thehive

#10 SPRING 2015 | COMMUNITY & PRIMARY HEALTH CARE

ACN

TACKLING CHRONIC DISEASE
How a stronger primary health care system can help

OPPORTUNITIES TO IMPROVE ACCESS FOR MEN TO PRIMARY CARE
Factoring gender into health service delivery

UNE/COLEDALE STUDENT-LED CLINIC
Award-winning community care initiative under threat

Clinical Care Standards

Clinician Fact Sheet:

Acute Stroke

The goal of the Acute Stroke Clinical Care Standard is to improve the early assessment and management of patients with stroke to increase their chance of surviving the stroke, to maximise their recovery and to reduce their risk of another stroke.

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

UNDER THIS CLINICAL CARE STANDARD

A person with suspected stroke is immediately assessed at first contact using a validated stroke screening tool, such as the F.A.S.T. (Face, Arm, Speech and Time) test.

FACE: Check their face. Has their mouth drooped?
ARMS: Can they lift both arms?
SPEECH: Is their speech slurred? Do they understand you?
TIME: Time is critical. If you see any of these signs call 000 straight away.

A patient with ischaemic stroke for whom reperfusion treatment is clinically appropriate, and after brain imaging excludes haemorrhage, is offered a reperfusion treatment in accordance with the settings and time frames recommended in the *Clinical guidelines for stroke management*.

A patient with stroke is offered treatment in a stroke unit as defined in the *Acute stroke services framework*.

A patient's rehabilitation needs and goals are assessed by staff trained in rehabilitation within 24–48 hours of admission to the stroke unit. Rehabilitation is started as soon as possible, depending on the patient's clinical condition and their preferences.

A patient with stroke, while in hospital, starts treatment and education to reduce their risk of another stroke.

A carer of a patient with stroke is given practical training and support to enable them to provide care, support and assistance to a patient with stroke.

Before a patient with stroke leaves the hospital, they are involved in the development of an individualised care plan that describes the ongoing care that the patient will require after they leave hospital. The plan includes rehabilitation goals, lifestyle modifications and medicines needed to manage risk factors, any equipment they need, follow-up appointments, and contact details for ongoing support services available in the community. This plan is provided to the patient before they leave hospital, and to their general practitioner or ongoing clinical provider within 48 hours of discharge.

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

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Cover: UNE/Coledale clinic associates and co-researchers on the steps at Toomelah

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

WELCOME

Kathleen McLaughlin FACN,
ACN Acting Chief Executive Officer

Welcome to the spring edition of The Hive. This edition focuses on the theme of Community and Primary Health Care Nursing with some interesting articles that profile the important contribution nurses are making in our communities and the need to ensure Australia's primary health care system maximises the full potential of nurses.

Primary health care typically considers the social, economic and environmental factors that can impact on an individual's health and wellbeing, but how does gender impact health status? In the article 'Opportunities to improve access for men to primary care', Del Lovett explores the importance of understanding issues men face concerning their health and associated health behaviours, and opportunities to support men's access to health care.

Suzanne Basford shares how the Southern NSW region came to establish the role of Neurological Clinical Nurse Specialist and highlights how health promotion and community engagement is making a difference to individuals in the area. And from a more personal perspective, ACN's Community and Primary Health Care Community of Interest key contact, Kate Partington, has written an article about her inspiring journey so far in primary health care nursing and what she believes is needed to provide and improve upon health care into the future.

Ensuring ACN has a voice in primary health care reform has been an ongoing focus for ACN for several years. A recent submission prepared by ACN was to the Australian Parliamentary Standing Committee on Health's *Inquiry into best practice chronic disease prevention and management in primary health care*. In the article 'Addressing chronic disease through a stronger primary health care system', the ACN policy team details the important contribution our members and the submission's co-authors made in putting forward recommendations for addressing the challenges posed by an ageing population and rising burden of chronic disease.

Continuing our overall focus on advancing nurse leadership, we also feature some interesting articles on the topic. ACN nurse educator Trish Lowe discusses the need to foster leadership in undergraduate nurses in her article 'Supporting nurse leaders by developing the leadership capacity of undergraduate and early career nurses', while Kath Riddell and Jo Mapes take us through a successful professional development model used at Eastern Health, one of ACN's membership affiliates.

In addition to these great reads, you'll find our regular features: the Policy Team's round up of stakeholder engagement activity in 'Policy Snapshot'; our regular columnists discussing Community and Primary Health Care, and we catch up with our Emerging Nurse leaders and Queensland South Region in our 'Member Engagement' section.

Enjoy!

ACKNOWLEDGEMENT

In the Winter 2015 edition of *The Hive*, Dr Rosemary Bryant was referred to as the first Commonwealth Chief Nurse and Midwifery Officer, holding the position from July 2008 to June 2015.

ACN would like acknowledge that, although the Australian Government announced Rosemary's role as newly established in 2008, Sr Paulina Pilkington was appointed in a similar role in 1975 as the first Director of Nursing for the Federal Department of Health, an appointment she held for seven years.

Paulina was the first sister to be permitted by her order, the Sisters of Charity, to work as a full-time public servant. Paulina was a passionate champion for community and primary health care, pushing for nursing education to broaden its focus from hospital beds to people in the community.

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PUBLICATION GUIDELINES

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

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

Please remember the ACN editorial team are here to assist you. For all enquiries or to submit an article, email publications@acn.edu.au.

CONGRATULATIONS 2016 ACN GRANT AND AWARD RECIPIENTS

MAYLEAN JESSIE CORDIA SCHOLARSHIP

In collaboration with the Cordia family, this scholarship offers a registered or enrolled nurse an opportunity to further his or her professional development in a chosen specialty area of nursing.

NATASHA MORRIS MACN

Natasha is a Critical Care Registered Nurse with 15 years' nursing experience. Natasha's career spans clinical nursing, clinical nursing education and nursing lecturing. Natasha is a PhD candidate at Monash University and Baker IDI Heart and Diabetes Institute in Melbourne. Her research project is titled the 'Aboriginal Australian Malnutrition Project' which aims to explore malnutrition screening practices by health providers; determine the prevalence, burden and impact of adult-malnutrition; and validate malnutrition screening in Aboriginal and/or Torres Strait Islander inpatients. The Maylean Jessie Cordia Memorial Scholarship will be used to help fund Natasha's research project.

"OLLIE" NURSE PRACTITIONER SCHOLARSHIP

Awarded in collaboration with the Australian College of Nurse Practitioners to an endorsed Nurse Practitioner for the purpose of growing the body of knowledge on the nurse practitioner role in Australia.

GIULIANA MURFET MACN

Giuliana is a Nurse Practitioner from regional north west Tasmania. She has undertaken roles in clinical services, management, quality and research, and modelling of services to improve coordination and health outcomes. Giuliana is presently the national vice-president of the Australian Diabetes Educators Association and a member of the Health Council of Tasmania. She has a keen interest in developing strategies to incorporate the Nurse Practitioner into health care teams to support sustainable and safe health care. The scholarship will be used to attend the European Association for the Study of Diabetes 52nd Annual Conference. Giuliana hopes that the knowledge and skills developed from attending the conference will be transferred to her clinical care practice, which can be translated to outcomes and/or products.

SISTER MARGARET Y WINNING SCHOLARSHIP

Awarded to a postgraduate nursing student at Queensland University of Technology.

FREDERICK GRAHAM MACN

Frederick is Clinical Nurse Consultant for Dementia & Delirium at Princess Alexandra Hospital, Brisbane, and a PhD candidate at Queensland University of Technology. His PhD is a descriptive correlational study exploring hospital nurses' decision-making. Fred will use the scholarship money to employ a technology expert to complete the construction of the data collection tool for his study – a virtual simulation of a clinical case scenario. Designed by Fred, the simulation is multimodal, integrating virtual human avatars, video clips and virtual clinical documentation. The avatars are built to realistically and spontaneously interact with users by speech and gesture.

ERIC MURRAY QUIET ACHIEVER AWARD

Awarded to an ACN student who is considered to be a quiet achiever.

REBECCA NOONAN

Rebecca is a registered nurse/midwife who works at the Royal Hospital for Women, Randwick. She started there in the NICU nearly nine years ago as a new grad. She left the unit for two years to complete her midwifery training in the same hospital, but returned to her first love, neonatal nursing. Rebecca completed her Graduate Certificate in Neonatal Nursing last year as she wanted to consolidate her skills and training with more theoretical education.

Rebecca will be using the scholarship funds to attend the Babies in the Vines conference in the Hunter Valley in 2016, a conference which provides an opportunity to learn about the latest technologies and practices that are being used around the world in the field of neonatology. This conference often leads to new ideas and procedures being brought back to the NICU to improve performances and outcomes.

THE HISTORY OF AUSTRALIAN NURSES IN THE FIRST WORLD WAR: AN ACN CENTENARY COMMEMORATIVE TRILOGY

ACN is proud to partner with Dr Ruth Rae FACN in a commemorative publication of The History of Australian Nurses in the First World War: An ACN Centenary Commemorative Trilogy (the Trilogy).

The three books contained in the Trilogy showcase the important contribution of Australian nurses in the First World War and highlight the valuable service Australian nurses provided to the ongoing professionalism of civilian and military nursing in this country.

The Trilogy also features the ACN First World War Nursing Nominal Roll – an additional, stand-alone document exclusive to the Trilogy box set – which features a list of nurses who served and provides families with a tangible keepsake honouring their relative's involvement in the war effort.

BOOK ONE – FROM NARROMINE TO THE NILE

Jessie Tomlins - An Australian Army Nurse in the First World War (2nd ed.) provides the reader with an introduction into the social, nursing, military and political history of the time through the experiences of one nurse, Jessie Tomlins.

Jessie's family history is a quintessential Australian pioneering story with a strong connection to the land and two of her brothers, Fred and Will, became Australian Lighthorsemen. This book follows Jessie's journey through her civilian training program at Sydney hospital to the wards of the 14 Australian General Hospital in Egypt and, after the war, to the rehabilitation wards in England.

Narromine to the Nile incorporates the different experiences of Jessie, Fred and Will Tomlins in the same theatre of the First World War, the present day Middle East, providing a unique snapshot of history. It also details the social changes in the immediate aftermath of the war while Australian nurses and soldiers awaited transport home from England.

BOOK TWO – SCARLET POPPIES

The army experience of Australian nurses during the First World War (3rd ed.) analyses the impact of the military paradigm upon the challenges faced by the 2,500 civilian trained nurses who joined the Australian Army Nursing Service.

Dr Rae researched, in detail, one such challenge which was the management of the 1918-19 influenza pandemic. The treatment of soldiers and their nurses at the Woodman's Point Quarantine Station near Fremantle (WA) provides an example of a lack of understanding of an essentially civilian medical and nursing emergency. The consequences were tragic for one of four nursing reinforcements, Doris Ridgway, who was '…such a dear little girl… ' and had recently completed her nurse training at the Adelaide Hospital. Doris was an outstanding student who received four first-class passes. Ironically, she never had one day of sick leave during her three years of training but, within a week of arriving at the quarantine station from Adelaide, she was dead.

In Scarlet Poppies, Dr Rae examines the complex relationship between the male dominated military model and the female dominated Nightingale system of nurse training undertaken by the First World War nurses.

BOOK THREE – VEILED LIVES

Threading Australian nursing history into the fabric of the First World War (3rd ed.) considers the family and social lives, civilian nurse training, military nursing experiences and the premature deaths of qualified Australian nurses who endured the horrors of the 1914–18 war. Veiled Lives uncovers the impact of their absence on the nurses' families, friends, colleagues and communities.

