thehive

#9 AUTUMN 2015 | GLOBAL NURSING

ACN

GLOBAL NURSING LEADERSHIP
now more than ever

DALLIANCES FROM DUBAI
cultural differences and nursing

EXPERIENCING THAILAND
perspectives from an international clinical placement

Clinical Care Standards

Clinician Fact Sheet:

Acute Coronary Syndromes

The goal of the Acute Coronary Syndromes Clinical Care Standard is to improve the early, accurate diagnosis and management of an acute coronary syndrome to maximise a patient's chances of recovery, and reduce their risk of a future cardiac event.

Clinicians and health services can use this Clinical Care Standard to support the delivery of high quality care.

UNDER THIS CLINICAL CARE STANDARD

A patient presenting with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives care guided by a documented chest pain assessment pathway.

A patient with acute chest pain or other symptoms suggestive of an acute coronary syndrome receives a 12-lead electrocardiogram (ECG) and the results are analysed by a clinician experienced in interpreting an ECG within 10 minutes of the first emergency clinical contact.

A patient with an acute ST-segment-elevation myocardial infarction (STEMI), for whom emergency reperfusion is clinically appropriate, is offered timely percutaneous coronary intervention (PCI) or fibrinolysis in accordance with the time frames recommended in the current National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand *Guidelines for the Management of Acute Coronary Syndromes*.

In general, primary PCI is recommended if the time from first medical contact to balloon inflation is anticipated to be less than 90 minutes, otherwise the patient is offered fibrinolysis.

A patient with a non-ST-segment-elevation acute coronary syndrome (NSTEACS) is managed based on a documented, evidence-based assessment of their risk of an adverse event.

The role of coronary angiography, with a view to timely and appropriate coronary revascularisation, is discussed with a patient with a non-ST-segment-elevation acute coronary syndrome (NSTEACS) who is assessed to be at intermediate or high risk of an adverse cardiac event.

Before a patient with an acute coronary syndrome leaves the hospital, they are involved in the development of an individualised care plan. This plan identifies the lifestyle modifications and medicines needed to manage their risk factors, addresses their psychosocial needs and includes a referral to an appropriate cardiac rehabilitation or another secondary prevention program. This plan is provided to the patient and their general practitioner or ongoing clinical provider within 48 hours of discharge.

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

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WELCOME

Adjunct Professor Debra Thoms FACN (DLF)

> *“ In this edition we are focussing on global nursing and its relevance to the Australian health care system. ”*

Welcome to the first edition of *The Hive* for 2015. In this edition we are focussing on global nursing and its relevance to the Australian health care system. Whilst it’s important to focus on our local communities, as nursing leaders, it is important to look to the wider international community for inspiration, motivation and ideas.

We feature a range of impressive stories related to the theme. Suzanne Volejnikova-Wenger has written about her experiences, *How one vocation has led me around the world,* as a nursing student and young nurse in Switzerland, her work-life within the Czech health system and her views as a mature aged nursing student in Australia. In *Dalliances in Dubai,* Jane Griffiths reflects on working in the United Arab Emirates and how the cultural nuances impact on her own individual practice and those she leads. Caroline Browne, Peter Wall and Tracey Jordan offer insightful reflection in their article, *Experiencing Thailand: perspectives from an international clinical placement.*

Santi Gurung, Elisabeth Coyne and Hazel Rands detail the experiences of I-Kiribati graduate nurses working in aged care facilities in Australia in *International I-Kiribati graduates’ transition into residential aged care,* while German nursing student, Patrick Lemli, offers some interesting insight into the nursing care delivered in Germany in his article, *Why international internships are valuable: a student’s perspective.* These articles demonstrate the significance of contemplating the nursing community on a global scale and recognising the benefit of international experiences.

Keeping with the global theme, we feature a ‘Q & A’ with the President of the International Council of Nurses (ICN) Judith Shamian; a Canadian nurse leader committed to equity and developing nurse leaders globally. We also feature an article from ICN CEO David Benton, *Global nursing: ensuring the voice of Australia’s nurses is heard worldwide.*

This edition offers our regular features including ‘ACN news and views’, articles from our ‘Communities of Interest’ and reflections from our ‘Regular columnists’ on what global nursing means to them. We also introduce a new regular feature – ‘Policy matters’. This feature will update members on recent Australian College of Nursing (ACN) policy activities and highlight relevant developments in the policy domain.

I hope you enjoy the read.

PUBLICATION GUIDELINES

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

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

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

Winter 2015 - Supporting our nurse leaders

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

OUT AND ABOUT

ACU graduation ceremony, Parliament House

Debra with ACN Emerging Nurse Leader and ACU graduate, Theresa Snijders MACN, at the ACU graduation ceremony

Another few months have flown by since the last issue of *The Hive.* This first part of 2015 has seen the commencement of the Leadership@ACN professional development workshops – workshops which provide nurses with the opportunity to enhance their leadership capabilities, in-line with ACN's strategic intent. Feedback on these has been very positive.

The planning for the National Nursing Forum is well underway with keynote speakers finalised. This will be a major opportunity for nurse leaders, in both service areas and academic settings, to come together to share and network as well as hopefully learn and be challenged.

In February, Kathleen McLaughlin FACN (ACN Executive Manager Member Relations) and I attended a roundtable on the *Reform of Federation* hosted by the Department of the Prime Minister and Cabinet. Not surprisingly, the focus of this particular roundtable was health. While no firm directions were identified from the day there was active debate and discussion on a range of areas.

In March, I attended the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) parliamentary breakfast at Parliament House. This was an excellent opportunity to showcase the work that CATSINaM is undertaking but also to demonstrate the widespread support of nursing and midwifery organisations for CATSINaM. During the same week there was the parliamentary breakfast for the *Recognition Campaign,* led by the Lowitja Institute - ACN is a founding member of this campaign. More information can be found at www.lowitja.org.au.

This last period has included several speaking engagements – I spoke at the Nephrology Nurse Educators Conference in Sydney on the theme of leadership; I provided an overview of ACN activities, covering ACN's purpose and strategies, at the Australian Nurses Recruitment Association meeting and also to the Australian and New Zealand Council of Chief Nursing and Midwifery Officers meeting; and, at the end of March, presented the Occasional Address at a graduation ceremony for the Australian Catholic University (ACU) Canberra, which was held in the Great Hall at Parliament House.

Internally there has been a lot of work undertaken, particularly in relation to the identification of potential locations for the Sydney office following the sale of the Burwood building; the final decision being to relocate to 9 Wentworth Street, Parramatta in June/July of this year. Planning for the relocation is proceeding at pace.

Staff in publications and communications have been heavily involved in the preparation of Dr Ruth Rae's FACN books - *The History of Australian Nurses in the First World War: An ACN Centenary Commemorative Trilogy* (the *Trilogy*). The *Trilogy* will be the key way in which ACN will mark the centenary of Gallipoli and the First World War. Dr Rae has written several books on nurses in war as well as the recently released biography of MP Tony Windsor. The *Trilogy* will be available for purchase through ACN by June of this year. You can indicate your interest in the *Trilogy* by emailing publications@acn.edu.au.

> *"This first part of 2015 has seen the commencement of the Leadership@ACN professional development workshops."*

ACU graduation ceremony photos courtesy of Susan Love, ACU

Q & A WITH JUDITH SHAMIAN

PRESIDENT, INTERNATIONAL COUNCIL OF NURSES

"Q"

Debra Thoms FACN (DLF)

Judith Shamian

"A"

Following on from this edition's theme of 'global nursing', ACN is proud to showcase a Canadian nurse leader - Judith Shamian. Judith is the President of ICN. She was elected to the position at the 2013 ICN Quadrennial Congress in Melbourne, Australia. The term of the Presidency is 2013-2017. In Judith's own words, "I am a global citizen, a champion of equity and a nurse who leads."

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

Judith: I have had multiple opportunities inside and outside of nursing locally, nationally and internationally. I have reflected on each experience and learned which helped me go to the next stage of leadership.

Debra: What led to your interest in nursing on a broader international scale rather than just within your home country of Canada?

Judith: I am truly a global citizen, born in one country, grew up in another and lived in Canada for 40 years, so my outlook was already a global one. My Masters in Public Health with International Focus took me down the international path. It is clear to me that, no matter where we live in the world, nurses share many common issues and concerns. We all live in a truly globalised world. Opportunities to meet nurses from other countries and share these concerns can bring us so much knowledge and insight.

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

Judith: I make sure that I have blocks of time with all my children and grandchildren and am purposeful about my relationships with the family, the same way I am purposeful about my professional commitment.

Debra: What have been your career highlights?

Judith: I have held some amazing positions as the first Executive Director of Nursing Policy at the Federal Government in Canada; being a VP (Vice President) of Nursing in a teaching hospital and having the privilege to build a superior nursing department which has been recently designated as the first Magnet* Hospital in Canada. I have been President of the Canadian Nurses Association and now the 27th ICN President.

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

Judith: In my opinion, one of the key challenges is the lack of involvement in the policy arena. Nursing is often not considered to be central to global agendas. It is essential that nurses are involved in the discussion surrounding the post-2015 agenda. That is why ICN advocates for nurses to be included on country delegations to the World Health Assembly (WHA) and why we have three leadership programmes to prepare nurses for high level policy roles.

Debra: Has mentorship played a role in your success?

Judith: Yes, I had great mentors whom I still consult often and they have become dear friends. As Lou Tice said, "Great coaches and mentors are so unshakably convinced that we have great things in us — their vision of what is possible for us is so clear and powerful — that they wind up convincing us too."

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

Judith: By paying attention to their values, commitment, intellect and track record of accomplishments and impact. Once you have identified a top performer you can help them to grow and develop by giving them challenges, helping them to push themselves further than they believed they could and letting them know that if they don't try they won't succeed.

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

Judith: In the various roles I have held over the years as a nurse manager and nurse leader, I learned that firstly you have to have a passion for what you do. But you also have to understand the organisation you work for from the bottom up and sideways; and you have to have very strong financial, analytical and executive management skills along with an understanding of health care and health care systems. My advice would be: make sure that your focus is health and - in that context - the nursing contribution; work hard; use science; and make sure you build relationships within and outside of nursing. Your credibility and reputation need to be guarded.

Debra: Do you have a leader that you admire?

Judith: I admire women in leadership as the gender issue is still alive and well. There are many examples I could give of amazing women in leadership today: Dr Margaret Chan, Director General of the World Health Organization (WHO); Dr Sheila Tlou, a nurse, who is Director of the UNAIDS Regional Support Team for East and Southern Africa; or Phumzile Mlambo-Ngcuka, Executive Director of UN Women, who is a long-term advocate for the empowerment of women.

Debra: Why do you think the concept of 'global nursing' is important?

Judith: The regional and national agendas are shaped by global agendas; as such nursing also needs to be global to have an impact. Let us take non-communicable diseases (NCDs) as an example. Globally, NCDs kill 38 million people a year; here in Australia, they account for 91% of total deaths. More than 190 countries have agreed to work together to address the causes of NCDs through a *Global Action Plan for the Prevention and Control of NCDs 2013-2020*. This year, countries will begin to set national targets and measure progress to attain nine voluntary global targets. The contribution of nursing is obviously critical to achieving these goals.

Debra: Do you have a favourite leadership quote?

Judith: "True leaders understand that leadership is not about them but about those they serve. It is not about exalting themselves but about lifting others up."

- Sheri L. Dew, American author and publisher

*The Magnet Recognition Program recognises health care organisations for quality patient care, nursing excellence and innovations in professional nursing practice. Consumers rely on Magnet designation as the ultimate credential for high quality nursing. This program is developed by the American Nurses Credentialing Center.

MEMBER UPDATE

AUSTRALIA DAY HONOURS

Order of Australia
Dr Diane Brown AO MACN

ACN would like to congratulate Dr Brown on her recent award of Officer of the Order Australia in the Australia Day Honours, 2015. Dr Brown's award was for distinguished service to nursing through the delivery of quality care, professional development and nursing education, and to the international advancement of the profession throughout Asia and the South Pacific. The award is a fitting acknowledgment of her contribution to the nursing profession.

Dr Brown was a clinician for more than 25 years before moving into academia, where her last post was Professor of Clinical Nursing at Charles Darwin University. Since her 'retirement ' she has worked in remote areas of Australia as well as in international development with the World Health Organization, the World Bank and AusAID. Dr Brown has been a member of ACN, and one of its founding organisation, The College of Nursing, for over 30 years. ACN is proud to have members of such standing.

"I have loved the opportunities being a nurse has given me. I've found that my willingness to give things a go has led me on a path I never would have dreamed possible, when I first started nursing."

– Dr Diane Brown

INTERNATIONAL NURSES DAY

REGISTER YOUR ACN NATIONAL NURSES BREAKFAST TODAY!

