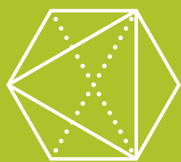
the hive

#3 SPRING 2013



Australian College of Nursing

Voice of influence

REFLECTIONS FROM *the ICN Congress*

CARRYING A TORCH FOR OUR FOREBEARS: *the Centaur nurses*

CAP ON WORK-RELATED *education expense deductions*

TRANSITION TO *the workforce*

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HEALTH & MEDICAL

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Cover
ICN Student Assembly Forum presenters and delegates.

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ADJUNCT PROFESSOR DEBRA THOMS FACN (DLF)

“The acknowledgement and recognition of those nurses who served before us is a subject close to my heart.”

The contributions and adaptability of you, our members, has allowed for a very successful first year of operations for the Australian College of Nursing (ACN). In this, our spring edition of *The Hive*, we take the opportunity to look back at the Royal College *of* Nursing, *Australia* (RCNA) Faculties, Chapters and Networks that made up our former structure and the framework to deliver the new ACN engagement structures.

The relevance of ACN's Grants and Awards program is evident in this edition. We feature two articles whose research findings were assisted by the receipt of an award offered through this program. Dr Madonna Grehan's article focusses on the *Centaur nurses*, eleven of whom lost their lives when the 2/3rd Australian Hospital Ship *Centaur* was torpedoed by a Japanese submarine in 1943, and Mary-Anne Ramis' article concentrates on the *experiences of Australian advanced practice nurses working in acute care settings.*

The acknowledgement and recognition of those nurses who served before us is a subject close to my heart. That's why I'm so pleased to feature alongside Dr Grehan's article another story which focusses on our nursing history. Be sure to read the review of Dr Judith Godden's (an ACN Honorary Fellow) book, *Australia's Controversial Matron: Gwen Burbidge and Nursing Reform.* This is an excellent review which I hope inspires you to purchase the book and absorb more details about one of our most influential nurse leaders of the 20th Century.

Springtime is a time for optimism and our student members need to look to the future, plan their education and for some, apply for their first jobs as registered nurses. ACN Executive Manager of Education, John Kemsley-Brown offers some practical advice when approaching interviews in the tough employment climate. Karen Clark-Burg also gives us insight into the potential of student nursing mentorship programs. Both articles offer great relevance not just for students but for all nurses to contemplate.

Our cover story highlights this year's International Council of Nurses 25th Quadrennial Congress by sharing some of the ACN community's experiences and images from this memorable event.

Finally, in the exciting spirit of events, we showcase The National Nursing Forum, now only a little more than a month away. I hope to see many of our Fellows and Members in attendance to not only absorb an invigorating Forum program but to welcome the new ACN Board of Directors, witness the investiture of ACN Fellows and enjoy the inaugural ACN Oration.

EVENTS

THE NATIONAL NURSING FORUM
Success through Synergy

HAVE YOU REGISTERED?

PROGRAM HIGHLIGHTS INCLUDE:

- ACN 'members only day' including a range of workshops and networking opportunities
- ACN Oration, presented by Professor Denise Fassett FACN, and investiture of Fellows awards, followed by the ACN Oration reception
- presentations from keynote and invited speakers
- a range of concurrent sessions on key topics within a variety of nursing practice areas
- panel discussion and exclusive workshop.

THE AUSTRALIAN WAR MEMORIAL HOSTS THE CLOSING SESSION AND DINNER – A NIGHT NOT TO BE MISSED!

The closing session and dinner will be held on Tuesday 22 October 2013 at one of Canberra's most iconic venues, the Australian War Memorial. The Memorial combines a shrine, a world-class museum, and an extensive archive. The Memorial's purpose is to commemorate the sacrifice of those Australians who have died in war. Its mission is to assist Australians to remember, interpret and understand the Australian experience of war and its enduring impact on Australian society.

Forum delegates will experience a nursing focussed tour of the Memorial, then dine below the 'G for George' aircraft. It will be a relaxed evening allowing the opportunity to experience Canberra while networking with new and old colleagues from the Forum.

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INVITED SPEAKER:
PROFESSOR MICHAEL CARTER

Dr Michael Carter is a native of the Missouri Ozark Mountains. He earned bachelor and master degrees in nursing from the University of Arkansas for Medical Sciences, the Doctor of Nursing Science degree from Boston University and the Doctor of Nursing Practice from the University of Tennessee. He is certified as a Family Nurse Practitioner and a Geriatric Nurse Practitioner; is a Fellow in the American Academy of Nursing; a Distinguished Practitioner in the National Academies of Practice and a Diplomat in the American Board of Comprehensive Care. He completed a Fellowship in Primary Care Health Policy in the United States Public Health Service.

For 18 years Dr Carter served as Dean and Professor at the College of Nursing, University of Tennessee Health Science Centre where he is currently a University Distinguished Professor. He is an Adjunct Clinical Professor at the University of Arkansas for Medical Sciences Department of Geriatrics. He maintains a clinical practice as a Nurse Practitioner at the Christian Health Centre in Heber Springs, Arkansas.

ACN ORATION

Professor Denise Fassett FACN accepted a formal invitation from the ACN Board and CEO to deliver the inaugural ACN Oration. We are very much looking forward to Professor Fassett's Oration which will be held prior to The National Nursing Forum, on Sunday 20 October 2013. More details about the Oration theme will be featured in an upcoming edition of NurseClick.

Following a number of senior academic positions in nursing, including six years as Head of Nursing and Midwifery at the University of Tasmania, Professor Fassett was appointed Dean of the Faculty of Health Science in 2013.

Professor Fassett is a registered nurse with a Bachelor of Health Science, Graduate Diploma in Aged Care, Master of Nursing and a PhD. She was Chair of the Nursing Board of Tasmania from 2006 until July 2010 and appointed a member of the Nursing and Midwifery Board of Australia in 2009, a position she currently still holds. Denise was appointed a Governing Council Member to the Tasmanian Health Organisation North, in 2012.

ACN is pleased to recognise Professor Fassett's contribution to the profession as the inaugural Orator.

MEMBER UPDATE

ACN FELLOWSHIP APPLICATIONS

> *"Candidates admitted as Fellows shall be entitled to be known as a Fellow of the Australian College of Nursing, use the post nominal FACN after their name and receive and display their certificate of Fellowship."*

Fellowship of ACN is a prestigious member status granted to those who have demonstrated a significant contribution to ACN and/or the nursing profession over time. Fellows represent the second largest member category of ACN. ACN is happy to announce that new applications can be submitted now for 2014.

Applications for Fellowship are assessed on the basis of professional commitment and professional achievements (this includes involvement with ACN's two founding organisations – Royal College *of* Nursing, *Australia* and The College of Nursing). Candidates admitted as Fellows shall be entitled to be known as a Fellow of the Australian College of Nursing, use the post nominal FACN after their name and receive and display their certificate of Fellowship.

Applications will be reviewed by the ACN Censors, Grants and Awards Committee. If successful, your application will be forwarded to the ACN Board of Directors for ratification. The next deadline to submit applications is Friday 20 December 2013. Please find the Fellowship application form and contact details online at www.acn.edu.au/membership.

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PRESTIGIOUS APPOINTMENT

Professor Patricia Davidson FACN

“ Professor Davidson’s appointment to such a world-renowned university reflects greatly on her competencies and high regard as an Australian nurse leader. ”

Professor Patricia Davidson has been appointed to the prestigious position of Dean of the School of Nursing at Johns Hopkins University (JHU), Maryland, USA.

JHU is currently ranked number one in the USA School of Nursing in National Institutes of Health research funding, as well as number one in graduate schools in nursing (US News & World Report 2013).

Professor Davidson is a global leader in cardiovascular and chronic care and has spent 23 years as a front-line clinician and nurse manager before her transition to research and teaching. Professor Davidson’s appointment to such a world-renowned university reflects greatly on her competencies and high regard as an Australian nurse leader.

ACN would like to congratulate Professor Davidson on her distinguished appointment.

US News & World Report 2013, *Best Grad Schools*, viewed 31 July 2013 http://grad-schools.usnews.rankingsandreviews.com/best-graduate-schools/top-health-schools/nursing-rankings

Reflections from

THE ICN CONGRESS

A few months have passed since the 'final curtain call' of the International Council of Nurses (ICN) 25th Quadrennial Congress and ACN Board and staff members have had time to reflect on their Congress experience. An experience that provided them with opportunities to share professional knowledge, discuss the challenges and prospects facing the nursing profession as well as the forging of many strong relationships between their national and international colleagues. Those lucky enough to attend the Congress in Melbourne took with them memories that will sustain them for years to come.

Photos left to right top to bottom: South Korean delegates in traditional dress at the ICN Opening Ceremony (Photo supplied by South Korean delegates).

ICN CEO David Benton, Minister for Mental Health and Ageing Mark Butler, ICN President Dr Rosemary Bryant and ACN President Carmen Morgan (Photo supplied by ICN).

ACN President Carmen Morgan, ICN President Dr Rosemary Bryant, Minister for Health and Medical Research Tankya Plibersek and Parliamentary Secretary for Health Georgie Crozier (Photo supplied by ICN).

International Council of National Representative special guests at the ACN Cocktail welcome.

The Qantas Choir, including the Australian Girls Choir and National Boys Choir of Australia performing at the ICN Closing Ceremony (Photo supplied by ICN).

Stephanie Fox-Young (ACN), Debra Thoms (ACN), Lee Thomas (ANMF), Alyson Smith (AHPRA), Anne Copeland (NMBA), Kathy Baker (ACN) and Carmen Morgan (ACN) at the Florence Nightingale Fund luncheon (Photo supplied by ICN).

ICN 25TH QUADRENNIAL CONGRESS TIMELINE OF EVENTS

COUNCIL OF NATIONAL REPRESENTATIVES (CNR)

16–19 MAY

CNR is the international governing body of ICN who meet every two years. The 130 NNA members of ICN came together to represent their national organisations and their members at this meeting.

ACN COCKTAIL EVENT

17 MAY

The ACN cocktail event was an official welcome for the CNR international guests.

ICN CONGRESS STUDENT ASSEMBLY FORUM – THE SOCIOTECHNICAL NURSE

18 MAY

ACN hosted the Student Assembly Forum, which showcased four dynamic presentations highlighting the various opportunities for the nursing profession to utilise and embrace this rise of technology, whilst being mindful of the ethical and legal implications social media can pose to both nursing students and nurses.

ICN CONGRESS – EQUITY AND ACCESS

18–22 MAY

The Congress objectives included advancing and improving equity and access to health care, to demonstrate the nursing contribution to the health of individuals, families and communities and to provide opportunities for an in-depth exchange of experience and expertise within and beyond the international nursing community.

18 MAY

Opening ceremony featuring Deborah Cheetham and the Short Black Opera, and the Parade of Nations.

20 MAY

The Health system of Australia presentation featuring The Hon Tanya Plibersek MP, Australian Minister for Health.

21 MAY

Florence Nightingale International Foundation luncheon, including Sheila Tlou, Director of the UNAIDS Regional Support Team for Eastern and Southern Africa and Ambassador for the Girl Child Education Fund.