For instance, the mother of Matron Nellie Miles Walker, Louisa, '…was in close correspondence all those four years with my beloved daughter'. When Nellie died, her mother's grief was clear when she wrote to the army that '… the very smallest trifle belonging to my child is most precious to me, and I wish no other hand to touch it first. This may sound sentimental but if you have ever loved anyone deeply you will understand it'.

Veiled Lives brings into sharp historical focus the reality for those who waited at home for more than four long years while these women, whose lives have been hidden from history for far too long, came home or were buried with the war dead.

The Trilogy is now available for purchase. For more information and to buy your copy, visit www.acn.edu.au/commemorative_trilogy

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POLICY SNAPSHOT

NATIONAL

AGED CARE

Parliament of NSW Inquiry into registered nurses (RNs) in NSW nursing homes

ACN responded to the NSW Parliamentary *Inquiry into registered nurses in NSW nursing homes* in July 2015. The inquiry's terms of reference focused on the impact of recent Commonwealth legislative changes on the ongoing requirement for RNs and the adequacy of nurse-to-patient ratios in nursing homes and other aged care facilities for residents requiring high-level care. The inquiry also focused on the role of the RN in responding to critical incidences and preventing unnecessary hospital admissions and the need for further regulation and minimum standards of care for assistants in nursing and other carers.

ACN members provided a number of responses emphasising the importance of RNs in ensuring the safety of residents and outlining the role of the RN in the escalation of care and responding to critical incidents that prevent unnecessary admissions to hospital. In its submission to the NSW Parliament ACN argued that the availability of RNs in nursing homes provides a high level of expertise to ensure the health and wellbeing of residents. ACN warned that the removal of legislated requirements in NSW to have an RN present in the nursing home at all times may potentially put residents' health and welfare at risk. This risk would be exacerbated should facilities opt to reduce the formal leadership that Directors of Nursing provide.

ACN's engagement with National Aged Care Alliance (NACA)

ACN is a member of the National Aged Care Alliance (NACA). NACA is a representative body of peak national organisations including consumer groups, providers, unions and health professionals. As members of NACA these organisations work together to determine a positive future for aged care in Australia. In 2014-15, ACN was represented at NACA meetings by an expert ACN member and ACN policy officer.

In March 2015, the Department of Social Services' Aged Care Sector Committee sought advice from NACA on the Aged Care Sector Statement of Principles. ACN took the opportunity to provide feedback to the Committee. ACN also provided direct input to NACA's April 2015 policy submission to the Department of Social Services' consultation on the Commonwealth Home Support Programme (CHSP). This consultation covered the CHSP Manual for Providers, the CHSP National Fee Policy Consultation Paper and the Good Practice Guide for Restorative Care Approaches (incorporating wellness and reablement).

More recently, NACA members, including ACN, worked to revise and update NACA's strategic "Blueprint" document to produce *Enhancing the quality of life of older people through better support and care - NACA Blueprint Series June 2015.* This document sets out NACA's shared visions and objectives for the future of the aged care sector, including recommendations on steps stakeholders can take to progress reform.

PRIMARY HEALTH CARE

Parliamentary Inquiry into Chronic Disease Prevention and Management in Primary Health Care

ACN partnered with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Australian Primary Health Care Nurses Association (APNA), Maternal Child and Family Health Nurses Australia (MCaFHNA), and the Australian College of Mental Health Nurses (ACMHN) to make a joint submission to the Australian Parliamentary Standing Committee on Health's *Inquiry into best practice in chronic disease prevention and management in primary health care* in August 2015. ACN's call for feedback to the inquiry's Terms of Reference was well supported by members with a large number of responses received.

The joint response focused on highlighting the pivotal role nurses have in the delivery of best practice models in chronic disease prevention and management. The response called on the Federal Government to consider the full spectrum of primary health care services throughout the reform process and argued that primary health care policy and associated funding allocations should enhance and further enable nursing's role in the prevention and management of chronic disease. The submission further highlights the vital role of nursing in preventing chronic disease by addressing the social determinants of health through community development, developing health literacy and screening activities.

The policy team at the Australian College of Nursing (ACN) provided responses to stakeholders, which included federal and state governments, on a number of significant issues in the third quarter of 2015.

Primary Health Care Advisory Group's (PHCAG) consultation on Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care

The Department of Health's Primary Health Care Advisory Group (PHCAG) released a discussion paper on *Better outcomes for people with chronic and complex health conditions through primary health care* in August 2015.

ACN's submission to the discussion paper argued that improving care for people with chronic and complex conditions requires reform across all primary health services including those delivered by government and non-government organisations. ACN also argued that the Australian Government should support chronic disease management models that reflect the following essential elements: consumer-centred care; multidisciplinary care; care coordination by a dedicated care coordinator; a focus on prevention and health promotion; support by eHealth technology; linkage to a broader population health framework; and adequate and well-structured funding.

ACN highlighted the considerable gaps that exist in the primary health care system for people with chronic or complex conditions. Significant issues include geographical variations in access to systematic care, together with inadequate access to services caused by unavailability of GPs, medical specialists, nurse practitioners and allied health specialists, resulting in long waiting times and cost implications.

REGULATION

Nursing and Midwifery Board of Australia's (NMBA) review of draft *Registered nurse standards for practice*

The Nursing and Midwifery Board of Australia (NMBA) has commissioned the Southern Cross University to review and revise the current *National competency standards for the registered nurse* and produce new *Registered nurse standards for practice.* In May 2015 the NMBA released the revised second draft Standards for public consultation. The consultation aimed to engage the profession in reviewing the draft Standards to further inform the development in its final stages. A large number of ACN members provided feedback.

ACN believes the second draft Standards constitute an improvement on the first draft Standards. However, based on members' feedback ACN provided a range of recommendations to the NMBA. ACN advised that the Standards require further development, emphasising that practicing and demonstrating person-centred care should be given greater prominence across the Standards.

ACN further stressed the need to place more emphasis on integrated and collaborative practice. As indicated in the members' feedback, collaborative and integrated models of practice are an essential component of providing holistic nursing care. Nurses do not work in isolation – they collaborate and consult with other health services and health professionals to support improved health outcomes for patients. ACN recommended the inclusion of more specific references to integrated models of practice to highlight collaborative practice.

INTERNATIONAL

HEALTH WORKFORCE

World Health Organization's (WHO) consultation into the draft *Global Strategy on Human Resources for Health: Workforce 2030*

ACN responded to the World Health Organisation (WHO) review of the draft *Global Strategy on Human Resources for Health: Workforce 2030* (draft Strategy) in August 2015. The draft Strategy was aimed at planners and policy makers of WHO member states, with a vision of accelerating "progress towards Universal Health Coverage and the Sustainable Development Goals by ensuring equitable access to a skilled and motivated health worker within a performing health system".

ACN reviewed the draft Strategy and overall supported its vision, goals and principles. However, ACN recommended including the central role of health care leaders in health workforce development. ACN advocated that the document feature the role of the nurse leader in overcoming the challenges of maintain and improving the productivity and cost-effectiveness of both nursing services and health services as a whole. ACN also included case studies demonstrating the valuable role and positive impact of nursing leadership in Australia.

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

ACADEMIC

DR MELISSA BLOOMER FACN

According to the National Primary Health Care Strategic Framework (NPHCSF), Australians enjoy some of the best health outcomes in the world (Standing Council on Health 2013). While this may be true and there are many countries less fortunate, our health system is under increasing strain from the growing burden of chronic illness and an ageing population (AIHW 2015). The vision for primary health care, according to the NPHCSF, is to improve health care for all Australians, particularly those who currently experience inequitable health outcomes, keep people healthy; reduce the need for unnecessary hospital presentations; and improve the management of complex and chronic conditions (Standing Council on Health 2013). For this vision to be realised, primary health care needs adequate funding, and a nursing and midwifery workforce to go along with it.

Recent data however indicates that total spending on primary health care grew by nearly $20 billion in the last decade and whilst there is a sustained increase in the proportion of Australian Government spending on primary health care, spending on hospitals was still $3 billion higher than primary health care in 2012-13 (AIHW 2014).

In terms of the nursing and midwifery workforce, the greatest majority of nurses by far are working in hospital settings, equivalent to 672 FTE per 100,000 population (AIHW 2014). These figures might suggest that primary health care is particularly under-resourced in terms of its nursing and midwifery workforce, an issue highlighted by the NPHCSF.

If we are to build a strong, responsive and cost-effective primary health care system, that will meet and continue to meet the needs of an ageing population where the burden of chronic illness is growing, the proportion of health spending in primary health care needs to increase significantly and primary health care needs to be promoted and prioritised amongst the nursing and midwifery workforce, and fast.

CLINICIAN

MS TOMICA GNJEC MACN

Primary health care – whose responsibility is it?

The ACT health system, like others in Australia and around the world, is facing increasing pressures on numerous fronts. These challenges are identified in the *ACT Primary Health Care Strategy 2011-2014* and include workforce shortages, increasing funding pressures, an ageing population, and growing rates of chronic disease (ACT Government Health Directorate 2011).

An area of priority of our local health area service is a commitment to increasing focus on early intervention, prevention, health promotion and consumer empowerment. The aforementioned strategy discusses the need to explore various avenues through the use of new models of care, different ways of providing services and, importantly, self-management and consumer empowerment. Anderson & Funnell (2010) discuss the patient 'empowerment' approach in the treatment of chronic illness through supporting patients in making self-selected changes such as dietary choices and acknowledgement that they are the one in control of their day-to-day activities.

The philosophy behind primary health care is based upon an appreciation of health as *wellbeing* rather than *absence of disease.* This can only be harnessed fully with increasing education and informed participation of the individual. Working in today's acute health care system, my colleagues and I confront many case scenarios – trauma, chronic disease – whereby a patient's individual decisions/actions are a major factor in their resulting illness or injury. We often discuss the need for acute care management to incorporate and encourage a level of personal responsibility and accountability.

A final thought and as activist Joseph Malins (1895) so eloquently described in his prevention-themed poem 'Ambulance Down in the Valley' – "…. an old sage remarked: 'It's a marvel to me that people give far more attention to repairing results than to stopping the cause, when they'd much better aim at prevention" (ANF 2009)

NEWLY REGISTERED

MS LAURIE BICKHOFF MACN

From diabetes education to cardiac rehabilitation to wound management, primary health care nurses can have a significant impact on the health of their community. Unfortunately, working in an acute care setting, I often see the negative consequences which can result from poor access to or lack of prioritisation of primary health care.

The importance of health promotion activities, regularly initiated and run by primary health care nurses, has been highlighted to me numerous times within my short experience in nursing. It's the person with coronary artery disease who does not know their smoking is contributing to their condition that we need to reach. It's the diabetic with poor blood glucose control that needs education. It's the young mother struggling with breast feeding who needs support. It's the overweight teenager who needs information and a safe place to talk. This is when primary health care nurses, and the entire multidisciplinary team, can make the biggest difference. Intervention in any of these cases can prevent long-term complications and enhance quality of life.

However, despite the efforts and dedication of these nurses, there are still members of the community who miss crucial messages or cannot access critical education programs. Primary health care nursing often remains under prioritised, under resourced and is given little recognition for the vital role it plays in keeping community members safe and healthy. The first step, in my opinion, to changing this, is for those nursing in other areas, such as acute or critical care, to acknowledge the importance of primary health care nurses and the vital role they play within our health system.