On 12 May 2015, ACN will once again be hosting the ACN National Nurses Breakfast, in celebration of International Nurses Day (IND).

The theme for IND 2015, *Nurses: A Force for Change: Care Effective, Cost Effective,* reflects on the importance of strengthening and improving health care systems around the world. The theme acknowledges the contribution that nurses can make to this cause and recognises that global health cannot be achieved without nurses and their contribution and participation in all levels of the health care system.

The ACN National Nurses Breakfast encourages members of the community to celebrate the invaluable contribution nurses make to the health of our society, by hosting a breakfast at their workplace, school or community centre. This nationwide event has been hosted since 2011 and sees over 4,000 nurses and their supporters come together at approximately 100 breakfasts around Australia.

Help us build on the continued success of the ACN National Nurses Breakfast by registering as a 2015 breakfast host today. We will send you a registration pack full of goodies to help you decorate and theme your venue, as well as some valuable information about IND and the important work nurses do.

Register your breakfast at: www.acn.edu.au/national_nurses_breakfast.

#ACNBreakfast

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HESTA Australian Nursing Awards

A LOOK BACK AT THE 2014 ACN NATIONAL NURSES BREAKFAST: AVONDALE COLLEGE OF HIGHER EDUCATION

In 2014, Avondale College of Higher Education celebrated IND by hosting its own ACN National Nurses Breakfast. During the event nursing students wrote messages of encouragement to registered nurses and students at Pacific Adventist University in Port Moresby, Papua New Guinea and Atoifi Adventist Hospital on Malaita in the Solomon Islands. The messages were hand delivered by a team of Avondale students on a clinical service-learning placement.

ICN UPDATE

GLOBAL NURSING: ENSURING THE VOICE OF AUSTRALIA'S NURSES IS HEARD WORLDWIDE

By David C. Benton

In early 2014, three West African countries began reporting a mass outbreak of the Ebola virus disease. By June, the death toll was huge, making this the worst Ebola epidemic ever recorded. When the first cases outside Africa began to occur, the world woke up to the realisation that health problems which emerge in one country can quickly spread around the world, and that solutions must be found on a global basis.

While there were no cases in Australia, no country is living in isolation and viruses such as Ebola, swine flu and avian flu do not respect country borders. In 2009, for example, swine flu killed over 12,000 people globally, including 1,600 in Australia. There is no denying that we are all global citizens and global nurses – and this idea is central to our global health efforts.

ICN is the first and widest reaching international organisation for health professionals. We provide a world stage for nursing and health priorities, ensuring that our members – including ACN - have a seat at the highest decision-making tables. ICN advances nursing, nurses and health through its policies, partnerships, advocacy, leadership development, networks, congresses, special projects and by its work in the arenas of professional practice, regulation and socio-economic welfare.

At the top of the global health agenda are topics such as universal health coverage, NCDs, health care financing and beyond. ICN enables nurses to be part of defining and shaping this health agenda. As an ICN member, ACN takes part in various international strategic meetings and working groups. ICN brings together nursing associations from all over the globe to discuss issues of concern to everyone – from working conditions, workplace violence and pensions to education, regulation of the profession and current concerns to professional practice such as NCDs, disaster preparedness, infectious diseases and so on.

As individual nurses, you also have the opportunity to make an impact on global health, working from the grassroots up: whether it be by providing innovative solutions to health challenges in families and communities, improving access to health care, or sharing your invaluable knowledge with your colleagues and your government. Let me give you one example where two nurses in Spain tackled the problem of obesity in their community. They recognised there was a need to help people read food labels in order to make their meals better and healthier. The nurses led special support groups to explain what is written on labels and to reinforce the importance of physical activity. This innovation meant patients were better able to follow their diets and improve their quality of life. You can find more of these innovations on CareChallenge.com, an online recognition programme that invites nurses to submit their innovative patient care ideas and projects.

Global nursing is particularly important in such a multicultural country as Australia, when you are caring for patients from other cultures, ethnicities or religions or for whom English is not their mother-tongue. It is also important when you are working with foreign nurses. Here in Australia, as in many other countries, there is, on the one hand, a shortage of nurses and, on the other hand, thousands of newly qualified nurses hard pushed to find jobs. Many put the blame on the influx of foreign nurses. The truth is that fewer and fewer Australian nurses are willing to work under present conditions: high workloads, lack of economic remuneration and lack of recognition. Any solution to nursing shortages and any workforce planning strategies must therefore address the key reasons why nurses migrate and consider the work environment.

This is a key example of where nurses need to make an impact on policy. As a member of ICN, Australian nurses have a voice at the global level. We successfully advocate for the inclusion of nurses in national delegations to the WHA, the decision-making body of the WHO. We provide briefings and information material to our members who are part of their country delegations or the ICN delegation to the Assembly, and we make regular interventions at the WHA. Our work with the specialised agencies of the United Nations system, particularly with the WHO and the International Labour Organization, are important for nurses everywhere. And your work, locally, nationally and globally is important as well.

As a key part of the global nursing community, each of you can lend your voice to the global stage and make an impact on global health care. ICN offers the opportunity for you, as Australian nurses, to enhance your knowledge, skills and attitudes of global citizens and develop a sense of social responsibility that will enable us to be well positioned to advance health locally and globally in our roles as nursing professionals. So the next time a disease like Ebola raises its head, nurses and the global community will be ready, with the structure, the infrastructure, the human resources, financial resources, teams and approach to avoid the loss of lives and unnecessary suffering.

Author details

David Benton is the Chief Executive Officer of ICN.

GLOBAL NURSING

ACADEMIC

Dr Melissa Bloomer FACN

Time for change in health service delivery

Despite improvements in health care and the increasing use of technology worldwide, chronic illnesses such as ischaemic heart disease, stroke, chronic obstructive pulmonary disease, diabetes and hypertension account for five of the top 10 leading causes of death in the world (WHO 2014). Also, in almost every country, the proportion of people aged over 60 years is growing faster than any other age group because of longer life expectancy (WHO 2015). As a result, the issues of chronic illness and the ageing population are becoming major public health challenges.

As people live longer, the likelihood that they are living with multi-morbid chronic illness is greater, and current health service delivery is not necessarily equipped to deal with these changes, particularly where the bulk of the health dollar is spent on acute care or hospital based services. In Australia the evidence shows that the bulk of health expenditure, which in the 2013/14 financial year equated to $55.9 billion, went on 'hospitals' which includes both private and public sectors (Australian Institute of Health and Welfare 2014). Primary health care received less funding.

The impact of this is significant if you consider the acute health system in Australia could be considered reactionary, in that it is utilised for restorative care. Primary health care, on the other hand, can provide proactive care aimed at disease prevention. If a higher priority was placed on primary health care, it is possible to reduce the health burden.

This is not a problem only in Australia. The WHO describe the current responses of the health sector to the changing world have been inadequate and naive, with health care massively under-resourced and in desperate need of structural changes to meet the changing needs of the population (WHO 2008). If we truly are aiming for health for all, then it is time for significant change.

References on page 11

CLINICIAN

Ms Tomica Gnjec MACN

Internationally qualified nurses and midwives – enriching our practice

Today I am in a clinical position whereby I am most blessed to work with an amazing group of internationally qualified nurses and midwives (IQNMs) from all corners of the globe. I believe these individuals have enriched our work environment, with welcoming layers of multiculturalism through the sharing of their wide and varied skills, and their special cultural backgrounds and values.

As the very proud child of migrants, I grew up with the lived experiences of both my parents - the many trials and tribulations of adapting and settling into a new country. I have often pondered whether similar challenges exist today for our IQNMs colleagues, in their process of transition. Recently, one of those colleagues graciously shared with me some of her personal experiences.

My colleague spoke of emotional, cultural and 'system shock' adjustments. She shared emotions surrounding leaving family and friends, the accompanying loneliness and the time it takes for new support systems to fall into place. Adaptation, too, was shared to very diverse cultural norms and our different health system. She also mentioned a sense of having to 'prove oneself' in the endeavour to progress within the workplace structure.

The transition and challenges in settling into a new country remain, in many ways, as they did for my parents. The discussion with my colleague highlighted the bravery, determination and resilience of our IQNMs and the need to recognise the significant impact that migration has on personal life, including social and emotional stresses (Wellard & Stockhausen 2010). As clinicians, we are in an ideal position to highlight and extend support within the clinical environment, by validating our IQNMs in their transition endeavours within our workplaces.

Reference

Wellard, S.J. & Stockhausen, L.J. 2010, 'Overseas trained nurses working in regional and rural practice settings: do we understand the issues?' *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*, vol. 10: pp 1-11.

ETHICIST

Professor Mary Chiarella FACN

A view from the other side: Australian nurses seeking registration overseas

Last year I undertook a review of the educational requirements for licensure as a registered nurse (RN) in seven jurisdictions: Australia, the United Kingdom (UK), Hong Kong, California (US), Washington State (US), Ontario (CAN) and British Columbia (CAN). Each respective jurisdiction researched required internationally qualified nurses, which would include nurses educated and registered in Australia, to complete an educational program that is equivalent to the minimum education required for their locally qualified nurses. Accordingly, most registration authorities compare a detailed breakdown of an internationally qualified applicant's education with the minimum educational requirements for an accredited RN program in their jurisdiction, to ascertain whether equivalence in education is present. By and large, similar processes occur in Australia.

What is different is the use of examination to assess equivalence. All jurisdictions researched, except Australia, require internationally qualified applicants to complete some form of examination in order to gain RN licensure. California, Washington State, Ontario and British Columbia require internationally qualified applicants to complete the same registration examination that their own applicants must complete. Ontario and British Columbia may require internationally qualified applicants to complete further examinations. Whilst Hong Kong and the UK do not require any examination for applicants trained within their respective jurisdictions, they both now require foreign applicants to undergo licensing examinations. The content of these examinations is indicative of the educational requirements for RN licensure in these jurisdictions. This is a brief snapshot to demonstrate how differences in the examination regimes for internationally qualified applicants between the jurisdictions reflects the ways in which 'equivalence in education' is measured in different ways.

GLOBAL NURSING

HISTORIAN

Dr Madonna Grehan MACN

Where it all began

At a meeting of the International Council of Women in the early 1890s, Ethel Fenwick, an English nurse and hospital administrator conceived of an international gathering of nurses. The idea of fostering a shared sense of practice and identity in nursing was not entirely new, but nurses lacked a structure to pursue their aspirations. In 1899, Fenwick's idea morphed into the International Council of Nurses, a global network where nurses from different nations could share their ideas.

Establishing trained nursing as a recognised, worldwide phenomenon was intricately linked with the cause of state registration and embedded in the drive to professionalising nursing. Within the British Empire and the English-speaking world, professional associations of nurses encouraged a globalisation of nursing. They shared knowledge through journals. They thrashed out reciprocal agreements, which accepted qualifications obtained within the Empire as legitimate. These reciprocal agreements enabled nurses to be highly mobile as employees.

That nursing's horizon was expanding to be a globally-recognised practice was not welcomed by all. In 1920s Victoria, for instance, parliamentarians were concerned that reciprocal registration between the Australian states would encourage nurses' mobility at a time when staff shortages were dire (Grehan 2009). In 2015, nurses can be even more highly mobile, courtesy of mutual recognition agreements. Nursing's sense of itself as a global fraternity is undisputed. Flourishing international linkages in research and professional realms underscore that nursing is indeed a global profession and a global practice.

Reference

Grehan, M. 2009, *Professional Aspirations and Consumer Expectations: Nurses, Midwives and Women's Health,* PhD Thesis, The University of Melbourne.

MANAGER

Adjunct Professor Cheyne Chalmers FACN

Nursing threads across the world

Over the past couple of months I have been struck by the extensive portrayal of the role of the nurse during war-time; this has been linked to the Anzac day commemorations. I have been impressed with how nurses who, at the beginning of the 20th century, were pioneers and, in fact, set the tone and led the way for the modern nursing that we know today. The skills of compassion, empathy, resilience, observation and monitoring, pain management and infection control were evident in the nursing practice during those times. The flexibility and adaptability demonstrated by those nurses to practise in the extremes of circumstances was outstanding, if not heroic.

Most of us, who have only worked in one country in a first-world system, can only imagine what it must be like working in third-world, war torn environments; knowing what best-care is but not having the resources to deliver it. Nursing is a global language, we are not limited by boundaries, and the nurse is the one role that can make the most difference regardless of the setting. As a nurse leader in a first-world country the diversity within the nursing group I work with is amazing; we have over 70 different cultures represented in my health system alone, all bringing their unique backgrounds, experience and context to our system. The strength of our system is in its diversity. I am proud I work in a country where we celebrate and harness that diversity and that nurses and nursing is the workforce platform that allows this to occur.

"She shared emotions surrounding leaving family and friends, the accompanying loneliness and the time it takes for new support systems to fall into place."

