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**#13 AUTUMN 2016** (March – May)
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We love to see member submissions in *The Hive*. If you're interested in having your submission considered for publication, please see our guidelines and themes at **www.acn.edu.au/publications**.
For enquiries or to submit an article, please email **publications@acn.edu.au**

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

## CEO WELCOME

Adjunct Professor Kylie Ward FACN, ACN Chief Executive Officer

Welcome to the Autumn edition of *The Hive*. With this year marking the 10th anniversary of the Closing the Gap campaign for indigenous health equality, it is fitting to be exploring this area within our theme, Multicultural and indigenous health.

We have some fantastic articles that delve into culture and health on a local and international level and celebrate the diversity within our health workforce, but also highlight the areas of need, where there is much more work to be done in improving access to quality health care for all.

Emerging Nurse Leader **Jenyfer Joy** MACN has written about her experience of volunteering in Cambodia to help teach basic health principles to communities in Phnom Penh and Veal Veng, while **Elisha Aigbokhan** MACN shares his journey of relocation to Australia from Africa to further his nursing studies and career.

We also hear from professionals working in the indigenous and multicultural health space in a collection of profiles with insightful forewords by **Janine Mohamed**, Chief Executive Officer of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) and **Dr Ruth De Souza** MACN, Stream Leader, Research, Policy and Evaluation at the Centre for Culture, Ethnicity and Health. It is wonderful to see such passion and energy for achieving equity across the health care system.

Palliative care nurse **Mandy Cleaver** MACN continues this exploration into the complexities and importance of cultural awareness in her reflective piece, *Varying degrees of diversity – Lessons in cultural awareness*.

Then, venturing outside of this edition's theme, **Heather Blackall** MACN gives us a remarkable look into the challenging, yet rewarding work of a correctional nurse in her article, *Nursing behind the razor wire*. Also making a difference in her area of expertise is **Bernadette Mulcahy** MACN, who explores the value of a holistic client-centred approach to care in a case study on Werribee Mercy Hospital's Health Independence Program.

Reflection is an important and powerful tool for professional development which we encourage our Emerging Nurse Leaders to harness. **Meg Bransgrove** MACN discusses the growing pains of a 'baby nurse' as she looks back at her first 12 months in the profession in her piece, *One year later…*.

It is excellent to see our members coming together for events across the country. **Nancy Arnold** MACN gives a rundown of Acting Chief Nurse and Midwifery Officer of Tasmania **Francine Douce** MACN's leadership workshop in Tasmania and we share a report from **Roma Dicker** MACN, who represented ACN at the Bangka Day Memorial Service in South Australia.

I hope you enjoy this inspiring read!

## PRESIDENT'S REPORT

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

Since being elected president in December last year, it has been a privilege to continue to work alongside the CEO and the Board to further strengthen the Australian College of Nursing's (ACN) strategic direction to enhance health care by advancing nurse leadership.

Advocating for and engaging with members, students and the wider nursing profession is key to ACN moving forward. The launch of the new website (acn.edu.au) has been an important step in facilitating this engagement through a contemporary and informative platform. It is excellent to see the organisation's leadership in policy, education and professional development presented so clearly. I hope you like the new look and functionality as much as I do.

> *"Advocating for and engaging with members, students and the wider nursing profession is key to ACN moving forward."*

An important move in the advocacy arena for ACN has been our involvement in the Choosing Wisely Australia initiative. I attended the launch in Sydney recently where ACN launched its key recommendations alongside 12 other medical colleges, societies and associations. These recommendations identified common tests, processes or procedures that evidence shows is unnecessary (See p3). This is an area in which nurses can influence and lead change to advocate for their patients' best interests.

Another influential event that ACN will be involved in is the World Health Professions Regulation Conference in May in Geneva, Switzerland. The event will provide insights and facilitate discussion around the current challenges in health professional regulation.

On a more local level, it is great to see our members connecting at our Region events. ACN will be facilitating many more valuable professional development and networking opportunities in every state, with our Leadership FIRST workshops and CPD courses running throughout the year, the National Nurses Breakfast in May, Community and Primary Health Care Nursing Week in September and the National Nursing Forum in October. I look forward to engaging with the membership base at many of our future events.

# NURSES ADVOCATE FIVE "WISE" RECOMMENDATIONS TO ELIMINATE UNNECESSARY PRACTICES AND IMPROVE PATIENT OUTCOMES

Adjunct Professor Kylie Ward at the Choosing Wisely launch

Choosing Wisely Australia
An initiative of NPS MedicineWise

The Choosing Wisely initiative supports the health care community and consumers to start conversations about eliminating the use of unnecessary and sometimes harmful tests, treatments, and procedures. The Australian College of Nursing (ACN) is proud to be the first nursing organisation to partner with the initiative, which launched a second wave of recommendations on 16 March encouraging nurses to influence current practice to ensure patients receive the most effective, appropriate and safe interventions.

There is an increasing complexity of tests, treatment and procedures available to clinicians across health care settings, however, not all of these benefit patients or result in efficient or effective use of limited health resources. ACN consulted with members to identify five tests, processes or procedures that are common in clinical practice and well within the sphere of nursing leadership to influence.

The five key recommendations by ACN and its members are:

1. **Don't replace peripheral intravenous (IV) catheters unless clinically indicated.**
   Peripheral intravenous catheters (IV) are routinely used for vascular access. The unnecessary removal and replacement of a functional IV catheter breaches skin integrity, posing an increased risk of health-care-associated infection and trauma to patients. This in turn frequently results in increased length of stay, less than optimal health care outcomes and unnecessary use of health resources.
   Evidence suggests there is no significant difference in cases of phlebitis if peripheral IV catheters are replaced only when clinically indicated. Common clinical indications for replacement include phlebitis, infiltration and blockage.
   Catheter related trauma and infection may also be minimised by vigilant monitoring of the insertion site by health care staff and removal of catheters as soon as it is no longer required.
2. **Don't restrict the ability of people with diabetes to perform their blood glucose monitoring unless there is a clinical indication to do so.**
   Imposing unnecessary blood glucose monitoring regimes that change a person's routine and are random, low frequency or do not provide patients or health care professionals with information that is of value in managing diabetes, will not enhance therapeutic goals.
   The ability to self-care also empowers people and helps to engage them in developing and maintaining behaviours and lifestyle choices that result in improved long-term health outcomes. Blood glucose monitoring should provide feedback relevant to a person's management plan, including frequency of timing and testing. In addition, unclear or inconsistent monitoring interventions can be needlessly traumatic, may confuse patients and even discourage them from the self-management process.
3. **Don't routinely administer antipyretics with the sole aim of reducing body temperature in undistressed children.**
   Fever is defined as a rise in body temperature above the normal range of approximately 37.8 degrees Celsius and is commonly seen as a primary indication of illness in children. It is a normal physiological response to infection and it will not place a generally healthy child at harm. The benefits of fever in slowing the growth and replication of bacteria and viruses are well documented within the literature, however, the administration of antipyretic therapy to reduce fever remains a common clinical intervention. Current evidence does not support the routine use of antipyretics solely to reduce body temperature but to maximise the comfort and well-being of the distressed child as an adjunct to the investigation and management of the cause of the fever.
   Antipyretic therapy is not effective in managing adverse symptoms of fever such as febrile convulsion. Supportive care that includes parental education is also important to increase understanding and to decrease anxiety.
4. **Don't use urinary catheters to manage incontinence unless all other appropriate options have proved ineffective.**
   Urinary tract infections (UTIs) are the most common health-care-associated infection, the majority of which can be associated with the use of indwelling urinary catheters (IDC). UTIs in hospitalised patients may increase morbidity and mortality, antibiotic exposure and often prolong the length of hospital stay. The use of indwelling urinary catheters to manage incontinence is not recommended unless as a last resort or to prevent wound infection or skin breakdown and should be removed as soon as possible.
5. **Don't initiate plain X-ray for foot and ankle trauma unless criteria of the Ottawa Ankle Rules (OARs) are met.**
   Traumatic injury to the foot and ankle are a common reason for presentation to the emergency department. The Ottawa Ankle Rules (OARs) are an effective screening tool to guide the use of plain X-ray in the evaluation of these injuries.
   Validation studies have found that the OARs have an almost 100% sensitivity in many studies in a number of clinical settings. The correct application of the OARs can identify patients who are likely to have a clinically significant fracture and reduce unnecessary use of diagnostic imaging resources by 30-40%.

"As the voice of the nursing profession, the Australian College of Nursing has a responsibility to take a leadership role in representing the expertise of our members and amplifying their collective voice about improving health care for patients and their families. A crucial part of this is not only the responsible management of finite health care resources but also ensuring that nurses' expertise and recommendations are an important part of shaping health care practice and policy," said Adjunct Professor Kylie Ward, ACN CEO.

ACN will remain engaged with members and will expand on the list in the future as necessary. We will engage with the nursing profession, through our members and networks to ensure that our recommendations are known widely and generate change in health care.
Visit **www.acn.edu.au/choosing-wisely** for more information.


Veronica Casey FACN, Executive Director, Nursing Services, Queensland Health, speaking at the 2015 National Nursing Forum.

## NATIONAL NURSING FORUM CALL FOR ABSTRACTS NOW OPEN: BE INSPIRED BY THE POWER OF NOW

The call for abstracts is now open for the Australian College of Nursing's National Nursing Forum and we invite interest from across the nursing profession in health and aged care, education, management, academia, clinical or research areas that address the most current and topical issues in nursing. Abstracts can be strengthened by identifying a clear link to the Forum theme, The Power of Now. Visit **www.acn.edu.au/nnf2016** to view the guidelines and submit your abstract. Submissions close 8 May 2016.


## EXPLORE THE LATEST IN NURSING RESEARCH AND PRACTICE

Have you heard? The new issue of the Australian College of Nursing's (ACN) official journal *Collegian: The Australian Journal of Nursing Practice, Scholarship and Research* is now available. Access to the digital journal is free for all ACN members. Simply login to 3LP at **3lp.acn.edu.au** and find it under the ACN Publications tab.

If you need support logging into 3LP, please contact the ACN membership team at membership@acn.edu.au or on 1800 061 660.


## CELEBRATE INTERNATIONAL NURSES DAY – REGISTER FOR YOUR BREAKFAST KIT TODAY!

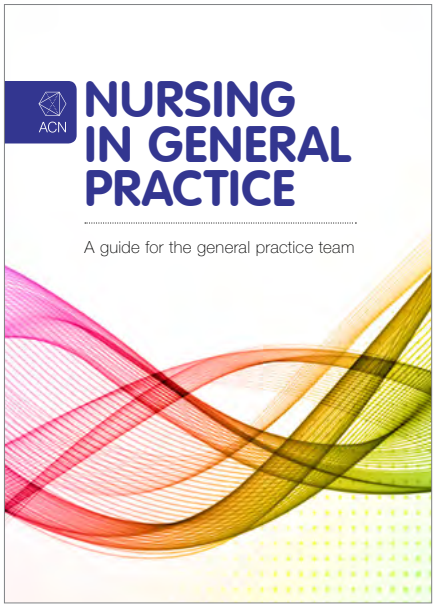
Do you have plans for International Nurses Day on 12 May? Register your workplace, university or community centre as an Australian College of Nursing (ACN) National Nurses Breakfast host and you will receive a free hosting kit full of materials to help theme and decorate your venue. The ACN National Nurses Breakfast is the perfect opportunity to come together with friends and colleagues to celebrate International Nurses Day and the invaluable contribution nurses make to the health of our society. Visit **www.acn.edu.au/breakfast** to find out more and register your event today.

## NURSING IN GENERAL PRACTICE HANDBOOK AVAILABLE TO ORDER

If you are a nurse working in a general practice setting, the Nursing in General Practice (NiGP) handbook is essential reading, and it's FREE.

The NiGP handbook was developed by the Australian College of Nursing to provide up to date and useful information about nurse and specialist nurse practitioner roles in contemporary general practice settings.

It contains details about employing and supporting RNs and ENs, the current regulatory environment, how to maximise the benefits, including the Practice Nurse Incentive Program and the range of MBS items that support nursing services in general practice. Visit **www.acn.edu.au/white-papers-handbook** to order a free printed copy or download a PDF.




## ICN CONGRESS 2017 CALL FOR ABSTRACTS

The International Council of Nurses (ICN) is inviting abstracts for the 26th ICN Congress in Barcelona, Spain from 27 May – 1 June 2017.

This international gathering of thousands of nurses will explore the key role of nurses in transforming care through practice, science, knowledge and equity to serve people. Visit **www.icncongress.com**

# POLICY SNAPSHOT

**The Australian College of Nursing (ACN) has received a wide variety of interesting consultation requests throughout the first quarter of 2016. Strong feedback from our members has provided the policy team with contemporary advice helping to shape ACN's responses to matters including nursing regulation, future health system plans and national education frameworks. The policy team has also developed ACN's first five recommendations as part of the Choosing Wisely Australia program, designed to improve health care quality by encouraging clinicians and patients to engage in conversations about unnecessary tests and treatments.**

## NATIONAL

### REGULATION

**NMBA Public Consultation Paper on Proposed Discontinuation of the Registration Standard for Scheduled Medicines Endorsement Registered Nurses (Rural and Remote Practice)**

The Nursing and Midwifery Board of Australia (NMBA) recently sought feedback on its proposal to discontinue the Registration Standard for Scheduled Medicines Endorsement Registered Nurses (Rural and Remote Practice) also known as the RIPEN endorsement standard.