"Primary health care nursing often remains under prioritised, under resourced and is given little recognition for the vital role it plays in keeping community members safe and healthy."

– Laurie Bickhoff

ETHICIST

PROFESSOR MARY CHIARELLA FACN

Putting the fence at the top of the cliff

We know we have to change the way we deliver health care. Einstein said, "Insanity is doing the same thing over and over again and expecting different results," and yet, in our funding strategies for health, that is what we do.

Back in 1953 the first ever Oration for the (then) NSW College of Nursing was given by Mary Isabel Lambie, who was not only the first Orator for the college, but the first woman to give an Oration in the Great Hall of the University of Sydney. She was the New Zealand Nursing Adviser to the World Health Organization (WHO) and Chair of WHO's Expert Committee on Nursing, and she had this to say of the problems in health care in the developed world:

"These facts have caused increasing demands on hospitals, the rapid turnover in surgical beds together with the larger numbers of elderly and chronic patients has forced consideration to be given to the whole problem of hospitalisation by many authorities. The increased use of hospitals means automatically more staff or the better use of existing staff" (NSW College of Nursing 1999).

It is clear that little has been done to change those problems and perhaps they have even been exacerbated by our innovations in health care. I am reminded of the poem by Joseph Malins about whether or not to put the fence at the top of the cliff or the ambulance down in the valley in order to manage the problem of people falling over the edge (as cited in ANF 2009). A primary health care approach to health, which is led by nurses in many countries around the world, would enable us to put the fence at the top of the cliff and implement strong primary health care strategies.

MANAGER

ADJUNCT PROFESSOR CHEYNE CHALMERS FACN

The continued success of the Australian first world health care system rests with our ability to interface care across the primary, secondary and tertiary interface. Whilst we will always need hospital care, the majority of health care delivered in Australia occurs in the community and this will only increase over time.

As we age and the number of people living longer rises, there will be an increasing burden on our system, as is happening now, this is forcing health leaders and clinicians to look differently at how we provide care for our population.

The advent of modern technology, which allows for care to occur through non-traditional models to even the most remote areas of our population, is slowly transforming how we view health care delivery. Nurses are key health care providers in these models and are often leading the innovative approaches to ensure these populations and communities have access to the best care possible. Often, however, nurses are not seen as the leaders of such models.

As a nurse leader, I am totally cognisant of how limited our existing funding and care delivery models are in providing holistic care for our communities. The impact of advanced nursing roles, such as nurse practitioners, in the community and primary care areas is well documented in Australia and internationally but, as yet, we still don't have the numbers we need to really affect the positive health outcomes that are, and will be, required. Obviously the necessity to provide care within our funding models is crucial and that is why I am adamant we need to more closely value the role of the nurse in community and primary care provision.

COMMUNITY & PRIMARY HEALTH CARE NURSING: ACN POSITION STATEMENT

ACN released a position statement during Community and Primary Health Care Nursing Week (21-27 September 2015), which identifies the need for primary health care policy and funding allocations to address the changing health profile of Australia's population and identifies nursing as a key partner for governments. You can read it in full on the next page or online at acn.edu.au/position_statements

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COMMUNITY & PRIMARY HEALTH CARE NURSING

Position Statement – September 2015

KEY STATEMENT

Australian College of Nursing (ACN) considers the roles of community and primary health care (C&PHC) nurses to be integral to ensuring optimal health outcomes for all people across their lifespan. Community and primary health care nursing (C&PHCN) applies a social model of health care that addresses the health needs of individuals and communities while considering the social, economic and environmental factors impacting their health.[1] C&PHC nurses are employed as generalists and/or specialists. They work across all geographical areas in Australia and in a wide range of service delivery settings. These settings include community health centres, women's health services, general practices, schools, prisons and peoples' homes and work places.

Population ageing, emerging infectious diseases[2], the increasing burden of chronic and complex disease and health inequalities between Australian subpopulations all require a community and primary health care response. For this response to occur, the health care system needs re-orientation from an emphasis on care delivery through the tertiary health sector to strengthening the primary health care sector to provide more services. The skill sets of C&PHC nurses enables them to make a large and substantive contribution to the delivery of community and primary health care through:

- combining care delivery with health promotion, illness prevention and community development;[3]
- providing generalist frontline services, that aim to improve the health outcomes of disadvantaged individuals and communities, that are responsive to cultural needs;[4]
- providing support and guidance to women, parents and families so children have a healthy start in life;[5] [6]
- case-finding people and groups requiring preventative health care such as health screening or immunisations;
- responding to health care needs arising from increased population rates of chronic and complex disease and more people reaching older age; and
- liaison within and coordination of care across the health care system[7] and between service providers from other sectors.[8]

Maximising the contribution of C&PHC nurses through multidisciplinary models of care that (1) utilise C&PHC nurses' full scope of practice and (2) consolidate their contribution are key strategies for strengthening the primary health care sector.

The national health reform agenda in Australia clearly identifies that a high capacity, integrated primary health care system is at the centre of any effective health system.[9] [10] Such a primary health care system should be underpinned by primary health care professionals partnering with people, communities, health service providers and agencies to support and achieve an optimal state of health for individuals and communities.[11] Workforce development may be required to embed the skills primary health care professionals require to undertake this partnering.

Primary health care policy and funding allocations should take into account the contribution that C&PHC nurses in all settings and at all levels of professional development make to primary health care. In particular, reform of primary health care needs to ensure that service models fully utilise the skills and knowledge of all C&PHC nurses through identifying and acting upon opportunities to enhance C&PHC nurses' role and contribution. Apart from fully utilising and legitimating C&PHC nurses' contribution, service models should also support the extensive range of health promotion and illness prevention activities they deliver. Attention should be paid to nurses' health promotion and illness prevention targeting older Australians, such as active ageing advice, falls prevention and immunisation.

C&PHCN is able to respond to a wide range of population health needs because the profession encompasses nurses with highly varied scopes of practice.[12] For this reason, C&PHCN is a key partner for governments and the community in actualising capable primary health care that effectively responds to peoples' and communities' primary health care needs.

"...reform of primary health care needs to ensure that service models fully utilise the skills and knowledge of all C&PHC nurses through identifying and acting upon opportunities to enhance C&PHC nurses' role and contribution."

BACKGROUND AND RATIONALE

PRIMARY HEALTH CARE

Primary health care (PHC) aims to reduce health inequities by addressing barriers to the creation and maintenance of health. Primary health care systems are built on the principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration.[13] Service delivery in PHC is based on a collaborative interdisciplinary model of managing the entire continuum of health care that encompasses health promotion and illness prevention, management of acute and chronic illness, rehabilitation and palliation.[14] The World Health Organisation (WHO) describes the ultimate goal of primary health care as better health for all and identifies five key elements to achieving that goal as:

- reducing exclusion and social disparities in health;
- organising health services around people's needs and expectations;
- integrating health into all sectors (e.g. Health in all Policies);
- pursuing collaborative models of dialogue about health policy; and
- increasing participation of all parties with a stake in primary health care.[15]

This need for the restructure of health care systems to include a highly effective primary health care delivery is shared internationally. In 2001 the WHO alerted governments that health care systems around the world must reorganise their health care to meet the rising burden of chronic conditions.[16] Some re-orientation is underway. For example, internationally and nationally, care for the aged is seeing a trend toward a community-based, enablement focused model of care.[17] In some settings, marginalised groups such as refugees and asylum seekers already have the majority of their health services delivered by primary health care nurses.[18]

COMMUNITY AND PRIMARY HEALTH CARE NURSING

The International Council of Nurses considers C&PHC nursing to be most effective when it consistently demonstrates the following attributes:

- people centredness, meaning comprehensive, continuous and person-centred care where nurses partner with people in the management of health;
- a public health perspective through which PHC teams have responsibility for a well-defined population;
- a partnering and an interprofessional perspective as C&PHC nurses network and collaborate with health and other sectors;
- effectual use of information and communications technology enabling C&PHC nurses to work 'smarter' and to their full potential.[19]

C&PHC nursing makes a substantive and far reaching contribution to the delivery of PHC services. This position statement features three areas of C&PHC nursing practice to demonstrate the C&PHC nursing breadth of expertise and strength of impact.

SUPPORTING PEOPLE WITH CHRONIC AND COMPLEX CONDITIONS

C&PHC nurses take on valuable roles in the care of people with chronic and complex multimorbidity,[20] such as chronic obstructive pulmonary disease,[21] cancer and palliative care.[22] In these roles primary health care nurses contribute through:

- facilitating the coordination and communication in the interdisciplinary team to deliver person-centred care and being a first point of contact in the team for patients;[23] [24]
- facilitating access to allied health services and social services;[25]
- working across acute and community care, both public and private;[26]
- undertaking health assessments and delivering health interventions;[27] [28]
- providing appropriate and timely referrals to psychosocial and other support services;[29] and
- providing timely education and information to improve peoples' health literacy[30] and skill in self-care.[31]

New health service models and models of care must further consolidate C&PHC nurses' roles as advisors and case managers of people who live with one or several chronic conditions.

CHILD AND FAMILY HEALTH NURSING

Child and family health nurses facilitate improved health and social outcomes for children and their families through promoting child and family health and educating parents on child development. A key focus of their role is the monitoring of child development, early detection of developmental delays or health conditions, and the coordination of early interventions. They also monitor for signs of family distress caused by postnatal depression or domestic violence and undertake steps to institute what treatment or help may be required and to protect vulnerable individuals.[32] [33] [34] [35]

PHC FOR MARGINALISED POPULATIONS

C&PHC nurses deliver services to marginalised populations such as homeless individuals and families and Aboriginal and Torres Strait Islander people. C&PHC nurses provide homeless people with health education, health assessment, clinical care, support of self-care activities and counselling.[36] Homeless people can find access to health services difficult because they lack financial resources and/or because of stigma. C&PHCN services working with homeless people seek to reduce these barriers by undertaking outreach, reducing discriminative attitudes and through referral and inter-sectoral liaison and collaboration.[37] In the Aboriginal Community Controlled Health Services (ACCHS) sector, C&PHC nurses work in a model of comprehensive primary health care. They deliver illness prevention and health promotion, clinical intervention, targeted programs (such as antenatal) and facilitate access to secondary and tertiary health services and social and cultural services. Successful interventions demonstrate genuine engagement with local Aboriginal and Torres Strait Islander communities that maximise participation up to, and including, full community control.[38]

ACN believes that the demonstrated potential of C&PHC nursing could be further maximised through policies and models of care that enable C&PHC nurses, including nurse practitioners, to utilise their entire scope of practice.

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MY JOURNEY IN COMMUNITY AND PRIMARY HEALTH CARE NURSING

By Kate Partington MACN
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Kate Partington MACN

In 1983 as a final year nursing student, within the hospital training system, I was required to complete a three-day clinical placement in the community. Never did I anticipate that this placement would be a life-changing experience…

The three days were spent with staff of the Sydney Home Nursing Service (SHNS) in the Balmain area of Sydney, NSW. During that time I had the opportunity to visit many different people in their homes – the younger disabled and the older frail and vulnerable. Providing care within the home somehow seemed "right" to me as the nursing was provided on the individual's terms – not the "institutions". In retrospect it was the beginning of my awareness and commitment to a person-centred care approach. I really enjoyed the opportunity to get to know these people within their own contexts and the privilege of being able to share intimately in their life stories.