– Tomica Gnjec

NEWLY REGISTERED

Ms Laurie Bickhoff MACN

Our nursing tribe

It's easy to believe our nursing world exists only within our workplaces. Each specialty has their own dialect, cultures and traditions. Our colleagues become our community, and venturing to another ward seems like travelling to a foreign land. However, as you travel from ward to ward, or even country to country, you realise, nursing has its own language, allowing us to connect with a truly global nursing community.

I first experienced this community as an undergraduate student. I travelled to Thailand and met with other nursing students from Bangkok and Chiang Mai in Thailand, as well as Japan and South Korea. Despite the cultural differences and language barriers, we found a common bond in nursing. We connected by sharing our experiences and individual perspectives on the profession we were about to join.

At the 2013 ICN Congress in Melbourne, I experienced this on a larger scale. With over 4,000 nurses from around the world attending, forming friendships was easy, as everyone spoke a collective nursing language. Despite which country we came from, we were all still part of the same nursing tribe.

I continue to connect with nurses from all over the world through social media. Social media has allowed me to join an international nursing community. We compare protocols, collaborate and share resources. We give advice, virtual high fives and pep talks when needed. We see time and time again how inspirational, supportive and intelligent nurses are.

Our nursing worlds are only as small as we choose them to be, so start exploring what exists beyond your borders and engage with the global nursing tribe.

POLICY SNAPSHOT

GP CO-PAYMENT THROWN OUT BY GOVERNMENT

In March, the Government announced the axing of the GP co-payment policy proposal. The policy, which was widely criticised because of its perceived potential damage to the Australian health care system, was originally planned to charge patients $7 to see their doctor, with some proceeds to be put into a new medical research fund. After facing opposition in the Senate, the policy was dumped in December in favour of a $5 'optional co-payment' to be charged at the doctor's discretion. This policy, too, was met with backlash and in March Prime Minister Tony Abbott announced the co-payment would be axed in its entirety.

THE INTERNATIONAL DAY OF ZERO TOLERANCE TO FEMALE GENITAL MUTILATION

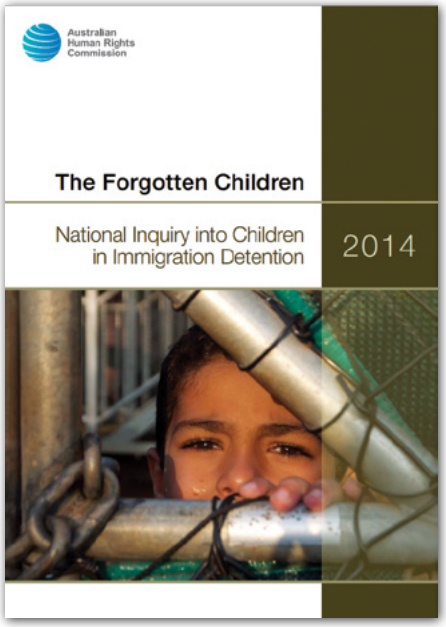
On 6 February, ACN marked the annual International Day of Zero Tolerance to Female Genital Mutilation (FGM). In 2014, ACN and the Australian College of Midwives launched an online portal, *FGM Learning,* for the dissemination of professional resources related to FGM. *FGM Learning* is a national hub where nurses, midwives and other health professionals can access reliable sources of information about FGM in order to inform the care they provide to women and girls affected by the practice. To access *FGM Learning* visit www.fgmlearning.org.au.

HIGHER EDUCATION REFORM BILL DEFEATED IN SENATE

In March, the Senate voted down the Federal Government's legislation to uncap university fees. Labor and the Greens were joined by crossbench senators to defeat the Bill 34 votes to 30. This is the second time the Coalition's higher education changes have been rejected in the Senate. Prior to the vote, Education Minister Christopher Pyne announced he would split the original legislation and consider the $1.9 billion funding cut at another time.

THE FORGOTTEN CHILDREN

In February, ACN welcomed the release of *The Forgotten Children* report by the Australian Human Rights Commission, and its recommendations. The report states that detaining children in immigration detention centres is detrimental to their health. ACN and Maternal, Child and Family Health Nurses Australia (MCaFHNA) made a joint submission to the *National Inquiry into Children in Immigration Detention* in August 2014.



NURSE LEADERSHIP WHITE PAPER

In March, ACN released the ACN *Nurse Leadership* White Paper. This is a key underpinning document to guide the ACN strategic intent over coming years. It is also a valuable resource for informing ACN policy positioning within government. The paper outlines the relevance of nurse leadership in the health care system, highlighting the connection between nurse leadership, workplace environment, staff retention and patient outcomes.

ACN SUBMISSIONS

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

HEPATITIS C

In response to a Parliamentary Inquiry into Hepatitis C in Australia, ACN worked with Drug and Alcohol Nurses Australasia and CATSINaM to develop a submission highlighting gaps in the prevention of hepatitis C and the care of people with the disease. Currently, only a small percentage of people with hepatitis C receive treatment for the disease. The three organisations involved in the submission argued for the development of innovative models of care, including nurse supported and coordinated models, to increase access to treatment.

ABORIGINAL AND TORRES STRAIT ISLANDER FRAMEWORK

ACN and four other nursing and midwifery organisations developed a joint submission on the Federal Department of Health's *Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families.* The five organisations involved were ACN, Australian College of Midwives, CRANA*plus,* MCaFHNA and CATSINaM. The submission indicated the organisations' support for the vision, principles and key elements of the *Draft Framework.* The submission also identified a number of issues requiring further consideration, including the need to enable the nursing and midwifery workforces to work to full scope of practice, to promote health service innovation and to continue learning to practice in a culturally respectful way. The five organisations also called for the development of an implementation plan to ensure the *Draft Framework* is translated into action.

CANCER COUNCIL VICTORIA: DRAFT OPTIMAL CANCER CARE PATHWAYS

The Policy team developed feedback to Cancer Council Victoria on two draft *Optimal Cancer Care* pathways for people with high-grade glioma and ovarian cancer. ACN used feedback from members, with relevant expertise, to develop the submission. ACN strongly supports the development of the *Optimal Cancer Care* pathways and has previously contributed to the review of pathways for people with lymphoma, melanoma, pancreatic cancer, colorectal cancer and lung cancer. ACN's submissions to Cancer Council Victoria underscore the contributions that nurses can make to the multidisciplinary care of people with cancer.

SOUTH AUSTRALIA TRANSFORMING HEALTH

The South Australian Government is currently in the process of consulting on wide-ranging changes to the structure of the state's health system. ACN called for feedback from members in South Australia on the government's proposed plans. ACN received a significant amount of feedback from members, which was collated and analysed by the Policy team to inform ACN's response to the South Australian Government's plans.

FEDERAL BUDGET SUBMISSION

ACN's Federal Budget Submission, for the 2015/16 Budget, features two proposed initiatives that ACN regards as key to understanding and improving the distribution and utilisation of the nursing workforce.

The first proposed initiative is a national system to guide registered nurse workforce utilisation. ACN proposed the Federal Government should fund a national system for the identification, collection, analysis and dissemination of nurse sensitive indicators (NSIs). The national system would collect data about NSIs from health services across Australia.

The second proposed initiative is a map of nursing roles in non-acute health care settings. ACN recommended that the Federal Government undertake a mapping exercise to collect data on the type, number and location of nursing roles in community and primary health care settings. Such a data source would support health service planning by making available some of the information required to match nurse workforce supply to population health needs.

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

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GLOBAL NURSING LEADERSHIP: NOW MORE THAN EVER

By ACN Policy Unit

The global nursing profession must develop and support more nurse leaders if improvements in global health outcomes are to continue. Much has been achieved over the past several decades, with commendable improvements in areas such as vaccination, tobacco control and HIV/AIDS prevention and treatment, but there is still much more work to be done. In the world's less developed countries, for example, many of the health-related United Nation (UN) Millennium Development Goals (MDGs) – encompassing child mortality, maternal health, and communicable diseases – have not been met across most targeted regions, with some even demonstrating decline (UN 2014). Moreover, in rich and poor countries alike, ageing populations, significant and rising chronic disease rates and a tight fiscal environment are placing ever increasing pressure on health systems and, with it, greater risk towards population health outcomes.

Nurses and midwives are at the forefront of health service delivery globally, meaning that maximising their roles not only as practitioners but also as leaders is essential if we are to effectively address the challenges posed by the world's rapidly evolving health needs. Specifically, creating and supporting nurse leaders at all levels of the health system, including clinical, organisational and policy development, will be essential to optimising scarce global resources and ensuring the efficient and effective delivery of health care into the future (Fyffe 2009).

With inadequate progress and new and emerging challenges, it is now more than ever that nurses must be engaged as active leaders in the global health care sector, drawing on their skills, knowledge, values and experience to influence and shape health policy across clinical, management, research and educational areas. Nurses must be visible in the public debate regarding future models of health and health care delivery. So important is the task of encouraging and supporting global nurse leadership that the WHO, at its 54th WHA (2000), passed a resolution (WHA 54.12) calling on all member states to 'further the development of their health systems and to pursue health sector reform by involving nurses and midwives in the framing, planning and implementation of health policy at all levels' (WHO 2001).

DEFINING NURSE LEADERSHIP

Nurse leadership, in broad terms, refers to the process whereby nurses influence a group of individuals – whether they be other nurses, health professionals, or politicians – to achieve a common goal; creating structures, implementing processes for nursing care and facilitating positive outcomes (Cummings et al. 2008). Their influence extends beyond nursing care to have a direct impact on health care systems.

Important for nurse leaders, and educational organisations responsible for contributing to their development, is the recognition that leadership must occur at different levels of the health system. At the clinical (micro) level, nurse leaders are needed to deliver improved patient outcomes through their involvement in the design and oversight of clinical care models. At the meso level, they are needed to work at the strategic/executive level of nursing organisations, where they have the ability to design and influence organisation-wide policies and practices, which target patient improvement across whole/multiple settings. The highest level of leadership, and that which nurses are less likely to engage in, is political leadership, which has a profound purpose. As Sue Antrobus (2003, p. 40) explains:

> *Political leaders aim to deliver improved health outcomes for patients and communities by creating and influencing public policies at a macro level, on a larger scale that takes account of the evidence and experience of caring for patients and the perspectives of users.*

THE IMPORTANCE OF POLITICAL NURSE LEADERSHIP

Political leadership by nurses is essential for engaging in and influencing public health and social policy, which has significant implications for both the nursing profession, in the way that it can practice, and for the broader population, whom the nursing profession serves. Nurses are essential stakeholders in the policy arena because of their professional ethics, advocacy skills and experiences, which afford them highly valuable insights and offerings in the health policy debate (Arabi et al. 2014).

Nurses' involvement in health policy development ensures that issues affecting the delivery of direct patient care are also considered. Empirical research undertaken by Shariff (2014), for example, indicates that when nurses participate in policy development, they are able to make valuable contributions and positively influence policy in areas such as service access, suicide prevention, and maternal and child care. Moreover, when nurses are engaged in the policy development process, their job satisfaction, self-esteem and autonomy are likely to increase (Shariff 2014).

ENGAGING IN THE POLICY PROCESS

To be able to effectively engage in public health policy, nurse leaders must have the relevant knowledge and skills, which includes knowledge of the broader health system and the policy development process, as well as being politically astute. As Arabi et al. (2014) state:

> *Nurses have the ability to affect health policies,* [but] *…this effect is impossible without the required knowledge of the health care system as a whole. Nurses need to be aware of policy agendas, policy makers, and political backgrounds… Their expertise, judgment, and policy influence, altogether help them to achieve their goals and to facilitate the professional process and efficacy of the health care system* (pp. 321-322).

Antrobus (2003, p. 44) supports this assertion in her claim that effective nurse 'political' leaders are:

> *skilled at communicating their message to policymakers, politicians and the public, …work*[ing] *inclusively with a wide range of stakeholders to develop and action strategies to achieve specific policy outcomes. Negotiating a pathway through different value systems, they are able to lead, facilitate and orchestrate healthy solutions to policy issues.*

Four key skills have been identified as necessary for nurses to effectively engage in the policy development process, which include:

- Being articulate – able to rehearse arguments and clearly and concisely present a case of political importance.
- Being an analytical critical thinker – having a clearly developed reasoning ability integrated with a well-established personal value system.
- Being an opportunist – able to recognise opportunities within the political system and mobilise resources to achieve particular ends.
- Being a politician – able to understand and use power appropriately and effectively. (Antrobus 1998).

SUPPORTING NURSES' POLITICAL DEVELOPMENT

To assist nurses in developing and applying these skills, there are several enablers that nurse leaders and their related associations must work to create. Firstly, health policy development needs to be pluralistic and inclusive of a range of nurse leaders practicing in positions related to policy development. Enhanced opportunities for nurses to engage in the process is found to enrich their experience, confidence and competence in the area. Additionally, nurse leaders need to proactively examine their own roles with regards to health policy and strive to formalise these roles with job descriptions that include participation in the policy development process (Shariff 2014).