22 MAY

Closing ceremony featuring the announcement of the new ICN President, Canadian Judith Shamian, the Qantas Choir, including the Australian Girls Choir and National Boys Choir of Australia.

PROFESSIONAL SITE VISITS

23 MAY

A day of professional visits was available to delegates to showcase Australia's nursing services, range of models of care, nurse workforce design, and clinical settings.

> *“To witness Palestine being accepted as a member of ICN and to hear the member for Israel comment that nurses and the mission of nursing was above the politics of racial, cultural and religious conflict was uplifting.”*

ADJUNCT ASSOCIATE PROFESSOR **STEPHANIE FOX-YOUNG** FACN (DLF), ACN BOARD DIRECTOR

I really enjoyed being able to observe at the CNR. There was quite a different perspective sitting at the back of the room than sitting among the representatives as I have previously [as RCNA President]. It was much easier to see some of the cross-regional alliances and negotiations taking place in huddles round the room. It is very much like the United Nations, especially in how long it takes for decisions to be made when there are so many perspectives to take into account.

The Short Black Opera Company will now be on my list of ‘must see’ events if they ever come to Brisbane. And the Qantas Choir was so good, at least one of us wanted to “pack them up and take them home”. However, we agreed that this could cause some international difficulties especially after the plenary session we had attended earlier in the week on modern day slavery, with children being transported illegally across borders to become servants and sex slaves. That was probably the most sobering session I attended, although the one that talked about the emergence of malaria in areas previously without it, as a result of global warming, was a strong contender.

The raising of a substantial amount of money for the Girl Child Education Fund at the Florence Nightingale lunch itself was a highlight – something that had not been done before. The story told by the guest speaker, Rose, a child who had been helped by the fund, I am sure helped to spark generosity. Helping the female children of nurses who have died of AIDS is a great initiative, one that ICN can justly be proud of.

STACIE MURPHY MACN, ACN POLICY MANAGER

Scrutineering at CNR was an immensely rewarding experience. The expertly chaired CNR sessions created a lively but effective environment – ensuring all essential business items were addressed, including the much anticipated election for the new ICN President and Board of Directors. The goodwill and professional way in which international country representatives interacted and demonstrated their genuine commitment to nursing globally and in their own countries was a credit to those participating. Such commitment to advancing public health outcomes by empowering the nursing community is inspirational.

DEBORAH COCHRANE MACN, ACN NURSE EDUCATOR

The ICN Student Assembly Forum showcased the nurses of tomorrow, and did the profession proud. The Forum generated lots of discussion about the regulations of social media and gave an excellent for and against approach to the use of social media. Discussion was held around the use of social media and if it should be regulated and, if so, should these regulations be taught in the undergraduate curriculum and/or as part of annual training. I found this to be one of the highlights for me and thoroughly enjoyed the Forum.

There wasn’t a dry eye for any of the proud Australians at the opening and closing ceremonies. The voices of both Deborah Cheetham and the Qantas boys and girls choir were breathtaking. These ceremonies made you proud to be Australian, a member of ACN (who organised this event) and, importantly, proud to be a nurse.

From the sessions I attended I gained lots of new ideas, information and knowledge from a global perspective, and had some great opportunities to set-up contacts internationally. The presentation that I found most profound and moving was a session on enslavement and equality. I had just never really thought about this issue as a nurse, the impact it can have and the degree it occurs within today’s society.

LEONE PIKE MACN,
ACN TERTIARY EDUCATION SERVICES MANAGER

ICN was an inspiring experience, reinvigorating my notions of what it means to be a nurse and what nurses are capable of; being the drivers of spreading health care widely and improving health care for the world.

To witness Palestine being accepted as a member of ICN and to hear the member for Israel comment that nurses and the mission of nursing was above the politics of racial, cultural and religious conflict was uplifting.

To be asked by the ICN member from the Netherlands if I was proud to be a nurse and to be able to answer both sincerely and enthusiastically that I was proud to be a nurse for me was both validating and gratifying.

KAY RICHARDS FACN, ACN BOARD DIRECTOR

As someone who attends conferences on a regular basis, attending ICN proved to be a unique experience; not just in hearing international perspectives on a range of topics but for the opportunity to meet so many nurses who are actively making a difference in their sphere of work.

Attending the CNR meeting as an observer provided the opportunity to witness the mechanics of the governing body of ICN and reminded me of the influence Australia has had on the international nursing profession through Dr Rosemary Bryant FACN as President of ICN for the last four years. She has led ICN admirably and I believe assisted wisely in achieving the ICN goals of bringing nursing together worldwide, advancing nurses and nursing worldwide and influencing health policy.

WITH THANKS
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Photos: Deborah Cheetham performing at the ICN Opening ceremony, cultural component (Photo supplied by ICN).

ANMF Federal Secretary Lee Thomas and ACN CEO Debra Thoms representing Australia in the Parade of Nations (Photo supplied by ICN).

ICN Student Assembly Forum presenters and delegates.

With thanks to our wonderful ICN volunteers – the Congress would not have been the same without you (Photo supplied by South Korean delegates).

Australian College of Nursing:

A DETERMINED ADVOCATE FOR NURSES

Advocacy is a key role of the Australian College of Nursing. ACN advocates on priority issues that affect the nursing profession and is regularly invited to provide input into consultations on nursing and health care matters. Over the last six months, ACN has contributed to a number of high-profile consultations, including Health Workforce Australia's (HWA) inquiry into Nursing Retention and Productivity and the Review of Australian Government Health Workforce Programs (the Mason review).

HEALTH WORKFORCE AUSTRALIA'S INQUIRY INTO NURSING RETENTION AND PRODUCTIVITY

Health Workforce Australia is an independent statutory body established by the Commonwealth Government to deliver a co-ordinated national response to health workforce issues and to drive reform in this area. In March 2013, HWA launched a consultation paper on nurse retention and productivity in order to help identify priority areas of concern and gather information about initiatives which have proved to be effective. ACN developed a submission to the inquiry outlining the measures that must be taken to improve nursing retention. HWA will use responses to the consultation paper to inform its final report outlining ways to increase nursing retention and productivity.

For more information, search for 'Nursing retention and productivity' on Health Workforce Australia's website: www.hwa.gov.au.

REVIEW OF AUSTRALIAN GOVERNMENT HEALTH WORKFORCE PROGRAMS (THE MASON REVIEW)

The Mason Review was established in September 2012 to analyse Australian Government programs that target the training, planning and distribution of the health workforce. The review was chaired by Ms Jenny Mason and informed by a series of stakeholder meetings which were attended by members of the ACN Executive. In July 2013, ACN provided the Minister for Health and Medical Research, Tanya Plibersek, with a detailed response to the review.

The Mason Review can be found by searching for 'Mason Review' on the Department of Health and Ageing's website: www.health.gov.au.

Both the HWA inquiry and the Mason Review provided valuable opportunities for ACN to make the voice of nursing heard in current health policy debates and, most critically, to present a nursing perspective on nurse workforce issues. ACN continually emphasises that the future of the health care system depends on a nursing workforce with the knowledge, skills, experience and

ACN advocacy is driven by the priorities and expertise of ACN members. Opportunities to get involved are regularly advertised in the *ACN e-Newsletter* and via direct emails to members with relevant interests or experience. Members can also indicate their interest in advocacy work by joining an ACN Community of Interest and filling out our online survey or by emailing policy@acn.edu.au.

> *“ACN was pleased to see that the Mason Review recognised the importance of leadership and recommended that the Government fund a feasibility study of a national leadership course for nurse managers.”*

flexibility to respond to community needs. In both submissions, ACN argued that national reforms should focus on building positive workplaces and strengthening nurse leadership at all levels, to ensure the availability of a sustainable nurse workforce into the future.

The importance of generalist nursing education is consistently highlighted in ACN's advocacy work. Generalist nurses have a critical role in community and primary health care and there are strong indications that the demand for generalist nursing skills will increase over the next decades. Generalist education also promotes workforce adaptability in all health settings and provides the necessary foundations for nurses to move into expanded or advanced roles. ACN's response to the HWA inquiry cautioned against promoting early specialisation as it has the potential to crowd the undergraduate curriculum and undermine the principle of generalist nursing education.

The need for effective preparation for practice and transition supports is one of ACN's core messages. Quality clinical placements, that support skill and competency development under the direction of dedicated clinical supervisors, are essential to prepare student nurses to enter the workforce. ACN's response to both the HWA inquiry and the Mason Review promoted the need for greater industry engagement in nurse workforce education in order to better align the expectations of employers with education providers. ACN indicated support for the Mason Review's recommendation that private health care providers in particular should be more involved in education training initiatives. It is ACN's view that there is significant potential for more active private sector engagement in nursing education across all health care settings.

ACN also made clear that effective preparation for practice should be complemented by targeted supports for early career nurses and nurses moving into new roles or workplaces. ACN has continually underlined the need for a national initiative to embed transition supports across the health sector in order to support professional development, retention and workforce flexibility. This was one of the central themes of ACN's response to the HWA inquiry.

ACN has consistently advised that the rural nursing and midwifery workforces are under pressure. It was therefore encouraging to see the need for better support for nurses working in rural areas emerge as a key issue in the Mason Review. ACN offered strong support for the Mason Review's recommendations that funding for postgraduate professional development in rural areas should continue to be supported through the Rural Health Continuing Education Program, and that financial support should be available for rural and remote registered nurses undertaking re-entry courses.

Articulating the critical importance of nurse leadership is a high priority in all ACN advocacy work. ACN argues that supporting nurse leadership must be the cornerstone of nursing workforce reforms. The evidence demonstrates that visible, respected and accountable nurse leadership has a direct impact on workforce retention and care outcomes. Nurse leadership is also an enabler that will support the introduction of other reforms, particularly if these changes are nurse-led and implemented with local ownership. In responding to HWA's inquiry, ACN argued that a new focus on developing the leadership capabilities of nurse managers is needed. Nurse managers at the unit or ward level are preoccupied with clinical concerns and overburdened with administrative matters, which often results in their leadership potential remaining untapped or underdeveloped. ACN was pleased to see that the Mason Review recognised the importance of leadership and recommended that the Government fund a feasibility study of a national leadership course for nurse managers. The review suggested that ACN would be an appropriate organisation to lead this work.

Each of the themes highlighted in the ACN response to the HWA inquiry and the Mason Review links back to the central message of investing in positive workplaces and nurse leadership. Positive workplaces are characterised by high levels of staff satisfaction, which depend on nurses receiving effective preparation for practice, transition supports and access to relevant and challenging professional development opportunities, as well as access to strong leadership. Investment in scholarships and continuing education, particularly in rural and remote areas, is thus vital. However, little will be achieved if we do not expand current investment in nurse leaders and enable them to take a larger role in driving change in their work environments. For this reason, the development of a national nurse leadership program must be a high priority.

INDIGENOUS AUSTRALIAN CARE IN MAINSTREAM SERVICES

BY MELISSA J BLOOMER FACN
PHD CANDIDATE, MONASH UNIVERSITY, VIC

BY ASSOCIATE PROFESSOR ANTHONY P O'BRIEN
UNIVERSITY OF NEWCASTLE, NSW

Australia's Indigenous and Torres Strait Islander people account for only 2.5% of the Australian population (ABS 2009), and when compared to other Australians across a range of socio-economic indicators they are significantly disadvantaged, with poorer health outcomes compared to the non-Indigenous Australian population (AIHW 2011).