Upon completion of my training I set about consolidating my acute care experience as I believed that I needed to strengthen my skills. After some time in major Sydney hospitals I then chose to travel abroad. With limited savings, work was eventually required to top up the dwindling traveller's funds! When I reached England a friend connected me with an agency that subcontracted to District Nursing Services. With limited experience but an interest ignited during my training days, I accepted work as a District Nurse in the East End of London.

I walked the streets of east London for six months (not keen on the bicycle option and no cars available!) with my black bag and limited tricks. I visited all sorts of people during that time – none very rich or famous – but all characters across the spectrum. Their needs varied from daily insulin injections to weekly wound care, to supportive care enabling them to remain at home. It wasn't easy work and there were some truly challenging personalities, but I loved it!

Upon returning to Australia I sought to update my clinical skills. I applied to the local hospital and the Deputy Director of Nursing who noted my overseas experience suggested she could speak to her sister who was in an executive position of SHNS. I felt that I needed greater depth of experience at that time so returned to the acute sector. However, in 1989 I applied for and was successful in a position with SHNS at Manly, NSW.

I worked at Manly SHNS for four years providing care to frail older, younger disabled and palliative clients. I enjoyed the work immensely but also challenged the traditional roles of registered nurses (RNs) within the service and the need for other organisations such as Home Care to provide some of the more routine care. My logic for this was that more people could be cared for at home more affordably if there was support for the RNs. During this time I completed a Graduate Certificate in Gerontology at the then College of Nursing, Sydney, and also an Advanced Certificate in Welfare Studies at North Sydney TAFE. I progressed to Clinical Nurse Specialist at SHNS and occasional acting Nursing Unit Manager.

Seeking a tree change, inspired somewhat by the British TV series *Heartbeat*, I found myself relocating to rural NSW after successfully being appointed to the role of Primary Health Nurse (PHN) in the Southern Highlands. I was surprised to find such an established Community Health Service and thrived in the environment. The role of PHN at that time incorporated post acute care, chronic and complex care, palliative care and school health; quite a mixture but somehow it provided a good balance and suited best to those with an ability to adapt. Some days I would travel up to 150 kilometres traversing picturesque countryside, visiting clients in their homes, tending to dressings, medications and providing support and care to clients and their significant others.

An opportunity came along to complete a Graduate Certificate in Child and Adolescent Health, also at the College of Nursing, which I completed and then worked part-time as a Child and Family Health Nurse (CAFHN) and part-time PHN. Such is the diversity within the community context.

After dabbling in health promotion within schools, I sought a change of environment and a position as Area Community Nurse Educator happened along. I welcomed this new horizon where I could start to shape and influence future PHNs. Families First followed, which afforded me the opportunity to design and facilitate a Graduate Certificate in Child and Family Health Nursing for nurses already working in the field.

In 2002, having completed a Bachelor of Business (Human Resource Management), I applied for and was successful in attaining the position of Nursing Unit Manager for PHN back in the Southern Highlands. During the following 12 years it was my privilege to support a team who provided great care venturing into the emerging areas of acute/post acute care (Hospital in the Home) and developing a reputation for excellence in community palliative care. A care coordination model within geographical sub-units (covering approximately 2666 square kilometres) was integral to the great care provided. In reality it enabled a client with chronic obstructive pulmonary disease (COPD) who developed pneumonia and may in the future be found to have an underlying cancer to be cared for by the same PHN within their own home – great continuity of care.

Over the past 18 months I have worked as the Manager of Community Aged Care Services in a Local Health District. I continue to be inspired by the nurses and allied health professionals I work with daily. There is a real commitment to seeking the best outcomes for the people within our care to maximise their ability to enable the best quality of life they can achieve with the support of our services. Indeed, not always an easy goal considering the sometimes unpredictable nature of the workplace beyond the "safety" of a health facility. A myriad of skills additional to clinical expertise are required to work in this area – from negotiator, to confidante, to grief counselor, to coach and many more beyond. The privilege of working with individuals in the intimacy of their own homes and communities, on their terms, is one which I continue to treasure.

The opportunities for community based nursing care are limited only by a vision to enable true "health" care and the commitment of funding to primary health care amidst a tsunami of demand on the health dollar. Community based nurses are finally finding their voice in the loudness of the competing acute care sector. The provision of quality affordable care into the future will require ongoing investment in this field to ensure that we have "Nurses where you need them".

Read more profiles from Community and Primary Health Care Nurses in ACN's special eBook, *Community and Primary Health Care Nursing Week: Nurses where you need them 2015,* visit www.acn.edu.au/primaryhealthcarenursingweek2015

OPPORTUNITIES TO IMPROVE ACCESS FOR MEN TO PRIMARY CARE

Del Lovett MACN

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By Del Lovett MACN, Dr Marc Broadbent, Associate Professor Patrea Andersen, Professor Alan White

Australian men continue to die on average 4.2 years earlier than women and experience higher avoidable and premature mortality rates from common conditions including heart disease and cancer (Australian Institute of Health and Welfare [AIHW] 2015). The reasons for this increased risk are due to both biological sex difference and cultural (gender) factors in the way men live their lives and engage (or not) with health services (AIHW 2011). The new Practice Nurse Incentive Program (PNIP) may be a way of creating new ways of working with men to improve their health and wellbeing.

The conceptualization of men's health as a specific health care need is a comparatively recent. Literature on men's health began to appear in the early 1980s with early attempts to define men's health (Fletcher 1997) based on a pragmatic interpretation that focused on men's disease or issues related to sexual or reproductive organs (e.g. prostate and testicular cancer). Since this time there have been major advances in our understanding of the issues men face with their health and health behaviour, with the recent Australian National Male Health Policy (Department of Health and Ageing [DoHA] 2010) being a very important step forward.

There are convincing economic and social arguments for improving men's health and wellbeing (Brott et al. 2011; Thorpe et al. 2013). These include the psychosocial impact on men, the burden of premature ill health and the consequences of risk-taking behaviour. For men, their partners and families, this includes reduced income, increased costs of medical care, the need for family members to become carers and men's reduced ability to fulfil roles as partners, fathers or carers.

For many health issues, both gender and sex are inextricably linked. For example, prostate and testicular cancer are unequivocally a sex-specific condition. These become gender-specific in that many men present later to their doctor with symptoms, or in the way men subsequently cope with their illness. It is vital to consider gender in the context of other social determinants of men's health, such as socio-economic status, education and ethnicity. Health service planning and delivery, health promotion and disease prevention strategies are often gender-neutral and based on the assumption that interventions will be equally successful for men and women.

In order to provide the opportunity for health care and produce effective policies to support health care delivery, the nurse or health provider must consider gender and how it can be interpreted (Hawkes & Buse 2013). The majority of nurses already possess many of the skills necessary to tackle men's health issues, but what is often missing is a conscious awareness of the impact of gender on men's health, the modifiable social factors and possible barriers and solutions for men accessing health care (table 1.1).

Men often have a functional view of their bodies and thus may be less inclined to attend health services until functioning is directly affected. Service accessibility can affect men's use of health services, for example, men may have difficulty attending appointments due to employment. In Australia, Foundation 49 (2008) found that the main reasons for men not having regular check-ups were: not getting around to it; lack of time; cost; questioning necessity because of good health or age; not having thought of it, or not having a general practitioner (GP).

Rather than examine structural factors that play a part in men's approach to health services, blame for non-attention to health issues is attributed to men being stoical and unwilling to talk about their physical and mental health concerns (Department of Health 2010). Factors influencing service use include: reduced opportunity to attend out-of-hours or weekend appointments; transport: available of service in some areas, and previous bad experiences.

There is evidence that men dislike long waiting times, feel uncomfortable in waiting rooms and see general practice as a service predominantly for women and children (Malcher 2009; Lovett 2014). Aboriginal men are resistant to seeking treatment and less comfortable talking about their

“The majority of nurses already possess many of the skills necessary to tackle men’s health issues, but what is often missing is a conscious awareness of the impact of gender on men’s health, the modifiable social factors and possible barriers and solutions for men accessing health care.”

TABLE 1.1: IMPACT OF GENDER, MODIFIABLE SOCIAL FACTORS AND BARRIERS AND SOLUTIONS TO MEN’S ACCESS TO HEALTH CARE

Impact of gender
exposure to risk factors
access and understanding of health information
men’s experience of illness and its social significance
attitude towards maintenance of men’s own and their family’s health
patterns of service use and perception of quality of care
(adapted from The Royal Australian College of General Practitioners [RACGP], 2011, pp. 138–139)

Modifiable social factors
use health and community services less and at a later stage of illness
lifestyle risk factors e.g. smoking, excess alcohol consumption and insufficient fruit and vegetables
participate in range of high risk activities
poor health literacy
(adapted from Department of Health, 2015 p. 2)

Barriers	**Solutions**
men use service less often	review and change services if necessary
lack of knowledge of men’s attitudes and behaviours	develop research/increase health professionals knowledge
lack of knowledge of how to work with men	develop good practice
men are ‘hard to reach’	true of some groups of men e.g. Aboriginal, rural and remote men. However, ask whether this is true of your male patients!
it’s men’s own fault	help to change male attitudes to their health with changing your own attitudes to their health care.
(adapted from MHF, 201, p.21)	

health with female doctors and other health professionals (Senate Select Committee on Men’s Health 2009), with many continuing to see the health delivery system as untrustworthy, authoritarian and threatening (Malcher 2009).

Despite these difficulties health service planning and delivery, health promotion and disease prevention strategies are often gender-neutral and based on the assumption that interventions will be equally successful for men and women. Developing men’s health-related knowledge, self-care abilities and engagement with primary care health services enhances their capacity to play an active and positive role in determining their health.

Recognising factors including men’s interest in their own health, health knowledge deficits, attitudinal beliefs that may restrict positive health behaviours, and a service system not attuned to men’s needs is important if health access is to be addressed. To engage men transitioning points in the life cycle for example: fatherhood and parenting may positively affect men’s health. The introduction of men’s health clinics, health screening,

health assessments, immunisation and travel advice may improve access and use of health services.

Welcoming 'male-friendly' health and community services environments that provide further opportunities to engage men including non-threatening, non-judgemental, respectful, confidential non-embarrassing/patronising advice, offering appropriate graphics and readily understandable information (Ashfield, 2004).

Masculinising the environment to provide flexible appointment times including evenings and weekend; using posters and displays with positive images of men; inviting men to attend health screening and health assessments; providing automatic email, text or mail reminder ensuring program names and descriptors are inclusive of men; marketing services to men; targeting information about services for men to men's partners and families; using language (no jargon or medical terminology) that is positive and focused on solutions; normalising help-seeking and emphasising men's strengths and diffuse anxieties about help-seeking and health issues particularly for 'sensitive issues' such as depression or sexual health, and the use of medical software that targets specific groups of 'at risk' (e.g. Pen Audit Tool, Canning data tool) are strategies that may positively influence access and enhance health services for men (Department of Health, 2015, p. 26).

Nurses working in primary care, particularly those working in general practice are ideally situated to help men understand the implications of their health and wellbeing and the possible consequences of risk-taking behaviour (Peate, 2008). A good starting point for the nurse is to ask themselves the question, "What is your own perspective about men's health?" It is important that the nurse consider their knowledge and possible embarrassment in discussing sensitive issues with men (Men's Health Forum, 2011). Men's health encompasses a lot more than 'below the belt' discussions and may require a shift in the nurse's attitude to move beyond feeling discomfort to more equitable nursing care for men.