Perhaps the most important enabler, and unequivocally linked to the others, is appropriate nurse education. Rains and Carroll (2000) find that being educated on health policy leads to increased self-perceived competence in knowledge, skills, and understanding within the context of health policy activity. The ICN similarly promotes the importance of nurse leadership in politics and policy development, recommending that nurse leadership preparation 'include the development of knowledge and skills for influencing change, engaging in the political process, forming coalitions, and working with the media and other means of exerting influence' (ICN 2000).

Despite the widely accepted importance of specialised nurse education, some argue that nursing education institutes have been slow and inadequate in their moves to educate and train nurses in political leadership. Shariff (2014, p. 2), for example, asserts that:

> *Although the need for political action and policy influence has been recognised, nursing education has been slow to respond to this call. The preparation imparted by nursing education does not adequately equip nurses with the knowledge and skills necessary for involvement in policy development.*

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“...it is clear that global nursing collaboration and exchange is an important enabler to creating global nurse leaders, and should be pursued and supported in developing both current and new nurse leaders.”

She goes on to say:

> *Nursing education as a whole needs to engender health policy development as a core area of nursing practice and relate clinical practice, education, research and leadership content to broader health policy implications. The nursing curriculum needs to reflect health policy education as a significant component of the educational process* (Shariff 2014, p. 11).

While Shariff’s call to have greater political and policy development education and training incorporated into the nursing education curriculum is a valid one, it should be noted that a number of institutions have been offering this type of training for some time, across different parts of the world. The National Health Service (NHS) in the UK, for example, has been running its nursing leadership program for well over a decade, which includes amongst the more traditional clinical and organisational management modules, political and policy development units. Likewise, the US, Singapore, and parts of East Africa, are engaging in nurse leadership programs that offer a similar type of education. Adding to this is ACN, which has taken a leadership focus and is developing a range of leadership supports, programs and opportunities for nurses in Australia at all stages of their career, and with varying aspirations. .

Key to the success of these national programs is the regular engagement with international counterparts in order to provide nurses with a highly diverse set of skills, experiences, and perspectives necessary for effective nurse leadership in a globalised world. Commenting on this approach, Marrone (2002, p. 8) states that:

> *If we look at how nurses and faculty from different parts of the world define nursing, nursing practice, the role of the nurse, and the skills and educational levels they bring with them, we can appreciate the variety of learning and communication styles among our own nursing staffs.*

Gantz et al. (2012, p. 434) also support the call for greater international collaboration with their finding that:

> *The experience of being a nurse is remarkably similar across countries, despite cultural differences: the critical challenges of getting the workforce numbers right, getting the skills right, and getting the teamwork right are concerns that link leaders on all continents.*

From the nursing profession’s shared aspirations and challenges, it is clear that global nursing collaboration and exchange is an important enabler to creating global nurse leaders, and should be pursued and supported in developing both current and new nurse leaders.

CONCLUSION

The need for nurse leaders to step up and engage in the public health policy debate has never been more important than it is now. Global health challenges require global nurse leaders. To effectively engage in the health policy space however, nurses require an understanding of how to lead clinically and politically, with the ability to switch between practice and policy. Achieving this will mean investing in developing political leadership capability, in addition to building the knowledge and skills needed for clinical leadership (Antrobus 2003). Work on this is already underway, with ACN in Australia, the NHS in the UK and other organisations and educational institutions from around the world all working collaboratively to educate and train the global nurse leaders of the future. With the continued support and engagement of nurses, along with other important stakeholders, these programs will no doubt help contribute to a more efficient and effective global health system and, with it, a healthier world population.

Author acknowledgement

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A better way to care for patients with dementia in hospital

Dementia causes progressive cognitive impairment, affecting memory, judgement, language and everyday tasks. Alzheimer's disease is the most common type of dementia.

Dementia is a national health priority

20% of patients in hospital aged over 70 have dementia

>50% of patients in hospital aged over 90 have dementia

311,000+

Australians have dementia

550,000+

Australians will have dementia by 2030

Patients with dementia are at greater risk of harm

Patients with Dementia are 2x more likely to experience falls, pressure injuries or infections in hospital...

6x more likely to develop delirium...

2x more likely to die in hospital, and...

2x more likely to be readmitted to hospital

50% of dementia episodes go undetected in hospital

Not recognising dementia is a safety and quality issue

We can improve hospital care of patients with dementia

Be alert to delirium and the risk of harm to patients with dementia

Recognise and respond to patients with dementia

Provide safe and high-quality care tailored to the needs of patients with dementia

www.safetyandquality.gov.au/abetterwaytocare #BetterWayToCare

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

HOW ONE VOCATION HAS LED ME AROUND THE WORLD

By Suzanne Lee Volejnikova-Wenger MACN

Looking around the big lecture theatre at the University of the Sunshine Coast (USC), full of new nursing students, many who could easily be my children, I felt panic rising within me. “What am I doing here? I don’t think I can do this! Why do this all over again?”

My nursing journey had started over two decades before, when all I wanted was to become a nurse - a vision in white gracefully healing everyone in sight with a lovely overturned teacup on my head. Born in Australia but growing up in Switzerland, nursing was a choice which I believed would give me possibilities for travel and exciting opportunities to help. While I did get that part of nursing right, the vision in white and the ‘teacup’ were replaced, by the time I started nursing school, with coloured uniforms and individual hair ties.

Switzerland has a rigorous educational system that combines trades with higher education. Vocational traineeships were, and still are, the main pathway into the workforce with the possibility of advanced modules and courses to gain higher recognition. In my village, in the German speaking canton of Zürich, few of my school-peers went on to university even though tertiary education has a long and prestigious history. Being accepted into the “Schwesternschule vom Roten Kreuz” (which translates into “Nursing school of the Red Cross”) depended on certain conditions. A minimum of six months working as an assistant in nursing, which was possible from the age of 16, school-fluent in French and a basic knowledge of the Italian language. My English language skills neither counted nor helped at that time. As I was initially considering paediatric nursing (a four year course), I also completed six months as a nanny in a family with three children under the age of three. Finally, I had to complete six months at a preparation school for health professionals where I was required to pass subjects such as biology, chemistry, mathematics, domestic duties and typewriting skills.

It was considered a privilege to gain entry to this three year hospital based nursing education, as the hospital and school had existed since 1882. Theory blocks prepared us for our placements, each building on what had previously been competently achieved. We practiced many procedures on each other, and sometimes on our family members. The day nasogastric tubes were on the timetable no-one in class felt like having lunch! These lessons and experiences of what certain procedures feel like for a patient are still etched in my mind. Empathy was not an idea we spoke of – we lived it. Looking back, as nurses we were able to undertake many more invasive procedures compared with what I have experienced elsewhere, although we did not practice them all on each other.

Placements were very exciting and included geriatrics, community nursing, medical, surgical, maternity, gynaecology, urology, burns unit, operating theatre, emergency department and psychiatric clinic. We were placed in and around our canton and were able to organise community nursing in our own villages and towns. I remember a four week placement in an old Abbey, which had been converted into a psychiatric hospital, on a small island in the Rhein river. Looking back it would have been a great setting for a scary movie. Of course we were also placed in our own school hospital which hosted many local and international VIPs as patients. One such patient asked my classmate to bring her father in to meet him, as he would like to work out a dowry price to take her back to the Middle East as his fourth wife. Suffice to say, neither the meeting nor the wedding ever took place!

We had to successfully pass exams on each theory subject until we were accepted to do our final diploma exam. This was structured into three parts. A “Diplomarbeit”, which is a like a research paper, an oral exam day and a practical exam day on the ward, where we had to organise and supervise the ward team during a day shift. Retention of students was not a problem, due to the strict screening process and only one of my peers did not complete her diploma. I was very proud to receive my numbered nursing pin on our graduation day.

Working in a small regional hospital as a fully-fledged nurse was a lot of fun as we knew everyone on staff and helped each other out. During night duty and between rounds, I was able to help out in the nursery but was also in charge of dispatching the ambulance. Each New Year’s Eve and on the first of August (the Swiss national day) we would fill all available bath tubs in the three storey hospital as we knew our

> *"Nursing has given me a skill set which I have been able to apply throughout my life, at work, within my family and in the wider community."*

emergency department would receive quite a few patients with burns due to fireworks and bonfires.

I moved to the Czech Republic a couple of years after the Velvet Revolution, when the then communist government was pressured by the Czechoslovakian people to step down, where I was not able to work as a nurse due to the language. In addition, Czech nurses already start preparing for their tertiary three year education in secondary school. Similar to Switzerland, the education is hospital based and has rigorous oral, practical and written exams before being registered. One big difference, however, between the two countries was the way patients were viewed in the health system. After 40 years of communist rule, where patients were not expected to have any input into their diagnoses, therapy and care, it was difficult for health professionals to change that attitude. A holistic approach to patient care was neither taught nor practiced. During my two pregnancies and births I was on the receiving end of this health care. Technically, the medical treatment was excellent; but asking questions and sometimes refusing certain procedures was met with disbelief and it was only due to my nursing knowledge that I was able to retain control over what was happening to me. Aged care was another area where there was a lot to improve. Most families cared for their elders, but in the cities the elderly were often left to their own devices if they did not want to enter institutions.

In Prague, the capital of the Czech Republic, I was involved in a pioneering project holistically supporting senior citizens to remain in their own homes for as long as they wanted to. A well-known radio director and his wife had a vision to create a big building in the middle of Prague which would be a centre for respite, community nursing care, allied health services, advocacy and advice for seniors as well as housing a second-hand shop, emergency call centre, theatre productions and much more. "Portus", as the four storey house was called, is now a bustling hub for all things relating to growing old with dignity and contentment.

From Prague, I came full circle back to Australia and, after completing a Certificate IV and working in home and community care, I cared for my father in our home until he died. I was then encouraged in my wish to, once again, be a registered nurse. Due to my diploma being completed so long ago I was advised to not even try to apply for recognition of my qualifications, but instead to complete the three year Bachelor of Nursing Science.

Now, a year on from that near panic-attack in the lecture theatre, I am in my element. I am fascinated by the deeper knowledge that I am acquiring, learning to see why certain care is given and in what situations. As a young nurse I was taught very well how to complete procedures, now I am gaining the understanding and evidence to support my clinical reasoning. All my past experiences are complementing this journey and I am able to draw upon my many nursing interactions from different countries and cultures.

Nursing has given me a skill set which I have been able to apply throughout my life, at work, within my family and in the wider community. It has proven to be a universal and global profession and even though I will never wear the 'teacup', I am proud to be a nurse.

Author details

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The Portus centre, Prague

DALLIANCES FROM DUBAI

By Jane Griffiths FACN

BACKGROUND

In 2003, the NSW Health Department was awarded a contract to commission a hospital in Doha, Qatar. I was asked to be part of the commissioning team for four months. This was my first experience working in the Middle East, in a country I had never heard of before!

In 2006, I was again approached to work in the Middle East, this time at the tertiary referral hospital in Dubai, United Arab Emirates (UAE). It took 12 months of negotiation by the Dubai Government to convince me to take the role of Director of Nursing. My plan was to originally stay a maximum of one to two years but I am still here eight years later. Most of this time spent as the Director of Nursing at the 600 bed referral hospital; a hospital that services not only the Emirate of Dubai but also provides care and treatment for patients from the five northern Emirates for trauma, psychiatry and infectious diseases. The Emergency Department sees 166,000 patients per year and 50% of cases treated in theatre are due to traumatic injury resulting from motor vehicle accidents or industrial accidents. It has provided me with the most extraordinary clinical experience of my career. I have had the privilege to be involved in the care of patients with both illnesses and injuries I had never seen before.

CULTURAL DIFFERENCES

The total population of the UAE is 9.4 million, with Dubai's population at 2.2 million (Dubai Statistics Centre [DSC] 2014). The UAE is an Islamic country with a melting pot of cultures and nationalities. The ethnic groups consist of:

Emirati – 13%

Arab – 26%

Asian – 53%

Westerners or expatriate – 8%

The distribution of patients and staff, however, do not follow this breakdown. The patients presenting to the referral hospital are 31% Emirati and 69% expatriates (Dubai Health Authority [DHA] 2014). This hospital is one of the few hospitals in the UAE that caters for expatriate workers, and 80% of patients are male. The staffing of the facility was also interesting. Only 1% of the nursing staff are Emirati nationals in Dubai. Across the entire UAE only 3% of nursing staff are citizens of the UAE. The remainder of the nursing staff establishment were evenly divided between India, Philippines and the greater Arab region (Jordan, Palestine, Lebanon, Egypt and Iran) and only two Westerners (both Australian). Due to the cultural constraints, focussed recruitment occurred to increase the number of male nurses. We finally reached a target of 22% male nursing staff, in comparison to the international male nursing staff rate of 8%. The demographics of the UAE also influenced service delivery as less than 1% of the population is aged over 60 years and only 9% of the population is aged less than 14 years (DSC 2011). This was a very different patient profile than what I had observed in Australia. The main reason was because the majority of the population (87%) are expatriate. When they reach 60 years of age, their resident visas are cancelled and they are sent back to their home country. This demographic is gradually changing as the life expectancy for Emiratis is now increasing to 75.6 years (DHA 2013). The implications of this data on care delivery has meant that there are no/limited services provided or facilities for geriatrics, rehabilitation or chronic care patients and acute facilities are faced with the dilemma of managing these cohorts of patients. The cultural, religious and spiritual aspects of society in Dubai also impact significantly on these issues.