Indigenous Australian culture is founded on kinship. The family, which extends to the greater community, is the most significant factor in the identity development of most Indigenous people. Similarly, the land is regarded as spiritual, and Indigenous culture emphasises this strong connection to the land, kinship and tribal country (O'Brien et al. 2013). Whilst some aspects of non-Indigenous culture may have been taken on by Indigenous Australians in the last 200 years (McGrath & Phillips 2008), their expectations of health care remain different from that of Australia's non-Indigenous population and in inpatient settings, the cultural divide is significant.

For Australia's first people, there is a clear reluctance to access/utilise mainstream hospital services. Not only because it requires them to be away from their home 'country' and community, but because non-Indigenous beliefs about health and illness are so different, and Indigenous Australians are concerned it lacks respect for their culture. Many Indigenous Australians can recount stories of dissatisfaction, even mistreatment and cultural irrelevance when accessing mainstream health services (McGrath 2007).

Where Aboriginal Health Workers (AHWs) are employed however, they play an integral role in bridging the cultural divide between mainstream health services and Indigenous culture and communities. AHWs have been shown to be very successful in not only improving access to mainstream services, but also improving acceptance of mainstream care (Thompson et al. 2011). Another study found that the presence of an AHW had a calming/settling influence on Indigenous patients, making them more likely to engage with other staff and prevent them from discharging early (Hooper et al. 2007).

Other factors such as access to outside areas and the provision of non-clinical spaces where family and community members can be together can help with acceptance of mainstream care (O'Brien et al. 2013). But wherever possible, a care delivery model that works with the Indigenous Australian population, by respecting the Indigenous person's link with the land and which acknowledges community and family, and cultural and spiritual beliefs about health and illness should be the mutually shared goal (O'Brien et al. 2013).

Australian Bureau of Statistics (ABS) 2009, *3238.0 - Experimental estimates and projections, Aboriginal and Torres Strait Islander Australians 1991 to 2021*, viewed 31 May 2013, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.

Australian Institute of Health and Welfare (AIHW) 2011, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, on overview, Cat. No. IHW 42*, Canberra, ACT.

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OUR JOURNEY THROUGH MEMBER ENGAGEMENT

“It has been an exciting time for us all and we are extremely positive about the changes ahead and the many opportunities the new structures will bring to ACN members.”

ACN recently began transitioning members from the former models of Chapters, Faculties and Networks to the new engagement structures of Regions and Communities of Interest (COIs). It has been an exciting time for us all and we are extremely positive about the changes ahead and the many opportunities the new structures will bring to ACN members. The new structures provide opportunities for every member of ACN to participate regardless of how much time they commit or the stage of their career.

Many of the Regions and COIs have commenced discussions and are planning activities. Others have scheduled events and are actively engaging on a regular basis. We look forward to keeping you updated with information about your Region and COI in our upcoming publications.

As we farewell the Chapter model and welcome the Regions, we acknowledge that for over 50 years the Chapters have been successful in providing unique networking and professional development opportunities for nurses across Australia.

Chapter Chair meeting at the national office in Canberra, 2003

THE HISTORY

Looking back at the history of how the Chapters evolved, we need to look at the establishment of the College of Nursing, Australia (CNA) in Melbourne, in March 1949. This was a turning point in professional development for Australian nurses, as they were able to undertake post-basic studies in education and administration in Australia rather than travel to the United Kingdom. However, it was difficult and costly for many nurses to travel to Melbourne to continue their studies, so during the 1950s, the CNA established committees in each of the states to carry out activities on a local basis. By the 1960s, most state committee business was conducted by sub-committees which dealt with study days, publicity, annual meetings, button days, library, social functions and fellowship.

In the 1970s, the transfer of nursing education to the higher education sector was occurring and diploma courses were being conducted at a number of state branches of the CNA. As nursing education moved into the tertiary sector in the mid-1980s, the number of attendees at meetings dwindled as there were other avenues for nurses to obtain education. In 1987, following a restructure of CNA, Chapters were implemented and were assisted by the national office to hold central seminars and regional information sessions. In some Chapters, ‘link members’ were appointed and regional functions were held.

In 1989, CNA became Royal College *of* Nursing, *Australia* (RCNA), and in 1994 moved its headquarters to Canberra. The Chapters continued to meet, respond to various enquiries and represent RCNA on a number of governmental and other committees. Some Chapters began publishing a quarterly newsletter until the national office decided to replace newsletters by having all Chapters contribute to *Colnursa*, in 1995. In 1996, the appointment of salaried professional officers for each Chapter came into being. Professional officers’ duties related to servicing the membership within the Chapter by responding to inquiries and providing information, recruiting new members, conducting seminars, meetings and workshops and supporting liaison members. From the late 1990s and until very recently, RCNA (now ACN) continued to be well represented by Chapter Committee members who were involved in a variety of professional activities related to fundraising, professional development, the administration of various awards and scholarships and policy responses.

> STATE AND TERRITORY REFLECTIONS

QUEENSLAND

There have always been people willing to put in a great deal of time and effort to provide continuing professional development for colleagues and to make the effort to get to Chapter meetings. Some of the people that stand out in my memory who should be recognised for their contributions over the years are Yvonne Osborne FACN, Claire Lees FACN(ret), Sue De Vries FACN and John Brown FACN. The history breakfasts have been a very enduring annual Chapter event – thanks to Sue De Vries' continuing commitment and uncanny ability to track down interesting presenters.

Adjunct Associate Professor
Stephanie Fox-Young FACN (DLF)

ACT/SOUTHERN NSW

A highlight for the ACT/Southern NSW Chapter has been the annual Acute Care Conference held in Wagga Wagga. This event was the culmination of significant work by the committee and provided a unique opportunity for rural nurses and health professionals to gain valuable professional development. For each year that the conference was run, expert clinicians from Southern NSW and the ACT presented sessions on a range of topics relating to acute health care, and health industry exhibitors presented information and education concerning the services that the health care industry provides.

SOUTH AUSTRALIA

Over the years the South Australian Chapter has offered quarterly educational and networking opportunities for members in the Adelaide area. These have attracted both metropolitan and rural members, depending on the topics. Topics have been themed to address aged care, acute and emerging issues in nursing. They have been an opportunity for frank and open discussion about the direction of nursing both locally and internationally. As the South Australian Chapter Secretary it has been a privilege to be a part of this dynamic team of professional and dedicated nurses.

Anne Davies MACN

VICTORIA

The Victorian Chapter Committee in recent years has been focussed on increasing collaborative activities, in particular extending outreach to regional areas in the state. Highlights among the Chapter's annual activities include the Gertrude Berger lecture and the Fellows dinner, both of which were well attended year in and year out.

WESTERN AUSTRALIA

The Western Australian Chapter Committee has always been a very active and dynamic group of dedicated members. The clinical sessions held bi-annually have been hugely popular, particularly with students. With a vast geographical region to cover, which brings with it its challenges, the WA Chapter Committee has worked tirelessly to maintain the interest of current members and grow the organisation within Western Australia.

NORTHERN TERRITORY

Every year was a busy year for the small number of enthusiastic committee members who worked towards organising at least ten CPD and social activities each year. CPD topics were varied and consistently attended by members. Committee members have been excellent at keeping ACN (and previously RCNA) informed of local nursing issues and topics relevant to the Northern Territory.

TASMANIA

The Tasmanian Chapter Committee has been extremely successful in bringing together members from all areas of the island state, through the use of both link members on their committee and video conferencing facilities.

Due to the success of the link members, education events were successfully held regularly in the North West, Northern and Southern areas of state with the total amount of CPD activities exceeding fifteen some years. The strength of the committee and their great team work ensured that a robust regional program was continuously provided.

HUNTER VALLEY/NORTHERN NSW

In 2009, the Hunter Valley/Northern NSW Chapter of RCNA celebrated 50 years as a Chapter. On 15 October 1959 the Central Northern Auxiliary of the NSW State Committee of the CNA held their inaugural meeting at the Royal Newcastle Hospital. The Auxiliary was born out of the need to offer ongoing education to nurses in the Hunter region, as at this time hospitals did not offer in-service programs or opportunities for ongoing education. Most recently, the Chapter Committee met monthly and held one hour education sessions every second month, with day long workshops being held once or twice a year.

Special mention should be made of Mrs Bette Ellerington who was one of forty inaugural members of the Central Northern Auxiliary of the NSW State Committee of the CNA and was still actively involved in nursing and the Hunter Valley/Northern NSW Chapter in recent years. This is an impressive record and demonstrates Bette's commitment to the profession.

WITH THANKS

The extent to which ACN has established itself in the states and territories has been principally due to the amount of interest shown in its activities by local members. Chapters played a huge part in enhancing the profile of RCNA, and ACN recognises the continuing need for the states and territories to have local professional representation.

We would like to take this opportunity to thank past Chapter Committee members for their valuable time and dedication. ACN recognises the high level of commitment members have contributed to these Chapter roles. Thousands of nurses, including ACN members and non-members have benefited from their work. It is with such support and active participation from members that together, through our new member engagement structures, we will continue to enhance the experiences and expertise of nurses throughout Australia.

ACN would also like to extend its thanks and appreciation to Janet Anderson MACN and Marsha Ellis MACN for their service to both RCNA and ACN, as Regional Coordinators. Their dedication has ensured increased local awareness and engagement, and we thank them for their service.

We look forward to this period in ACN's development; building on this strong foundation and the discussion with members at the National Nursing Forum's member only day.

For further information on ACN's Membership Engagement Structures, please visit our website www.acn.edu.au/engagement or email engagement@acn.edu.au

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Photos left page left to right:

Queensland Chapter members, 2001.

Sue DeVries presenting the High Achiever award, 2008.

ACT/ Southern NSW Chapter members, 2003.

Acute Care Conference, 2011.

South Australia CPD event, 2008.

Victorian Chapter members, 2008.

Above left to right:

Donna Watmuff, Debra Cerasa (RCNA CEO) and Sussan Pleunik at the Victorian Fellow's dinner, 2010.

Joyce Hendricks presenting Marie Tyrrell-Clark with Fellowship, 2009.

Western Australian CPD event, 2010.

Northern Territory Chapter members and RCNA staff, 2001.

Tasmanian Chapter members – Jenny Tuffin, Elaine Hosken, Saz Newbery and Donna Gallagher, 2012.

Hunter Valley/ Northern NSW Chapter event, 2008.

Hunter Valley/ Northern NSW booth – International Nurses Day, 2009.

Simone Kairouz

VOLUNTEERING

MY SAMOAN EXPERIENCE

BY SIMONE KAIROUZ, REGISTERED NURSE, MERCY PRIVATE HOSPITAL (EAST MELBOURNE CAMPUS) AND BRIGHTON PLASTIC SURGERY (BRIGHTON)

In 2008, I was invited by a plastic surgeon to participate as a volunteer nurse in Interplast's surgical program to Samoa. I recall feeling honoured while at the same time a bit apprehensive, as I had never done anything like this before. However, by the end of the 12 days I had a distinct feeling of satisfaction and accomplishment. I had never experienced such a sense of personal, as well as professional fulfillment in all my years of nursing. The trip had such a huge impact on my outlook about my contributions to those less fortunate that I have returned to Samoa each year since.