Medicare is a major part of Australia's national health care system and therefore impacts on general practice, GPs, allied health professionals, nurses and patients. The Practice Nurse Incentive Program (PNIP) was introduced on 1 January 2012 to support the expanded and enhanced roles for nurses and/or Aboriginal health workers (AHWs) in general practice, Aboriginal medical services and Aboriginal community controlled health services.

In areas of workforce shortage, an allied health professional instead of/or in addition to a general practice nurse (GPN) and/or AHW may also utilise the program. The PNIP simplifies the previous funding Medical Benefits Scheme (MBS) arrangements by offering medical practices a single quarterly payment to cover the diversity of activities nurses perform that include, but are not limited to, health promotion, illness prevention and sexual health care. Nursing roles are therefore no longer determined by specific Medicare item numbers but can now be determined by clinical need. The PNIP funds all services GPNs perform and it offers greater opportunities to further develop their role in general practice. (MBS, 2014).

Little research has been undertaken to explore the impact of the PNIP initiative and its contribution to resolving issues surrounding men's access to health services. It is important to understand how GPNs currently utilise the PNIP to engage men in targeted health promotion and illness prevention education and identify facilitators or barriers to this funding mechanism.

Del Lovett is a PhD student working with Dr Marc Broadbent and Associate Professor Patrea Andersen from the University of the Sunshine Coast (USC), and Professor Alan White, (Leeds Beckett University / Adjunct Professor, USC) to research General Practice Nurses' use of

"Little research has been undertaken to explore the impact of the PNIP initiative and its contribution to resolving issues surrounding men's access to health services. It is important to understand how GPNs currently utilise the PNIP to engage men in targeted health promotion and illness prevention education and identify facilitators or barriers to this funding mechanism."

the Practice Nurse Incentive Program with regard to men's health. It is anticipated that this research will inform approaches to health service planning and delivery for men's health services in general practice and make recommendations to improve access for men to health promotion and illness prevention education for men and develop nursing practice.

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ADDRESSING CHRONIC DISEASE THROUGH A STRONGER PRIMARY HEALTH CARE SYSTEM: ACN'S SUBMISSION TO THE PARLIAMENTARY STANDING COMMITTEE ON HEALTH

By ACN Policy Team

Australia must have a stronger primary health care (PHC) system if it is to overcome the challenges posed by an ageing population and rising burden of chronic disease. The community and primary health care (CPHC) nursing sector must play a major role in the PHC system and PHC must be supported with adequate government funding and evidence-based policy enablers. These are some of the key messages advocated for in ACN's most recent joint submission to the Australian Parliamentary Standing Committee on Health's *Inquiry into best practice chronic disease prevention and management in primary health care.*

Coordinated by ACN, the submission was co-authored with four of the country's other leading national nursing organisations: the Australian College of Mental Health Nurses (ACMHN), the Australian Primary Health Care Nurses Association (APNA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), and Maternal, Child, and Family Health Nurses Australia (MCaFHNA).

The Standing Committee's Inquiry was specifically interested in gaining insights from PHC stakeholders on matters such as national and international best practice chronic disease prevention and management models. The Inquiry also investigated the role that Medicare, private health insurers, Primary Health Networks, and state and territory governments can play in chronic disease prevention and management.

ACN and its co-authors set out to develop an evidence-based submission that not only featured best practice models, but which also highlighted the critical role that nurses play in designing and delivering these models of care. To do this, ACN invited members to provide input into the Inquiry, which attracted 37 detailed contributions from respondents representing a range of health care settings and nursing disciplines. Of particular importance was the role of the ACN Community and Primary Health Care Nurses Community of Interest (CPHC COI), which provided invaluable expertise and advice.

ACN used this information, coupled with that provided by ACN's submission partners, to advocate for PHC reform to specifically target the system's short and long term chronic disease related challenges. In particular, the submission emphasised the critical role that nurses currently play, and will need to continue to play, if the challenges of chronic disease prevention and management are to be overcome.

ADVOCATING FOR THE BREADTH OF PRIMARY HEALTH CARE TO BE RECOGNISED

From the outset, the joint submission makes it very clear that PHC is much broader than the often used confined conception that PHC stops with general practice. Primary health care consists of a range of services, service settings, and service providers, such as mobile cancer screening services provided by grant-funded non-government organisations (NGO), family violence services provided by state-funded community centres, health education provided in schools, and aged care services provided in people's homes, among others. While general practice is no doubt a key pillar of Australia's PHC system, it is only one part of a much larger system. In making this case, the submission specifically recommends that the Australian Government take into account the full breadth of PHC when designing chronic disease prevention and management policies and supporting particular models of care. Special consideration should be given to the role that nurses play in the design and delivery of models of care, and how nurses can best be supported to enhance these roles.

TACKLING CHRONIC DISEASE THROUGH ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

ACN's joint submission argues the critical importance of addressing the social determinants of health (SDH) if Australia is to tackle the rising prevalence of chronic disease effectively and sustainably. The conditions in which people are born, grow, work, live, and age are better determinants of people's health outcomes than is their access to health care alone. Research demonstrates, for example, that between one-third and one-half of the gap in life expectancy between Indigenous and non-Indigenous people can be explained by differences in the SDH.[1] Poor education and literacy is linked strongly to low income and poor health status; smoking, overweight and obesity. Other chronic disease risk factors are also strongly associated with low socio-economic status. Finally, poverty reduces access to health care services and medicines, further exacerbating already at risk populations.[2,3,4] The submission highlights to the parliamentary inquiry the role that nurses do, and will continue to play in addressing SDHs. The submission specifically notes that through their holistic approach to care, nurses have the ability to identify SDH-related problems affecting people they see, and that through their coordinating roles, they are able to link people with services beyond the usual clinical setting, such as employment and housing. ACN noted however that for this role to be extended and made more effective,

supportive government and organisational policies are needed. These policies should acknowledge the breadth and value of nurses' skills, especially those of CPHC nurses to enable them to work to their full scope of practice. Equally importantly, nurses' efforts must be supported by healthy public policy, such as by the Australian Government taking a Health in All Policies approach to public governance and administration – similar to that employed by the South Australian Government.

BEST PRACTICE CHRONIC DISEASE PREVENTION AND MANAGEMENT MODELS

Input from ACN's members, coupled with ACN's own research, identified numerous national and international best practice chronic disease prevention and management models. Among these, ACN and its submission partners identified a list of key elements that are essential to any effective chronic disease model of care. Any chronic disease prevention and management model must:

- Start early and continue throughout life
- Be consumer-centred, where the consumer and their carer (where appropriate) are equal partners in the decision making processes and outcomes to be achieved
- Ensure consumer self-determination is central to the care planning process through the provision of adequate information, education, aids and supports
- Be multidisciplinary in nature, where each health and social care professional is an equal partner in the health care team and works to their full scope of practice
- Involve a care coordinator who has primary responsibility for connecting the consumer's services, as well as communicating with, and supporting, the consumer in a way that promotes their health and wellbeing
- Promote family/carer involvement as part of the health care team wherever possible
- Be supported by a funding model that recognises and fairly remunerates the work of the entire health care team, including nurses, and that supports team collaboration and rewards improved health outcomes
- Be supported by information and communication technology (eHealth), which promotes access, coordination, safety and quality, and cost-effectiveness
- Fit within a broader population health framework which is based on prevention, health promotion, and addressing the social determinants of health.

In the submission is included a number of examples of models of chronic disease prevention and management, provided by members, which demonstrate all of these elements. These examples include nurse clinics, where nurses work autonomously and to their full scope of practice in the provision of chronic disease prevention and management; the Mental Health Nurse Incentive Program; Aboriginal Community Controlled Health Services; Victoria's Hospital Admission Risk Programs (HARP); and community-based specialist nurse models, such as the Parkinson's disease and movement disorder nurses, among others. ACN's joint submission highlights the value in the Australian Government providing further support to these models, and in looking at these models for potential expansion.

A MEDICARE PAYMENT SYSTEM TO ENCOURAGE AND SUPPORT BEST PRACTICE CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PHC

ACN's joint submission maintains that a reformed Medicare could better encourage and support best practice chronic disease prevention and management in PHC. Perhaps more importantly though, there is an opportunity, and indeed necessity, to look further than Medicare in identifying opportunities for funding reform. Specifically, the Australian Government, in partnership with the states and territories, must undertake a broader review into all PHC funding arrangements, to help identify inefficiencies, gaps, and waste. This should subsequently feed into reform that works to better coordinate and integrate services between the different tiers of government. In the interim though ACN and our partners recommend that the government reform Medicare to properly acknowledge the role of nurses in chronic disease prevention and management, and to enhance their role. The recommended reform includes increasing the value and availability of chronic disease management MBS items for nurse practitioners, who are currently underfunded and undervalued. Alternatively, block funding arrangements could fund such nursing services.

ACN's joint submission also advocates for the review and subsequent reform of the predominantly fee-for-service general practice funding model. Specifically, the submission argues that the Australian Government should begin developing options, in consultation with necessary stakeholders, for a blended funding model that includes fee-for-service, capitation, and pay-for-performance. Such a model would provide greater flexibility for practices to engage in prevention, health promotion, coordination, and collaboration. A blended funding model should remunerate all health care team members' participation in collaborative work, such as case conferencing – something that only the GP is currently remunerated for. It should also allow for health professionals to be remunerated for non-face-to-face consultations, such as through telephone and email, creating greater efficiencies, improving access, and increasing the opportunity for consumer engagement.

OPPORTUNITIES FOR PRIMARY HEALTH NETWORKS TO COORDINATE AND SUPPORT CHRONIC DISEASE PREVENTION AND MANAGEMENT IN PHC

Primary Health Networks (PHNs) have an important role to play in planning, coordinating, funding, and where necessary, delivering chronic disease prevention and management services. Part of this role should involve the development of comprehensive population health needs assessments for their respective populations, picking up from where the Medicare Locals left off, and drawing on the work and support of the National Health Performance Authority (NHPA).

PHNs have a role to play in supporting the uptake and use of eHealth technology, by both consumers and health professionals. In particular, there is an opportunity to support clinics through education and training around software, such as clinical decision support programs and inter-professional and professional-consumer communication tools. This support should particularly be targeted toward nurses who play key roles in care coordination and consumer engagement. For example, practice

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nurses were found to use the patient support IT tool five times more often than GPs in the recently completed national Diabetes Care Project pilots.[5]

Furthermore, PHNs have a role to play in the identification, production, and dissemination of best practice clinical governance models, such as by supporting continuous quality improvement initiatives like the Australian Primary Care Collaboratives (APCC), and the Mental Health Professionals Network (MHPN), as well as working with bodies like the Australian Commission for Safety and Quality in Health Care. Critical to this role, ACN argues, is the inclusion of nurses on PHN Clinical Committees, which are being mandated with providing advice on clinical service design and implementation.

THE ROLE OF PRIVATE HEALTH INSURERS IN CHRONIC DISEASE PREVENTION AND MANAGEMENT

There is an opportunity for private health insurers (PHIs) to improve chronic disease prevention and management outcomes in both their member populations, and the broader public. For their members, PHIs should be encouraged to continue down the path of proactive chronic disease prevention and management, such as by providing health screening services, coaching, health advice hotlines, and care coordination – as provided already by some PHIs. However PHIs also have an opportunity to contribute to the public health system, such as through ensuring that their private hospitals have correct discharge and follow-up plans for those members who transition to the PHC setting for subsequent treatment. Furthermore, the joint submission argues that as a publicly subsidised industry they should share relevant (de-identified) member health and service data in order to feed into the chronic disease prevention and management evidence-base.