During the transition to the National Registration and Accreditation Scheme (National Scheme) in 2010, the NMBA identified that there were endorsements in place in both Victoria and Queensland that enabled registered nurses practicing in rural and remote areas to supply scheduled medicines in accordance with approved protocols, a practise in place since the 1990s.

To enable these registered nurses to continue to supply medicines after the start of the National Scheme, and the introduction of the Health Practitioner National Law, the Ministerial Council agreed to approve the NMBA proposal for an endorsement in relation to scheduled medicines for registered nurses (rural and isolated practice). It also approved the NMBA's Registration Standard for Endorsement for Scheduled Medicines Registered Nurses (Rural and Isolated Practice) (RIPEN endorsement standard). This registration standard was due for review within three years of implementation.

ACN members voiced a number of concerns regarding the discontinuation of the standard. While ACN's response acknowledged the significant amount of time during which appropriate arrangements might have been made by jurisdictions to support nurse initiated medicines, members were primarily concerned that discontinuing the standard would adversely affect the ability for patients to access medicines in a timely manner.

The response called upon the NMBA to consider how and when an appropriate model of non-medical prescribing might be implemented to support and maximise the nursing scope of practice particularly in the many situations where nurses often provide frontline health care. ACN argued that a transition period that enables RIPEN endorsed nurses to translate their current qualifications into a non-medical prescribing model would help prevent the delay caused by retraining and lessen the impact of discontinuing the standard.

### PRIMARY HEALTH CARE

**Healthy Tasmania Five Year Strategic Plan – Community Consultation Draft**

In February 2016 ACN responded to the Tasmanian Government's *Healthy Tasmania Five Year Strategic Plan – Community Consultation Draft.* ACN has previously offered a number of submissions to the Tasmanian Government including most recently a white paper on Delivering Safe and Sustainable Clinical Services. The Tasmanian Government came into office in 2014 with the ambitious goal of making the state of Tasmania the healthiest population by the year 2025 and a clear focus on investment in preventative health care.

In its submission, ACN stressed the importance of nursing roles in preventative health care such as health promotion, health literacy and addressing the social determinants of health (SDH). ACN highlighted that the challenges of addressing the SDH were well within a nursing scope of practice however, constraints in funding and jurisdictional and national policy often restrict nursing's full potential. ACN highlighted particular roles nurses have in delivering health care amongst vulnerable populations including the elderly and individuals with mental health conditions. ACN also expressed the view that a person-centred approach should be the centre of the design process.

**Choosing Wisely Australia: The Next Wave**

ACN is proud to be the first nursing college in Australia to be included in the Choosing Wisely initiative by the NPS MedicineWise (NPS). Choosing Wisely is an initiative that enables health care provider's consumers and stakeholders to raise questions about tests, treatments or procedures where evidence shows they provide no benefit and in extreme cases may lead to harm. With an ever increasing number of tests available, health professionals including nurses frequently initiate tests that are often unnecessary resulting in suboptimal use of limited health resources.

ACN is participating in Wave II and has put forward five recommendations. Members have been heavily involved in the development of recommendations via ACN's website and publications, culminating with the Choosing Wisely session at the National Nursing Forum. Initial collaboration with peak professional

*“With an ever increasing number of tests available, health professionals including nurses frequently initiate tests that are often unnecessary resulting in suboptimal use of limited health resources.”*

The ACN Policy Team formed a response to the draft National Immunisation Education Framework for Health Professionals.

nursing bodies was also sought and specialist nursing groups were approached for comment on the recommendations.

ACN has presented the recommendations at the Choosing Wisely Australia Wave II launch which was held on 16 March in Sydney (See page 3).

**National Immunisation Education Framework for Health Professionals**

In January 2016 ACN was asked to comment on the draft *National Immunisation Education Framework for Health Professionals* released by The National Immunisation Committee (NIC) Provider Competency Working Group (IPCWG). The draft document is a revision of the 2001 National Guidelines for Immunisation Education for Registered Nurses and Midwives (the National Guidelines) and defines the changing face of the immunisation workforce. The document defines the minimum education standard for health professionals to be authorised as independent immunisers. ACN believes that the *National Immunisation Education Framework for Health Professionals* is a positive step toward consistency in the education and training of the immunisation workforce.

ACN highlighted concerns regarding the minimum standards by which authorised immunisers are educated and raised concerns regarding the inconsistency across immunisation education courses currently available. ACN believes that there needs to be a formal process to ensure consistency with the proposed standards occurs across jurisdictions.

## INTERNATIONAL

### HEALTH WORKFORCE

**Australian College of Nursing Examples of Collaborative Primary Health Care (PHC) Models, Best Practices and Tools for Supporting National Non-communicable Diseases (NCD) Efforts in Australia**

ACN is a member of the International Council of Nurses. In February 2016 ACN provided a response briefing for Dr Frances Hughes, Chief Executive Officer for the International Council of Nurses (ICN), for the Stakeholder Forum – First WHO Global Meeting of National NCD Programme Managers and Directors organised by the WHO GCM (Global Coordination Mechanism). This meeting included six interactive stations, focused on elements of the four time bound commitments in the 2014 United Nations Outcome Document. Dr Hughes chose to attend the station on health systems to present PHC models from different regions where nurses play a significant role for the effective prevention and management of NCD.

ACN’s policy team composed advice on a number of collaborative national models to which nurses contribute to address non-communicable disease efforts in Australia. This included the Mental Health Nurse Incentive Program (MHNIP), Practice Nurse Incentive Program (PNIP) and the Nurse Endoscopist Training Pathway. ACN emphasised that amendments to legislation in 2010 such as admitting nurse practitioners and midwives as eligible providers under Medicare, the backbone of Australia’s Commonwealth funded universal health care scheme, had been a positive step towards utilising nurse led models of care.

## ACADEMIC

### MR JAMES BONNAMY MACN

Nursing courses now have an increasingly culturally diverse mix of students and educators. This is fuelled by increasing numbers of overseas students and growing access to nursing courses (De & Richardson, 2015). Multicultural health and cultural safety are mandated themes within nursing education which is unsurprising given steady changes in Australia's cultural demographics.

Nurse educators must use various strategies to help students develop a culturally competent practice of care. This is required to prepare students to deliver care within their patient's cultural identity. Consideration must be given to multicultural health and cultural competence in every aspect of the nursing curriculum. A siloed approach to teaching multicultural health only further isolates an often underrepresented topic within the nursing curriculum (Starr, Shattell, & Gonzales, 2011).

There are many ways that multicultural health can be embedded throughout a nursing curriculum, including multicultural health projects, placements and interprofessional simulations and use of culturally diverse patient case scenarios during tutorials and lectures. Nurse educators are encouraged to embrace topics including cultural differences in clinical encounters, strategies to resolve racial and ethnic health disparities and the elements of effective communication among culturally diverse individuals and populations (Flowers, 2004).

Creative approaches are necessary to prepare culturally diverse student populations for intercultural care competence to strengthen the skills of the nursing profession and ensure safe, culturally competent care for all.

**References**

De, D., & Richardson, J. (2015). Ensuring cultural safety in nurse education. *Nursing Times*, 111(39), 17-19.

Flowers, D. (2004). Culturally Competent Nursing Care: A Challenge for the 21st Century. *Critical Care Nurse*, 24(4), 48-52.

Starr, S., Shattell, M., & Gonzales, C. (2011). Do nurse educators feel competent to teach cultural competency concepts? *Teaching and Learning in Nursing*, 6(2), 84-88.

## CLINICIAN

### MS TOMICA GNJEC MACN

Some 15 years ago I nursed an elderly non-English speaking Japanese gentleman (Mr T) with a terminal cancer diagnosis. On his arrival at the hospice facility his family explicitly requested that we not discuss nor disclose his diagnosis with him. I struggled with this at the time, wondering if Mr T wanted or needed to know what was going on. On further exploration, I found that it is an old Japanese tradition of not explaining to terminally ill individuals the true nature of their condition (Kimura 1996). It was also accepted practice of family members making surrogate decisions on behalf of patients.

Despite not being able to understand the communication between Mr T and his family, I witnessed a deep level of respect, care, love and support for the head of their family. I sensed no fear, apprehension or sorrow in Mr T, but a level of comfort, peace and reassurance with his family journeying alongside him during his last days.

Vogel (2014), in her blog on Transcultural Nursing in Australia, reviews the ingredients of the previously developed ACCESS model to aid health professionals in bridging the cultural gap and providing acceptable transcultural care. The six pertinent points outlined are cultural assessment (health beliefs and practices), communication, cultural negotiation and compromise, establishing respect and rapport, cultural sensitivity and safety.

As clinicians it, too, is important to carry a level of self-awareness of our interactions with individuals and their loved ones with the ultimate goal of achieving appropriate multicultural health care.

In the above scenario the family knew Mr T intimately on so many levels. They chose the 'right' final road for Mr T in providing unconditional love and care whilst respectfully upholding his ancient cultural beliefs and traditions of the dying process.

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Kimura, R. 1996, 'Death and Dying in Japan', *Kennedy Institute of Ethics Journal,* vol. 6, no. 4, pp. 374–378, <http://www.bioethics.jp/licht_biodying.html>

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## NEWLY REGISTERED

### MS LAURIE BICKHOFF MACN

When discussing multicultural health, the focus often remains on how we can safely care for patients from a wide variety of cultures. However, just as important is acknowledging and respecting the cultures of our colleagues. As nurses, we need to ensure our workplaces are culturally safe and this responsibility lies not only with health care executives and managers, but with all those who work within health.

This issue was highlighted to me whilst I was completing my honours research project. The project explored if undergraduate nursing students would question poor practice they witness during clinical placements and what motivated them to intervene. I found one student's experience very interesting. This student was from Zambia and he explained to me that within his culture, it was considered extremely disrespectful to question anyone older than yourself. This made him reluctant to question other nurses; even if he knew what they were doing was wrong. He described his struggle to balance his duty as a patient advocate with his cultural background.

I couldn't help but feel we had let this student down. His teachers, both at university and his supervising nurses during placements, had solely focused on the patients' cultural backgrounds and missed a crucial factor – how his culture would influence his future nursing practice. Luckily, the student found the support he needed.

It is reassuring to know his classmates – our future colleagues – were able to offer the support this student needed and already have the insight needed to create culturally safe workplaces. Hopefully, their influence will spread and our multicultural nursing workforce will be celebrated.

## ETHICIST

### PROFESSOR MARY CHIARELLA FACN

Conduct statement 4 of the NMBA Code of Conduct (2008) (the Code) states that "Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues". This is absolutely in keeping with the "minimum standard" expected of a health professional, but how well do we achieve this?

Explanatory statement 1 reads as follows: "In planning and providing effective nursing care, nurses uphold the standards of culturally informed and competent care. This includes according due respect and consideration to the cultural knowledge, values, beliefs, personal wishes and decisions of the persons being cared for as well as their partners, family members and other members of their nominated social network. Nurses acknowledge the changing nature of families and recognise families can be constituted in a variety of ways." (p.3)

How "culturally informed and competent" are we? How much homework do we do to understand our clientele and their "cultural knowledge, values, beliefs, personal wishes and decisions"? How do we respond if they differ from ours?

We live in a diverse and wonderful multicultural society. That brings with it huge responsibilities for us as nurses and the Code makes these responsibilities explicit. It is important to realise that the three purposes of the Code are to outline a set of minimum national standards of conduct members of the nursing profession are expected to uphold; to inform the community of the standards of professional conduct it can expect nurses in Australia to uphold, and to provide consumer, regulatory, employing and professional bodies with a basis for evaluating the professional conduct of nurses. Not an aspirational standard – a minimum standard.

How many of us can honestly say we always meet this minimum standard? I am sure I cannot. There are many cultures about which I know very little and thus on occasion I may be at risk of transgressing some cultural norm. Cultural awareness and cultural competence must become mainstream education for nurses if we are to be serious about multicultural health.

## MANAGER

### ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

**The role of the nurse leader in multicultural health**

When thinking about multicultural health it's hard to differentiate between the diversity we face in terms of the population we serve and the workforce we employ.

In my organisation alone the top cultural backgrounds of nurses are Australian followed by India, United Kingdom, Philippines, China, New Zealand, Sri-Lanka, Malaysia, South Africa and Zimbabwe, with a further 40 different nationalities. Our population in South East Melbourne speaks over 100 different languages. As the world has become smaller with travel and the internet, those stark cultural differences are blurring.

Where we are seeing the differences more pronounced is in the refugee populations, particularly from highly disadvantaged third world and war torn countries. Nursing is in a perfect position to support and lead the care for those people struggling to transition to their new lives. The opportunity for nurses to develop new models of care, as well as nursing roles to respond to these challenges is happening today. We now have refugee health roles, nurse practitioners and midwives who are working in refugee communities leading and coordinating care across the lifespan.