Samoa's access to specialised medical care is limited, so plastic and reconstructive operations are life-changing opportunities for the locals. I spent my time in Samoa in the capital, Apia, at the 150 bed local public hospital. The hospital has no elevators, only stairs or ramps, and no air conditioning apart from theatre. On the wards, staffing is minimal with three to four nurses per 30 to 35 patients, leaving the patients' families to do all the caring, even having to provide their own sheets.

WHAT WE DO

On each deployment, the volunteer team usually comprises two surgeons, an anaesthetist and two nurses. We are met at the airport by one of the program coordinators who hands over approximately 300kg of equipment and relevant documents. A few times while lining up at the check-in, I have been asked whether I belong to a rock group because of all the black equipment cases. When I explain I am a nurse on my way to volunteer on a surgical program and the boxes contain medical equipment, the enquirers are suitably impressed! Most of the team members have been on an Interplast trip together to Samoa before, so it's great catching up with colleagues who have this special common interest. The social aspect of the trip makes it even more enjoyable and rewarding.

On the day we arrive, there is a lot of unpacking, sterilizing and setting up to do. We also start the process of assessing referred ward patients and reconnecting with Samoan friends and colleagues from our previous visits. Quite often, however, we meet new staff who are eager to broaden their skills and learn. By the end of our first clinic day in the Outpatient Department, we will have assessed approximately 50 patients and made the very difficult decisions about those cases we can help and those that do not fall within the brief of the program. Typical operations we perform include repair of cleft lips and cleft palates, releasing burn scar contractures and grafting, removal of large skin cancers and the excision of accessory digits.

NURSES' ROLES

While one nurse is allocated to theatre duties, my participation is primarily focussed on educational and organisational roles such as:

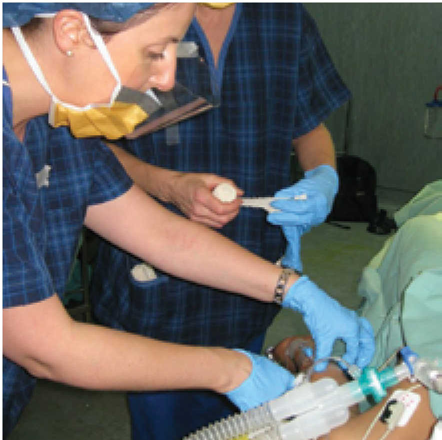
- educating nurses on the wards on cleft lip and palate post-operative care and any other procedures with which they are unfamiliar
- using one-on-one coaching methods, demonstrating and supervising staff while they attempt complex dressings including graft dressings
- educating the parents on suture line, mouth care and appropriate soft foods
- helping the surgeons on the clinic day with all the patient documentation
- formulating and circulating the daily/weekly theatre lists to the theatre, theatre manager, the local surgical registrar and our anaesthetist
- assisting as anaesthetic, scout and recovery nurse, until required back on the wards for supervising dressings
- writing a daily handover sheet for our team to assist morning and evening rounds
- setting up, in the second week, a temporary dressing clinic to see discharged patients requiring review and removal of sutures.

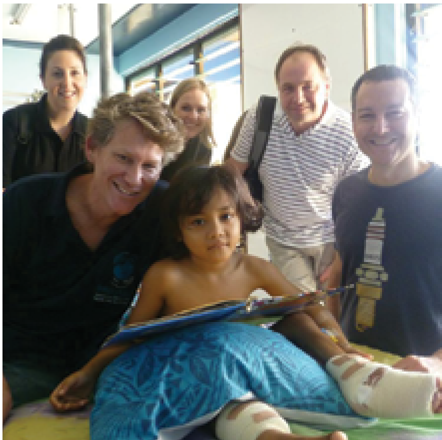
DO WE MAKE A DIFFERENCE?

Yes we do, as the following examples will highlight.

Interplast, a not-for-profit organisation, sends teams of medical volunteers to perform plastic and reconstructive surgery and training in neighboring Asia Pacific countries.

For more information please visit www.interplast.org.au.





Photos:
Simone treating a young Samoan child
Simone with a Samoan colleague
Simone treating a patient
Simone with colleagues and their young patient

CASE STUDY ONE

PJ, a brave seven-year-old boy, presented on his own to the clinic with upper body burn scar contractures after his clothing caught on fire. He had been unable to elevate his right arm for the last 12 months. He required release of the contractures in the axilla and graft to the wrist. It was so rewarding to see him post-surgery, when he greeted us with a big smile and lifted his arm up to wave. This procedure made a big difference to PJ's capacity to function normally, despite still wearing massive scars.

CASE STUDY TWO

In Australia, cleft lip repairs are usually performed at the age of 10 to 12 weeks, with palates being repaired at six to nine months of age. But, in Samoa, children present at an older age because they do not have access to treatment. Pati, a four-year-old boy, presented in 2011 to have his cleft lip repaired. The following year, it was good to see the progress he had made when he returned to have his palate repaired. You should have seen Pati's broad smile and that of his mother, who told us that Pati was eating so much better after the lip was repaired and now they were looking forward to the benefits of the palate repair. His mother, like most of the parents we see, are very diligent in following our instructions with suture line and mouth care. Educating them about soft foods, however, is sometimes challenging. Some cleft lip repairs are performed on children up to five years of age, who do not appreciate the need to recover on a soft food diet when all they want is Twisties and Coke!

CASE STUDY THREE

We also operate on adults such as Filamena, an 85-year-old, who presented with a skin cancer on her nose positioned very close to her right eye, which, if not treated, would have invaded her eye. She required an excision and repair with a forehead rhinoplasty pedicle flap and graft. Ward nursing staff had not seen such complex wound care before and were very pleased with the new knowledge they had gained.

I am thrilled to be part of such an important and humanitarian organisation such as Interplast. These trips make me realise how my own skills and expertise can make such a huge difference to the lives of people who otherwise would continue living with health issues that we, here in Australia, have easy access to address. Seeing the joy and gratitude on these patients' faces keeps me coming back each year. If you ever have the opportunity to participate in a volunteer program, I would encourage you to grasp it. Yes, you give freely your time and expertise but you come away with a sense of achievement and personal satisfaction that surpasses any material reward.

TRANSITION TO THE WORKFORCE

BY JOHN KEMSLEY-BROWN FACN, REGISTERED NURSE, ACN EXECUTIVE MANAGER – EDUCATION

John Kemsley-Brown

Applying for nursing positions can be highly competitive; in fact many nurses in different stages of their careers currently face the challenge of finding employment in Australia.

OVERVIEW

- When you graduate from your nursing degree, and upon registration with the Nursing and Midwifery Board of Australia, you are able to gain employment as a registered nurse (RN).
- Whilst this may be through a transition to practice program, remember, this is not your only avenue to employment as an RN.
- While a graduate place might be desirable, it is actually not a mandatory requirement. The stress and pressure felt by final year students to obtain a competitive graduate position is often unnecessary.
- Within a supportive environment, there is no reason why you can't launch a very successful career without being part of a 'formal' transition to practice program.
- There are some fantastic aged care and mental health positions out there; it's not all acute care and metro public hospital based.
- If you have the skills and abilities, don't let failure set you back, learn from your mistakes and let that make you stronger – challenges are good things.
- Doors of opportunity open for a reason, it is your choice to walk through that door or wait for another.
- Seize the opportunity to grow and develop.
- Love what you do.

YOUR JOB APPLICATION

- Job applications include a cover letter, your written address of the essential selection criteria and desirable criteria from the job description, and a list of your referees. Remember, it is not *War and Peace*. Keep it simple.
- Your cover letter includes what you are applying for, where you found out about the job, what you have included with the letter and that you look forward to meeting them.
- In the selection criteria, you MUST address the essential requirements of the role. Additionally, if you do not meet the criteria let the employer know what you are planning to do about it.
- Desirable criteria is not as essential, however it is nice to have and may be the difference between you and the next applicant.
- Referees should include your current employer and personal referees are fine in the beginning. Remember to have a minimum of three references.
- Often when submitting applications it is through a centralised application system, so you may be limited with the content you can submit.
- Whilst the content of your application is critical, so too is the appearance. Check, check and triple-check the spelling, design and presentation of your application.

YOUR INTERVIEW

- Before the interview do some homework. Research current projects and future plans of the organisation, read the Annual Report, speak with current staff, and visit the organisation.
- The 'essential criteria' from the job application should be an excellent guide to what questions you will be asked.
- Prepare some questions you might like to ask. What opportunities will be available to you regarding professional development? Why do people like working with this organisation? What is the salary range and annual leave entitlements? And, who can you contact for feedback regarding your interview?
- This seems obvious, but make sure your personal appearance is neat and tidy.
- Make sure you arrive early so you have plenty of time to find the interview room.
- Once the interview commences be calm and succinct in your answers and, most importantly, be yourself. People will be able to tell if you're not being authentic so now is not the time to trial a new persona!
- Make sure you have a copy of your application and resume, as well as a notebook and pen.
- Once your interview is over, debrief with a friend or colleague and look for areas where you could improve for your next interview.

YOUR ONGOING EDUCATION

- Create an Annual Education Plan; a yearly plan of what you would like to achieve, and how you plan to incorporate this into your clinical practice, and professional and personal development.
- Create a CPD portfolio; courses that you have undertaken, what you have done so far and how this has changed/impacted on your clinical practice.

ACN Emerging Nurse Leaders Sherrie Lee and Laurie Bickhoff, currently registered nurses in their graduate year, share the lessons they learnt as they applied for their first registered nurse position.

SHERRIE LEE MACN
REGISTERED NURSE

When you are required to start applying for nursing positions it's an exciting time; the completion of your Bachelor of Nursing degree. In choosing a graduate program you will try to put your finger in every pie to achieve the optimal outcome – a graduate nurse position. You will sit many interviews and may also receive many rejections. It's important to not get disheartened if you don't get offered the position you really wanted.

The careers department at my university educated us on how to structure our resume, how to write a graduate nursing application and advised us on what employers are looking for. We received presentations from each of the local hospitals, and information on each facility. It was really good to meet the employers and understand what they are looking for. These presentations also prompted me to think about what type of graduate role I was looking for. What were the values of the hospital and did they match my values? What opportunities did I want to be offered in my graduate year? Did I want to work full-time or permanent part-time? I was also fortunate to receive advice from a nurse and lecturer I really looked up to; this support really helped me and I would encourage all students to seek out the guidance of someone they respect.

From one nurse to another, you are in charge of your nursing career and your life – make sure you pick the position you want to do, not what others want you to do. Work hard at university; your grade point average does matter. Be yourself and never forget why you signed up to be a nurse in the first place.

LAURIE BICKHOFF MACN
REGISTERED NURSE

In terms of choosing a graduate program, you need to do a bit of research. When on placement, talk to the new grads on your ward – ask about their program. Programs differ in the amount of support and number of rotations you receive.