THE ROLE OF STATE AND TERRITORY GOVERNMENTS IN CHRONIC DISEASE PREVENTION AND MANAGEMENT

State and territory governments currently play a critical role in chronic disease prevention and management and will do so well into the future. They are particularly critical in their funding and administration of non-GP PHC services, such as those provided in community health centres and schools. One of the advantages of state and territory involvement in PHC service planning, funding, and provision, is that they are able to better respond to local needs and circumstances than would the Commonwealth acting alone. The downside however is that the existence of multiple tiers of government in the health sector creates service siloes and fragmentation, resulting in gaps, duplications, and waste.

To help overcome this issue, the submission emphasises its argument that a national funding and service provision review is needed to identify the inefficiencies created by multiple levels of government, which can subsequently feed into reform aimed at increasing coordination, integration, and health system efficiency.

SUMMARY

Australia needs a stronger primary health care system if it is to overcome the challenges associated with an ageing population and a rising chronic disease burden. Community and primary health care nurses must be supported through adequate funding and evidence-based policy enablers to lead this change and meet these challenges. ACN's joint submission, importantly informed by ACN members' contribution, with particularly valuable input from its Community and Primary Health Care Nurses Community of Interest, makes a strong case for what is needed to make this change happen. ACN, with the support and involvement of its members, will continue to monitor and keep pushing for effective PHC reform as we all work together for better health outcomes for all.

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COMMUNITY AND PRIMARY HEALTH CARE NURSING WEEK: NURSES WHERE YOU NEED THEM

On 21 September 2015 ACN was pleased to announce the inaugural launch of Community and Primary Health Care Nursing Week national campaign.

ACN has introduced the week to raise awareness of community and primary health care nursing roles and their impact on the health and wellbeing of individuals and communities. The ACN Community and Primary Health Care Community of Interest (COI) Advisory Committee worked with ACN to bring this campaign to life with the aims to:

- Raise awareness of the current and potential contribution of community and primary health care nursing and its impact on the health and wellbeing of individuals and communities;
- Inform the general public in order to increase their health literacy about community based health care options;
- Inform nurses of community and primary health care nursing roles and career opportunities;
- Inform state and territory governments as funders of many community and primary health care services and drivers of state health reform of the capacity of community and primary health care nurses;
- Inform the federal government as a funder of community and primary health care services and general practice based services and as a driver of national health reform of the capacity of community and primary health care nurses; and
- Inform other health professions active in community and primary health care to raise their awareness of community and primary health care nursing services.

Across the country nurses and the broader community participated in a range of activities during the week to raise awareness of the importance of community and primary health care nursing roles; these included lectures, networking events, social gatherings and group readings from the *Community & Primary Health Care Nursing Week: Nurses where you need them eBook*, developed by ACN. The eBook profiles the many and varied community and primary health care nursing roles and the impact they have on health outcomes.

The ACN Canberra and Sydney offices gathered together for 'orange' inspired morning teas in celebration of the week. Stories from the eBook were read and the ACN Community and Primary Health Care Nursing Position Statement was officially launched by ACN Acting CEO, Kathleen McLaughlin FACN.

Acting ACN CEO Kathleen McLaughlin FACN

ACN staff members

The *Community & Primary Health Care Nursing Week: Nurses where you need them eBook* maps out the vast geographical distribution of nurses across Australia and profiles the many varied roles they undertake. You can find the eBook at **issuu.com/australiancollegeofnursing**

SUPPORTING NURSE LEADERS BY DEVELOPING THE LEADERSHIP CAPACITY OF UNDERGRADUATE AND EARLY CAREER NURSES

By Trish Lowe MACN

Budgetary restrictions, chronic staff shortages, sub-optimal staff-to-patient ratios and an ageing workforce stimulate health professionals to seek efficiencies within the Australian health system (Health Workforce Australia 2014). Due to the burdens of chronic disease and an ageing population, the contemporary health care landscape is impacted by rapid throughput and high patient acuity (Zilembo & Monterosso 2008). The resultant dynamic, and at times hostile workplaces contribute to workforce attrition, absenteeism and horizontal violence (Health Workforce Australia 2014).

In this climate, demands for progressive nurse leadership and effective management are made. Nurse leadership has been identified as the cornerstone for driving retention and productivity improvement (Health Workforce Australia 2014). While it is true that significant benefits flow from developing the leadership skills of middle managers, the inherent leadership capacity of enthusiastic and highly motivated undergraduate and early career nurses remains largely unrecognised and untapped. Given the pressures outlined above, it is essential to acknowledge and develop this capacity.

There is an urgent need for nurses to be more capable of leading themselves (Hurley & Hutchinson 2013). Nurses at all stages of their careers must be able to disassociate leadership from management and harness the capabilities within themselves to positively impact on their work environments, colleagues and clients, such that nurse managers are supported in the achievement of organisational goals, key performance indicators and patient outcomes.

Student and early career nurses are commonly cast as 'followers' in any dissertation on nursing leadership. Yet research supports the assertion that undergraduate and early career nurses may be altruistic, optimistic, assertive, positive and conscientious; personality traits ideally suited to the assumption of leadership roles (Baldacchino & Galea 2012). This study found that conscientious people adhere to their ethical principles and moral obligations, think carefully before acting, display diligence, self-discipline, reliability and a sense of direction and determination to achieve their life goals (Baldacchino & Galea 2012). Interestingly, the personality traits demonstrated within this study cohort, whilst undoubtedly influenced by genetics, religion, self-esteem, family, social, clinical environments and education, were both consistently apparent and comparable with the nursing and midwifery profession overall. Similarly, another study comparing the personality traits of Australian nurses and general practitioners reached similar conclusions, suggesting that, compared with population norms, both groups were found to be highly self-directed, cooperative, compassionate, responsible, confident and objective (Eley & Eley 2011).

These pre-existing personality traits are further enriched by tertiary education in preparing graduates to assume leadership roles. In Australia, Bachelor of Nursing programs are delivered at an Australian Qualifications Framework (AQF)-Level 7, as dictated by the Tertiary Education Quality and Standards Agency (Commonwealth of Australia Tertiary Education Quality Standards Agency [TEQSA] 2012). Successful completion of programs such as these enables graduates to meet the *National Competency Standards for the Registered Nurse* (Nursing and Midwifery Board of Australia [NMBA] 2006). Graduates in receipt of such an award or qualification are expected to demonstrate the application of knowledge and skills, autonomy, well-developed judgement and responsibility (Commonwealth of Australia TEQSA 2012).

In Australia, the *National Competency Standards for the Registered Nurse* provide a broad, principle based framework for assessing nursing competence for the purposes of obtaining and retaining registration (NMBA, 2006). These standards outline the requirement for all registered nurses, regardless of their seniority to 'take a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes' (NMBA 2006, p.2). Therefore, it follows that the early identification and development of leadership capacity is not only ideal, but essential. Leadership capacity can be further enhanced by the provision of knowledge pertaining to leadership theory. *Transformational leadership, Authentic leadership* and *Complexity leadership* theories have been broadly associated with improved safety, sustained performance and enhanced job satisfaction across a variety of work settings (Banmford, Wong & Laschinger 2013).

Transformational leaders typically demonstrate charisma, the ability to inspire and advance team purpose towards the achievement of stated goals (Lievens & Vlerick 2012). *Authentic leadership* theory suggests that life experiences, the psychological capacity for hope, optimism, resilience, self-efficacy and sound moral perspective can be directed towards the fostering of wellbeing and genuine, sustained performance (Avolio & Gardner 2005). While *Complexity leadership* theory recognises interconnectedness and change as normal operating conditions,

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rendering it an appropriate model for integration into the dynamic health care system, where both financial and human resources are scarce and adaptive challenges are frequent (Weberg 2012). Whilst no one theory provides a panacea for the challenges apparent in contemporary health settings, understanding these theories provides stakeholders with the insight and knowledge required to initiate and enact change.

The challenge for experienced health professionals is to recognise, support and build upon the organic leadership capabilities of undergraduate and early career nurses in order to build workforce capacity. Nurse leadership capability that is constructed, nurtured and supported from pre-registration level appears to benefit all health stakeholders (Hurley & Hutchinson 2013). Precepting, mentoring and educating are examples of ways in which leadership capacity can be identified, harnessed and nurtured, thereby positively impacting on workforce retention, job satisfaction and workforce capacity.

Precepting is defined as the provision of a short-term relationship with the immediate goal of achieving a specific task, increasing a particular body of knowledge or learning a new skill, while *mentoring* describes the establishment of a long-lasting relationship (informally established within or outside the workplace, or beyond), which serves to enhance a protégé’s career (Kram 1988). Meanwhile, the facilitation of postgraduate education has a valuable role to play in building workforce capacity, as registered nurses with post-basic specialist education demonstrate higher levels of commitment to the nursing profession as a result of enhanced autonomy, work diversity and remuneration (Cleary et al. 2013).

Establishing a workplace culture which encourages autonomous practice is also vitally important; a perceived lack of autonomy has been associated with low job satisfaction, lowered engagement with the nursing profession, high staff turnover and burnout (Cleary et al. 2013). It has been argued that in order to build an autonomous, motivated and highly skilled nursing workforce, the inherent leadership capacity of undergraduate and newly registered nurses must be recognised, utilised, enhanced and developed.

The existing knowledge, personality traits and capabilities of student and early career nurses can be utilised by nurse managers to achieve organisational goals and optimise outcomes across the health system. Strategies for enhancing leadership capacity in early career nurses have been outlined. It is envisaged that if employed, these principles may help build workforce capacity and, in so doing, address current and future health needs of the Australian public.

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SIGNPOSTING THE LEADERSHIP PATHWAY: EASTERN HEALTH'S NURSING/ MIDWIFERY LEADERSHIP FRAMEWORK

By Kath Riddell MACN and Jo Mapes

Developing leadership skills is a challenge experienced by many nurses and midwives, particularly when they find themselves in a senior clinical or managerial role without having prior knowledge, education or experience in leading others. Similarly, when aspiring to advance a career along a particular professional pathway, often the necessary guidance or 'sign posts' are hard to find.

