the symbols of a group (Styles, 1982). The term thus has a more subtle meaning than indoctrination, which can simply mean, “teaching” but today carries the more sinister meanings of brainwashing, propagandising or proselytising.

Acculturation has to do with, “collective memory”. French Sociologist, Maurice Halbwachs, first coined this term in the 1920s. He suggested that, “a collective memory…is understood to express some eternal truth about a group,” (Halbwachs, 2010). According to Halbwachs, collective memories originate within a social framework, so that what we remember often depends on the social context and group with whom we identify and relate. Individual memories, reconstructed according to the relationship an individual has with a social or work group, are sustained and survive in this fashion (Hutton, 1993). At times, it is a risky activity to question collective memories. It is precarious because so much of a person’s identity can be immersed in such memories, for example, the memories of Holocaust victims or the graduates of any hospital or university.

Acculturation is wrapped up with identity: who I am as a nurse, finding my place (and accepting it or not) in the hierarchy of the nursing world. Our memories ought to prompt historical inquiry, that is an inquiry into the historical past as it was experienced not just as it is remembered. Memories of nursing experiences while vivid are also associated with and arise from the cultural context in which they are acquired. Such experiences can also involve a forgetting. We repress, very often, those memories, which recall unpleasant or embarrassing experiences in favour of recollecting and reconstructing the humorous, poignant or flattering encounter. Memories, we all know, can be either positive or negative.

Acculturation also has to do with culture. Every culture has its beliefs and rituals, and the culture of nursing is no different. In the context of nursing, acculturation has to do with the culture of nursing, of health care, and to some extent with the culture of the medical world. In the health care environment, the culture of binaries – health/wellness; illness/suffering and living/dying come to the forefront.

More importantly, the culture of nursing ought to be centred upon compassion, the ability to care in any health care environment or organisation. *A culture of care* barometer developed in England in 2015 measured the culture of care in the National Health Service (Rafferty et al., 2015). The development of this instrument stemmed not only from failures of compassion in health care settings but also from the realisation that a culture of care had the potential power to shape the experiences of both the patient, nursing staff and health organisation resulting in positive outcomes for all three entities. A study of the methodology and testing of this instrument is documented in the British Medical Journal (Rafferty et al., 2017). To date, the

barometer remains a tool as there is no further evaluative data available concerning its implementation (Rafferty, 2017).

Acculturation is certainly a process that happened to all young women and men who entered nursing in the period of hospital based training schools. Take for example the female nurses' uniform, universally recognised throughout the 19th to the early 20th Centuries. Most nurses who donned their uniform each working day were proud to wear it; acknowledging the recognition and status it brought. Today, this historical nurses' uniform is often disparaged as representing domestic service, as regimental, restraining and a convention that did away with individualism. The uniform of the nurse in training certainly promoted uniformity with the starched collar, cuffs and white apron. As well, associated with the uniform were many rituals. The ritual of rolling the sleeves down while doing rounds with a doctor or matron, or when serving meals to patients was accepted practice in one hospital. The nurses' cap with differential markings pointed to and symbolised the nurses' status, from probationer to 4th year senior nurse. Above all, the ambition of every nurse in training was to aspire to the sisters' veil, which signified power and authority. Yet how many trained nurses hid behind the authority of the veil and were left with a sense of disempowerment when it was discarded?

SO WHAT? IT'S ALL PAST HISTORY AND HAS NOTHING TO DO WITH THE PRESENT

North American nurse, Margretta Styles wrote some sound advice way back in 1982: if nursing was to change it was necessary for nurses to change, "We must change the way we think, the way we feel, and the way we act," (Styles, n/d). Nursing has examined its past and exposed many of its myths and rituals. We might, nay should, critique the changes that have happened in nursing. However, what if the past inhabits the present? What if the past is encapsulated within the present and is alive and active, albeit in different forms and disguises? There is a need to discern the positives to be sustained and the negatives to be discarded. Wisdom comes in knowing the difference.

I am aware that history helps define and validate us. It helps us understand who we are as an individual and as a profession. History can help us make wise judgements: by assessing, researching, questioning and analysing our past, we can acquire some valuable lessons about how to proceed, or not, and gain some insight into where our actions might take us.