As a nurse leader I get to experience the challenges that diversity can sometime cause. Respect and patience go along way when working with a patient or a nurse from a different culture. I see my role as pivotal in ensuring those values are present in our workplaces and that the patient no matter what their cultural background is at the centre of the decisions and care we provide.

Providing care for the multicultural population by our multicultural workforce is what we do every day.

# COURAGE, COMPLEXITY AND COMPASSION IN CAMBODIA

*By Jenyfer Joy MACN, Emerging Nurse Leader*

## ARRIVAL

The midday heat hit my face. Under my black jeans and thick woolly jumper, my skin slowly boiled. I had not realised how hot Cambodia could be in June. I had left the frosty winter breeze of Sydney at five in the morning on the 28th of June 2015 and arrived in Cambodia's capital, Phnom Penh, the next day. I had been selected as part of a team of university students to teach basic health principles.

As a third year nursing student this was an excellent opportunity to work closely with rural communities and schools to increase awareness about life-saving techniques such as basic life support. For the first week, I collaborated with eight other university student volunteers to come up with lesson plans. We were going to be teaching basic life support to the high school students and communities in the afternoons and begin with health and hygiene lessons in the morning for the primary school students.

## COMPLEXITY IN PHNOM PENH

As the only nursing student in the group, I was in charge of coming up with the content of the lessons for the basic life support lesson. "Basic life support would be easy," was my first thought. The principles of basic life support was drilled into me as a student in the first year of nursing. The afternoon of our first lesson arrived and we travelled one hour by tuk-tuk to a railway track.

Our group of volunteers were guided by the coordinator of the Australian Volunteers International organisation through the railway tracks and down a hill. We were led into the bottom level of a small concrete building consisting of four rows of wooden tables inside. My team set up our lesson and anxiously awaited as the community members arrived. The majority of the members were women, especially mothers with their babies. Our interpreters looked at us with a smile and we began our introduction. We jumped straight into the lesson and I was slightly surprised when some of the members started leaving the room. At the end of the lesson, I felt exhausted. The heat and the constant movement in the room was something I had not expected.

The time for questions arrived. We were asked by one of the members what they would need to do in the event of finding an unresponsive person. "Send for an ambulance," said one of the volunteers. The interpreter informed us that ambulances were an expensive luxury and often took time to arrive at the location. Our team did not have an answer.

Teaching health and hygiene to school children

The situation was complex. We were not aware that ambulances were expensive and defibrillators were not commonly available. Furthermore, in Phnom Penh it was normal for cars and motorbikes to continue moving around an unconscious person on the road.

I felt disappointed. I had arrived thinking that I would be able to help. But the complexity of the situation was something that would only change over time. At the end of the first lesson our coordinator congratulated us. He stated that it was normal for people to move in and out of the rooms. Most of the mothers were working mothers and it was out of their willingness to learn that they decided to come to our lesson.

Teaching in the schools was a different experience. Some children peered through the window grills into the classroom as we taught health and hygiene. In South-East Asia, Cambodia has an increasingly high number of children engaged in child labour, with up to 90% of them being unpaid five to seventeen year olds (Kim, 2011). Although there has been a significant increase in education enrolment, nearly half of the students drop out before finishing their higher school certificate. Again, this was another complexity.

After delivering over 30 lessons in Phnom Penh, we had learned to answer some of the questions of the community members. We became more flexible in our approach to basic life support. The best approach, I soon found, was to integrate the principles of basic life support with the practices already in place. For instance, the community members found the first aid acronym DRSABC easy to remember. It was straightforward and could be applied by almost any young adult. There were other practices such as rubbing on the person's chest or jumping over their bodies. I appreciated learning the traditional practices from the members and found it insightful to hear about how the community members responded to a life-threatening event. But just as I got used to teaching in the capital city, the time came to depart for the rural city of Veal Veng.

*"I appreciated learning the traditional practices from the members and found it insightful to hear about how the community members responded to a life-threatening event."*

The beautiful Cardamom Mountains

## BEAUTY OF VEAL VENG

After one full day of driving through the rural district we finally arrived at our location. With the beautiful view of the Cardamom Mountains as a backdrop and with the roads not half as busy as Phnom Penh, Veal Veng was refreshing. Like our first day in Phnom Penh we were slightly nervous as to how the community members would react to us. But any preconceptions we had were shattered when we were welcomed by a stampede of school aged children on our first day in the schools. The community members stopped what they were doing and waved to us as we walked by.

Rural Cambodia was bustling with exciting activity. The people were busy preparing food and all types of delicacies in the markets. Children ran freely on the streets and docile dogs wandered around. At the end of our first lesson, the elder in the community, a woman who was 80 years old, asked us what the best practice was to treat superficial wounds and burns. She described the typical approach involved soaking the wound in salty water. However, she stated that soon the wound would become infected and the person would have to drive a whole day to go to the main hospital in Phnom Penh.

We discussed about whether it was practical to clean the wound with clean running water first and then cover the wound with a clean cloth. This addressed the problem of infection. Another member stated she had great results by applying honey topically and even achieved healing by covering it with a clean banana leaf. Our group agreed that the simplest techniques were the best and the members were pleased to incorporate the principles that achieved the best results. Since the closest hospital was more than one day's worth of travel and the nearest pharmacy contained the basic supplies, some women were trained in the basics of first aid and incorporated traditional medicines in their practice.

One of the most memorable parts of the trip to Veal Veng was the visits to the local villagers' houses. Here I learned the basics of communicating in Khmai, the local language and learned some new skills such as traditional cooking of a banana syrup dessert and making a hammock from dried water hyacinth stems.

## PEOPLE OF COURAGE

The time came to bid farewell to the beautiful country of Cambodia. I will never forget seeing young school-aged children carrying bucketloads of water and dirty laundry in their school uniforms. These children were helping out with the laundry business before their school commenced so that they could help their families earn an income. Nor will I forget the harrowing experience of walking through the haunting corridors of the buildings in the Tuol Sleng Genocide Museum and seeing the overwhelming pictures of the victims of Khmer Rouge led by Pol Pot.

The smiles of the children and the look of triumph on their faces upon learning CPR is something that is still engrained in my mind. Nor will I forget the pride on the face of the elder as she described her experience of raising her children and running her business without a husband. In the few weeks I was there, I witnessed a country which was still healing from its past and which needed much compassion. I had the privilege of befriending people who had experienced so much in the past yet had the resilience and courage to continue striving.

Going to Cambodia required sacrifice but it was the best part of my three-year degree. I am so grateful and honoured to have worked with the people and be accepted into their lives for that short period of time. The traditional practices and rituals I learned about was instrumental in understanding about the Cambodian health care system. As clichéd as it sounds, I gained more than I gave. My ability to be culturally sensitive, emotionally intelligent and to be flexible in trying situations was constantly tested throughout the time I was in Cambodia.

Witnessing the Cambodian way of life and being part of the people's joys and sufferings helped me see the bigger picture. It has made me realise that such volunteering programs are crucial in improving the health care system but also important in giving back as a privileged country. If more students are supported in volunteering in rural health care, both internationally and within Australia, there is a significant potential in the development of culturally sensitive health professionals and the enhancement of the health care system of the present and future.

Making a hammock from dried water hyacinth stems

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# EMBRACING UNCERTAIN GROUND

## FOREWORD

**Dr Ruth DeSouza FACN**

Dr Ruth DeSouza is Stream Leader: Research, Policy and Evaluation at the Centre for Culture, Ethnicity and Health (CEH) at North Richmond Community Health. She has held a wide range of academic, clinical and governance roles, including Senior Lecturer in Nursing at Monash University, Melbourne (2013–2015) and AUT University, Auckland (2005–2012) where she coordinated the Centre for Asian and Migrant Health Research. Ruth's mission is to develop research that translates to improved outcomes for marginalised groups, with a particular focus on cultural safety, consumer participation and health literacy.

*"The word 'translation' comes, etymologically, from the Latin for 'bearing across'. Having been borne across the world, we are translated men. It is normally supposed that something always gets lost in translation; I cling, obstinately to the notion that something can also be gained."*
– Salman Rushdie, Imaginary Homelands: Essays and Criticism 1981–1991

Salman Rushdie writes in Imaginary Homelands about being a migrant and the uncertain and shifting territory that accompanies it, making one's identity both polar and partial. Sometimes one straddles both the country of origin and the new country comfortably, and at other times falls in the space between (1992, p.13). Rushdie challenges the notion that migration only represents loss, and suggests that the uncertainty of migration and settlement can reinvigorate new spaces. The migrant is changed by migration, but the migrant also changes the worlds they enter.

The uncertainty that accompanies the migrant is also processed by the receiving society. Here, however, uncertainty and unpredictability are often viewed as a loss and threat, rather than as spaces of possibility. My own work in cultural safety has advocated for those who are already at home to foster uncertainty. To effectively work cross-culturally requires engaging with our own cultural beliefs as well as those of others, and to consider culture as contingent, contested, negotiated and open-ended. A constructive and conscious examination of the culture of the health system that sees seemingly fixed constructions as variable can yield new practices, resources, metaphors and practical strategies (De Souza, 2013). This special feature focuses on practitioners who are both translators and translated, who bring other ways of seeing things, and whose arrival has the potential to invigorate new thinking and practices.

Contemporary health care is no longer a single national culture. In 2014, there were 610,148 registered health practitioners. Over half of whom (352,838) were nurses or midwives – over three times the size of the next largest group, medical practitioners (AIHW, 2014). More than half of general practitioners (56%), just under half of specialists (47%) and one third (33%) of nurses in Australia were born overseas in 2011 (The Australia Bureau of Statistics, 2013). Nearly 20% of nurses born overseas and one fifth of general practitioners and specialists (both 19%) had arrived in the preceding five years. Their countries of origin have also changed, where once the United Kingdom (UK) overwhelmingly dominated as a source country, an increasing proportion of overseas born nurses and medical practitioners come from outside Europe.

In this new dynamic, the health system is transitioning from a command-and-control colonial institution to a responsive, agile and networked set of practices. Demands from consumers, carers, families and communities have required the health system to reorientate itself from being system-focused to be more patient and family centred. The changes in response to these demands are backed by evidence that doing so enhances effectiveness and quality. I served on the board of a large health organisation in New Zealand that emphasised the idea of the Triple Aim – enhancing patient experience, improving population health, and reducing costs – as a way of optimising health system performance. More recently, the three goals have been expanded to include a fourth aim to improve the work life of health care providers, as evidence shows that doing so also enhances the patient experience. This is particularly important as the toll a complex system exacts on the physical, emotional and mental health of workers is high, as seen in the levels of burnout.

Australia's health system, like those of other settler societies, was based on a colonial model of care exported from the metropole to the colony. Hospitals are recognisable wherever you are in the world, and have been imposed over indigenous modes of healing and wellness in the interests of modernisation. This modern movement was informed by the imbrication of Western scientific and industrial knowledge, focused on efficiency and effectiveness. In this factory model, people are moved through the universal health system as standard units of personhood and treated similarly in order to reach an identical outcome that assumed a homogeneous monoculture.

In Victoria today, the most culturally diverse state in Australia, a quarter of our population were born overseas, originate from more than 230 countries, speak over 200 languages and follow more than 135 different faiths. The shift to patient-centredness in this context requires a broader range of skills. Professionals from culturally and linguistically diverse (CALD) backgrounds bring new ways of seeing and doing health that allow those of us working in health care to expand who we imagine the ideal user of health care to be. They bring different ways of knowing that are assets and which can help innovate the health system. The health leaders profiled in the following pages bring commitments to equity and social justice, a wonderful range of life experiences, and innovative ways of providing health care. Their inspiring work creates opportunities for the health system to consider new and innovative ways of ensuring the needs of diverse people are met.

## CHIEDZA MALUNGA

**Team Leader, Refugee Health and Wellbeing, Monash Health**

**Why did you decide to pursue a career in health care?**
A combination of factors I reckon and what comes to mind immediately is that my work experience soon after my undergraduate qualification in social work led me to a career in health care.

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
My undergraduate qualification is in social work and my first job was in a program addressing psycho-social supports for young women on HIV medication clinical trials. Then I moved to working in sexual health education and prevention of poor sexual health outcomes. This led me to pursuing my Masters in Public Health and from then on I have been working in the health care sector.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I am currently working in Refugee Health and my decision to work in this space was influenced by an interest social justice and health. My role is a good combination of both a social model and medical model of health. After working in sexual and reproductive health for seven years I was ready for a new challenge and opportunity to grow as a young health professional.

**What has been a defining moment in your career?**
Migrating to Australia has definitely been a defining moment as I had to make a critical choice about career pathways in a system that was new and far better resourced. This gave me a different perspective to the nature of social work practice in primary prevention in health care, which I find intriguing. I also found that the importance of culture and diversity is explored in health care and that was a bonus for me.

**What has been your experience working with and caring for CALD people in the health care sector?**
It is a never-ending rollercoaster for both the CALD communities and the professionals. Health systems are constantly evolving which does not make navigating the system any easier for CALD communities. Professionals on the other hand are faced with trying to balance relearning skills in an ever-changing system with time constraints while also needing to grow in their cultural competence. I would say health care professionals are making some inroads into culturally sensitive practice, however, the policies and structures of the health system are a lot slower in that regard.