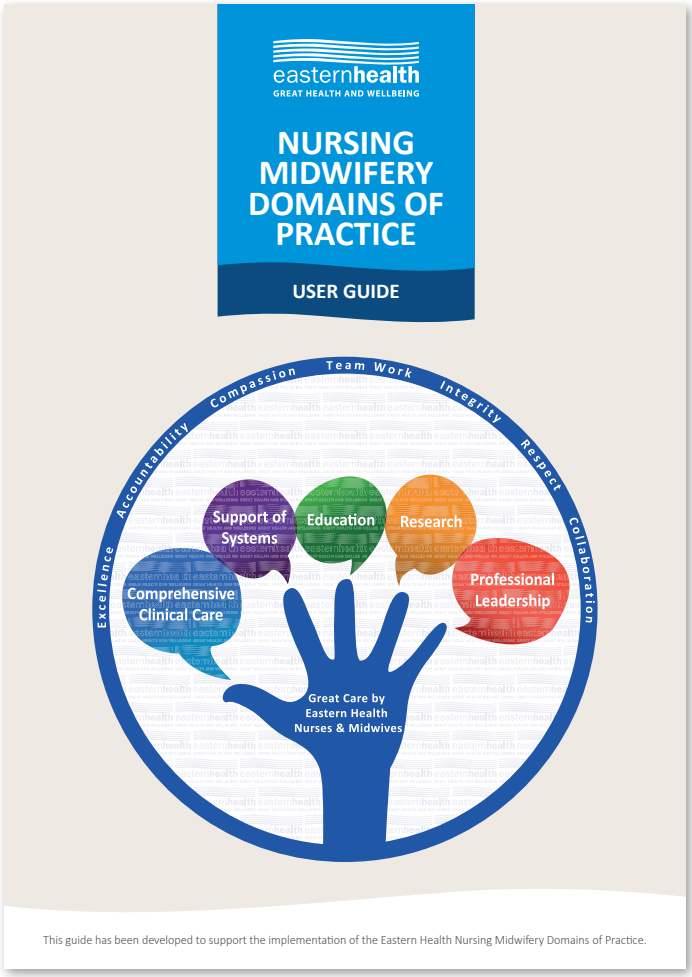
BACKGROUND

At Eastern Health, one of Melbourne's largest metropolitan health services, the nursing and midwifery leaders recognised the need to enhance support for the professional development of the workforce; in particular to cultivate leadership skills. Although many nurses and midwives are cognisant of expectations within their clinical role, the diversity inherent within nursing and midwifery can make it challenging for the individual to appreciate their responsibilities and the impact of their practice and behaviours across the broader health care system.

This gap was apparent to Eastern Health's Nursing and Midwifery Executive team who sought to define the expectations of practice across the diversity of roles and experience; whilst also supporting the individual toward their career advancement goals.

Utilising the work of Ackerman et. al. (1996) and referencing the National Common Health Capability Resource (2013), a professional development framework was developed; the *Domains of Practice*.

The Domains of Practice seeks to make explicit the expected, and aspirational, standards of professional practice and the desired behaviours and skills which comprise and represent the complex nature of nursing and midwifery. In addition the framework aims to support managers (at various levels) to undertake meaningful conversations to develop the individual within their team.



Eastern Health Domains of Practice User Guide

“The Domains of Practice seeks to make explicit the expected, and aspirational, standards of professional practice and the desired behaviours and skills which comprise and represent the complex nature of nursing and midwifery. In addition the framework aims to support managers (at various levels) to undertake meaningful conversations to develop the individual within their team.”

DESCRIPTION

Ackerman defined five domains of practice, which are considered core components of the role of all nurses and midwives; comprehensive patient care, support of systems, education, research and professional leadership.

These five domains have been adopted throughout Eastern Health's nursing and midwifery professional programs and governance models *(see Table 1)*.

Appreciating that skills and knowledge are developed over time and are inter-dependant on a number of factors, the framework was aligned with the acquisition of skills and knowledge as prescribed by Dreyfus & Dreyfus (1980) and translated for nursing practice by Benner (1984).

Behaviours are specified at five different levels, and reflect an increasing degree of autonomy, complexity, awareness and activity being performed *(see Table 2)*.

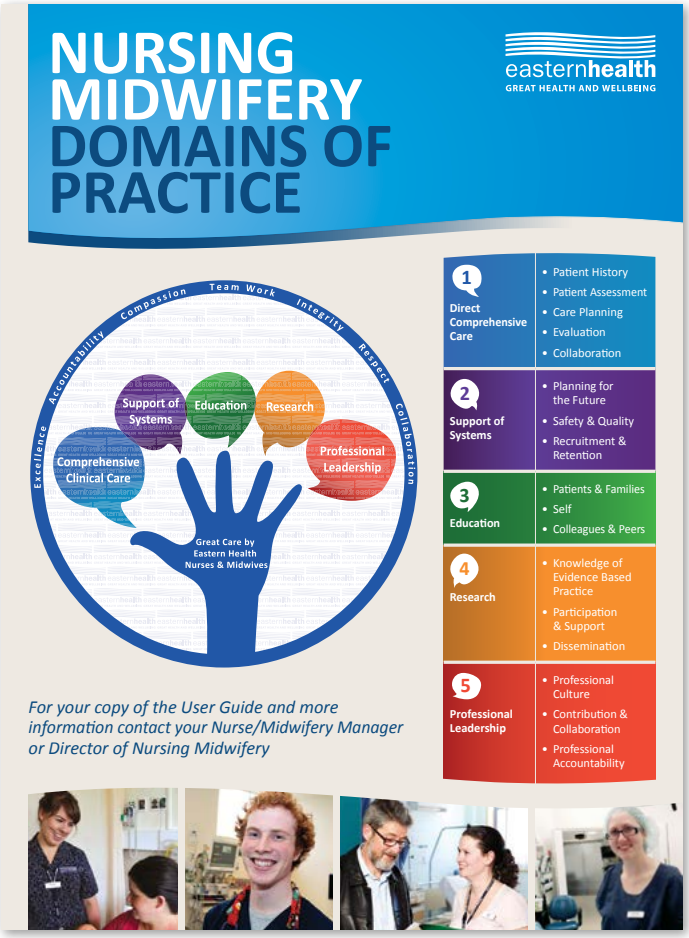
Levels do not equate to roles or hierarchy within the workforce. Instead, the levels reflect what behavioural skill is required to achieve the desired goals or outcomes in a given situation. The levels are considered cumulative, meaning that behavioural indicators at subsequent levels in the scale should be read in conjunction with the behaviours specified at any lower level.

TABLE 1: ACKERMAN'S FIVE DOMAINS OF PRACTICE

Direct comprehensive care	Support of systems	Education	Research	Professional leadership
• Patient history • Patient assessment • Care planning • Evaluation • Collaboration	• Planning for the future • Safety and quality • Recruitment & retention	• Patients & families • Self • Colleagues and peers	• Knowledge of evidence based practice • Participation and support • Dissemination	• Professional culture • Contribution and collaboration • Professional Accountability

TABLE 2: SKILLS AQUISITION IN NURSING PRACTICE

Novice	Advanced Beginner	Competent	Proficient	Expert
Works within a known and stable context, consulting when abnormalities arise before taking action	Works within a known and stable context, consulting when abnormalities arise	Acts independently in routine situations within scope, and responds to known dilemmas	Acts independently in complex situations within scope, and responds to unknown dilemmas	Provide vision and direction and shape and implement strategies and initiatives that enable others to perform as required



Eastern Health Domains of Practice poster

Eastern Health Domains of Practice logo

APPLICATION

The Domains of Practice logo was developed to promote quick recognition of the framework and as a point of reference to seek further information.

Within the centre of the hand is the Professional Vision: *Great Care by Eastern Health Nurses and Midwives.*

Each digit corresponds to a specific domain and circling the outside are the Eastern Health values, which are integral to the work expectations of all employees.

The Domains of Practice have been incorporated into standard nursing and midwifery processes and templates across the organisation. It serves as a guide and a 'road map' when undertaking recruitment, induction, career planning, modelling for advanced practice roles, performance appraisal and recognition. The framework offers a point of reference for nursing and midwifery staff, managers and leaders in developing roles, responsibilities, undertaking skill mix analysis and workforce planning.

The Domains of Practice are incorporated into all formal programs and induction information.

Various materials have been developed to support the communication campaign and the useability of the tools.

Posters promote the Domains and the 'user guide' provides more detail including examples of what to consider or undertake in order to progress from a novice to expert along any of the domains or career pathways.

In some cases Eastern Health has been explicit with regard to expectations of the nurse or midwife within each domain, for example when undertaking advanced practice or entering specific roles.

CONCLUSION

Launched early in 2015, Eastern Health has just started the shared governance journey towards enhanced professional leadership; however the executive team is already receiving positive feedback from nurses and midwives of various levels of experience throughout the health service.

From the graduate program through to manager and senior leadership forums, the Domains of Practice are incorporated into the professional nomenclature and are helping to shift the nursing midwifery leadership paradigm in the most practical sense.

Just as all clinicians have a shared responsibility to deliver optimal patient outcomes, so too all clinicians have a responsibility to continue their professional journey, contribute to the broader objectives of the health care system and to refine and development their leadership practice.

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OUT AND ABOUT WITH ACN'S EMERGING NURSE LEADERS

By Katrina Horne MACN

In July, Southern Cross University – Lismore campus was the venue for one of the Australian Indigenous Mentoring Experience's (AIME) regular mentoring sessions of which I am a volunteer. In attendance were 110 Indigenous Australian mentees from Years 9-11 representing high schools in the Northern Rivers (NSW), as far south as Maclean, north to Byron Bay and west to Kyogle supported by 32 mentors (the majority being university students).

So what is AIME? Established in 2005, AIME uses mentors to facilitate a dynamic educational series which supports Indigenous students through high school and on to further education (such as university or TAFE) or employment. Achievements can been seen via the 2013 national statistics for Year 9-11 completion rates, where AIME participants completed at the rate of 76% compared to other Indigenous student completion rates of 41.4% (non-Indigenous completion rates were 81.2%). The goal is to involve more Indigenous students, close the gap on education completion rates and support students transitioning from school to have the same opportunities as all Australian students. AIME provides skills and opportunities, belief and self-confidence, which together enable students to grow personally and plan for their future.

As we all know, Indigenous Australians suffer inequality in many areas, including poorer health outcomes and lower life expectancy than non-Indigenous Australians. Therefore, from a nursing perspective, I view this program as an asset with the ability to begin to address the social determinants of health for the next generation in the areas of education and employment (with associated flow-on effect).

The program allows me to cultivate professional skills such as leadership, cultural competence, communication, education, mental health and skills in working with adolescents. But for me it is about the intrinsic reward I gain from the opportunity to get to know and work with an incredible group of young Indigenous people. Like all teenagers, some can be a 'tough bunch' at times, but I am also humbled by the way it makes me feel when they participate and I can literally see their self-confidence growing before my very eyes. I have seen, heard and felt the shame that is carried by some for which I had only heard and read about.

Katrina Horne MACN

As for the session in July, I mentored a group of Year 11 students for the day. One of our themes included resilience. Our first activity was to brainstorm on a piece of paper what resilience meant to them. Some students did not know its meaning but, after explanation (with an example) and viewing of an Indigenous audio-visual storyboard, came up with some great ideas. One of the students wrote "Johnathan Thurston". Taking the time to help him unpick what it was about his Aboriginal footy hero that he admired, assisted him in gaining a better understanding by being able to put it into words.

There were too many wonderful experiences had on this day to write of them all. Suffice to say, there was much laughter, creation of dreams and personal development had by all, myself included. No wonder it is called a 'mentoring experience', as it is truly a reciprocal experience and I keenly await our next session.

For more information about AIME visit aimementoring.com

“Paul and I were delighted to find ACN members enthusiastic and willing to embrace the social media sweep. Members were thrilled with the professional potential social media offers, however some apprehension was expressed around how the practice is carried out in a professional manner. This highlighted the lack of social media training for nurses, which is a certain contributor to its current underuse and misuse.”

By Evan Casella MACN

Evan Casella MACN

Recently, I had the wonderful privilege of presenting to ACN Queensland Far North Region members on the topic of professional social media use in nursing. This privilege was further garnished by presenting alongside social media guru Paul McNamara (@Meta4RN), whose opinions on professional social media use are respected internationally. The plans of engagement were to connect the current underuse of professional social media in nursing with sociotechnical theory, which states there must be a balance between the social (communication etc.) and technical (palpating pulses etc.) aspects of work. The presentation highlighted the possibility of enhancing the social aspect of nursing’s sociotechnical sphere by further implementing professional social media use. This would – according to sociotechnical theory – increase workplace productivity and morale. All the forms of social media were explained, and then examples were given of how social media is already being used to enhance the social aspects of nursing. A blue-sky discussion then ensued around enhancing nursing practice through the further implementation of social media, segueing nicely into questions and answers.