Ask your university year co-ordinator if they have contacts/arrangements with health providers. Look up how many new graduate positions your local areas had available for their most recent intake. This will give you an idea of the competition you will be up against.

If you have a specific area of interest, research the hospitals that are leaders in that field. For me, I am interested in trauma and emergency. A little research showed John Hunter and Westmead are the two biggest trauma centres in NSW.

Look for an undergraduate AIN position within the health district you want to apply to. This will give you great experience as well as giving you the chance to make an impression on your NUM.

Put effort into your studies now. You need to be able to answer the scenario based questions at interview time.

Consider volunteering with a health-based program. This looks great on any application and will give you more to discuss in an interview.

Practice interviewing with groups. Google 'Sample new graduate nursing interview questions' and you will find plenty of questions to practice with. The more prepared you are, the less nervous you are likely to be and the better impression you will make.

On your placements – introduce yourself to the NUM. Treat your placement as interview processes as well as teaching environments.

Don't forget to get your clinical reference forms filled out on each third year placement. You need two CLINCIAL references for new grad applications.

If you don't get a new grad position, it doesn't mean you won't get a job. This is when those contacts you made on prac really count. If you made a great impression on a NUM, they may be willing to offer you a job outside the new grad program.

Finally, don't put all your eggs into one basket. Apply to all the private hospitals' new grad programs and consider rural programs as well.

MENTORSHIP AND THE NEW UNDERGRADUATE STUDENT

BY KAREN CLARK-BURG MACN
ACTING ASSOCIATE DEAN, SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF NOTRE DAME AUSTRALIA, WA

BY ADIL VAKIL
SENIOR LECTURER, SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF NOTRE DAME AUSTRALIA, WA

The transition to university impacts upon students' wellbeing, affecting diet, health, and behaviour. These are often noticeable in the new students who constitute a collection of school leavers and mature age entrants (Salinitri 2005). While the university's student support services and pastoral care staff deliver good assistance, a mentor program can introduce the new student to peer input which enhances their overall experience (Bulut et al. 2010; Holloway et al. 2010). The School Of Nursing and Midwifery of the University of Notre Dame, Fremantle Campus has developed a mentorship program to enhance and improve the experience of the first year nursing student (Crisp & Cruz 2009; Reilly 2012).

The mentoring program was made compulsory to all first year undergraduate nursing students in 2010. Previous to this, students did not have a formal, structured program and not all new entrants were assigned a mentor. Now, each student is allocated a mentor who is an experienced nursing student in their second or final year. This pairing of mentors and mentees is done randomly, prior to the commencement of the semester. On orientation day, new students are given a form to complete to register their interest and consent to participate in the program. The new students are then provided with pertinent information about university life, information in regards to their studies and more importantly, have someone other than an academic as a point of contact should the need arise.

Student mentors are recruited throughout the year. Regular emails are sent to all second and third year students stating the benefits of being a mentor and what is involved in the program. All mentors are required to attend a compulsory workshop which is conducted by the Student Life Office at the university. This workshop on the principles of mentoring, prior to undertaking the role, provides them with skills and knowledge to be effective mentors. Their mentor role is to ensure that they are in contact with their mentees, either by email or phone on a weekly basis.

To assist with the communication flow between the mentor and mentee, the School of Nursing and Midwifery and the student services developed a series of five emails with topics such as the *Getting around* unit for week one, *Useful resources at uni* for week two and *Writing your first essay* in week five. These emails are provided to the mentors for emailing onto the mentees and have been an effective way to disseminate information to new students, with an avenue for them to discuss with their mentors about that specific email topic. Mentors and mentees also meet over morning tea. Mentors are provided with coffee vouchers to a local cafe which is an incentive to 'catch-up' in an informal way and exchange contact details.

All mentors are given a badge to wear with the title 'Mentor', setting them apart from their peers and providing a form of recognition for the extra work that they are undertaking in conjunction with their studies. At the end of the semester, mentors receive a certificate from the Dean to acknowledge their participation in the program.

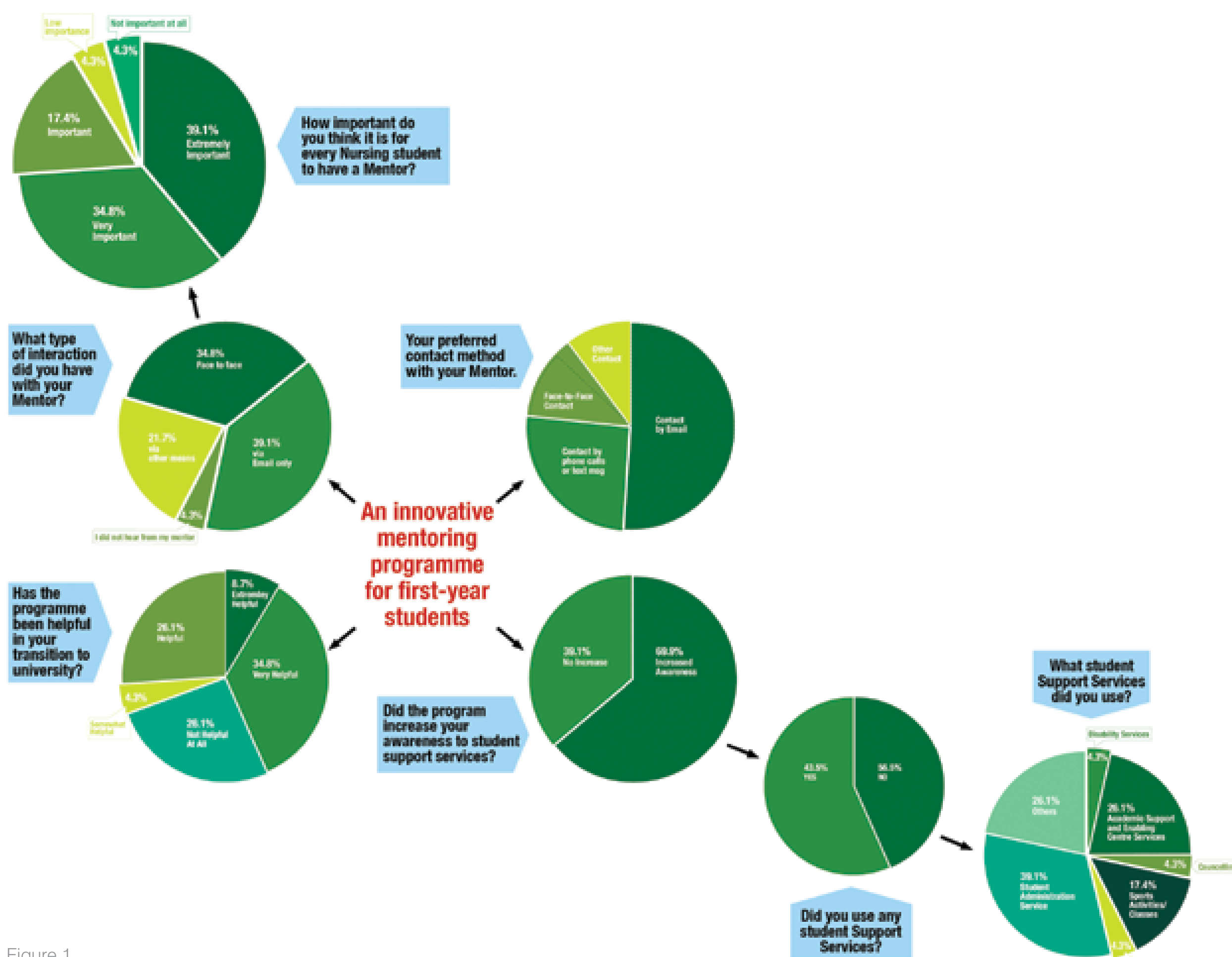


Figure 1

A survey was conducted at the end of the semester on the experience of the mentees. This survey was posted on SurveyMonkey® and all the mentees were sent an email with a link to participate. Being an online questionnaire and voluntary in nature, this allows all participants to be anonymous. The cross-sectional survey consisted of eleven questions about their experiences in the program and support they had during the mentor program. The survey was 'live' for two weeks, and a total of 23 participants responded. An overwhelming majority of respondents considered this mentorship program was important to new nursing students (Figure 1). Nearly two-thirds of the students felt the program was helpful, in various degrees, in their transition to university. Their preferred mode of communication with mentors was via emails and texting, clearly suggesting a blended approach to e-mentoring may be the way forward. The program was helpful at directing new students to better integration and use of various student services offered at the university. An additional bonus of the mentor program has been the positive impact it has had on the second and third year mentors.

This sounds like a great idea, I would love to be involved. I remember struggling somewhat when I started so it would be wonderful to be able to help someone out who may be struggling a little too.
Second year nursing student

I have enjoyed being a mentor & have met some lovely fellow nursing students that I would never have without the program. In fact being a mentor for uni has inspired me to strive to be a mentor in my future career as I see how vital a resource having a great caring mentor is to one's development.
Third year nursing student

This mentorship program was found to be of value to students due to the nature of the intensive theoretical semester and an early practicum start in the course. Pre-practicum readiness was also greatly improved by the weekly emails from the mentors and it was found that small incentives such as a reward program were useful in attracting mentors. There is a need to look into engaging students from other courses including postgraduate students within the university in a modified program and explore the use of e-mentoring using online chatting and blogs.

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HOSPITALISATION OF PEOPLE WITH DEMENTIA:

what we all need to know

BY MELISSA J BLOOMER FACN
PHD CANDIDATE, MONASH UNIVERSITY, VIC

BY ROBIN DIGBY MACN
PRINCIPLE NURSE, THE MORNINGTON CENTRE, VIC

“For the person with dementia, who may have reduced comprehension and coping ability, busy ward settings and unfamiliar noises such as the nurse call system contribute to environmental stress.”

Older Australians are the largest group of health care users and current estimates suggest as many as 266,000 Australians are diagnosed with dementia. As more of the Australian population reach advancing age, it is projected that the number of people with dementia will grow to over 940,000 in the next 40 years (Deloitte Access Economics 2011). This situation however, is not unique to Australia; in fact there are over 7.7 million new cases of dementia diagnosed globally each year (WHO 2012).

With hospitalisation comes the need to consider how the hospital environment can impact upon a person with dementia, particularly because of their diminished ability to adapt to the new environment (Marshall 2009). This can be further complicated when one hospital admission may result in several ward changes and bed moves between specialty areas, resulting in spatial disorientation. Even when hospitalisation extends to several weeks, the person with dementia is unlikely to have a clear understanding of their environment.

Spatial disorientation, a common early symptom of dementia, can exacerbate other symptoms and behaviour changes including anxiety, agitation, aggression, withdrawal, and navigational difficulties and wandering (Marquardt G & Dr-Ing 2011). For those with limited mobility or who are confined to bed, they are unlikely to have an understanding of the ward environment beyond their door (Digby et al. 2001). Noises from unidentified sources can be misinterpreted and frightening, leading to an increase in anxiety in the person with dementia.