**What do you hope to achieve throughout your career as a health care professional?**
I hope to learn and continue growing changing and adapting and eventually contribute to research and training of the future generations of health care professionals.

**Do you think it is important that CALD communities have access to specialist health care services?**
I believe CALD communities should have access to specialist health care services as a pathway to transition to generalist health care services. It is a reality that generalist health care services are still difficult to navigate and require additional supports to be able to respond to all vulnerable client groups and until such a time specialist heath care services are the only option. Specialist health care services I would describe as a team that sits in the health care sector to ensure that CALD communities and other vulnerable communities, primarily First Australians and SSA (same sex attracted) people, are not discriminated against.

## CHRIS LEMOH

**Infectious Diseases and General Physician, Monash Health**

**Why did you pursue a career in health care?**
I wanted to do work that was interesting and benefited others, rather than just being about making money.

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
My parents very early instilled in me the importance of people and of living in a way that does some good in the world. I grew up partly in Australia, the UK and in Sierra Leone – my father's home country. He worked as a paediatrician. I could see that his work helped the lives of other people in a place where few had his skills and training. I could see that even a single person's work could make a big difference in the right place.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I am a physician, specialising in infectious diseases. I work in a busy suburban hospital, both in general internal medicine and infectious diseases. I also work in a clinic for refugees and asylum seekers. I have done postgraduate studies in clinical and social epidemiology.
I decided to become a physician because I realised that a surgeon must love operating more than anything else in the world (and I also became very drowsy in theatre during long operations). I entered physician training because I appreciate complexity and always want to hear the end of the story. Infectious diseases appealed to me because I am interested in the interplay between our bodies and their microscopic inhabitants, as we exist in the wider social and physical environment.

**What has been a defining moment in your career?**
My doctoral studies on HIV in Victoria's African communities taught me the importance of humility, respect and critical thinking when examining the impact of social factors on individual and public health. It made me confront the prejudices I had accumulated during my upbringing, education and training. One crucial moment was a conversation I had with a woman whom I met at a workshop for people working in HIV-related health promotion. I had seen her as a patient during my training. She reminded me of this and told me I "had obviously learned a lot since then." I asked her about this at a conference a couple of years later and asked, "Was I really s**t, then?" She said yes, I had been insensitive, tactless, and full of stereotypical assumptions about her and her life… but that I had clearly evolved in my outlook since that time. It was quite challenging, but very gratifying, to receive such honest and – eventually – positive feedback about my development as a clinician and health professional.

**What has been your experience working with and caring for CALD people in the health care sector?**
On the whole, people are polite and considerate towards others, but under stress, the latent prejudices and systematic discrimination surfaces: people who are not fluent in English present more challenges in taking a history, explaining investigations and treatments, or

discussing the short and long term risks and benefits of treatments and procedures. As a result, these discussions are often curtailed, at the very times when they are most important: emergency situations, life-threatening illnesses, or novel, complex treatments. Interpreters are under-utilised, but overworked. Relatives, friends and staff who speak a patient's language are press-ganged into informal interpreting roles for which they may be unready.

**Do you think it is important that CALD people are encouraged to enter the health care sector?**
It is important that health care workforces are inclusive and strive to erase the false dichotomy between the patient and the health worker, or between the health service and the public. The "CALD" label is applied to distinguish "Them" from "Us", but the more perspectives and social linkages that exist between the workforce and those we serve, the more ethical and empathetic we will be in caring for our patients. I have tried to approach every patient first as a person, aligning myself as much as possible with their perspective and trying to see their problems as a common challenge to be overcome, rather than an abstract intellectual exercise. I have been variably successful, but I keep trying!

## ALISON COELHO

**Stream Leader, Multicultural Health Improvement, Centre for Culture, Ethnicity and Health**

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
I am a woman, a mother and have been a migrant twice. I'm a woman of colour, a post-colonial feminist, a human rights activist from a mixed cultural/ethnic background and I am Catholic. These key elements, my learnt and lived experiences, my relationships influence all that I do. They help me to identify and challenge gaps and system failures that pose barriers to good health care access. I am driven to change systems that perpetuate inequity and discrimination.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I currently manage the only statewide BBV/STI prevention service, specifically targeting multicultural communities. I chose this area as it is highly stigmatised and sensitive both at a community level but also at a mainstream service access level. I have embedded a community led focus in program design and planning, implementation and evaluation. I believe that better systems of care and support exist when those that use them, run them; not in a traditional organisational sense, but in a flexible, culturally competent and safe manner.

**What has been a defining moment in your career?**
During my study, I was profoundly influenced by the teachings of a number of great social theorists and lectures. This inspired me to take a more active role in social justice and environmental issues. While there was no particular defining moment, no epiphany as such, I thrived on ideas and working alongside affected communities. I am privileged to still work with committed people, developing partnership and strategic alliances and improving the lives of communities by informing and influencing policy at all levels of government regarding the health and wellbeing of multicultural communities.

**What has been your experience working with and caring for CALD people in the health care sector?**
My experience working with and caring for multicultural communities has led me to understand that communities are the experts of their own lives. This therefore necessitates their involvement in decision making at all stages of programs and health policy development. This idea has become intrinsic to my practice over the years and in the development of all the programs and projects I currently oversee.

**Do you think it is important that CALD communities have access to specialist health care services?**
Absolutely, I believe that CALD communities and other communities with people of shared experiences need their own tailored services. We know that without adequate targeting, generic health promotion messages are lost and diluted on communities who have the poorest health outcomes.

Ideally, everyone's needs should be met by generalist services, however, the reality is that services and the health care system operate on individualist models that negate the importance of collectivism and alternate health beliefs. In the case of Aboriginal health, I believe it would be difficult for a contemporary mainstream health service, at this point in time, to fully understand the impact of a history of dispossession and intergenerational trauma and then to respond to this in practice. Likewise, multicultural communities require services that understand the complexities of issues, such as health beliefs, reconfigured families, visa status and migration history and integrate these into appropriate care and support.

**Do you think it is important that CALD people are encouraged to enter the health care sector?**
Absolutely, I see my mentoring role as a manager as a key component of what I do. Employing and supporting the development of CALD workers, inevitably, contributing to a diverse workforce is a privilege.

## DR MICHAEL OLASOJI

**Lecturer, School of Nursing and Midwifery, Monash University**

*"Nursing is such a fantastic profession that places you in a unique position to look after people at a vulnerable stage of their lives."*

**Why did you decide to pursue a career in health care?**
The health care sector offers a unique opportunity not available in most other sectors to positively impact the lives of people at a time when they need it the most.

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
I migrated to Australia about 15 years ago from Africa as a Skilled Migrant. I previously worked as a biochemist prior to coming to Australia. I have always loved helping people and enabling them to be the best they can be in any situation they find themselves. I did not really get this satisfaction working in the laboratory with specimens and chemicals, hence the decision to pursue a career in nursing. I was also fascinated with the options and flexibility that comes from nursing.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I currently work as a mental health nurse and the turning point for me was during a clinical placement in mental health during my undergraduate nursing degree which I really loved. Mental health nursing gave me the opportunity to spend more time with my patients, establish therapeutic relationships, listen to their stories and offer support where needed.

**What has been a defining moment in your career?**
I looked after a gentleman some time ago who, a few weeks later, took his own life. I remember my last interaction with him in which he expressed so much gratitude about the way I looked after him. This struck me deeply and reinforced the fact that every opportunity we get with those we are looking after offers a unique moment to make a difference in their lives. It may literally be the last. It is always important to leave a good impression.

**What has been your experience working with and caring for CALD people in the health care sector?**
I guess coming from a CALD background makes you appreciate the challenges faced by people from such a background, particularly in the area I work in, which is mental health. A number of people go through a wide range of emotions; coming to terms with a new environment, new culture. It is very important to acknowledge and put this into perspective when providing care.

**What do you hope to achieve throughout your career as a health care professional?**
Like most people, I hope I can make a difference in the lives of people. Nursing is such a fantastic profession that places you in a unique position to look after people at a vulnerable stage of their lives. I hope to make a difference in not only the way care is delivered but the type of care delivered. I work presently as an academic as well as a clinician and I like the ability to work across both worlds.

**Do you think it is important that CALD communities have access to specialist health care services?**
I guess I would be cautious not to further marginalise people from CALD background by creating "specialist care services". I would love to see a situation in which if I turn up as someone from a CALD background to receive care at the local hospital, the health care professional looking after me not only appreciates the cultural difference but is also well equipped to tailor and provide care in a culturally sensitive manner.

## NADIA CHAVES

**Refugee Health Fellow, Victorian Infectious Diseases Service, Melbourne Health**

*"I love learning about different cultures and hearing people's stories and I'm lucky I get to do that every day."*

**Why did you decide to pursue a career in health care?**
I've wanted to be a doctor since the age of 10. I think I had an image of being the traditional family doctor who got to know a community through their lives. I love working with people and I loved science; medicine seemed the perfect combination of the two!

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
I am of Indian heritage but I only lived there for six months when I was three. Dad was in shipping, so we lived in six countries and I went to 10 schools. This helped me to build resilience and also made me realise that people are fundamentally the same wherever you go.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I'm currently working in refugee health and I am an infectious diseases (ID) and general physician. After my experience in the Kimberley and Top End (see below) I really wanted to work in public health. I love learning about how public health policies can change the world – from the importance of washing your hands before looking after patients to the incredible reduction in diseases because of vaccinations.

**What has been a defining moment in your career?**
I really learnt a lot when I stepped away from medical school and the hospital and spent time up in the Kimberley and the Top End. I had the privilege of being able to work in public health in urban and remote Aboriginal communities and to learn about people and health problems away from the statistics. I learnt about the challenges of implementation of evidence-based practice away from the mainstream. I also learnt about the importance of community consultation, something I feel is distinctly lacking when it comes to working in refugee health.

**What has been your experience working with and caring for CALD people in the health care sector?**
I work in an infectious diseases refugee and asylum seeker health clinic in cohealth Kensington, and have been a Victorian refugee health fellow based at the Royal Melbourne Hospital for the past two years. Both jobs allow me to work with people from CALD backgrounds. I love learning about different cultures and hearing people's stories and I'm lucky I get to do that every day.

**What do you hope to achieve throughout your career as a health care professional?**
I'm not sure. I think if I try to live authentically and to be a good person (in how I work with people as well as in what I do) I will have achieved something. There are a lot of good people around all trying to do their bits. I think it is important to work together.

**Do you think it is important that CALD communities have access to specialist health care services?**
It is a good question. I think it is important that people who identify as 'not the mainstream majority' have access to equivalent health services to the majority, whether they are CALD, come from a low socio-economic background, are women, LGBTI or Aboriginal.

**What are your hopes for the future of health care in Australia?**We are lucky to have Medicare and a strong public hospital system and we are able to provide great health care for people who are not able to afford it. I would hate to see this change. I would like the Australian health care system to continue to strive to provide more equitable health care. But I do think that means that we should look closely at what we are spending our health dollar on. We need to improve the health care system to make sure it is easier for us to spend the money on what the evidence shows us is necessary and more difficult to do things like ordering unnecessary investigations or non evidence-based procedures.

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**1–2 JUNE**
**Leadership First**
2 days | 12 CPD hours | **Melbourne**

**24 JUNE**
**Immunisation update**
RN | 1 day | 7 CPD hours | **Melbourne**

## ACT

**28–29 APRIL**
**Palliative care**
RN/EN | 2 days | 14 CPD hours | **Canberra**

**10–11 MAY**
**Leadership First**
2 days | 12 CPD hours | **Canberra**

## NT

**28–29 APRIL**
**Palliative care**
RN/EN | 2 days | 14 CPD hours | **Alice Springs**

**17–18 MAY**
**Leadership First**
2 days | 12 CPD hours | **Darwin**

## SA

**5–6 MAY**
**Clinical assessment for nurses**
RN/EN | 2 days | 14 CPD hours | **Port Lincoln**

## QLD

**12–13 MAY**
### Wound management
RN/EN | 2 days | 14 CPD hours | **Cairns**

**12–13 MAY**
### Clinical assessment for nurses
RN/EN | 2 days | 14 CPD hours | **Gold Coast**

**24–25 MAY**
### Leadership First
2 days | 12 CPD hours | **Brisbane**

## TAS

**3–4 MAY**
### Leadership First
2 days | 12 CPD hours | **Launceston**

**12–13 MAY**
### Wound management
RN/EN | 2 days | 14 CPD hours | **Launceston**

**27 MAY**
### Clinical assessment for the older person
RN/EN | 1 day | 7 CPD hours | **Hobart**

## WA

**18–19 APRIL**
### Leadership First
2 days | 12 CPD hours | **Perth**

## NSW

**28 APRIL**
### Radiotherapy update
RN/EN | 1 day | 7 CPD hours | **Parramatta**

**29 APRIL**
### ECG: introduction
RN/EN | 1 day | 7 CPD hours | **Newcastle**

**29 APRIL**
### CPD portfolio and documentation: meet your registration requirements
RN/EN | 1 day | 7 CPD hours | **Parramatta**