Jane assisting at Al Maktoum Airport

The Dubai Government awards 2010

Jane opening a safety program in 2013

“The sense and importance of family is also a core concept for all Muslims and health care decisions will usually involve the family rather than just the patient.”

Before I arrived in the Middle East I had a very limited understanding or knowledge about the Islamic religion or the Muslim culture. The most important piece of advice is to undertake some research about both the religion and the countries of the Middle East region **before** travelling – either for work or pleasure. Dubai is an interesting and exciting place to visit, live or work. The UAE is only 43 years old and this alliance between the seven Emirates was signed in 1971. The growth and development during these 43 years has been, and continues to be, phenomenal. Dubai has been designed to be the ‘western face’ of the UAE with a much more liberal approach for visitors focussed on tourism, real estate and finance. It is a spectacular city with unique architecture. It is a Muslim culture which Westerners may find challenging, but needs to both acknowledged and respected.

It is essential that nurses coming to work in the Middle East have an understanding of both the Islamic religion and the Muslim culture as both significantly impact on the context in which nurses’ practice in this part of the world. The Islamic religion has five pillars which must be upheld by all Muslims. These pillars are the faith (Iman), prayer (Salat), giving alms (Zakat), fasting (Siyam) and the pilgrimage to Mecca (Hajj). It is essential that nurses understand these pillars as the majority of their patients will follow these foundations whilst they are in hospital. For example, patients will pray five times per day and will need to wash before praying. During Ramadan many patients will want/try to fast from sunrise to sunset and patients’ spiritual health will mean that they will want access to the Qur’an (holy book) to pray and obtain guidance. The sense and importance of family is also a core concept for all Muslims and health care decisions will usually involve the family rather than just the patient.

These activities may be difficult for non-Muslim nurses to understand, particularly if they are perceived to interfere with routine nursing care. Families and visitors pose significant issues for nursing staff as it is expected that the extended family will visit the patient. If they do not visit then this will bring shame on the family. This means the staff will have to deal with 20-30 visitors per patient each evening. It is a very social occasion and an entire buffet of food will be brought into the hospital including cooking implements.

The laws and legal system may also challenge non-Muslim nurses. The laws of the country are governed by the Sharia Courts which are quite different. Variations include the fundamental aspect that a defendant is guilty until proven innocent, ‘white collar’ crime (e.g. credit card debt) is a criminal offence, and if a patient is classified as a ‘non-viably sustained life’ life support **cannot** be removed or the clinical staff involved will be charged with murder. Approximately five nurses per week end up in jail. It became such a significant issue that the Dubai Government now has a leave classification on the human resource system of ‘incarceration leave’. Once the investigation is complete and the nurse is found not to have a case to answer then they are released and return to work!

Jane with Emirati nurses in April 2011

EXPERIENCES

My experience here has been both entertaining, enlightening and sometimes frustrating. The nursing staff have mostly come from an educational background where ‘rote learning’ was the norm. This was an unbelievable challenge when we were trying to introduce critical thinking and evidence-based practice into nursing models of care. The temptation was to simply introduce western models. Lovering (2012) describes that these models ‘… are not always congruent with cultural and religious beliefs’. Often we were faced with having to use the appraisal system as a method to introduce change as staff were **very** competitive and every occasion was celebrated. I felt I was being invited to and attending the ‘opening of multiple envelopes’. It was a very stimulating experience where we had the opportunity to introduce strategic planning into both nursing and health care. There have been several highlights including the development and implementation of a local and federal disaster response that has won international awards, and a clinical, education and managerial leadership program which has led to a number of nurses gaining promotions regionally and internationally.

It has been a privilege to work in Dubai. Prior to this appointment, I spent many years working in senior management positions in Australia. When you ask nurses why they went into nursing, the response you will often get is that they wanted to make a difference. Dubai has given me that opportunity. Here you know you have made a difference when the critically injured expatriate worker walks out of hospital, or the expatriate worker with an infectious disease recovers, or a patient with a chronic mental health illness is treated in the community rather than in an institution. This experience has been good for my soul.

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INTERNATIONAL I-KIRIBATI GRADUATES TRANSITION INTO RESIDENTIAL AGED CARE


Santi Gurung MACN


Dr Elisabeth Coyne MACN


Hazel Rands

By Santi Gurung MACN, Dr Elisabeth Coyne MACN and Hazel Rands

OVERVIEW

The Kiribati-Australian Nursing Initiative (KANI) was a scholarship program sponsored by the Australian Agency for International Development and offered to I-Kiribati students through Griffith University, QLD (Logan campus), in collaboration with Metropolitan South Institute of TAFE. KANI students, upon graduation, struggled to secure jobs in Queensland Health as a result of workforce exclusions. As a result, many began their nursing practise in residential aged care facilities (RACFs). The transition period for I-Kiribati graduates had multiple levels of transition, including cultural changes, challenges of transition from student to registered nurse (RN) and practicing in the demanding aged care sector.

> *As an international graduate from Nepal, I completed my Bachelor of Nursing (Griffith University) and began my graduate year in a RACF. This was an experience that was both exciting and challenging. I have continued studying and over the last year completed a research project at Griffith University for my Masters of Health Practice. This study explored the experience of international nursing graduates from I-Kiribati working in Australia and completed their graduate year in RACF.*
>
> – Santi Gurung

Research identified that the transition from a student nurse to an RN is a complex and challenging experience (Nash et al. 2009). Several aspects have been noted such as the culture of the workplace. Are the newly registered nurses supported and guided in theory transition or is there a lack of support? The ability of the new nurse to deal with complex and challenging situations has also been noted as an influencing factor in their transition to the workplace (Heath 2010). This study sought to explore this experience and increase our understanding of the complex nature of transition for the international graduate.

THE STUDY

A literature review for the study identified that international graduate nurses have unique cultural, professional and educational needs that are different to domestic graduate nurses (Pokharel & Anichukwu 2012). Challenges in understanding how to communicate with other staff and the differences in showing respect have been noted as problems for international graduates (Thekdi et al. 2011). International graduates were also noted to have increased levels of stress due to the difficulties with socialisation into the workforce. This stress is related to their language and difficulties in understanding the different roles in the workplace (Tregunno et al. 2009).

This study used an interpretive phenomenological approach to explore the experience of transitions into RACFs for six new graduates. The participants were all RNs, aged between 25 to 29 years and had been working in an RACF for one year. Ethical approval for the focus group interviews was granted and anonymity of participants was guaranteed. All participants were provided with an opportunity to ask questions and reminded of their right to withdraw from the study should they wish to do so.

FINDINGS

Findings identified the challenges they faced during their journey to professional development and were grouped into three main themes:

- Feeling anxious about their role and expectations.
- Difference in aged care working environment as opposed to a clinical nursing environment.
- Doubts about competency.

Participants were unsure of their role expectations and had to deal with workplace challenges, which included having little supervision and lack of support from senior registered staff. Participants were relied upon to make decisions about situations they had never experienced - 'If you're in a hospital setting you still have somebody to turn to but in aged care during afternoon or night shift you don't have that.'

In addition, participants who had only begun their practice had to deal with a wide variety of patient acuity. Participants expressed the challenge of having to manage the different levels of patient demand – '…most of our residents, they've got heart condition, kidney condition, basically everything.'

Participants had to also deal with the difference in working environment. Participants were used to having to care for smaller number of patients

in acute care settings and had to re-learn how to manage the large number of patient to nurse ratio. One participant commented that in 'hospital you're in charge of four people and that's okay…', another participant also expressed 'you go to aged care [and] you're in charge of maybe 100 people and that's very challenging'.

Due to the large resident to nurse ratios, participants spent most of their time administering medications instead of gaining a better understanding of the residents' background. In addition, participants struggled with the large amount of paperwork required, including assessment forms, commenting, '…sometimes it takes a lot of time'.

After about six months of practice, participants learned to handle the challenges and felt more confident about their own practice. Participants felt proud that they were able to overcome the challenges as they increased their own knowledge of medications and improved their communication skills, 'Now it's pretty amazing. I just can't believe that I know their routine, medications and stuff'.

RECOMMENDATIONS

Recommendations from the study included further exploration of the challenges faced by international graduates practicing in RACFs. Specific recommendations included:

- Provide specific training for graduates, including topics on communication skills with families, dealing with dementia and managing death and dying.
- Supplement training with online workshops to inform newly registered nurses of gerontology nursing.
- Use of a preceptor to provide support and guidance in the first six months of practice.
- Face-to-face meetings to allow graduate nurses to debrief and receive feedback on their strengths and areas for improvement.

This research improves our understanding of the international graduate transition into RACFs, highlighting that it was a challenging yet rewarding experience. Given the higher levels of resident acuity in the aged care sector, it is important to look at various strategies to support international graduates.

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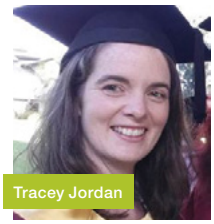
Elisabeth Coyne with I-Kiribati graduating students

EXPERIENCING THAILAND: PERSPECTIVES FROM AN INTERNATIONAL CLINICAL PLACEMENT


Caroline Browne MACN


Peter Wall MACN


Tracey Jordan

By Caroline Browne MACN, Peter Wall MACN and Tracey Jordan

International clinical placements have been offered by Murdoch University, Western Australia, to its nursing students since 2010 with students travelling to India, Laos, Thailand and Tanzania. These placements offer students the opportunity to experience nursing in another country (Charles et al. 2014), develop an appreciation and understanding for another culture (Tuckett & Crompton 2014) and extend themselves both personally and professionally (Lee 2004).

The role of the clinical facilitator, during an international clinical placement, is vital to ensuring that students are able to meet their clinical requirements whilst providing them with a supportive framework that allows them to immerse themselves in the experience. Furthermore, facilitators help the students to make the link between the theoretical components of the course and the clinical environment, through modelling good practice (Koskinen & Tossavainen 2003). However, clinical facilitation in an unfamiliar environment can be a challenging experience, particularly when entering health care settings for the first time in the presence of students who are requiring support and guidance.

Each year, two clinical facilitators and 10 students undertake a three week placement to Om Koi, Thailand working with local nursing and medical staff to hold health clinics in hard to access rural villages. In 2014, the group consisted of a returning clinical facilitator, a new clinical facilitator and 10 second and third year nursing students; for each the placement presented different experiences and challenges.

MY EXPERIENCE AS A RETURNING CLINICAL FACILITATOR – **CAROLINE BROWNE**

I have been privileged to participate in a number of international clinical placements since I began working at Murdoch University. Whilst each placement follows a similar format, with students conducting mobile health clinics in rural areas, the students selected and the dynamic which these teams create make each trip a remarkably different experience. I love travelling in Asia, and have lived and worked in the region and enjoy sharing this experience and passion with students. The people, culture and amazing remote countryside that we travel through in rural Thailand make each trip unique.

The students who participate have personal motivations for wanting to undertake an experience such as this; however, it was rewarding to see how they worked together as a team to overcome the challenges that presented during their time overseas. We ask the students to assume the role of team leader, with each student responsible for at least one clinic during the placement, with some students taking to this role easily while others found it a major challenge. As a facilitator it was gratifying to be able to support the students and see them overcome obstacles, growing both personally and professionally and developing strong leadership skills along the way.

Initially this type of placement can be daunting for a facilitator as you are in an unfamiliar environment, with limited resources and 10 very eager nursing students. I felt it was important I conveyed to students the importance of being able to assess their patients, with one of the key messages that students took away from the placement being the importance of actually looking at and listening to the patient in front of them. The basic nursing health assessment skills were essential in this environment, without modern equipment and diagnostic tests to assist, students had to rely on their knowledge and skills to help the patients they saw.

MY EXPERIENCE AS A FIRST TIME CLINICAL FACILITATOR – **PETER WALL**

As a nursing academic, my first international clinical facilitation experience contained several challenges. My previous nursing practice has been based around surgical and perioperative care and, as this placement focussed on primary health care, I initially struggled and was professionally challenged. On many occasions I found myself facilitating students who were performing health assessments on Thai villagers, feeling that I lacked the knowledge base required to properly assist them. Though I had a proficient colleague and knowledgeable local nurse practitioners that I could consult, I still found that having these sensations while working with students and patients was an unpleasant experience. Consequently, this placement has been beneficial in developing my skills in the areas of primary health care and student facilitation.