Navigating surroundings, also known as ‘wayfinding’, can also be compromised in people with dementia in wards where colours, textures and design are monotonous. Everyone relies on visual cues to assist with navigation; however this patient group is less able to filter relevant from extraneous information and is therefore easily confused by a cluttered environment, multipurpose rooms which change function, or long corridors with multiple closed doors. Ensuring that the toilet is visible from the bed, that rooms have obvious functions and are smaller in scale are simple effective strategies to assist navigation. Clear landmarks and decision points are more accommodating to cognitive disability.

The ambiance of the ward environment can also impact upon a patient’s mood and behaviour. For the person with dementia, who may have reduced comprehension and coping ability, busy ward settings and unfamiliar noises such as the nurse call system contribute to environmental stress (Dewing 2010). Similarly a lack of access to outside areas or a view to the outside may also impact upon the person with dementia, resulting in negative behaviours and diminished well-being. A view of the outside allows people to be in-tune with the time of day and the seasons, assists with the synchronization of circadian rhythms and lifts mood (Brawley 2009).

Hospitalisation can also be a traumatic time for lay carers of people with dementia. This person may have been the primary decision-maker and carer at home, whereas in the hospital setting they are

relegated to the role of visitor, and often not included in care planning or decision making (Higgins et al. 2007). Furthermore, the delegation of care tasks to clinicians can be equally distressing to the person with dementia and their lay carer. Often, these people are life partners, with bonds that span many years, and interrupting this caring relationship can impact significantly on the person with dementia and their lay carer.

A recent Australian study investigated this issue in the context of the sub-acute/rehabilitation setting, using interviews with persons with dementia and their carers to explore their views (Digby & Bloomer, 2013). This study showed that while the 'care' was considered more important than the ward environment, participants indicated that it was imperative to consider the impact that the ward environment has on the person with dementia.

Considerations for caring for the person with dementia in hospital

- Movement between wards and specialty areas should be minimised where possible, and simple clear explanations used to explain any moves.
- Regular orientation and re-orientation is necessary for the person with dementia to comprehend their new surroundings. Clear and simple explanations can assist with comprehension of their admission, and diminish adverse behaviours.
- Visual cues can aid the person with dementia to understand their surroundings, such as allocating them a bed nearby the toilet/bathroom. Similarly, a view outside can help with orientation to time.
- The role of lay carers should be acknowledged, and where possible, they should be included in care activities such as showering or feeding, as well as care decisions.

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LIFE LESSONS FROM THE EMERGENCY DEPARTMENT

BY LAURIE BICKHOFF MACN
REGISTERED NURSE, GREATER NEWCASTLE CLUSTER, HUNTER NEW ENGLAND HEALTH, NSW

Laurie Bickhoff

“I will always be grateful to those patients and their families who let me be part of their story. I only hope that I, in some small way, was able to make that story a little bit brighter.”

During my final clinical placements last year, I spent twelve weeks in three different emergency departments (EDs) across NSW. As you could well imagine I saw an amazing variety of patients, all who taught me something. I thought I would share with you some of the lessons that stuck with me the most.

1: The majority of patients who come into the ED are scared and anxious. Many will be in pain, most are feeling far from well, some can be tired and overwhelmed; all require care, in the truest sense of the word. From life-saving interventions to reassuring words, the care nurses provide is often what will be remembered most.

2: At times we can forget there is a patient behind the signs and symptoms, someone with a name, not just a triage number. We can feel disheartened when bearing the brunt of an irritated patient or family member. At these times I try to imagine how I would feel if it was me in the waiting room or hospital bed. I know the patient isn't reacting to me, but to the situation and probably needs a little extra care at that particular moment.

3: The patients who have the most to complain about are often the nicest, and often it's the smallest thing you do for a patient that will make the biggest difference to them

4: I think the biggest lesson I learnt was the need to be part of a team. Yes, this is critical for patient care but it is also imperative for the well-being of the nursing staff. We are witnesses to some miraculous moments, but also many heart-breaking ones as well. A close team with whom you can debrief and share some of that truly unique nursing humour should be considered an essential aspect of any ED.

Undertaking placements in some of the biggest EDs in NSW was an amazing experience. I will always be grateful to those patients and their families who let me be part of their story. I only hope that I, in some small way, was able to make that story a little bit brighter.

A few more ‘unexpected’ lessons learnt from the ED.

- Letting your mate practice his ‘sleeper hold’ on you is not a great idea – especially if he lets you fall on the concrete floor when you lose consciousness.
- Twelve year old boys probably shouldn't be allowed to play with brand new Swiss army knives.
- The human bowel feels very spongy and weird.
- Knowing all the plots and characters from Disney and Pixar movies is crucial when trying to calm a child down.
- Skipping a couple days of your daily dialysis could kill you.
- If you're going to do a backflip on your BMX bike, try to make it all the way around rather than landing on your head, and you definitely should have a helmet on.
- Surprisingly, handcuffs don't interfere with electrocardiography traces.
- Don't fix your own TV antenna. Unless you have a safety harness, best to pay someone to do that or just live with fuzzy TV reception.
- Don't use a chainsaw anywhere near your feet.
- Don't trust your friend behind the wheel of a golf buggy.
- Car cup holders are brilliant inventions. Hot drinks should not be held between your legs while driving.

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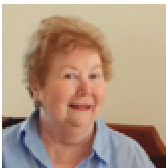
PRIMARY HEALTH CARE AS THE FRAMEWORK

BY CATHERINE WILKIN FACN, NURSE ACADEMIC, MONASH UNIVERSITY, VIC

I have had more feedback from people who read my brief article 'I live in a community not in a hospital', which appeared in the Autumn edition of 'The Hive', than I have ever had from academic articles I have written and feel a follow-up article may be the avenue best suited to further this discussion.



I have been thinking about the issue of health care in Australia and the formal adoption of primary health care (PHC) as the framework within which health care workers must function on a day-to-day basis. This is an important issue to me as I perceive PHC is often misunderstood and limited in its effectiveness by the attitudes of some health care workers.

PHC may be confused with primary care, a component of PHC, and a convenient way of focussing on the traditional illness orientated approach we have used in the past. As practitioners, we know that change is a function of what we do, and very often this change is driven by pragmatic reasons such as funding, as well as more dramatic reasons such as change in practice. A change in role function is always a challenge in potentially moving us out of our comfort zone. I do remember the sigh he gave when I told a senior obstetrician that I, as a midwife, was doing a PhD. "I just want things to stay the same", he said. This was a contentious response on so many levels.

One of the issues raised at the 2012 RCNA Community and Primary Health Care Conference in Western Australia was that of 'branding' and role delineation within the PHC framework. The argument was that it was difficult to develop a role description for a PHC nurse as so many different disciplines and sub-sets of disciplines fell under this umbrella. Examples include the mental health nurse in the community who functions differently to the mental health nurse in an acute care setting; the midwife in a large referral hospital's antenatal ward who functions differently to a home birth midwife; both of these roles are still classified as PHC. What about the community nurse and the clinical nurse practitioner? Health carers are becoming specialised very quickly. Developing a role description is as wide or specific as we wish to make it but fundamentally we function as nurses as health care workers.

The issue about branding misses the point that PHC is for the patient and not just the health care worker. The patient/client is not always unwell; they may require information about diet, immunisation, raising a healthy child, and rehabilitation after breaking a bone. That is, PHC should be integrated into their life as should health care workers such as nurses, working as we do in such a diversity of practice roles. We, as nurses, should be strongly incorporated into the life of the community not just the hospital.

I have tried to determine why we work in 'silos' of practice, where one discipline communicates inefficiently with another to the detriment of the patient/client and where we then run the risk of that person being poorly served at the expense of their health, because vital interactions are duplicated or, worse, missed. Given that most interactions today should not only be linear (person-to-person) but also system wide (person-to-system), this means that we are missing opportunities to interact with the wider community, and other organisations who can assist the patient/client and also learn and apply new information and care to themselves.

There is also a reasonable expectation in health care that there will be a response to a referral so that subsequent changes in practice may be incorporated into patient/client care. This sharing of information is a feature of PHC and is easy in the secondary prevention (illness-orientated) area of PHC where all disciplines are linked from the same office or ward. Geographic distance is one feature which encourages the 'silo' mentality, since dictating, proofing and sending a notification of outcome by letter or email to a health care worker who is not based at an office, is time consuming. The fear that technology may not be secure ignores the reality that sending a letter has the same possibility of being intercepted as an email. Pressure of work and necessary time lapses waiting for appointments also means that responses are delayed. We, as health care workers need to realise that the patient/client is the focus of our care, not our work load or day-to-day stress.

So, what about PHC in the future? As with any change, time and money need to be devoted to winning the hearts and minds of health care workers toward a new paradigm. Health care workers are ageing but we are not all rigid and wishing for the 'good old days'. Making the links between 'silos' transparent and accessible will mean that these links will be used more readily. Giving the patient/client access to their medical information so that they too can track what is happening will increase their sense of ownership and involvement. The involvement of the patient should mean that individual issues are missed less and less. The health care team does, as some of us need to remember, include the patient.

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CARRYING A TORCH FOR OUR FOREBEARS:

the Centaur nurses

BY DR MADONNA GREHAN MACN, REGISTERED NURSE, HONORARY FELLOW,
MELBOURNE SCHOOL OF HEALTH SCIENCES, THE UNIVERSITY OF MELBOURNE, VIC

Dr Grehan was the recipient of the 2011 RCNA Bequest Fund for Research Grant ($10,000) for postdoctoral research – 'Nurses of the 2/3rd Australian Hospital Ship Centaur'. Below are the reflections from her research.

Over the last eighteen months, with the support of a Bequest Grant awarded by the Royal College *of* Nursing, *Australia*, I've been researching a group of twelve members of the Australian Army Nursing Service (AANS). My interest in the 'Centaur nurses', as I have come to refer to them, was stimulated in 2008 when preparing material for a commemorative service at the Nurses Memorial Centre in Melbourne. At the time I was surprised that few details about the nurses were on the record. Subsequently I learnt that colleagues and friends had carried a torch for the nurses of the *Centaur* but the intimate, personal connections with this formative episode in Australian nursing's history were lost as those friends and colleagues died.

By building a biography of each of the *Centaur* nurses, covering her formative years, her training and employment positions, as well as her military service, my aim is to reconnect this group of Australian nurses with current generations. Uncovering their stories has taken me to South Australia, Queensland, New South Wales and rural Victoria. Data have been obtained from the National Archives of Australia, the National Library, the Australian War Memorial, Returned Service Nurses Clubs, and hospitals. I've delved into personal collections and those of local history societies to locate images and details of memorials to individuals or the group. I've spoken with relatives and others about the nurses. Through what has been a fascinating and rewarding research journey, I've begun to appreciate some of the effects of this 1943 war crime, on families, communities, the nation, and on the profession of nursing.

The twelve AANS nurses were an integral part of the medical staff of the 2/3rd Australian Hospital Ship Centaur, a newly-outfitted transport vessel brought into the Pacific war effort in March 1943 (*Army News* 1943). Seven of the twelve *Centaur* nurses were experienced at ambulance transport work, having served aboard 1st Netherlands Military Hospital Ship, Oranje, during 1941 and 1942. A 20,000 ton luxury liner, Oranje was a gift of the Netherlands Government to the Australian and New Zealand Governments for war service as a hospital ship. With capacity for 600 beds, Oranje retrieved Australian, New Zealand and British soldiers from the Middle East and, over these lengthy journeys, the AANS nurses came into contact with many serving personnel and forged firm friendships (Goodman 1992).