**5–6 MAY**
### Advanced wound management
RN | 2 days | 14 CPD hours | **Parramatta**

**10–11 MAY**
### Diabetes management and current guidelines
RN/EN | 2 days | 14 CPD hours | **Wagga Wagga**

**18–19 MAY**
### Infection prevention and control
RN/EN | 2 days | 14 CPD hours | **Dubbo**

**20 MAY**
### Understanding dementia
RN/EN | 1 day | 7 CPD hours | **Coffs Harbour**

**20 MAY**
### Organ and tissue donation awareness for perioperative nurses
RN | 1 day | 7 CPD hours | **Parramatta**

**26–27 MAY**
### Physical health care in mental health
RN/EN | 2 days | 14 CPD hours | **Parramatta**

**27 MAY**
### Pressure injury prevention and management
RN/EN | 1 day | 7 CPD hours | **Batemans Bay**

**7 JUNE**
### Day surgery nursing
RN/EN | 1 day | 7 CPD hours | **Parramatta**

**9–10 JUNE**
### Pain management
RN/EN | 2 days | 14 CPD hours | **Coffs Harbour**

**15 JUNE**
### Legal issues for registered nurses
RN | 1 day | 7 CPD hours | **Parramatta**

**17 JUNE**
### Perioperative anaesthetic nursing
RN | 1 day | 7 CPD hours | **Parramatta**

**17 JUNE**
### Introduction to clinical facilitation
RN | 1 day | 7 CPD hours | **Port Stephens**

**17 JUNE**
### Immunisation update
RN | 1 day | 7 CPD hours | **Batemans Bay**

**21 JUNE**
### Understanding dementia
RN/EN | 1 day | 7 CPD hours | **Parramatta**

**23 JUNE**
### Immunisation update
RN | 1 day | 7 CPD hours | **Parramatta**

**29–30 JUNE**
### Team dynamics and clinical leadership
RN | 2 days | 14 CPD hours | **Parramatta**

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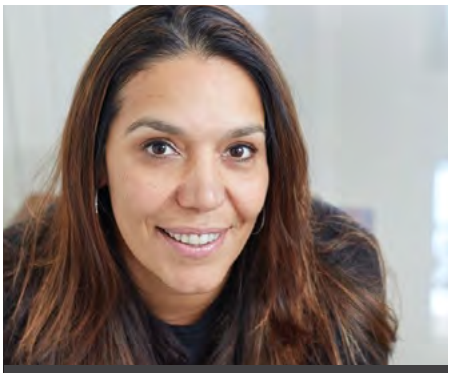
# RESILIENCE AND COMMITMENT: SUPPORTING ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES

## FOREWORD



**Janine Mohamed**

Janine Mohamed is a proud Narrunga Kaurna woman from South Australia. Over the past 20 years she has worked in nursing, management, workforce and health policy, and project management in the Aboriginal and Torres Strait Islander health sector. Many of these years have been spent in the Aboriginal Community Controlled Health Sector at state and national levels. Internationally, Janine has represented the ACCHS at the UN Permanent Forum on Indigenous Issues on two occasions. Currently, she is the CEO of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), which is the sole representative body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. CATSINaM's primary function is to implement strategies to increase the recruitment and retention of Aboriginal and Torres Strait Islander peoples into nursing and midwifery professions.

The Puggy Hunter Memorial Scholarship Scheme helps give flight to Aboriginal and Torres Strait Islander people's desire to make a positive impact. The scholarship, administered by the Australian College of Nursing (ACN) and funded by the Australian Government, enable recipients to attain the goals they hold for themselves and their communities at a much faster rate. But this is matched by the resilience and personal commitment that recipients bring to their endeavours.

When we talk with Aboriginal and Torres Strait Islander nurses and midwives about why they decide to pursue a nursing and midwifery career, strong and persistent themes emerge. Inevitably, they talk about their commitment to making a positive contribution to the health of their and other Aboriginal and Torres Strait Islander communities; this is often couched in the sense of 'giving back' to their communities of connection. They want to be part of empowering communities within the health arena, including through supporting community-controlled health services where they often choose to work.

They want our people to experience high quality and culturally safe care – in our eyes, these two things are indivisible. There is a strong desire to play an active role in achieving equity in health outcomes, to close the gap. This will only occur if cultural safety is valued equally by everyone involved in health services and systems, which requires health professionals and systems to recognise, value and utilise Aboriginal and Torres Strait Islanders knowledge, values and practices.

Aboriginal and Torres Strait Islander nurses and midwives speak about a sense of responsibility to be role models in their communities – to inspire self-belief in others that becoming a nurse or midwife is an achievable goal. They are willing to be role models when they may not have experienced a nursing or midwifery role model in their family. However, they can usually identify other family members who have been role models for the qualities they will require in order to achieve their ambition of joining the nursing and midwifery profession. People who have shown enormous strength in the face of significant and persistent adversity. People who have maintained cultural values, beliefs and practices despite the dedicated and systematic effort over many decades to diminish and destroy Aboriginal and Torres Strait Islander peoples and cultures across Australia. No Aboriginal and Torres Strait Islander nurse or midwife is untouched by this history.

Any Aboriginal and Torres Strait Islander person who joins the nursing and midwifery profession knows that their role will be bigger than any other nursing and midwifery role. Their role will not end when they remove their uniform or sign out of their shift for the day. They will be sought out in their community at any time to provide information and support, to offer advocacy and assistance, or to hear about their community's experiences in the health services in which they work. There will be an expectation that they speak up, advocate and take action to address issues in these health services. By virtue of the fact they decided to be a nurse or midwife, they know this will be part of the experience, one that may not be recognised or always appreciated by health services.

In the 2014 ACN Oration, Professor Roianne West spoke eloquently to what Indigenous nurses draw on to maintain their commitment to community and nurture their resilience, and what the wider nursing profession must recognise and honour:

*Indigenous ways of knowing, language, lifestyle and practices remain today and it is this knowledge, experience, talent and style of leadership that we, in the nursing profession, have to capitalise on to close the gap in health inequality.*

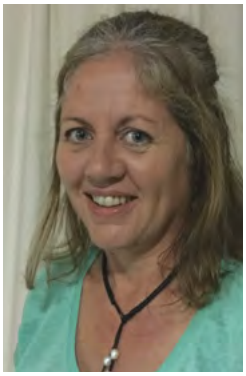
*My experiences in education have led me to recognise the importance of utilising the strength of the profession of nursing in improving the circumstances facing our people and how designing and delivering services responding to the Indigenous health crisis, requires the input of our people. This…is best practice program design and implementation in any field – to involve the people affected most so as to maximise the outcomes.*

*…Indigenous knowledge is not possible without Indigenous people. Indigenous nursing knowledge is not possible without Indigenous nurses. Indigenous nurses have the exclusive ability to proficiently entwine nursing knowledge with Indigenous knowledge to lead our profession to rising to the challenge of our time. (p. 5)*[1]

It is clear from their profiles that the following Puggy Hunter and Nursing and Allied Health scholars are committed to this task. They have chosen the health field deliberately to help bring about much needed change in health service experiences and outcomes for Aboriginal and Torres Strait Islander Australians. They understand that a patient-centred approach means taking a family-centred approach across generations, with an appreciation of the broader community in which people live.

Collectively, we have much to do in a short amount of time to achieve the intention to close the gap in life expectancy within a generation. Enabling and advancing the careers of Aboriginal and Torres Strait Islander nurses and midwives through scholarships and support is a critical part of the process and this is matched by the resilience and personal commitment that recipients bring to their endeavours.

1 West R 2014, Rising to the challenge of our time: better health and wellbeing for our Nation's First People, Australian College of Nursing Oration, Adelaide, 2nd November 2014, viewed 23 March 2016 <https://www.acn.edu.au/sites/default/files/publications/Oration_Booklet_2014_C7_Rising%20to%20the%20challenge%20of%20our%20time.pdf>.



## FIONA BROOKS

**Clinical Nurse, Kilcoy Hospital Aboriginal medical services clinical placement scholar, Nursing and Allied Health Scholarship and Support Scheme**

*"I love the challenge out bush. You've got to think out of the box. I feel privileged to work with Aboriginals and live in their communities."*

**Why did you decide to pursue a career in indigenous health care?**
I decided to work in health care because I like helping people. I like Aboriginals. They communicate differently than other people: through body language rather than speech. They like to watch people. They get an aura about you. I like to watch them watching me. Working in remote Aboriginal communities has made me less judgemental and more open minded.

It's hard yakka, it's challenging, it's fun, it's difficult – I love it. You learn every day and you do stuff you couldn't do anywhere else. I love the challenge out bush. You've got to think out of the box. I feel privileged to work with Aboriginals and live in their communities.

**Was the Nursing and Allied Health Scholarship and Support Scheme a defining influence on your career choice?**
It wasn't so much a defining influence, but it did help me receive the training I needed to handle difficult colleagues. At the time, I was working with some difficult colleagues. This scholarship helped me gain the skills to step up as a leader and handle conflict.

**How did your Graduate Certificate in Leadership and Management from ACN help prepare you for working within the health care sector?**
One of the big things I learnt while studying was the difference between being a good manager and a good leader. I may not always be the best manager but I am a good leader. My door is always open.

**What has been a defining moment in your career or during the course of your studies?**
One of my most defining moments was when my clinic was the second in the country to get accreditation, first round. I was studying my graduate certificate at the time and I think that was a major factor.

**What are your hopes for the future of indigenous health in Australia?**
Now that's a million dollar question. We need to see change. I've been in this a long time and I've seen little change. We need to change how we approach issues. We also need to look after the nurses working in these communities..

## MARYSIA SKRET

**School Based Youth Health Nurse, Cairns and Hinterland Hospital and Health Service Aboriginal medical services clinical placement scholar, Nursing and Allied Health Scholarship and Support Scheme**

*"Reflective practice opened my eyes to my personal constructs that I was not aware of and as such was able to explore these and adapt my practice. It really has made me a better nurse."*

**Why did you decide to pursue a career in health care?**
I decided to become a nurse when I was at school and was required to do work experience. I was 15 years old, my mother had always said she wanted to become a nurse but her mother would not let her and my sister had just started nursing. I have been nursing for a good part of 37 years and am thrilled for anyone wanting to take up nursing as a career. It has never occurred to me to change my profession but I have changed my direction in nursing several times.

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
My father was a Polish refugee post World War 2. My mother was a white Australian. I was the youngest of four siblings. My father suffered from the traumas of war, which spilt onto my early family life. My father would go on binge drinking episodes, gamble and perpetuate domestic violence. At times he would totally breakdown and spent occasions in a psychiatric hospital ward. He said he had bad nerves. I lived in a single parent family at about the age of 12. My family always supported me to do nursing.

**Was the Nursing and Allied Health Scholarship and Support Scheme a defining influence on your career choice?**
The Nursing and Allied Health Scholarship and Support Scheme definitely influenced my choice to undertake further study. It supported me to complete a graduate certificate in child and family health, something I had been interested in perusing for quite some time.

**What division of the health care sector are you working in? Why did you decide to work in this particular area?**
I am currently working as a youth health nurse in two secondary state schools. I have always enjoyed working with young people and supporting young people facing challenges of life as they transition from childhood to adulthood.

**How did your studies help prepare you for working within the health care sector?**
The recent study at an academic level has had an immense impact on advancing my practice. I have further developed evidenced-based logic and language when articulating ideas and advocating for populations and individuals.

**What has been a defining moment in your career?**
There have been many defining moments in my career. Working as a remote area nurse in an Aboriginal community earlier in my career is a main influential highlight. The beautiful country that I was given permission to enjoy as well as the friendships and sincerity of acceptance and trust given to me by the traditional owners was extraordinary.

A defining moment during the course was when I did a clinical placement and, much to my surprise, enjoyed being a student rather than a preceptor. Reflective practice opened my eyes to my personal constructs that I was not aware of and as such was able to explore these and adapt my practice. It really has made me a better nurse.

**Do you think it is important that indigenous communities have access to specialist health care services?**

The reality of the disparity of health between indigenous and non-indigenous Australians when working in an indigenous community is confronting. I believe it is important that indigenous communities have access to specialised health care services. Services however need to work in collaboration with indigenous communities, empowering and engaging community members such as community control.

What are your hopes for the future of indigenous health in Australia?

That's simple, close the gap in health and all aspects of wellbeing.

## SHERRY HOLZAPFEL

**Registered Nurse and Midwife, Health Services Manager, Mamu Health Service Scholar, Puggy Hunter Memorial Scholarship Scheme**

*"As a proud indigenous Australian, a highlight in my working career is to be nursing my people and fulfilling my dreams by doing something that I believe in and am passionate about."*

**Why did you decide to pursue a career in indigenous health care?**
From a young girl I wanted to be a nurse and to pursue this pathway was a goal that I wanted to achieve in my working career.

**Tell us a little bit about your background and how it contributed to your decision to enter the health care sector?**
I'm a Yidinji woman, born and bred on the Atherton Tablelands, married with three children 18, 20 and 22 years old. I commenced working at a young age (16 years). I worked as a packer in the meatworks for a number of years and continued to work in other factory positions for a further 10 years or more. During this time, I put my family first and this meant schooling and family needs came first, however, I decided to study while the kids were at school. I completed a Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care and commenced work as an Aboriginal and Torres Strait Islander child health worker. I enjoyed this position as I was out in the community working with my people. This then gave me the burning desire to commence my nursing studies.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I am currently working in the Aboriginal and Torres Strait Islander health sector. This area is where I wanted to work after completing my Bachelor of Nursing. I felt this is where I could really make a difference with my people by contributing to closing the gap, empowering them and being a role model within the community.