Another challenge related to missing the ‘creature comforts’; luxuries like a bed and a bathroom with hot running water. But I can now look back on sleeping on bamboo mats on the floor and cold bucket washes as being part of the whole experience. Despite these

Murdoch University students on international placement in Thailand

A Murdoch University student conducts a patient assessment in Thailand

challenges the positive experiences of my first international placement far outweigh any negatives.

The experience was simply remarkable and can be summed up with the term 'cultural immersion'. We lived in a traditional house in an isolated Thai village, ate the local food and experienced the village life, surrounded by the magnificent environment. All of this while providing care to the friendly and welcoming local people (including hundreds of school children) in health clinics conducted in village schools, churches, Buddhist temples and children's playgrounds.

So, what did I come away with from this international placement? A sense that I had just undergone a significant experience while developing a new appreciation for what I have. The villagers that I met live a hard, demanding life with little food and no luxuries, and while the Thai health system in the regions is basic, the health practitioners accomplish a lot with few resources. Finally, the international placement made me appreciate the importance of team work, as the placement would not have been as successful without the hard work of the translators, drivers, cooks, local nurse practitioners and pharmacists, students and the facilitators.

MY EXPERIENCE AS A NURSING STUDENT – TRACEY JORDAN

As a nursing student travelling to a rural and remote area of Thailand, and to a country I had never visited before, I was excited for the challenges I would face. However, I was also overwhelmed with the amount of preparation required for the trip, particularly during my final year of study.

There were times on this placement that I felt challenged, with language barriers one of the most difficult to overcome. We had three translators and volunteers from the villages to translate from the local dialect to Thai to English and back again. Available resources were minimal, so we made do with what we had. For example, we were aware that many villagers had vision problems, and we were able to collect second-hand reading glasses through fundraising efforts in Australia prior to departure. Whilst far from ideal, it was the best we could provide for communities that had no access to regular eye testing.

I also felt challenged when I had to assume the role of team leader; however, I found this to be one of the most personally rewarding and enjoyable experiences. There was a lot to consider and organise, as I coordinated the clinic at a school with over local 500 children. A personal highlight of the trip was the people of Thailand; they were so relaxed, gracious and caring.

This opportunity has helped me to value the importance of evidence-based practice and the continual learning and knowledge we require to ensure best practice. Experiences like these are so valuable to student nurses and we can learn so much from other cultures. It has helped me to think critically and not to judge when some rationales seem far from evidence-based in other countries, as change takes time and the choice has to be theirs. I now feel more confident in my own abilities of health assessment, education and to work within a nursing team. I have enjoyed the total cultural immersion and I have gained a new appreciation for translators and for minority groups within our society.

These placements provide both staff and students with the opportunity to develop professionally and personally. International clinical placements, whilst being challenging for all involved, lead to a greater exposure to different cultures and health care settings, and provide students and staff with opportunities to develop new knowledge and clinical practice.

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WHY INTERNATIONAL INTERNSHIPS ARE VALUABLE: A STUDENT'S PERSPECTIVE

Patrick and Elizabeth at work at North Shore Private Hospital

FOREWORD

By Elizabeth Matters FACN

For the last two years, I have been working on a project with colleagues from Germany to allow clinical nurses and nursing students to experience the reality of their profession in a different cultural context. Regular readers of *The Hive* may remember my own positive experiences at several hospitals throughout Germany in 2013 and the subsequent international internship program which I established at North Shore Private Hospital in Sydney. In February 2015, we welcomed our third intern, Patrick Lemli, from the University of Ravensburg-Weingarten in Southern Germany. Patrick had worked extra shifts and sacrificed most of his annual leave to make the trip but he was well rewarded with an insight into Australian nursing which proved both inspirational and thought-provoking. In this article, Patrick reflects on his experiences and explains, in his own words, "Why working during your holiday is a marvellous idea".

By Patrick Lemli

In 2013, at a congress for nurses in Germany, I met Elizabeth Matters, a registered nurse from Australia. We spoke about our work and the differences between our two countries, and Elizabeth suggested that it might be possible to establish an intercultural internship program for nurses in Sydney.

My career had started off as a paramedic but I had found after several extremely difficult emergency cases, where the patient nearly died, that I was frustrated by the fact that I didn't know what happened to any of my patients. The dissatisfaction of not knowing what happened to the people, who I had worked so hard to save, was the reason that I decided to study nursing. I am currently a fourth year Bachelor of Nursing student at the University of Ravensburg-Weingarten, near Lake Constance, on the border of Switzerland. University study for nursing is a very new concept in Germany as most nursing preparation courses are taught in nursing schools at a certificate level. After three years of combined university and nursing school study, I received a certificate in nursing and was able to work in a hospital as a qualified nurse while continuing the academic part of my Bachelor's degree. I currently work in a psychiatric hospital but I also have an interest in health care politics and improving patient outcomes; it was to broaden my experience in this area that I came to see nursing in another country.

During my studies in Germany, I heard a lot about the goal of professionalising nursing and how this process had been carried out in other countries. I had particularly heard about how the profession was structured and educated in the English-speaking countries and I wanted to experience this kind of professional environment for myself. I think it is very important for there to be a global network of nursing professionals so that we can all share mistakes, educational methods and improvement with our international colleagues and learn from each other. The health care systems in Germany and Australia are actually quite similar in their structure with case-mix style financing and a reliance on private health insurance, but I wanted to know if there were other differences between the two systems and what effect these differences had on patients. I wanted to improve nursing at home by bringing back new ideas from other countries. As Germany is an increasingly multicultural country with more and more immigrants, it was very beneficial for me to come to a country where there were many different cultures represented among the staff and patients. I was excited to hear about how cultural differences affect nursing care and I was also keen to learn more about Aboriginal health.

Having now experienced some time in an Australian hospital I think the most positive aspect of the Australian health care system is excellent nursing ratios. In Germany, each nurse can be asked to care for up to 20 patients. I have seen that there is more time to perform much higher quality nursing with smaller patient ratios. I have seen that the multidisciplinary teamwork is better in Australia and that the work of a nurse is respected by their patients as much as the work of a doctor. As a nurse and friend, who I met during my stay, explained:

> *The main goal is to do every task well so that the patient's time is not wasted and the overall nursing care remains high. As a result, each patient will feel comfortable, well informed and a participant in achieving the goals of treatment. If good care is done properly at the beginning, then health outcomes are achieved faster and at a higher level of success. Organisational structures need to allow nursing staff to perform quality care because little things make the difference.*

Patrick enjoying the Sydney Harbour

It is this philosophy which I will take back to Germany along with everything else I have had the opportunity to experience in Sydney. I am grateful to Elizabeth and to all the nurses who mentored me during my visit and allowed me to participate in their work. I am lucky to have had such an experience.

Author details

Patrick Lemli is a fourth year Bachelor of Nursing student at the University of Ravensburg-Weingarten, Germany.

Elizabeth Matters is a Nurse Educator at North Shore Private Hospital, NSW.

A better way to care for patients with delirium in hospital

Delirium is an acute disturbance of consciousness, attention, and cognition that tends to fluctuate during the course of the day.

Delirium is common in hospital

10% of patients aged 70 and over have delirium on admission to hospital

Up to 80% of patients aged 70 and over in intensive care have delirium

Patients with dementia are 6x more likely to develop delirium

Patients with delirium are at greater risk of harm

Delirium is easier to prevent than to treat. 30-40% of cases are preventable

50% of the time delirium is misdiagnosed, not detected or not identified in hospital

Not recognising delirium is a safety and quality issue

Patients with delirium have more falls, pressure injuries, functional decline and ongoing cognitive difficulties

Patients with delirium are more likely to die

45% of delirium in older patients is unresolved on discharge from hospital

Patients with delirium are 2x more likely to go into residential care prematurely after discharge

We can improve hospital care of patients with delirium

Be alert to delirium and the risk of harm for patients

Recognise and respond to patients with delirium

Provide safe and high-quality care tailored to the needs of patients with delirium

www.safetyandquality.gov.au/abetterwaytocare #BetterWayToCare

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

GET INVOLVED!

Integral to ACN's core business is the engagement of members in our activities. This enables ACN to act as a conduit between the nursing profession, government bodies, nursing and health related organisations and other stakeholders. We recognise the importance of members being able to meet and network with other members both locally and with those who share a similar area of practice or professional interest.

Since the introduction of the ACN Regions and Communities of Interest (COI), ACN Regions have provided opportunities for members to network, focus on local and state issues and facilitated continuing professional development opportunities for nurses. COIs have provided opportunities for members to focus on the identification of practice and policy issues related to their particular area of practice, contributed to ACN publications and enabled ACN to tap into a cohort of practitioners with experience and expertise.

Together, these modes of engagement are invaluable in influencing conversations, actions and the work of ACN and its members.

Participation in such activities raises the profile of ACN as a key influencer in health care delivery and provides direct access into national health care policy development.

What does it mean to be a Key Contact?

An ACN Key Contact is required to be accessible to both members of the Region/COI and ACN.

The Key Contact will liaise with Region/COI members and assist in the coordination of activities for the Region/COI, with the assistance of other members and the ACN Member Engagement team.

Interested in becoming a Key Contact?

If you have an interest in filling a vacant Key Contact position in your Region or COI, please send through an expression of interest addressing the following criteria to engagement@acn.edu.au.

Criteria

1. Ability to work both individually and as part of a team.
2. Previous involvement in ACN activities is an advantage.
3. Willingness to drive activity within the Region/COI.
4. Experience in motivating and engaging others.
5. Ability to respond to emails and requests in a timely manner.

Want to support your Key Contact and become more involved?

If you are looking for ways to become further involved in your Region/COI but don't think you're ready for the Key Contact role, there are other ways to support your Region/COI. Please email engagement@acn.edu.au and our friendly team will connect with your ACN Key Contact.

WITHOUT NURSES A HOSPITAL IS JUST BRICKS AND MORTAR – THE ST GEORGE HOSPITAL NURSES BY JUDITH CORNELL AM FACN

Review by R Lynette Russell AO FACN

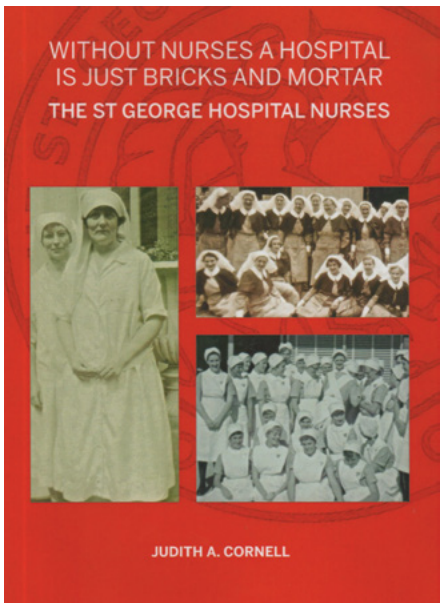
This history of the nurses at St George Hospital, Kogarah is the last work of Judith Cornell who we, sadly, lost in 2014. Judith was a very proud graduate of St George Hospital and retained an active role – Judith was a member of The St George Hospital Graduate Nurses Association up until the end. The importance that Judith ascribed to nurses as a vital component of the health care system is well demonstrated by the title of the book.

This publication tells the story of the many nurses who trained at her beloved St George Hospital, Kogarah. Many of these nurses became legendary in their field and contributed to some of the most significant changes to nursing in Australia since the arrival of Lucy Osburn in 1868. St George graduate nurses have made their mark in a wide range of settings, including clinical practice and hospital and educational reform, service in wartime and in missionary endeavours.

It also tells the story of what it was like to train in a hospital based school of nursing at this time. It tells of the triumphs, tragedies and also the humour and good fellowship that was part of nurse training in this period.

It is a great read and many of those who trained in hospital based schools of nursing will recognise themselves and others in the story as it unfolds.

The book can be obtained from the St George Graduate Nurses Association at St George Hospital or through ACN Archives. The ACN Archives Team can be contacted Thursday on 1800 265 534.



CRITICAL REFLECTION IN COMMUNITY NURSING

By Debra Gilbertson MACN

INTRODUCTION

In nursing literature, critical reflection is promoted as being good for nursing and nurses (Cotton 2001). It has traditionally been used as an attempt to link practice with theory, using a scenario from practice to illustrate a practice dilemma (Crowe & O'Malley 2006). Registered nurses (RNs) working in the community usually work independently and often need to make swift autonomous decisions. Community nurses identify with a client's individual environment, including lifestyle, workplace, culture and family (Brookes et al. 2004) and take into consideration the social, political and economic influence on the client.