As Japanese forces advanced in the Pacific throughout 1942, the Australian Government commissioned the motor passenger vessel, *Centaur*, for service as a hospital ship. After two short journeys tested the vessel's capacity as a functioning hospital ship, *Centaur* then made its first return voyage from Sydney to New Guinea to retrieve injured soldiers. A small but fast vessel, *Centaur* delivered speedy retrieval of the injured personnel. But, unlike the Oranje, *Centaur* was prone to rolling and pitching, with the result that, on this first retrieval, some staff were so seasick they were unable to perform their duties.

On *Centaur's* second voyage to New Guinea, it was torpedoed by a Japanese submarine, without warning, on the morning of 14 May 1943 just north east of Brisbane. Of the 332 staff aboard, 268 lives were lost. Among them were eleven AANS nurses: Matron Anne Jewell and Sisters Mary McFarlane, Margaret (Marg) Adams, Cynthia Haultain, Evelyn (Eva) King, Myrle (Moss) Moston, Alice (Ali) O'Donnell, Eileen (Nan) Rutherford, Edna Shaw, Jenny Walker, and Joyce Wyllie. Australia's Prime Minister, John Curtin, urged the nation to avenge the deaths of all of the *Centaur's* personnel by contributing more fully to the war effort (*Canberra Times* 1943).

In the weeks that followed *Centaur's* sinking, the Federal Government capitalised on Australians' special relationship with nurses. The nurses killed aboard *Centaur* became the focus of a national advertising campaign aimed at lifting productivity and encouraging the purchase of war bonds. Colour posters, produced by artist Bob Whitmore, were sent to

Work, Save, Fight and so AVENGE THE NURSES! Poster by Bob Whitmore, Australian War Memorial ARTV09088

every business, factory, coal mine, and wharf. One well-known poster features *Centaur* on fire, with mountains of black smoke billowing from the deck. Personnel jump from the vessel; survivors scramble to a life boat; in the foreground a woman and a man cling to debris afloat on a dark sea, all set against a starry Pacific sky. The caption for this poster is: *Work, Save, Fight and so AVENGE THE NURSES*. A second poster featured *Centaur* as it sank, bearing the caption: *Save for the brave. 'Let us avenge the nurses'* John Curtin.

The nursing profession grappled with ways to acknowledge the deaths of their colleagues too. In 1943, a campaign by public subscription was mounted in Victoria, aimed at establishing scholarships for nurses undertaking postgraduate courses. The 'Centaur War Nurses' Memorial Fund' was engineered by Miss Edith Hughes-Jones, a nurse and owner/matron of Windermere Private Hospital at Prahran. Hughes-Jones' motivation for the Fund was both professional and personal. One *Centaur* nurse, Sister Nan Rutherford, was Deputy Matron to Miss Hughes-Jones at Windermere and worked in the operating theatre (*The Argus* 1943).

Individual nurses from the *Centaur* were remembered in memorial plaques, erected at schools and hospitals. At Melbourne's Alfred Hospital, for instance, family and friends of Nan Rutherford installed a brass sundial in the grounds. In Bundaberg, Joyce Wyllie is remembered in a war nurses' pavilion and park. Named prizes were instituted at training hospitals. The King Prizes at Cootamundra Hospital, for example, were given in memory of trainee Sister Eva King. The Children's Hospital in Melbourne inaugurated the Margaret Adams Prize. In Sydney, The Women's Hospital Paddington instituted a midwifery prize in Mary McFarlane's memory, while Newcastle Hospital introduced the Edna Shaw Prize. There are many, many other memorials, all of which underscore the esteem that families, friends, and communities held for the nurses.

By war's end in 1945, the tally of nurses who had died during active service was more than seventy. Ideas emerged about collective memorials. One concept centred on installing postgraduate nursing education in Australia. Gradually, funds were committed by the Australian public to purchase properties where that much-needed postgraduate education could be based. In Victoria, the Centaur Fund campaign eventuated in the Nurses Memorial Centre at St Kilda Road. It was a club for socialising, with accommodation and education facilities. Similarly, Queensland's Centaur House was established via a fundraising campaign beginning in 1948. Western Australia and South Australia also founded Nurses Memorial Centres.

At *Centaur* commemorative services around the nation on or near 14 May each year, representatives of the nursing profession continue to carry a torch for their professional forebears. I encourage any nurse who hasn't been to a memorial service to attend one. Our collective commitment to memorialising is important. It does not celebrate war. It acknowledges the sacrifice paid by the *Centaur* nurses and other non-combatants at work. For members of the nursing profession, the public act of remembering such anniversaries enables us to pay tribute to the thousands of Australians who, in the 1940s and 1950s, gave so willingly to the development of our profession. Australians shared the aspiration of making postgraduate education for nurses available on Australian soil. Australians' generosity helped to make that aspiration a reality. *Lest we forget.*

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AUSTRALIAN ACUTE CARE ADVANCED PRACTICE NURSING IS A COMPLEX EXPERIENCE

BY MARY-ANNE RAMIS MACN, REGISTERED NURSE, THE JOANNA BRIGGS INSTITUTE, UNIVERSITY OF ADELAIDE, SA

Mary-Anne was the recipient of an RCNA Scholarship Grant for postgraduate studies – Master of Philosophy (Clinical Science): 'A qualitative systematic review of the experiences of Australian advanced practice nurses working in acute care settings'. Below are the reflections from her research.

A recent review of qualitative studies has highlighted the experience of being an advanced practice nurse (APN) in Australian acute care settings. The study was undertaken as part of a Masters of Philosophy (Clinical Science) award and utilised the framework for qualitative synthesis from the Joanna Briggs Institute (JBI) in conjunction with the University of Adelaide.

The review was completed in order to provide a deeper understanding of what the APN experience is, in the defined context. Both the International Council of Nurses and the Royal College *of* Nursing, *Australia* refer to context of practice as shaping APN characteristics (ICN 2001; RCNA 2006); however no context specific review had been previously undertaken. Context specific reviews have been completed on other aspects of nursing research (Hannes & Harden 2012) and have been suggested to be of benefit for policy development and practitioners within the context under review, due to their specific relevance.

Using the JBI framework, eight studies were chosen for critical appraisal out of 1220 titles. From these, three published, phenomenological studies meeting strict inclusion criteria were agreed upon for inclusion in the review. One unpublished dissertation was also included in the review. The main criteria for inclusion was that the studies must include rich, open data from the nurses' own voice. From these four studies, 216 findings were extracted and grouped according to similar meanings, to create six synthesised findings, articulated as statements under the headings of *Expert knowledge, Work activities, Confidence and familiarity, Negative experiences, Relationships and Patient centred experience* (Ramis et al. 2013).

An intuitive and insightful nature of APN practice was identified in the review, as was the deep trust and empathy that is part of the nurse-patient relationship. The findings also identified the extent of specialty knowledge required by APNs in the acute care setting which is inextricably linked to their role. The evidence also demonstrates that the experience is paradoxical, for example, APNs are often called to be in positions of great responsibility yet are often expected to complete non-nursing duties such as administrative tasks, which can take the nurse away from patient care. This paradox is further explained in one of the included papers by Walters (1996).

The findings of the review identified positive and negative experiences. Most positive experiences were the result of positive patient outcomes and effective relationships, while many negative experiences related to organisational pressures and restraints. It is suggested that organisations must be made aware of the personal and professional impact they have on the APN experience in order to commit to retention and consequent patient safety. Professional and organisational support is required to support these nurses; otherwise they appear to be at great risk of burnout due to overwhelming demands and increased pressure to fill gaps in an increasingly burdened health care system. Despite many negative organisational related findings, there was an overwhelming presence of professional behaviour and the nurses' ability to utilise personal attributes to effectively conduct their relationships and practice.

It was interesting to note, and perhaps not surprising, that the search process identified many different titles in use under the umbrella of 'advanced practice'. Out of 154 abstracts retrieved for analysis, only 29 used the title of 'advanced practice'. This may be a reflection of the relatively short time frame APN terminology has been in use in the Australian nursing workforce (particularly nurse practitioners), or it may be a reflection of the lack of use of the actual title within Australian health care. Further investigation of this would be required to identify the actual cause, however due to the limited number of papers found using the term advanced practice, it may be more appropriate, if conducting further reviews on this phenomenon, to use a specific title such as acute care nurse practitioner or clinical nurse consultant. Consistent titles,

education and qualification criteria for an APN would allow greater uniformity for comparing roles in the future and has been discussed by other researchers (Gardner et al. 2007; Duffield et al. 2011).

The heterogeneity of role titles for Australian acute care APNs caused the review to be a complicated process and may be seen as one of the main limitations. It is important to note however that this review was not aimed at defining role characteristics for individual role titles; it was focussed on interpreting the available evidence to transcend role title and illuminate the lived experience of the described population for the voices of the nurses themselves. The temporal parameters of the review (1990–2011) may also be seen as a limitation by some, although it was interesting to note that issues that were discussed in the earlier publications are still relevant to current practice and research.

The review provides evidence to support that being an APN in Australian acute care settings is a multi-faceted and complex experience, with intertwining issues that are influenced predominantly by the organisation within which the nurse works and also by the inherent unpredictable nature of working with people. The methodology and results of the review were presented at this year's ICN Congress in Melbourne.

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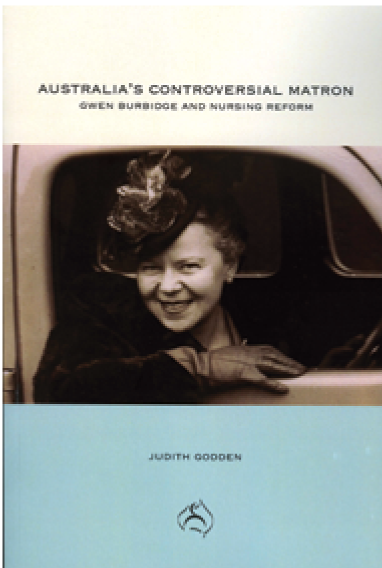
AUSTRALIA'S CONTROVERSIAL MATRON:

GWEN BURBIDGE AND NURSING REFORM

By Judith Godden

REVIEWED BY RICHARD TREMBATH, UNIVERSITY OF MELBOURNE



Australia's Controversial Matron: Gwen Burbidge and Nursing Reform By Judith Godden. Sydney: College of Nursing, 2011. Pp. 357, A$30 paper.

Dr Judith Godden is an Honorary Fellow of ACN and we are proud to feature this review of her book, 'Australia's Controversial Matron'.

Gwendolen Burbidge was born near Birmingham in January 1904. Between 1925 and 1928 she trained as a nurse at the Melbourne Hospital under its redoubtable, often frightening Matron, Jane Bell. An excellent student, Burbidge then undertook midwifery training at the Women's Hospital before returning to Melbourne. Much to Jane Bell's horror, Burbidge moved in 1933 to the Alfred Hospital to become a Sister Tutor at its Preliminary Training School. Here she published *Lectures for Nurses*, an early and influential Australian textbook which would have been even more successful had it not fallen victim to the endemic jealousies and fissures within the hospital and nursing worlds. From 1936 to 1938 Burbidge undertook postgraduate training in the United Kingdom, graduating with a Diploma of Nursing from the University of London. On its own this would have marked her out as special at the time. Returning to Melbourne in 1939 Burbidge took up the position of Matron of the Queen's Memorial Infectious Diseases Hospital, better known as Fairfield. Here she stayed until her retirement in 1960.