In conclusion, I want to leave you with some questions to ponder. How are young women and men who enter the nursing profession acculturated/socialised today? What traditions (if any) have been/are being passed down? What (if anything) has been lost or gained in postmodern nursing culture? How can we reflect positively on the nursing culture of today?

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LESLEY POTTER PHD MACN

Our tribe

Career Coaching

At ACN, we are committed to supporting the next generation of nurse leaders to reach their full potential and create a bright future for our profession. That's why we introduced our career coaching initiative, allowing *Undergraduate* members to receive advice and guidance from knowledgeable and experienced Fellows and Members.

ACN Career Coaching is flexible and intuitive, recognising that each nurse's experience is unique. The initiative not only offers valuable support for nurses starting their careers but also provides a rewarding and insightful experience for our coaches.

We asked some of our passionate *Undergraduate* members and Career Coaches to share their experiences...

WHAT DID YOU GET OUT OF THE CAREER COACHING EXPERIENCE?

"Being in contact with a Career Coach gave me valuable advice for my nursing graduate application, selection criteria and interview. It was great to get realistic information from another nurse, who has gone through a similar process."
– Noelene Groenewold MACN (Undergraduate)

"I have been matched with the most amazing mentor, we have a great connection and I can always ask her questions and get a rational level-headed answer."
– Sarah Moon MACN Emerging Nurse Leader

"This experience offered me a fresh perspective. Someone who listened to my goals and provided me with realistic expectations was a great experience. It made me more comfortable and confident about my future."
– Katie Rae MACN (Undergraduate)

"I was so grateful to have someone to write to when I was feeling lost in my studies, someone who could refocus my mind and get me back on track. It was a really uplifting experience and I'd recommend it to anyone looking for more guidance on how to make the most out of their career in nursing."
– Madeline Hawke MACN (Undergraduate)

"This experience enabled me to see different directions and opportunities I could take, after hearing stories about my coach's nursing experiences. She was also able to help me with developing an article, answer questions about nursing overseas, and give tips about how to choose hospitals to apply for in the new graduate program."
– Judith Lee MACN (Undergraduate) Emerging Nurse Leader

If you are interested in finding out more about ACN Career Coaching or becoming involved head to our website www.acn.edu.au/career-coaching

WHAT HAS BEEN A HIGHLIGHT OF THE EXPERIENCE FOR YOU AS A CAREER COACH?

"The highlight for me was listening to an Emerging Nurse Leader's (ENL) stories about study, work, family and life in general, and how commencing work as a graduate would impact on their life. I found it challenging and rewarding to work with this ENL to discover what it means to them to be a nurse and what attributes, life experience and skills they have that will help them stand out from the crowd."
– Courtney Hayes MACN

"One of the highlights for me has been connecting with someone new to the profession who has a passion and boundless energy for nursing, helping them harness that to develop and achieve their career goals."
– Musette Healey MACN

"Undoubtedly the highlight has been to connect with someone who was keen to engage with the career coaching process and spend time with them discussing issues relevant to their journey into the nursing profession. This was topped off by being able to meet with my coachee in person at the recent National Nursing Forum in Sydney and catch up with their career decisions and subsequent progress."
– Dianna Burr MACN

"Meeting an incredibly humble, motivated and clever young person whose contribution will 'value add' to the world of nursing."
– Tomica Gnjec MACN

"It gave me an opportunity to reflect on the diversity of people working as nurses and that despite all the differences, we still share the same values of care, compassion and professionalism."
– Mark BrayBrook MACN

SHARE YOUR STORY WITH US

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

Thank you to all of our authors!

LAURIE BICKHOFF MACN

Obesity and judgement-free care making you unhealthy?

ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

The role of the nurse leader in obesity and diabetes

SUZANNE CARROLL MACN

Are your neighbours making you unhealthy?

PAULA HESSION MACN

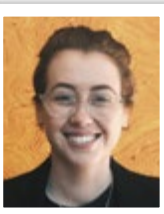
Diabesity

LEIGH SPOKES FACN

The art of listening

EVELYN BOYCE MACN

My role as a diabetes educator



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First Australians

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LESLEY POTTER MACN

Handing down traditions

MARILYN GENDEK FACN

The evolution of credentialled diabetes educators in Australian society, and 150th anniversary of a milestone in Australian nursing

Australian College of Nursing

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together we're unstoppable!

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