Critical reflection can be a valuable tool for community RNs to develop self-awareness and to evaluate the appropriateness of these decisions and how they impact the client as an individual. In this article I aim to critically reflect on some of the dilemmas I have encountered over the last 20 years of working as a community RN, from novice to advanced practice nurse, and how, with experience and maturity, my methods of practice and decision-making have changed.

WHAT IS CRITICAL REFLECTION?

The concept of critical reflection first emerged in nursing education and practice in the 1980s (Crowe & O'Malley 2006). It involves using a questioning approach to evaluate practice with a view to enhance learning which will lead to improved patient care (Cotton 2001). Nursing has undergone many complex changes over the past two decades. In order to deal with the increased demands and accountability in the health sector, nurses need to be skilled in their ability to think and reason at a higher level (Simpson & Courtney 2002). Some techniques used for reflection include journaling, debriefing sessions, diarising, clinical supervision, reflective essays and examining case histories (Cotton 2001).

By critically reflecting, an RN may view a scenario in a completely different way, which can translate to taking an alternative course of action. Bringing issues to the conscious level is a major step in personal and professional growth (Yoder-Wise 2011).

PERSONAL EXPERIENCE

Having trained in a hospital in the 1980s, my nursing education was very much geared towards employment in the hospital environment. However, a one day placement with a district nurse changed the course of my career forever. I thoroughly enjoyed visiting clients in their own homes, and found working and thinking independently to be invigorating. The RN had the ability to spend time with her clients, liaise with their family and offer holistic care, focussing more on wellness than illness.

Six years post-graduation, and after working in varied nursing environments around the world, I was offered the opportunity to work as a community nurse. The timing was right. I had gained the necessary skills and training to be an exceptional community nurse. I had excellent communication skills, had worked with different multicultural groups, had experienced working with clients with acute and chronic health problems and had confidence that I could work independently – all the qualities necessary to fulfil the position, or so I thought.

Three different clients come to mind when I reflect on the changes and growth I have made both personally and professionally. Three different clients, similar nursing needs, similar environmental concerns, identical hoarding behaviours but with different outcomes. Mr B was referred to my service for wound care and management of a chronic ulcer by his local doctor. On arrival at the client's home my immediate impression was that the yard was a little untidy in comparison with other houses in the street. I was met by Mr B at the front door and welcomed inside. I was totally overwhelmed by the internal environment of the house; I feared he may have seen through my poker face and realised that I was appalled by his living conditions. Piles of rubbish and clutter were stacked almost to the ceiling, covering all of the floor space, with the exception of narrow pathways allowing access to other areas of the house.

Inspection of other rooms revealed the same status; the kitchen was encumbered with all manner of debris and the bedroom shambolic, with the exception of one small area where the client obviously slept. Showering was impossible as the shower and bath were full of possessions and Mr B had resorted to washing himself at the basin.

This was my first encounter with hoarding syndrome, an obsessive-compulsive disorder, which is defined as collecting excessive quantities of poorly usable items of little value, failing to discard items and difficulty organising tasks (Valente 2009). Hoarders acquire and cannot dispose of worthless items and clutter leading to functional impairment, indecisiveness, perfectionism, procrastination and diminished coping (Valente 2009).

My immediate instinct was to decline home visits to Mr B and request that he visit the district nursing office to have his wound care attended, or return to his local doctor. I informed Mr B that I would be unable to attend home visits until he cleared at least one room that would be usable, citing workplace health and safety (WHS) regulations as my excuse. Mr B stated that he couldn't clean out a room, as his council wheelie-bins were both full, being located somewhere inside the house currently covered with piles of rubbish.

“By critically reflecting, an RN may view a scenario in a completely different way, which can translate to taking an alternative course of action.”

Thinking I was being helpful, I phoned the local council to obtain additional bins for the client. I arranged for Mr B to visit the office the next day, where wound care would be attended and negotiated to attempt a home visit the following week - only to find the newly acquired wheelie-bins inside the house, full of old newspapers and magazines. Retrospectively, I should have felt honoured that this gentleman invited me into his home. I should have rejoiced with him when his wound healed but I couldn't overcome the sense of failure, in that this gentleman would continue to live in what I considered to be squalid conditions.

The next time I encountered a client with hoarding syndrome I was able to draw on these reflections and improve on the care provided. Mrs S, a 78-year-old widow, lived alone in an old weatherboard house, in which she had resided for 55 years. She was referred by her local doctor for wound care to a chronic leg ulcer. On home visiting, I found the central corridor that ran from the front to the rear of the house had yellowed newspapers stacked continuously from floor to ceiling.

On this occasion, I accepted the surroundings and found a way to safely attend to the wound care. I negotiated with Mrs S to attend her wound care on the front veranda, which was uncluttered and screened to ensure privacy. On each visit, Mrs S would bring a basin of warm water and a clean towel from the house so that I could bathe her leg prior to redressing the wound. I provided a sealed container for storage of the required wound products to ensure they remained clean.

Over the following months, as wound healing progressed I earned the trust of Mrs S and she disclosed the reason for the hoarding. Her husband had disappeared during active service in the Second World War and his body was never found. From the time her husband left to go to war, Mrs S had bought a variety of newspapers to keep informed of events, as she did not own a radio at the time. She continued to do this after being notified of her husband's disappearance until the present day, feeling unable to discard the papers as she felt they represented a connection to her husband. This was to be an 'a-ha' moment – enabling a better understanding behind the causes of hoarding syndrome.

Many years later, and now a Nurse Manager, I was asked to intervene and provide support to a nurse encountering similar issues with a new client to our service. The client required wound management and resided in an extremely cluttered environment (Image 1) making it difficult to perform the required care. There was no provision for attending staff to wash their hands (Image 2) or store required wound care products. The immediate reaction of the visiting RN was to delay care until a thorough spring clean was attended and the house met minimum WHS standards.

I spent time with the RN, who was new to community nursing, to discuss the client's rights to live as they choose and not enforcing our own standards upon them. I asked her to research hoarding syndrome and told her of my own experience and reflections. I attended a joint visit, and asked the client if we could relocate some of her possessions to another area, in order to have a small area cleared where we could provide the assistance required. We adapted our practice to suit the environment while maintaining best practice and abiding by policies that governed our work.

On a subsequent visit, the client confided to the RN that she had been in a concentration camp during the Second World War, during which time her entire family had died. Her only possession during this time was the clothing she wore; these were reduced to rags over the years she was interned. At the end of the war she migrated to Australia and met her husband. Since his death, she had been unable to throw anything out, fearing that one day she would again have nothing. On learning this, the staff involved became more accepting and caring towards the client.

CONCLUSION

The primary health care philosophy that directs the practice of community nurses is founded on principles of equity and social justice (World Health Organization 1978). It is this philosophy, supported by a holistic approach, which underpins community nursing practice to ensure that all people, including marginalised and isolated clients, obtain equitable care (Rose & Glass 2006).

Throughout my career, I have endeavoured to examine and critically reflect upon my performance as a community RN. I have always found the exercise of critical reflection empowering and endorse its use to my colleagues from novice to more advanced practitioners. I am committed to the continual development of my colleagues and myself in the field of community nursing and I thank the district RN, who unwittingly, almost 30 years ago, led me to this rewarding nursing specialty.

Author details

Debra Gilbertson is a Nurse Manager in Community Care, Gold Coast, QLD.

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Image 1

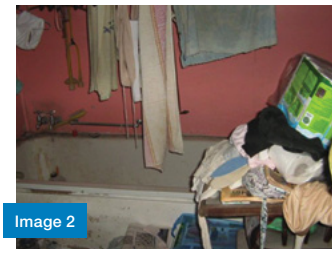

Image 2

TEN TRIGGERS FOR ADMISSION

By Sally-Anne Wherry MACN

Parkinson's disease (PD) is the second most common neurodegenerative disorder, with 1 in 350 Australians living with it, $8.3 billion annual impact on the economy and 30 people diagnosed daily (Deloitte Access Economics 2011).

Abrupt changes in mobility or cognition for people with PD is often incorrectly blamed on the disorder itself, while reality is a systematic response to a trigger, such as a urinary tract infection or constipation. In most cases, further deterioration can be prevented and the patient's condition stabilised by treating underlying issues.

A recent study by Magennis and Corry (2013) demonstrated the need for all members of the multidisciplinary team to be aware of the signs and symptoms, to allow them to play their part in the management of these issues. The study analysed the records of all suspected cases of deterioration in patients cared for by a Parkinson's Disease Nurse Specialist (PDNS). They identified the causes and categorised them according to frequency of occurrence, as seen below:

1. CONSTIPATION

Constipation is an extremely common issue and recognised symptom which adds to the burden of disease and impacting on quality of life. PD affects the muscles of the bowel, causing slow transit and poor coordination of muscles, compounded by anti-Parkinsonian medications which impact on appetite and slow the bowel. Chewing and swallowing problems reduce intake of dietary fibre, people often underestimate the amount of fluids they need, or overestimate the amount they are drinking (Continence Foundation of Australia n.d.). Constipation can prevent absorption of Levodopa (Sinemet, Madopar or Stalevo), causing a vicious spiral (Holden n.d.).

Nursing actions

- Ask about frequency, consistency and time of day. Patterns that are normal to people living with Parkinson's (PLWP) may indicate constipation.
- Encourage a diet high in fibre, fruit, vegetables, cereals and bread.
- Encourage 1.5L – 2L fluid, unless otherwise indicated; avoid fizzy drinks and spread the drinks evenly throughout the day.
- Encourage regular exercise, ideally 30 minutes a day.
- Encourage the PLWP to practice good bowel habits.
- Many people with PD require medications such as laxatives. Iso-osmotic laxatives (i.e. Movicol) are recommended as they are most effective (Kyle 2011). These can be used to reduce further episodes.
- Educate the PLWP on how to identify differences between overflow and diarrhoea.
- For advice: National Continence Helpline 1800 33 00 66.

2. DEHYDRATION

As dehydration takes effect, blood volume is reduced, constipation, drowsiness and confusion increase, urinary output decrease (Dougherty & Lister 2011). These can delay or prevent the absorption of anti-Parkinsonian medication (Scott & McGrath 2009). All worsened by constipation and low fluid intake.

Nursing actions

- Educate and highlight the need for fluid intake during high temperature and humidity.
- Inform about the impact on fluids of caffeine and diuretics.

3. ILLNESS, INFECTION OR SURGERY

Respiratory tract infection, influenza or urinary tract infections lead to abrupt deterioration of mobility or cognition, including hallucinations or confusion, in the PLWP (Magennis & Corry 2013). Dehydration increases risks of a urinary tract infection.

Periods of immobility post-surgery, combined with pain-relieving and anaesthetic medications, create a situation they may experience increased hallucinations, confusion or sleepiness.

Nursing actions

- Monitor for abrupt changes in condition and perform appropriate screens, such as urinary tests, chest x-rays, or bowel monitoring, if these symptoms are noted.
- Avoid medications that are dopamine-antagonistic, including antiemetics (Metoclopramid and Prochlorperazine).
- Find local support for PLWPs.

4. STRESS

An increase in tremor, word finding or freezing of gait is common when worried, stressed or excited. Tremor and gait are most impacted and reassurance that this is a temporary glitch reduces on-going problems.

Nursing actions

- Use relaxation and stress management techniques such as mindfulness, which has been shown to make physical changes in the brain in people with PD (Pickut et al. 2013).

5. MEDICATION NON-COMPLIANCE, CHANGE IN DOSING OR ABRUPT WITHDRAWAL

Grosset et al. (2009) reported that 75% of PLWP in their study were not taking their PD medications as prescribed, due to lack of understanding about importance of timings and impact the difference may have on the disorder. People with depression or with low quality of life are not likely to follow the medication regimen (Grosset et al. 2009), as are people in denial or experiencing apathy. We frequently see patients who have changed their medications, without discussion with their health team.

Medication changes can cause deterioration for short periods of time as body adjusts. This can take a few days to a week. Side effects can also be seen during this adjustment period and medication may need to be adjusted again, if these cannot be tolerated.

Abrupt withdrawal of anti-Parkinsonian medication can cause deterioration in PD symptoms. Surgical interventions or bowel obstructions are often responsible. Prolonged periods of withdrawal can place the PLWP at risk of neuroleptic malignant syndrome (Chaudhuri & Odin 2010), a life threatening issue that includes hyperthermia, autonomic lability, altered mental state, rigidity and elevated serum creatine phosphokinase levels.

Nursing actions

- Educate and support people to self-manage medication.
- Lists of daily medication schedules supports appropriate use of medication. Identify areas where communication or prescription errors are occurring. The use of pill timers and dosette boxes can also support someone in using their medication in timely manners.
- Confirm at each appointment to ensure that medication, dosage and schedules are monitored.
- Follow up from medication changes to support with persevering or adjusting as required.
- Encourage contact with their team before making their own medication changes.
- Do not withhold anti-Parkinsonian medication for prolonged periods of time. If the person cannot have oral medication, or have issues with their bowels that may prevent absorption, consider non-oral alternatives such as apomorphine or rotigotine.