Judith Godden is well qualified to write a biography of such a significant figure in Australian nursing. Her previous work has been on nineteenth-century nursing, including the struggle to establish this career on a professional basis. Thus she appreciates the powerful influence exerted on succeeding generations by the Nightingale model. For a nurse like Gwen Burbidge this inheritance was both a blessing and a curse. A blessing in the sense that it helped give her the moral authority to administer a nursing department. A curse in the sense that any proposals for reform could be met by stonewalling and charges that the nursing 'vocation' was being threatened. Godden's excellent work reveals these pressures and how her subject surmounted many of them. Australian nursing was too often a Byzantine world of institutional and personal rivalries where the mere fact that something was done in NSW meant that Victoria frowned on it. Godden analyses these forces clearly and dispassionately, showing how competing visions of nursing influenced Burbidge's work.

Burbidge was always busy. Memorably, she described herself in 1954 as just 'an educational battle axe' who sat 'on far too many committees' (131). In what time she had outside Fairfield, Burbidge sat on the Victorian Nurses Board, the National Health and Medical Research Council and the board of her own professional organisation, the Royal Victorian College of Nursing. As an early adherent of postgraduate education she fought for the establishment of the College of Nursing, Australia. Nursing shortages were partly overcome by Burbidge's espousal of introducing nurses' aides and overseas-trained staff. At Fairfield she worked hard to turn what had been a feared isolation hospital into a more open institution, one, for example, where families could visit their loved ones. Nurses' educational, recreational and professional conditions at Fairfield were

> *Nursing shortages were partly overcome by Burbidge's espousal of introducing nurses' aides and overseas-trained staff.*

transformed. There was also the perennial power struggle with the administration, a struggle fought in many other Australian institutions. Victories could be short-lived. For instance, Burbidge won the right for the Fairfield Matron to attend Board meetings. As soon as she resigned this privilege was rescinded in what appears to be little more than a piece of petty spite. Hospital managers were good at that sort of thing.

Godden has a deft hand in tracing these campaigns and manoeuvres. A reader new to the subject matter is guided through the different interlocking bodies and their changing nomenclature. She does not lose sight of the big picture, setting her account of Burbidge's time at Fairfield against a background of post-war expansion of the health system and major changes within hospital practice. Burbidge helped break down public fear of infectious diseases just as those scourges were being overcome by the antibiotic revolution. To describe Burbidge as 'Australia's controversial matron' is in some ways misleading. Other nursing leaders in the post-war world also fought against sluggish health systems and politicians wishing to do things on the cheap. However, it does indicate how Burbidge was willing to take on authority if she felt that change was necessary.

Thoroughly researched and very well written, *Australia's Controversial Matron* treats its subject with respect and affection without succumbing to hagiography. The high-quality photographs are also revealing, showing Burbidge as conservatively but impeccably presented, well aware of the impression she was making and looking very competent. It is pleasant to read that after a life devoted to her profession and its place in the world, Burbidge appeared to have few regrets about leaving it and enjoying a happy retirement. This is a significant addition to Australian nursing history.

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CAP ON WORK-RELATED EDUCATION EXPENSE DEDUCTIONS TEMPORARILY POSTPONED

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With the release of the August 2013 *Economic Statement*, the Australian Government announced their decision to defer the introduction of a $2,000 cap on work-related education expense deductions until 1 July 2015. In the Statement, the Government explained that further consultation is required to determine how to rein in excessive tax deduction claims while minimising the impact on university enrolments and legitimate continuing professional development.

ACN is relieved that the Government has effectively acknowledged that the $2,000 cap would pose concerning risks to postgraduate course access as well as to continuing professional development more broadly. However, this recognition and decision to defer the introduction of the cap is just the first step toward developing a more appropriate tax reform measure. Adjunct Professor Debra Thoms, CEO has made it clear that,

"ACN will continue to oppose the $2,000 cap as it's too low to realistically support continuing education for nurses and presents a barrier to retaining nurses in the workforce."

ACN members are encouraged to read the joint submission and recent media releases available at www.acn.edu.au and we welcome your feedback.

“The submission highlighted to Treasury that the introduction of a $2,000 cap on education expense deductions would have a profoundly negative and disproportionate impact on the nursing and midwifery professions.”

While the Government undertakes further consultation ACN will continue to repeat our emphatic calls for a complete rethink of the proposed cap for education expenses incurred by nurses and we will reiterate the key concerns outlined in our joint submission to the Government on this critical issue.

JOINT SUBMISSION TO TREASURY – VOICING NURSING AND MIDWIFERY CONCERNS

In May 2013 the Australian Government Treasury released a discussion paper *Reform to deductions for education expenses* which outlined proposed reforms to tax deductible education expenses. Recognising the implications for nurses and for concerned members, ACN joined Australian Primary Health Care Nurses Association (APNA) and Australian College of Midwives (ACM) in developing a submission to Treasury opposing the proposal to introduce a cap on deductions for education expenses for nurses and midwives.

THE KEY MESSAGES OF THE SUBMISSION WERE:

Nursing or midwifery work-related education leading to an accredited award **should not** be subject to expense deduction capping – *to ensure that the professions continue to access higher education to maintain and improve on standards of nursing and midwifery care across the health system.*

A work-related education expense deduction cap for education that **does not lead to an accredited award** should be set no lower than $10,000 per year for nurses and midwives – *to avoid creating a financial burden for nurses and midwives undertaking continuing professional development to maintain currency of skills and knowledge and registration requirements.*

The submission highlighted to Treasury that the introduction of a $2,000 cap on education expense deductions would have a profoundly negative and disproportionate impact on the nursing and midwifery professions. It was argued that in its proposed form, the recommended cap fails to differentiate between types of education and between the varying incomes of different professional groups. Therefore, professional groups, such as nursing and midwifery, traditionally on lower incomes would be disproportionally affected by the introduction of a cap.

The submission also explained that the health system is highly dependent on the flexibility and adaptability of the nursing and midwifery workforces to meet population health needs and, ultimately, it will be patient care that is compromised if nurses and midwives can no longer afford to self-fund their continuing education and professional development. The submission made it clear that the individual pursuit of continuing professional development throughout a nurse’s or midwife’s career is essential if the workforces are to remain responsive particularly at a time of increasing health care demands when we need to be emphasising workforce retention, productivity and quality care.

Through the submission, the Treasury was reminded that the retention of nurses and midwives is currently a national health policy priority with Health Workforce Australia predicting unprecedented nurse workforce shortages in the medium and long term. The submission stressed that ongoing education has been identified as being critical to improving nursing and midwifery workforce retention. Retaining current nurses and midwives through the promotion of up-skilling and self-education will be a key measure in addressing anticipated shortages within our workforces.

The Australian Government proposal to introduce a $2,000 cap on deductions for education expenses would impose a major barrier to continuing professional education for nurses and midwives and become a significant obstacle for the enhancement and expansion of the nursing and midwifery workforces. Moreover, its introduction would present a retrograde step in the overall reform of the Australian health care system. By choosing to defer its introduction until 1 July 2015 to allow time for further consultation, the Government is recognising there are risks associated with the proposal. Given the risks, it is critical that following the consultation period, the Government abandon any plan to set a $2,000 cap on work-related self-education expenses.

EDUCATIONAL COLLABORATION FOR BREAST CARE NURSES

With one in eight women likely to be diagnosed with breast cancer by the age of 85, breast cancer is the second most common cancer causing death in Australia.

The McGrath Foundation and ACN have developed a memorandum of understanding whereby both organisations have committed to working together on projects, ensuring the best possible education and professional development of Australia's breast care nurses. This commitment has been demonstrated through close collaboration over the last 12 months in the provision of specialty education and scholarships, contributions to health and nursing policy and an ongoing engagement in best clinical practice development.

ACN'S GRADUATE CERTIFICATE IN BREAST CARE NURSING

There is a growing body of research that supports the relationship between nursing education and the quality and safety of patient care. The delivery of structured education can provide improved support for patients by ensuring up-to-date, evidence based knowledge in informing practice. The McGrath Foundation has enhanced its ongoing support to the breast care nurse profession by increasing the provision of scholarships – McGrath Foundation Scholarship – for registered nurses to complete an ACN Graduate Certificate in Breast Care Nursing from one to four. This takes the total value of the scholarships provided by the McGrath Foundation to $23,000.

McGrath Foundation Scholarship winners

2012 Virginia Sykes

2013 Leanora Gelding MACN
Teresa Clark
Joanne Lovelock MACN
Cheryle Cosgrave

McGRATH FOUNDATION BREAST CARE NURSE EDUCATION SERIES

Another McGrath Foundation initiative, developed with ACN, is the Breast Care Nurse Education Series to deliver structured breast cancer education to breast care nurses and, where possible, those nurses who identify that they provide care to patients experiencing breast cancer. The workshop is aimed at beginning to intermediate breast care nurses to update their knowledge on evidenced based care and current therapeutic approaches to the care of the breast cancer patient.

The McGrath Foundation will run five education workshops for a total of 120 participants across Australia, to provide both McGrath Breast Care Nurses and other breast care nurses the opportunity to further their professional skills and understand key developments in the field of specialist breast cancer care.

The 2013 workshops will be held in:

Adelaide – 15 October

Melbourne – 25 October

Brisbane – 1 November

Perth – 21 November

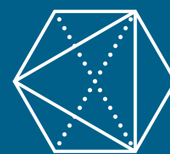
Sydney – 28 November

Fiona Farmer
Workshop presenter

Kim Kerin-Ayres
Workshop presenter

Content will be the equivalent of seven CPD hours and will be delivered by Fiona Farmer MACN, ACN Tertiary Education Cancer and Haematology Nurse Educator and Kim Kerin-Ayres, McGrath Clinical Nurse Educator. The theme will be *What's new?* and will focus on clinical updates across the early breast cancer diagnostic and treatment spectrum.

The McGrath Foundation is committed to providing quality education and the proven track record of ACN enables the delivery of that. The McGrath Foundation wishes to provide education and professional development opportunities not only to the McGrath Breast Care Nurses, but to other nurses working in breast care nursing, to improve the delivery of care in breast care nursing right across Australia.



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- X-ray interpretation | 15 November | RN | 7 CPD hours | Burwood NSW
- Palliative care | 20–21 November | RN, EN | 14 CPD hours | Brisbane QLD
- Chronic and complex disease self-management | 28–29 November | RN | 14 CPD hours | Sunshine Coast QLD
- Nursing patients with movement disorders | 2–3 December | RN, EN | 14 CPD hours | Burwood NSW
- Diabetes update | 9–10 December | RN, EN | 14 CPD hours | Hobart TAS
- Perioperative anaesthetic nursing | 13 December | RN | 7 CPD hours | Canberra ACT

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