**How did the Puggy Hunter Memorial Scholarship Scheme help you progress your career?**
The Puggy Hunter Memorial Scholarship helped financially by supporting me to pursue my goal in gaining a Bachelor of Nursing. The Nursing and Allied Health Scholarship Support Scheme provided me with the initiative to continue studying a number of other courses to pursue my career pathway. I've progressed my studies to a Master of Midwifery, immunisation endorsement and now completing a Master of Applied Management (Nursing).

**What has been a defining moment in your career?**
While studying my Bachelor of Nursing, one of my clinical placements was back in my home town. This was a highlight for me to be nursing in the town I was born and bred in.

**What has been your experience as an indigenous Australian working in the health care sector?**
As a proud indigenous Australian, a highlight in my working career is to be nursing my people and fulfilling my dreams by doing something that I believe in and am passionate about.

**What do you hope to achieve throughout your career as a health care professional?**
I have worked my way through the career pathways as a registered nurse, midwife and nurse immuniser. I am currently in a management position. I commenced in this new role in January this year. After 29 years away from home (Atherton Tablelands), I am working on 'country' and I am back home with my mob. I felt this was my next career pathway to enable me to have more of an input in making a difference in the indigenous community. For example, to liaise, advocate and create new initiatives/strategies in the workplace to provide a more culturally appropriate and holistic service for the indigenous community.

**Do you think it is important that indigenous communities have access to specialist health care services?**
Yes, most definitely a huge need. I believe we should be providing a holistic approach in servicing indigenous communities. Access is a huge problem, therefore providing specialist services is important to meet the needs of every indigenous community.

**Do you think it's important that indigenous Australians are encouraged to enter the health care sector?**
Yes, we need more indigenous workers. This will enable us to provide a more culturally appropriate service to our communities and empower our people to have ownership of their health care needs.

## STACEY MCDERMOTT

**Community health nurse/nurse immuniser, Rumbalara Health Service**
**Aboriginal medical services clinical placement and continuing professional development scholar, Nursing and Allied Health Scholarship and Support Scheme**

*"Working in an Aboriginal community health service which is community controlled encompasses a holistic model of care that enables ongoing connections with health clinicians and clients during their health journey."*

**Why did you decide to pursue a career in health care?**
Ever since I was in Grade 5 in primary school I wanted to be a nurse. We had to do a presentation on what we wanted to do when we grow up, and I choose nursing.

**Tell us a little about your background and how it contributed to your decision to enter the health care sector?**
I grew up on a farm and helped a lot around the farm as the oldest child, whether it be fixing fences or helping a cow who was having trouble calving before going to school, which would end up in me being late for school. Blood and 'gross' stuff didn't bother me, unlike by brother and sister. My grandmother, an uncle and an aunt were nurses and it interested me in being able to help people.

**What division of the health care sector are you working in? Why did you decide to work in this area?**
I currently work in an Aboriginal community health service and private surgeon's rooms.

At university I completed two degrees: nursing and public health. I worked in a private hospital for seven years then decided I didn't want to do shift work anymore. I have since worked in district nursing, general practice and in a nursing home. My current jobs allow me to use the knowledge from both degrees and I have also completed a nurse immunisation course, which allows me to perform childhood immunisations. My current jobs also allow me to be involved with and follow people's ongoing lives and their health. I can see how I can influence or help change their health outcomes. Working in community health has also allowed me to learn a lot in assessing patients and how health influences in so many other aspects of life, such as housing and education. A sense of community also influenced me working in this area, and that the whole community care for the family, and you can have three generations in a consult with you at one time.

**How did your Nursing and Allied Health Scholarship and Support Scheme scholarship help you complete your studies and progress your career?**
The scholarship to complete a Graduate Certificate in Breast Cancer Nursing has helped me gain more knowledge in my area of interest. It has also allowed me to become more involved with breast cancer patients as well as promotion and screening for breast cancer. We are very lucky to have the BreastScreen bus visit our Aboriginal health service every two years. This allows the women in the community to have their screening done in a comfortable environment and allows staff involvement which the women feel more at ease with. We have had the bus visit twice and have had great numbers of women screened, with many of them being their first time. I am also working on incorporating cancer care nurse into my role, which would allow me to become the contact person and help coordinate care for cancer patients within the health service. The current ongoing education scholarship I have received will contribute to me going to the World Indigenous Cancer Conference, which will allow me to learn methods of care for people around the world.

**Do you think it is important that indigenous communities have access to specialist health care services?**
Yes. Closing the gap is an important need in providing health care to indigenous communities. It helps to provide specialist health services to indigenous communities that they may not be able to access privately. Working in an Aboriginal community health service which is community controlled encompasses a holistic model of care that enables ongoing connections with health clinicians and clients during their health journey. We have a number of visiting specialists that run clinics within our health service as it allows our clients to come to a place that they feel comfortable in, that they have a connection to the land they are on and they know will be culturally sensitive to their needs. Since working in indigenous health I have been told by clients that they still experience racism from some mainstream services and this is disappointing. Visiting specialists that see clients at our health service are educated on cultural training and history of indigenous Australians. By having these specialists visit our service it also develops good relationships with the specialists, GP and nurses, and ensures comprehensive collaboration between services, resulting in good treatment plans for clients.

# MY MULTICULTURAL JOURNEY

*"I am so glad I made the decision to relocate to Australia because it has given me this once-in-a-lifetime privilege to understand people's culture and how such culture impacts human relationships."*

*By Elisha Aigbokhan MACN*

Elisha Aigbokhan MACN

I come from an African background. I grew up and studied in West Africa. I kickstarted my nursing career in Africa after graduating from a three-year Diploma in Nursing. I qualified as a Registered Nurse in 2004 and worked in both private and Federal Government settings prior to relocating to Australia to pursue my Bachelor of Nursing in 2010. I would say my Australian nursing career has been satisfactory and fulfilling. I have never had any reason to regret my intention to come to Australia to study and continue my career.

After my graduation from Flinders University in 2011, I received a graduate program offer in the Northern Territory. My very first rotation was in a nursing home. In fact, I was one of the pioneers that started graduate nursing home placement in the state. Apart from the clients I looked after, the home wasn't really multicultural. Most of the staff working there had been there for ages and they were mainly Caucasian. I did receive the basic support that I needed to complete the rotation. There were several occasions where I had to be the nurse in charge for the shift, even as a new graduate nurse. It wasn't much of an issue for me because of my past clinical experience back home.

My second rotation was in an acute surgical care unit located in a government hospital. I would say the ward was very multicultural. We had roughly a total of 25 nurses (RNs/ENs); about four were from the Philippines, two African, 10 Indian, three English, one Russian and the remaining were Australian. It was indeed a good mix of races, with a majority of the continents represented. I wouldn't say I enjoyed my rotation the way I would have wanted. The clinical support I received from my preceptor (an English guy) was fantastic and memorable, but there was no staff relationship and, on top of that, there was some level of fault-finding behaviours and a backstabbing attitude amongst staff.

I noticed there were factions amongst different group of nurses. Staff of similar race would request a similar roster so they could work together. On other occasions, they would prefer to go on their lunch breaks together. The Caucasians would rather chat with their fellow Caucasian nurses in the tea room and isolate non-Caucasians. You could sense the negative body language towards the non-Caucasian nurse when she tried to be part of the conversation. Hence, she was left isolated and, in most cases, would have to leave the tea room to another location to have her lunch. There was a tense atmosphere on a daily basis.

When I completed rotation I applied for a position in the medical unit. My stay in the medical unit was great. The staff were welcoming and warm. The ward was also very multicultural, comprising of people from India, Africa, Indonesia, the Philippines and Europe. We socialised together at lunch and even outside working hours. We celebrated multicultural day together and each brought a plate of our respective cultural dishes to share. Suffice to say it was a remarkable experience. I worked there for close to two years and then moved to the psychiatry ward to pursue a specialty in mental health. I have completed a Graduate Certificate in Mental Health Nursing and I am more than halfway through a Master of Nursing in Mental Health (course work and research).

I am currently working as a case manager for community mental health clients in a team of about 15 multicultural staff from all over the continents. These include psychiatrists, registrars, medical officers and allied health professionals. I am really happy where I am. I have always wanted to work in an environment where nurses can exercise their autonomy and make an informed holistic decision for the betterment of the client's health and wellbeing. I am so glad I am in a place where such a privilege is permitted and encouraged. I am in a place where everyone shares their personal experiences in terms of what it feels like working in their country of origin in the past and now working in Australia. You really get to learn from these experiences and enhance your own career and knowledge with such stories.

Apart from staff multiculturalism, we do also manage clients who migrated from overseas and they do contribute to the overall multiculturality of the service because you learn from them in one way or another and that in itself contributes to expanding your horizon and thinking beyond the box. Like they say, "travelling is part of education" and I am a living testament to that. I am so glad I made the decision to relocate to Australia because it has given me this once-in-a-lifetime privilege to understand people's culture and how such culture impacts human relationships and shapes us to be what and whom we are today.

# VARYING DEGREES OF DIVERSITY – LESSONS IN CULTURAL AWARENESS

*By Mandy Cleaver MACN*

Now at the risk of sounding really silly, I've only very recently had a revelation – that I can still experience dilemmas and differences between myself and people who share the same culture as I do, not just between those with a differing one. Please allow me to explain…

I remember learning some broad and specific details pertaining to other cultures when I was a student. There were common obvious themes, such as a need for respect for, non-judgement of and accountability towards those from other cultures. There were practical aspects, such as where to locate resources for people who, for example, may need an interpreter. There were also some specific cultural customs explained to our cohort. For example, we learned it is not appropriate to mention the name of an Indigenous Australian who has passed away. Similarly pertaining to death (particular interest to me as a Palliative Nurse), cultural beliefs around what happens to someone's spirit when they die or how long the deceased's body should remain in the family home – if at all – and so on.

We were given specific tools to add to our nurse toolbox – consideration, reflection, deliberate enquiry, how to maintain dignity and the like, all with the goal of achieving good health outcomes, as determined by the patient and/or their family. So with my toolbox packed, I set off to work as a nurse. Over time these tools have been used and refined, sometimes even replaced. There isn't a day I don't learn something. There's always new medications, new reactions or new symptoms congruent with diseases other than what the patient presented with. I learn from my colleagues' experiences, I learn from what families say, I learn from what the patient says. I continue to learn more about me not just as a health professional but as a person.

If I'm honest, sometimes I've been intimidated by other cultures – not because they're scary but because I've been afraid I will get it wrong and offend someone. Quite a few years ago an Indigenous man had passed away on the ward I was on. Of course, a sad but "expected" death. Around his bedside gathered a number of close relatives. I went into the room to see if they needed anything – cup of tea, coffee, more chairs etc. One of the family said, "Sister, can you take those things out please?", referring to the nasal cannula still insitu (the oxygen had already been turned off). I felt cold inside. I had been told that it was considered very disrespectful to touch the face of an Indigenous person after they had passed away.

In what was only a moment I had so many thoughts – "What did they mean?", "Was I actually allowed to take them out?", "What if I accidentally touched his face?", "What if they were only saying that to see if I knew I shouldn't?" Okay, yes that was far-fetched, but I really panicked. I was so fearful I would get it wrong. I regained my composure, took out a tool from my nurse toolbox: "It's not about me; it's about the patient", and I clarified. "You'd like me to take the oxygen tubing off," and gestured taking tubing off my own ears to indicate the possibility my fingers may just ever so lightly touch the face. To which they said, "yes, please". So with all eyes on me (probably weren't but it felt that way), I very carefully removed the tubing from around the ears, then out of the nose. I placed the tubing on top of the bedside table and looked at the person who had asked me to remove it. They nodded. I left the room.

When I look back at that event, it is with mixed feelings. I was so fearful I would get it wrong that I turned it into a bigger than Ben Hur moment! But I also added a new tool to the toolbox – clarifying! It's totally okay to clarify a family's expectation/request, irrespective of culture!

I've since had countless interactions with patients, families and health professionals from other cultures. All of which have been positive and many of which I've still learned from. However, I do think I have a slightly heightened awareness of my desire to not get it wrong with people from cultures other than my own. Guess what? It transpires that same fear of getting it wrong also flows over to those who appear to share my cultural values. I now work as a community nurse. I am just one little part of an enormous team, however, for the majority of my home visits, I am there alone. The weight of responsibility that accompanies working as a sole practitioner, can at times be overwhelming. In one week I had three separate but similar incidents all involving people who, I believed, shared my cultural background. When a similar outcome occurs three times in as many days, one really must begin to wonder – "What I am being taught here?"

The first was a gentleman who, although very unwell, was insistent that he would remain at home. His only "give" was that we could "visit again in the morning". The second was another gentlemen who, again, was very unwell but he refused my advice to get immediate medical help – no matter how I worded it or who else agreed with me. The third was a family member of a deteriorating patient who, together with the patient, refused my encouragement to bring a medical review appointment forward from its original date, due to his decline.