6. USE OF DOPAMINE ANTAGONISTS

Antipsychotics (neuroleptics), some antiemetics (prochlorperazine and metoclopramide) and other medications that block the dopamine receptors (such as sodium valproate) may induce Parkinsonism and can cause sudden deterioration in people with PD (Chaudhuri & Odin 2010). These are most often prescribed during an acute hospitalisation.

Nursing actions

- Be aware of potential contraindications with medications and find alternatives. For example, Domperidone and Ondansetron are the recommended anti-emetics for people with PD (Saunders & Gillig 2012).
- Provide the PLWP with a list of contraindicated medications they can share with their health professionals. These are available on the PD Australia website.

7. DEPRESSION

Depression is a common issue for up to 50% of people with PD and is known to worsen other symptoms, such as tremor, cognitive status and motivation. It is a complex situation, since it is rarely possible to work out how much is related to the altered chemical imbalance and how much is the stress of living with a chronic illness (Muzerengi et al. 2007).

Nursing actions

- Assess for the cause of the acute depressive episode. This may include a stressful event, the need for a review of the anti-Parkinsonian medication, or one or more of the other top 10 causes of deterioration.
- Treat the cause of the depression, not the Parkinsonian symptoms.
- If the depression is related to stress or anxiety, consider a therapeutic discussion or a referral to psychology or psychiatry.
- Consider whether antidepressant medication may be appropriate and useful.

8. ANXIETY OR PANIC ATTACKS

Of people with PD, 40% experience anxiety which frequently co-exists with depression. If left untreated, it can lead to depression, or an acute deterioration of PD.

Nursing actions

- Support the people with PD in identifying the symptoms and understanding the underlying anxiety.
- Explore causes and ensure that management of anxiety is tailored to the cause.
- Consider a medication review including antidepressants.
- Explore strategies such as relaxation therapy or cognitive behaviour therapy.
- Consider referral to psychiatric or psychological services.

9. POOR SLEEP OR LACK OF SLEEP

People with PD often experience insomnia, motor fluctuations, urinary symptoms or neuropsychiatric symptoms which can impact on routine sleep. This can lead to tiredness and poor motor function in the following days.

Nursing actions

- Education on sleep hygiene should be provided.

Consider sleep studies to exclude restless legs syndrome, REM sleep disorder or sleep apnoea.

Continues on next page >>>

10. ACUTE OR CHRONIC PAIN

Approximately 50-70% of people with PD experience pain, which can be musculoskeletal, caused by rigidity, dyskinesia, nerve problems, restless legs, muscle cramp, postural hypotension, dystonia or gastrointestinal problems (Parkinson's UK 2007).

Nursing actions

- Consider comorbidities such as arthritis and back pain.
- Ask about location, type, severity, when it starts, how it is relieved.
- Ask whether the pain is relieved soon after levodopa medication, present before the next dose is due or worse after taking oral medication.
- Consider the need for a review of the anti-Parkinsonian medication or pain relief.

Early identification of causes of rapid deterioration is vital for effective management of the symptoms and adjustment of the anti-Parkinsonian medication is not advised. Contact with the local PDNS or their treating team is recommended prior to changing or ceasing medications, particularly during an acute crisis. Education and support of the people with PD and their carers can prevent or minimise many of these issues, reducing impacts on their lives and admissions to hospitals.

Author details

Sally-Anne Wherry is a Parkinson's Nurse, ACT.

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LEARNING THE AUSTRALIAN WAY

By Huiping Huang

ACN offers the ACN Entry to Practice for Internationally Qualified nurses (EPIQ) course referred by the Australian Health Practitioner Regulation Agency. Huiping Huang is originally from China and moved to Australia with 16 years of nursing experience in China. She completed the EPIQ course in August 2014 and now lives and works as a registered nurse (RN) in Australia.

I have been studying in Australia since 2010, and the most inspiring study experience was doing the ACN EPIQ course. Having worked for many years as a nurse in China, I already had a good knowledge base and strong nursing skills before attending the program, but what I learnt at ACN greatly enhanced my knowledge, skills and practice, in particular my communication, critical thinking and analytic skills.

Good communication is a basic skill that is used every day. Being able to communicate effectively is particularly essential to nursing staff, as they communicate with people with different educational, cultural and social backgrounds. My communication skills have been greatly developed by taking part in group presentations, which involve discussion, negotiation and decision-making. During the process of preparing a presentation, I learnt how to clearly convey messages to my team members, how to negotiate when we had different opinions and how to make a decision to achieve a win-win situation. I also learned how to communicate in difficult situations. The HELP strategy - honesty, empathy, listening and pointing your toes (directly facing the person you're engaging with) – taught me to deal with tough situations. I used it to deal with conflict amongst co-workers.

Critical thinking and analytical skills are other abilities I developed. These skills urged me to reflect on my practice and enabled me to identify my learning gaps, set learning goals and develop learning strategies to achieve my goals. My first learning goal originated from my first shift in an Australia nursing home. It was an afternoon shift and I was the only RN in charge of the whole village. I was called by an assistant in nursing who stated that one of the residents, with a history of congestive cardiac failure, was unwell. On examination, the resident presented tachypnea, clammy skin and blood pressure that was sky high. I realised that she was having heart failure and needed rapid response. I used all the available resources to relieve her symptoms and maintain her safety. After the shift, I wrote a piece of reflection and asked myself, how do I evaluate my performance in this event? What have I done well and what have I not? What would I do differently if the same thing happens again? Is there any measure that I can use to prevent heart failure? All these questions motivated me to re-read and re-study my textbook, to search the updated academic articles on the cardiac area and take notes. All these activities further consolidated my knowledge and enhanced my practice.

What I have discovered from studying in Australia has benefitted both my professional and personal life. Effective communication skills make me more confident and assertive to work as a nurse in this country and critical thinking and analytic skills motivate me to commit to my professional and personal development.

Author details

Huiping Huang is a former student of ACN and Registered Nurse, NSW.

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JANICE (JAN) ELIZABETH STOW

Jan was a long standing member of both The College of Nursing and Royal College of Nursing, Australia (RCNA). ACN is proud of her contribution to our organisation and to the profession more broadly.

The nursing profession lost a great nurse on 26 December 2014 – one who leaves an incredible legacy around nursing and nursing care.

Jan Stow had a very successful and productive nursing career. It started in 1964 as a student enrolled nurse at Burwood Hospital in Christchurch, New Zealand. She moved to Timaru to undertake her general nursing and worked there as a registered nurse. Following some overseas nursing, Jan returned to Timaru as the Charge Nurse in the Intensive Care Ward. She moved to Australia in 1973 to undertake the postgraduate intensive care nursing course at St Vincent's Hospital in Darlinghurst and ultimately became the Unit's Clinical Nurse Educator and Course Co-ordinator.

In 1982, Jan moved from St Vincent's to Royal North Shore Hospital as Nursing Supervisor of the high dependency units. In 1984 Jan returned to St Vincent's as Assistant Director of Nursing. In 1986 she was appointed Deputy Director of Nursing at Prince of Wales and remained there until 1989 when she was appointed Director of Nursing and Clinical Services at Westmead Hospital – the position she held at the time of her retirement.

After several years 'retired', Jan then moved to Tasmania to live. She worked for a time as night duty supervisor at Rosary Gardens Nursing Home until her illness meant that she had to retire completely.

We have never encountered anybody who had an unkind word to say about her – even by those who were on the receiving end of a decision they did not agree with. Given the diverse and challenging nature of the nursing workforce in any large hospital that is an astonishing achievement

Jan's patient advocacy, staff advocacy and her successful collaboration with medical and allied health professionals and other health service staff are legendary. Jan achieved a great deal as an intensive care nurse and nurse educator as well as in the delivery and management of clinical services. She also published and presented papers on a wide variety of subjects.

Our lives were the better for knowing Jan Stow.

(Edited extract from *The Lamp,* NSW Nurses & Midwives' Association - written by Patricia Staunton AM and Judith Meppem PSM FACN)

ANNE DAVIES MACN

Anne was a member of RCNA and ACN for almost 20 years. Anne was an active member of the RCNA SA Chapter and the Health and Wellbeing in Ageing Faculty Advisory Committee. Her generous contribution of time and expertise was greatly appreciated.

After completing school, Anne matriculated into physiotherapy; although her time studying physiotherapy was short lived as she moved into a nursing career.

While pursuing her nursing training at the Princess Alexandra Hospital in Brisbane, Anne married Lieutenent Rick Davies. With army life providing postings to various places around Australia, children were bound to arrive in different parts of the country - Jessica in Canberra, Roland in Toowoomba and Gerwyn at the Ipswich Hospital.

After her marriage breakup, Anne returned to study, retraining and completing her nursing degree, graduating from the University of the Northern Territory. This was also the start of her academic career and passion for the empowerment of Indigenous women in their communities.

In 2005, Anne completed her Master of Health Studies through the University of Queensland, receiving the highly acclaimed Dean's commendation of Academic Achievement. She spent several years in and around Tennant Creek and Alice Springs, training Indigenous nurses and initiating programs in aged care. It was during this period that Zoe and Patrina entered her life as foster children – a protective role she cherished - managing to care for them and eventually reuniting them with their custodial grandparents.

It was no surprise for her family when she was the recipient of the Northern Territory's 'Living Legend Award' for her service to the Aboriginal community. Anne moved to Adelaide where she cemented her teaching role as she accepted a position as Senior Lecturer in Nursing at Flinders University. Anne provided great insight and influence in the University's research work of the health care of the older person group. As a highly respected and valued colleague she paved the way for her peers in the engagement and improvement in care of the older person.

Anne placed great importance on the training of efficient, empathetic, professional and caring nursing staff - something she witnessed in the many hospitals she visited during her own 18 month struggle with cancer, particularly the oncology, palliative care and nursing staff at the Mater Private Hospital in Brisbane.

When discussing her illness with Roland once, in her usual upbeat manner, Anne said, "Don't worry Roland, it is just another part of my journey."

(Edited extract from Anne's eulogy delivered by her brother, Peter)

TAKING LEAVE IS NOW EVEN EASIER!

The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is an Australian Government funded program that supports rural and remote nurses, midwives and eligible allied health professionals to take leave by providing their employers with access to locum support.

NAHRLS is a component of the Australian Government's National Health and Hospital Network Reform agenda and has been established to address some of the challenges and barriers that rural and remote health professionals face when trying to take leave.

CLIENT CASE STUDY

June Swearse
Clinical Services Coordinator
Peterborough Hospital

Peterborough Hospital is a small rural hospital approximately 250km north of Adelaide, just off the Barrier Highway, South Australia. We have 23 beds, eight resident aged care, accident and emergency (AE), theatre, post-natal care and visiting allied health.

We have around 1,600 people in our community but upwards of 2,000 in surrounding areas. Our socio-economic disadvantage lies in our population breakdown which has a high number of elderly patients with many varied diagnosis. Our hospital also looks after mental health patients, AE cases from motor vehicle accidents and farming and slaughtering industries.

The challenges we face in getting support are that it is often difficult to attract casual staff that need financial security. Long distances to travel for agency staff are also a deterrent. We are budgeted only for one registered nurse and one enrolled nurse per shift so minimal permanent staff are available to cover staff on holidays or study leave.

We heard about NAHRLS from other units, who had used the program, and it was easy to register for help. NAHRLS Recruitment Advisers were very helpful, as we hadn't done this before. We also didn't have to pay any commissions or fees.

NAHRLS has helped us cover much needed support for annual leave. It gives our staff the chance to take holidays or study leave and ensures that other permanent staff are not having to work extra shifts to cover their absence.

We have used three different locums and all were excellent professionals, very good and supportive to our staff. I hope they enjoyed their experience with us here at Peterborough Hospital. We would certainly use the program again and we highly recommend NAHRLS to others.

USING NAHRLS IS EASY AND COST EFFECTIVE

NAHRLS can provide a suitably matched locum for up to 14 days (per request). We can also relieve multiple staff that need to get away at the same time. There are no fees, the hosting organisation is only responsible for covering the base locum wage (including superannuation and GST) for the period the locum is required.

NAHRLS is responsible for all the administration associated with recruiting and credentialing appropriate locums. We also arrange and cover all the costs of the locum's travel, accommodation, meals and incentives payments whilst on placement.

NAHRLS will help your health service save on expensive locum agency fees, reduce the administrative burden in engaging locums for short periods and assist you and your staff with accessing training and leave. NAHRLS can also assist with requests to place multiple, simultaneous locums to cover leave requirements for more than one staff member.

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