Each patient had the capacity to make an informed decision. They were aware of their disease and its progress and the consequences of their decision, and I was confident there was nothing like hypoxia or anything that potentially may have clouded their capacity. They were safe in that there were other people around them, should things change suddenly.

However, I left each of the visits feeling like I'd failed. The "what ifs" started – "What if I had worded my assessments differently?", "What if I had not said this?", "What if I had gone into more detail about that?", "What if I had just called the doctor or ambulance anyway, despite their absolute insistence not too?", "What if the people those patients were with at the time don't cope if things go pear-shaped?," What if the patient changes their mind later and regrets not getting medical intervention?"

I felt I'd failed these patients by not convincing them to go to hospital for a medical review and potentially, interventions, which I believed they should have. For me, at the smallest sign of ill health, I want medical treatment immediately. Even though the three patients had similar

*“The weight of responsibility that accompanies working as a sole practitioner, can at times be overwhelming. In one week I had three separate but similar incidents all involving people who, I believed, shared my cultural background.”*

ideas, customs and social behaviours to what I have, what we consider to be a good health outcomes, it turns out, is poles apart. One of the patients absolutely hates hospital, not due to negative reflections on hospital staff in any way, just for their own personal reasons. For them to be forced to go to hospital would have been a detrimental outcome. Similarly with the second patient. The third declined urgent assistance for different reasons but, again, if I had forced the issues or tried to force them I would have been doing the very thing I fear so much with people from other cultures – I would have got it wrong.

I've had patients with Not For Resuscitation (NFR) orders that, in the event of their passing, I respected and did not start resuscitation measures as obviously that would have been against their wishes. So why were these people not wanting to go to hospital so hard for me to grapple with? I was imposing my beliefs and my preferences onto other people. I was certain they weren't making a good choice. I was wrong. Where it becomes tricky though, is that overwhelming sense of responsibility – “Did I really do everything possible?”, “Were my assessments impeccable?”, “Did I really give them all the information they needed to make their decision”. And it is just that, their decision.

With each patient I sought advice from senior colleagues. Two of the patients were seen by senior colleagues over the following days and were met with the same response I was (and both patients have actually improved). The third did attend their scheduled medical appointment (who I had informed of their health status as per multidisciplinary protocols, of course with the patient's consent), just as they wanted to.

So what did I learn? It reconfirmed that as a nurse I have an obligation to do my best. I have to be able to stand up at the end of every day and honestly say I tried my hardest to deliver the best nursing care I possibly could have. But at the end of that day, irrespective of culture, adults with full capacity are responsible for their own health decisions that lead to the best health outcome as they see it. Just because we share a culture, doesn't guarantee we'll share the definition of a “good outcome”. It's not something I need to fear. It's something I need to respect, as it maintains dignity and good health outcomes – as individual patients define it.

# NURSING BEHIND THE RAZOR WIRE

*By Heather Blackhall MACN*

Thirty years in nursing accumulates fast when you are having fun, but nursing was not my first career choice. As a child in the 1960s I wanted to be a school teacher and my neat cursive handwriting reflects the hours I practiced my writing skills in preparation for the day I would stand in front of a class of children and pick up a piece of chalk to scrawl lessons on a giant blackboard. But that didn't work out. The young idealistic me decided teaching children wasn't what I dreamed it would be. So fast forward to a different decade in a different century, and far from being a jaded old schoolmarm, I am a nurse working in a very different environment – I work in a jail.

In a remand correctional centre behind metres of coiled razor wire and heavy security perimeter fencing I tend to the physical, emotional and mental health needs of South East Queensland's accused drug addicts, dealers, criminal bikie gangs, murderers, sex criminals, accused terrorists and paedophiles. My patients are often violent men who have lived turbulent lives with tormented pasts. Somewhere in my nursing education I was taught that as nurses, caring is our business and that the judgment of accused people should be left to the judges and juries of our judicial system. Most days I don't know what the man sitting in front of me requiring bloods to be taken, an ECG or a dressing to the wound on his hand, leg or torso has done to be in jail. Some days I am standing in front of the person who was in yesterday's media headlines. Every day I try to step over my prejudice and just be a professional nurse to help this person.

I used to drive past the prison on my way to the hospital where I worked and wonder what went on behind the walls of a prison. In my spare time, I avidly read crime fiction and crime

*“It is not glamorous, but every day is extraordinarily different, busy, exciting, difficult at times, and professionally challenging.”*

reports, and watched *Crime Scene Investigation* and other TV shows for glimpses of a world that is out of bounds to most law-abiding citizens. One day there was a small advertisement in the local paper and without much thought of what correctional nursing might entail, I applied for a Clinical Nurse position at my local jail and took a professional leap into the unknown.

It is not glamorous, but every day is extraordinarily different, busy, exciting, difficult at times, and professionally challenging. We start before 6am with security checks. Like travellers at modern airports, our bags (prison issue clear plastic carry bags) are scanned for contraband items and we walk through a rotating door that checks for metal objects on our person or in our pockets. Sometimes it takes two or three attempts to get through the revolving door. There might be car keys in my pocket or metal rods in my shoes or the machine is particularly sensitive today and alarms for no reason at all.

For obvious security reasons, mobile phones and other modern technologies are banned and must be left at home or locked in the car. Accidently bringing a phone into the centre sparks a major incident and confiscation of the phone. At the very least it can lead to police interviews and the possibility of criminal charges. After seven years as a prison nurse, I don’t have the close relationship with my phone that most of my friends do.

Other environmental factors that can be a bit daunting are the long corridors of wire that enclose the concrete paths that link the accommodation buildings and facilities. Wild cockatoos, galahs and lorikeets sometimes land on the wire and it is ironic that the birds are on the outside and the humans are in the cage. The first time I was buzzed through a heavy metal door and it slammed shut behind me locking me into an airlock or corridor I felt a strong sense of loss of my freedom (however temporary), but now I am used to the buzzers and electronic locks and banging doors and sometimes find myself waiting to be buzzed through doors that are not locked. It is strange what you can get used to.

In our medical centre treatment room our team of doctors, nurse practitioner and nurses see patients with a huge variety of acute and chronic illnesses – diabetes, epilepsy, CVAs, cancers, blood pressure and cardiac illnesses. We record nearly 300 prisoners attending our centre per day. We have prisoners presenting with injuries post-motor vehicle or motor bike accident before arrest and post-arrest injuries including head injuries and concussion, fractures and skin conditions including lice and scabies.

We treat drug withdrawals and sometimes drug overdose. We vaccinate and educate the prisoners about the risk of communicable diseases. We tell them not to do prison tattoos, share needles, share cups or razors. We dress their wounds and treat their infections and boils. We race down the walkways with our emergency trolleys to attend episodes of chest pains, illness or injury that occur in the units – I never cease to be amazed at how many of our prisoners sustain injuries from slipping in the shower or falling on the stairs.

Our crime rates have never been higher and our prisons have never been so crowded. It is a simple equation: when society accommodates a large number of men in a space designed for fewer persons, the jail can become a violent place and the nurses are left to patch up the broken bodies before calling the ambulance and transferring them to the hospital to be X-rayed, surgically repaired or sutured.

By far the most distressing incidents are deaths in custody. During the 1990s when I worked in Western Australia, it was a familiar term in the media and the words invoked images of indigenous men tragically dying in bleak police watch-house cells. Apart from being totally aghast at some of the circumstances of these deaths I never imagined that the term could touch my life or affect my nursing career. ‘Death in custody’ is every correctional nurse’s greatest fear.

Every prisoner is subject to a comprehensive physical and mental health assessment at admission by counsellors, psychologists and nurses. We also have a team of visiting psychologists and psychiatrists who struggle to see the hundreds of people in jail with diagnosed mental illness. We screen all prisoners for thoughts of suicide, suicidal intent, self-harm and signs of depression, however, the consequences of their crimes, the effects of separation on their spouses and their families, the media exposure and social disgrace, and the despair of facing a period of incarceration can be overwhelming and nearly every prisoner is at risk to some degree.

Despite all of our efforts, when despair is high and hope has ebbed, taking their own life seems the only logical solution to the situation they find themselves in. Alone in their cell some prisoners take an overdose of hoarded drugs or they secrete a razor and cut their wrists or their throats, or are found hanging from the door with a noose made from a torn up sheet or towel or piece of clothing. Suicides in the community are tragic and leave more questions to be asked than answered. Suicides in custody are no different.

Attending these incidents affects the whole correctional team. They are difficult to predict. They are nearly always unexpected. They don’t happen very often, but deaths in custody feel like failure and they leave the entire correctional team and nursing team feeling empty and afraid of confronting the possibility of it happening again tomorrow or the next day. They can also make you feel legally and professionally vulnerable, particularly if you are called to give evidence at a coronial inquest into the incident.

At the end of a 12-hour shift, I often stumble home mentally and physically exhausted. I didn’t know what to expect when I first answered the ad in the local paper for a Clinical Nurse in a remand centre. It is a nursing specialty that has hidden behind closed doors and been protected by high razor wire fences for a long, long time. It is a challenging role and not for the faint hearted. But even in this most hostile of hostile environments, my colleagues and I proudly deliver professional evidence based nursing care to some of society’s most difficult patients and that in itself is rewarding. I am not just a nurse. I am a Correctional Nurse.

# CARING, ENABLING, ACHIEVING TOGETHER – THAT'S HIP!

*"The evaluation identified a number of improvements which included fewer hospitalisations for long term chronically ill clients as well as better coordinated care..."*

*By Bernadette Mulcahy MACN, Brigitte Grant, Jemima Bradford-Flego, Colleen Pollitt, Wendy Dick and John Stafford*

In 2014, Melbourne's Werribee Mercy Hospital (WMH) amalgamated services that previously worked independently of each other to form the Health Independence Program (HIP). These services included the Complex Care Program (formerly known as HARP) Community Based Rehabilitation, Residential in-Reach plus two SACS Specialist clinics – continence, falls and balance. It was envisaged that the model would provide a responsive and flexible approach between acute health services and community and social support services. HIP incorporated a multidisciplinary approach recognised as best practice for client centre care (RACGP 2011).

HIP's aim is to be client centred, increasing healthy behaviours and improving the health status of clients attending the service, while reducing health service utilisation – the "right care, in the right place at the right time" (Department Human Services 2008). In an effort to investigate the impact the amalgamation had on client wellbeing, HIP undertook a process of evaluation through file audits – pre and post HIP amalgamation, a narrative evaluation through The Most Significant Change (MSC) tool and quantitative program data collection.

The evaluation identified a number of improvements which included fewer hospitalisations for long term chronically ill clients as well as better coordinated care, but it was the results of the MSC questionnaire that were overwhelming in what the clients identified as an achievement. This information surprised a number of the HIP team given that it wasn't necessarily what the client was being treated for.

Thirty clients were asked to participate in the MSC with results showing profound changes in health outcomes that were not always expected following the clinical assessment. Of the 30 clients interviewed 29 showed significant changes with one client remaining the "same as when I started".

Seven emerging themes of change were identified following the audit of MSC. These included:

- Education – "learnt more"
- Improved management – "back on track"
- Reduced isolation
- Increased confidence/feeling safer
- Received help
- Capable of doing more
- Challenged

Comments included:

*"My most significant change was making the effort to get dressed and getting out of the house. They have instilled some of my earlier confidence in myself and my ability to work my body more than I have for a few years. I have bi-polar but it's under control now and I'm very proud of that."*

*"I've gained confidence in myself. I'm now able to shower myself."*

*"I was frightened of returning back to addiction and where would that have led me? I feel better now that I have things in place – we're good now."*

*"I feel really good. I no longer have to rely on my wheelchair. We went to the zoo the other day. I pushed my grandchildren in my wheelchair instead of them pushing me. I'm really pleased with that!"*

The evidence collected gave HIP an insight into what can be achieved through a holistic client-centred approach to care, with improved service delivery from point of intake through to individual and group based intervention. The benefits from having a multidisciplinary approach to care improved partnerships both internally at WMH and externally. HIP will now incorporate the MSC tool into a number of the programs to provide direction in improving the experience of the client journey.

**Author details:**

Bernadette Mulcahy MACN, RN/intake officer/care coordinator, Health Independence Program, Werribee Mercy Hospital.

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# BANGKA DAY 2016

*By Roma Dicker MACN, Key Contact, Adelaide Metro/ SA South Region; and ACN Representative*

Guest speaker Colonel (Rt'd) Susan Neuhaus CSC addresses the service.

Each year on the nearest Sunday to the 16th of February a deeply moving ceremony is held at 10am at The Women's Memorial Playing Fields in suburban Adelaide. The time is significant as it is approximately the time at which an incomprehensible massacre occurred.

On the 16th of February 1942 Australian Army nurses, soldiers and civilians were stranded on Radji Beach following the sinking of the Vyner Brooke – a small boat on which they had been evacuated from Singapore. They had no choice but to surrender to the local Japanese Army commander. The ensuing atrocities shocked Australians deeply, when they were revealed in 1945.

The survivors were first separated into groups. Firstly the officers and non-commissioned officers were taken away and quietly bayoneted to death. Then the other men were taken to the same spot and shot. The 22 nurses and one elderly civilian woman sitting on the beach realised what was happening and that their turn was next. The soldiers retuned and marched the 23 women into the water where they proceeded to shoot them.

The soldiers left believing that their work was complete. However one nurse had survived, although wounded. She was able to escape into the jungle where she met up with a soldier who had also survived. Eventually they again surrendered to the occupying forces and became prisoners of war. The soldier was an Englishman named Pat Kingsley who died of his wounds a few days later. The nurse was Vivienne Bullwinkel who spent the rest of the war in prison, on Sumatra, with other nurses who had survived the sinking of the Vyner Brooke.

Remarkably two other men also survived the massacre although wounded and also spent the remainder of the war as prisoners. All kept their story a closely guarded secret until they were freed in 1945. Sister Bullwinkel became a revered leader, nurse educator and administrator and died in 2000.

In 1956 the women's playing fields at St Mary's were rededicated as a memorial to all women who had made the supreme sacrifice for their country. Each year their sacrifice is remembered and a guest speaker relates the story of a specific group of women who served their country. This year the guest speaker was Colonel (Rt'd) Susan Neuhaus CSC, an army surgeon and advocate for veteran's health.

Colonel Neuhaus has written the first history of women doctors who served in times of war and also of the women hospital administrators, doctors and technicians who continue to serve with the Australian Army.

Next year will mark the 75th anniversary of the events on Radji Beach on Bangka Island. I would encourage all nurses to attend the ceremony if they are able. The captives prayer, written in 1942, is sung and representatives of all levels of government, the RSL and nurses' and women's groups lay wreathes or other tributes. It has been my privilege to attend as a representative of ACN in recent years and to lay a tribute on behalf of ACN.

The story of the nurses who survived the fall of Singapore is beautifully told in Ian Shaw's book, *On Radji Beach*, published by Pan MacMillan, Sydney in 2010.

The story of medical women in the Australian Army is told by Susan J Neuhaus and Sharon Mascall-Dare in *Not for Glory*, published by Boolarong Press Brisbane in 2014.

For further information on the Bangka Day Memorial Service in South Australia, please visit the South Australian Women's Memorial Trust **www.sawmpft.org.au** or **www.womensmemorial.org.au**.

# LEADERSHIP LESSONS IN HOBART

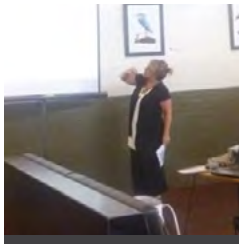
*By Nancy Arnold MACN,*
*Key Contact, ACN Tasmanian South Region*

ACN Tasmanian South Region held a 'Nursing leadership globally' breakfast workshop presentation earlier this year at Room for a Pony restaurant in North Hobart. Francine Douce MACN, Acting Chief Nurse and Midwife with the Department of Health and Human Services in Tasmania, spoke to the audience of her experiences in attending the Global Nursing Leadership Institute in Geneva.

The week-long program saw nurses from around the world put into groups to develop a presentation that was then viewed by an audience. Francine discussed how at first she found it difficult to find her inner core but then she just relaxed back into the program as it unfolded throughout the week. Although Francine said her group failed to deliver a slick presentation at the end the experience has reinforced some valuable leadership lessons. The one that I took away from the presentation is that "*Sometimes you have to fail to succeed*" or "*sometimes you have to lose to learn how to win*."

At the end of the presentation the 18 attendees had the opportunity to network with each other and it was great to meet Emily Murray who is a participant of the ACN Emerging Nurse Leader Program.

Anne Wallace, Penny Dale and Emily Murray MACN



Francine Douce MACN, Acting Chief Nurse and Midwife with the Department of Health and Human Services in Tasmania

A captive audience at Room for a Pony Restaurant

# ONE YEAR LATER...

*"After a year of hard work the reward is looking back and seeing how much I have learnt and grown as a nurse. I savour the little triumphs like trusting my instincts and seeing patients get better as a result."*

*By Meg Bransgrove MACN, Emerging Nurse Leader*

Meg Bransgrove MACN

I was having brunch with a close group of friends recently and one of the couples was regaling us with stories about her eight month old's nightmarish antics over the course of her short life. While I fawn over this little cherub, her parents are dealing with intense mood swings, at times near constant tears, a crawling baby getting into everything within reach and a new little personality. Through hoots of laughter I realise something; Matilda's start to life has not been unlike my own past year as a baby nurse.

At the moment she is in the middle of a 'leap' and during these periods she adapts to changes in her own development and it can get very stormy. Sound vaguely familiar? A new graduate nurse is constantly developing everything from motor skills to knowledge and adapting to changes in their environment and it can sometimes seem like things are getting a little hairy.

Last year I leapt from the comfort of the classroom into the cold belly of industry where I cried in exasperation when a thick folder of critical care competencies thumped me to life in a room full of nurses and doctors. Life changed quickly as I ate, slept, worked, slept, ate, worked, slept. The clinical floor was overwhelming and every day my eyes opened a little more to the incredible knowledge contained in the nursing world. There were tears and tantrums, bumps and bruises, many were mine and some I attempted to fix as the bedside nurse. I learnt to crawl and walk albeit slowly and with a lot of falls, but the guiding hands of my colleagues grasped my arms and pulled me up giving me a pat on the back in comfort and sent me off to have a bottle (of wine).

As I was upskilled to new levels of complexity in the ICU I went through my own stormy leap complete with mood swings and inconsolable crying to my parents as my novice brain processed tasks and attempted holistic nursing practice among the chaos. I had play dates with the other baby nurses where we played with the new toys, belly-laughed and talked in our own secret language about our trials and tribulations. There were sleepless nights on shift and bad dreams that woke me up at 1am with heart racing as I panicked about 'did I do that thing for that patient and hand it over?' as ventilator alarms sung in harmony within my sleepless daze. There were teething problems with unfamiliar pieces of equipment and toilet training as I coached my bladder to keep itself together during busy shifts.

Transitioning is tough – it happens from the start to the end of life and most of the time we forget after a while just how hard and terrifying it can be, which I think is why some of the cranky nurses are less empathetic towards us baby nurses. But, hey, the positive is that one day it won't feel like this (just don't forget completely because the baby nurses need you to be kind to them) and most people understand you are still finding your feet so they actually don't expect you to know everything.

So, to all the baby nurses out there, I will say three things:

1. The person you are is the nurse you are – don't apologise for caring, always stay true to yourself but check yourself too. If there is something you think you need to improve on then get onto it; self improvement is impressive, don't let anyone tell you otherwise!
2. The sooner you do something, the sooner it is done – Athletes often use this mantra to train successfully so make a solid plan on a piece of paper towel and do as much as you can before your breaks.
3. Work a little less than full-time – this is no ordinary job; it is mental, physical, spiritual stress, and taking a little more time to yourself will make you a happier and healthier person. Many graduate programs in Australia are offering positions working 0.84 (4 shifts a week) for good reason.

After a year of hard work the reward is looking back and seeing how much I have learnt and grown as a nurse. I savour the little triumphs like trusting my instincts and seeing patients get better as a result. You will learn to trust yourself and before you know it another fresh-faced anxious baby nurse will be looking to you for guidance and you will be able to say it gets easier!

# IS BED REST A SIGNIFICANT PATIENT SAFETY RISK?

Now, more than ever, the evidence is clear that immobility can lead to delayed patient recovery and is a key contributor to a number of preventable medical conditions. The key buzz phrase that is being spruiked in Australian critical care units in 2016 is 'early mobilisation' with clear evidence that early patient mobilisation will lead to avoidance of secondary clinical 'preventables'.

Two clear 'preventables' are pressure injury (PI) and venous thromboembolism (VTE), both shown to increase in prevalence in the immobile patient. Mobilising a patient early or providing prophylaxis against PI or VTE is paramount as both are costly to the health system and detrimental to patient recovery.

PI, formerly known as pressure ulcers and bed sores, is a consequence of prolonged unrelieved pressure. PI can contribute to devastating wounds, sepsis and death, and is a significant burden on modern health care. The Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline (available from Wounds Australia: www.awma.com.au/ptpu) outlines mobility as a key determinant in risk of injury from pressure and advocates mobilisation including the use of alternating pressure mattresses in circumstances of reduced mobility (EPUAP, NPUAP & PPPIA 2014).

The guideline goes on to state that small cell alternating pressure air mattresses or overlays should not be used and that alternating pressure air mattresses with small cells (diameter <10cm) cannot sufficiently inflate to ensure pressure relief over the deflated cell (EPUAP, NPUAP & PPPIA 2014). ArjoHuntleigh's full range of active support surfaces have cells greater than 10cm and meet these criteria along with all the recommendations within the guideline.

VTE, which encompasses deep vein thrombosis (DVT) and pulmonary embolism (PE), are the most common preventable causes of death in Australian hospitals (Cohen et al. 2007). In 2008, the financial cost of VTE was $1.72 billion. Including the value of lost wellbeing, the cost approaches $1.5 million per person (Access Economics 2007).

Effective preventative measures to reduce VTE events are not being administered as often as recommended. Statistics show that 50% of all hospital inpatients may be at risk and yet only half receive adequate protection despite the wide availability of effective preventative measures (Cohen et al. 2008).

Once patients become immobile, venous stasis occurs, reducing blood flow, which then encourages clots to form. This is why early mobilisation is so important after an operation or illness to prevent the incidence of VTE. Along with venous stasis, thrombus formation is also associated with vessel injury and hypercoagulation, collectively known as Virchow's triad.

Hospitalised patients are over 100 times more likely to develop a DVT or PE compared with the rest of the community (Heit et al. 2001). Simple and effective preventative measures are available to reduce the risk, which includes both mechanical and pharmacological prophylaxis. The ArjoHuntleigh Flowtron range is a proven mechanical prophylaxis system that will reduce a DVT rate to less than 4% in all high risk patients.

A number of national and international best practice guidelines have been developed to ensure adequate prophylaxis and timely preventative measures are initiated, allowing the best possible outcomes for patients at risk. For further information please visit www.nhmrc.gov.au/guidelines/publications/cp115 and www.nice.org.uk/CG092

ArjoHuntleigh has solutions to assist in early mobilisation strategies as well as prophylaxis devices for the prevention and management of VTE and PI.

To learn more: call **1800 040 072**, visit **www.arjohuntleigh.com.au** or contact your local ArjoHuntleigh representative

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# MARGARET ANN STEVENS FRCNA (Ex)

*By Elizabeth Foley FACN, Marie Dell and Trina Jones*

Born on 15 June 1936, Margaret began a lifetime of learning, mentoring, teaching and innovation. On completing her secondary education at University High School, Parkville, Victoria, Margaret commenced general training at the Austin Hospital Heidelberg, Victoria, in 1953, qualifying in 1956, and so entering the field that was to influence her life as much as she was to influence it.

In May 1970, after moving to Ballarat with her husband, Laurie, Margaret joined the staff at Ballarat Base Hospital and took up a Florence Nightingale Scholarship to study the Nurse Educator course at the College of Nursing Australia[1]. She was appointed Principal Nurse Educator on 1 February 1975, entering a period of major change in nursing. In preparation for the move to a tertiary program, Margaret facilitated her department staff to gain postgraduate qualifications in nurse education. Margaret's expertise was recognised and she was seconded to the Ballarat College of Advanced Education to finalise a training program for submission to the Victorian Institute of Colleges for Accreditation. The Ballarat program was one of the first accepted.

Margaret was appointed inaugural Head, School of Nursing, University of Ballarat in 1985. The first intake of students occurred in February 1986 and over the next three years increased from 85 to a total of 320. Ill health forced Margaret's retirement in 1989.

June Cochrane, Executive Director, College of Nursing Australia, in a letter to Margaret at this time stated:

*"As one of the pioneers of nurse education in the tertiary sector, your contribution as founding Head of a new campus at Ballarat CAE will join the ranks of others who have had to deal with an enormous change, not only in education, but attitudes at many levels.*

*As with some other nurses, a very busy workload has not prevented you from extending your commitment to the profession through your (sic.) activities as Chairperson of the Victorian Chapter…Thank you Margaret for all the time and effort you have given to the College over the years."*

Over the years, Margaret served on a multitude of boards and committees for nursing, government, community, church and volunteer organisations.

Margaret's sudden death on 23 March 2015 as a result of a fall, was a great shock to all. Everyone who knew Margaret admired her exceptional kindness and devotion to helping people. Margaret will be remembered for the contribution she made to nursing, health and the well-being of the community.

**Reference:**
The College of Nursing Australia is the predecessor to the Royal College of Nursing Australia, which today is known as the Australian College of Nursing

# GAYLE WOODFORD

The Australian College of Nursing is very saddened by the death of nurse, Gayle Woodford, and would like to express its sincere condolences to Gayle's family, friends and all those whose lives she touched and who she helped during her career as a health professional. As a Remote Area Nurse, Gayle provided access to quality health care for Australians living in the most isolated parts of this country. Gayle, originally from Stansbury on the Yorke Peninsula, was working for the Nganampa Health Council on the APY Lands in the remote north west of South Australia in the five years before her death in late March 2016.

Photo: Facebook

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