Paul and I were delighted to find ACN members enthusiastic and willing to embrace the social media sweep. Members were thrilled with the professional potential social media offers, however some apprehension was expressed around how the practice is carried out in a professional manner. This highlighted the lack of social media training for nurses, which is a certain contributor to its current underuse and misuse.

Overall, the event provided a wonderful setting for learning, networking and, of course, a good old chat. Personally, I was inspired by my fellow nurses’ enthusiasm towards social media innovations, proving once again our adaptable nature. This has motivated me to advocate for more social media training for nurses in both the university and health care sectors.

By Carol Mudford MACN

Carol Mudford MACN

‘Out and about’ as a busy student and grad nurse for the past three-plus years, I am now happy to focus on wrapping up some commitments and stripping back to focus on my clinical development for the next stage of my nursing life. Last week I completed my graduate year at Royal Darwin Hospital, and I have also recently moved on from my co-president role at the Australian Student and Novice Nurse Association (ASANNA). This month it is two years since I initiated a lunchtime meeting of students at a conference, who became the Working Party to establish ASANNA.

I have greatly enjoyed my grad year in Darwin and I am happy to be staying on with permanent work. It amazes me to remember how I felt on my first day as a grad: walking into the ward and feeling petrified, wondering what I had done for the past three years because I felt like I didn’t know anything, and worrying I might unwittingly poison a patient by the end of the day. By the end of that day I hadn’t poisoned anyone (yay), and I had signed my name as ‘RN’ without a co-signature, and administered medications and answered patient questions and done so many nurse things all by myself. I floated out of there on a cloud of relief and awe at 1530 (yes, on time even). By the end of my grad year I feel like a different person: I feel like a nurse. I have learnt more than I realised, I know what the acronyms stand for (and that no one knows what they all are), I have my bodily fluid stories to share over dinner, and I have held my patients’ hands and supported their journeys.

And I live in the tropics, so how can I be anything but happy? What I’m most excited about now is that I’m the new owner of a 4WD, and have a great wide land to literally get out and about in. I encourage us all to support each other in our personal and professional growth, and to trust in our human capability.

Katrina Horne MACN and Alaina Evanson MACN

REGIONS @ACN

QLD SOUTH REGION

It was with great anticipation that I headed north to the border enjoying a collegial evening for my first ACN region event. On the 4th of August we joined together for a journal club style exploration of the article *'Vivian Bullwinkel: A model of resilience and a symbol of strength'* (M. McAllister; *Collegian*, vol. 22, no. 1). Over dinner we reflected on the standout messages each of us extracted from the article, in addition to our own strategies to express resilience. Perspectives were explored from the undergraduate experience through to academia, expert nursing and leadership.

I would encourage readers to take a moment to reflect for yourselves, if you are taking sufficient time to nurture yourself and if your own coping techniques promote resilience. If not, what steps can you take to improve this? McAllister stated "resilience has a double purpose" therefore, by cultivating resilience in ourselves, we gain invaluable knowledge that when shared as an intervention with our patients can lead to their empowerment.

On a lighter note, Barbara Healey attended the recent ACN History Conference in Sydney and regaled us of accounts of her training days at Prince Henry Hospital supported by photographs of the Hospital, Nursing and Medical Museum.

The Christmas event is set for the 1st of December, with the theme 'Reflections on 2015.' Participants may choose to reflect on both a personal and professional feature of their year. Additionally, those who attend the ACN National Nursing Forum in October may share their highlights.

Katrina Horne MACN
ACN Emerging Nurse Leader

Ilze Jaunberzins MACN
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WOMEN WANT TO KNOW ABOUT ALCOHOL AND PREGNANCY

Did you know that 97% of Australian women wanted to be asked about alcohol use in pregnancy?

Most women visit a health professional when they are pregnant for advice on a range of topics, including alcohol. These visits present the ideal opportunity to discuss alcohol consumption and reinforce to women that not drinking alcohol during pregnancy is the safest option.

However research shows that health professionals encounter a range of barriers in initiating these conversations. Some say they are reluctant to discuss alcohol consumption, as they are concerned that women may feel uncomfortable, or they are unsure of what advice to provide and where to refer women if necessary.

A new national campaign, *Women Want to Know,* aims to overcome these barriers by educating health professionals about the effects of alcohol consumption during pregnancy to ensure that women are fully informed.

Conversations about alcohol with women who are pregnant or planning pregnancy are important as these can assist women to stop or reduce their alcohol use and prevent adverse consequences from occurring. Alcohol consumption during pregnancy is known to cause birth defects[1,2,3] and is also linked to other adverse effects including miscarriages, premature births, low birth weights and Fetal Alcohol Spectrum Disorders (FASD).

FASD is a lifelong disability is primarily associated with brain damage caused by prenatal alcohol exposure. People with FASD also experience growth restrictions, developmental delays and social, emotional and behavioural deficits.

SO HOW MUCH ALCOHOL IS SAFE DURING PREGNANCY?

Despite numerous studies having been undertaken a safe level of alcohol during pregnancy has not been determined and there is no known level of alcohol or time during pregnancy where damage to the fetus will not occur.[4,5] For these reasons Australia's National Health and Medical Research Council (NHMRC) recommends that "for women who are pregnant or planning a pregnancy, not drinking is the safest option".

WHAT IS THE ROLE OF HEALTH PROFESSIONALS IN EDUCATING WOMEN ABOUT ALCOHOL CONSUMPTION?

As a health professional you can positively influence a woman's choices about their alcohol consumption by initiating conversations about alcohol with them.

Australian women consider health professionals to be the best source of information regarding alcohol consumption during pregnancy and many are willing to make changes if advised to do so. However many women do not ask about alcohol as they expect all important issues will be raised by a health professional.[6]

To learn more about the *Women Want to Know* campaign and order FREE print materials visit www.alcohol.gov.au

FREE accredited online training is also available through the:

- Australian College of Midwives;
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists; and
- Royal Australian College of General Practitioners.

Women Want to Know has been developed by the Foundation for Alcohol Research and Education (FARE) in collaboration with the Australian Government Department of Health, the Royal Australian College of General Practitioners (RACGP), the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Australian College of Midwives (ACM), the Australian Medical Association (AMA), the Australian Medicare Locals Alliance (AMLA) and the Maternity Coalition.

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A NEUROLOGICAL CLINICAL NURSE SPECIALIST ROLE ESTABLISHED IN NSW

By Suzanne Basford MACN

Approximately 80,000 people in Australia are living with Parkinson's disease, a progressive neurological condition, which has motor and non-motor symptoms. The service provider in the southern region of NSW, which was formerly a Medicare Local organisation[1], established a Neurological Clinical Nurse Specialist (CNS) service to meet the needs of people living with Parkinson's disease and their carers in October 2014. The position is new to the Southern NSW area but the role of the Parkinson's nurse specialist is not new to Australia, with about 50 Parkinson's nurses in Australia.

The background to the role includes a high level of support from Parkinson's NSW and a strong campaign by the local Parkinson's support groups, which identified a need for a Parkinson's nurse. The service was established to cover three local government areas in rural southern NSW: Eurobodalla, Cooma-Monaro and the Bega Valley, which have a combined population of 80,620[2]. These areas have limited access to visiting neurologists. Initially the registered nurse, Suzanne Basford, spent time with the Shoalhaven Medicare Local Neurological Nurse Specialist to learn the role. The lead-in time until the first clinic was six weeks.

Contact was established with Parkinson's NSW following the initial communication by the Specialist Services and Tele Health Coordinator, Primary Health Care Support and Development. This was followed up by the registered nurse visiting the Parkinson's support groups in the Eurobodalla, Bega Valley and Cooma-Monaro regions.

Flyers were developed with the aid of the communications department and information shared by other Parkinson's nurse services and sent out to the general practices. Referrals were received either by secure messaging or patients presenting with their referrals when they attended the clinic.

There was local media interest in the neurological nurse role and the service was promoted through media releases to the regional newspapers in the regional local government areas. The chair of the organisation was interviewed on ABC Local radio about the role, which helped with introducing the service to the community.

On the suggestion of one of the consumers of the Parkinson's support groups, a brochure for patients was developed and made available to general practices and members of the support group. By March 2015, the website of the service was updated to include information on the service and links to the flyer and brochure.

The service is run as monthly clinics at three sites, which are about 90 minutes apart by road. Initially, a referral was required by a general practitioner or medical specialist, but this has now changed to facilitate easier access to the service. The referral can now come from allied health services, community services, the patient themselves or a carer. The criteria for referral is simply that the patient must have a diagnosis of Parkinson's disease.

There is no charge to the patient for their visits and a carer or support person is encouraged to be at the appointment. An appointment is up to two hours long depending on the needs of the individual. Follow-up appointments are offered every six months or more frequently depending on need. The patients and carers are given a contact number to call the nurse if they require an earlier appointment.

The global health questionnaire is used to assess the current overall health and wellbeing of the individual with Parkinson's and their carer's opinion. Then three assessments are undertaken: a Montreal Cognitive Assessment, a Non-Motor Symptoms assessment and the Movement Disorder Society - Unified Parkinson's Disease Rating Scale assessment, which were being used in the Shoalhaven region.

The assessments include a thorough review of the experience of the person living with Parkinson's disease, allowing their carer to add to the information if they are present. During the assessments the CNS is able to get an overall clinical picture of the patient and their needs. Referrals to allied health, respite care services, home help etc. can be made by the neurological CNS.

Information and education on Parkinson's disease can be given specific to the needs of the individual. Patients are made aware, if they are not already, of the support offered by Parkinson's NSW and can be provided with links to the Parkinson's support group in their area.

Communication back to the patient's general practitioner or referring medical specialist has been an essential part of the process and letters are sent with copies of the assessments. There was an evaluation of the service in April/May with feedback forms sent to the referrers and also to the patients who attended the clinics. Overall the feedback was positive.

Talks at residential aged care facilities have been offered, commencing in Cooma and the Bega Valley in January 2015. Communication with the Parkinson's support groups is ongoing, with a Eurobodalla carer's group trialled from April 2015 and a positive response from the small group who attended.

The role is set to continue with the Rural Doctor's Fund (RDF) funding the position for another year with the area's new service provider, Grand Pacific Health, which is covering the Shoalhaven and Southern region. The service and the establishment of the neurological CNS role requires further development, but may prove useful for other regions in their response to this growing problem.

References

1 The Southern NSW region was formally covered by Southern Medicare Local and is now covered by Grand Pacific Health

2 Population numbers from SNSW Local Health District: Our Population January 2015

JOAN LILLIAN ENGLERT AM FACN

By Judith Meppem PSM FACN

Australia has lost another significant nurse in Joan Englert, who had a very long, successful career as a clinician, manager, board member, surveyor, and mentor to many nurses who have gone into senior influential roles.

Joan undertook her general nursing at War Memorial Hospital and her midwifery at the Royal Hospital for Women. Her career highlights include managing roles at War Memorial Hospital and Prince Henry Hospital, and then Director of Nursing at the Prince Henry, Prince of Wales and Prince of Wales Children's Hospitals Group. She later served as Area Director of Nursing Services for the Central Sydney Area Health Service as well as NSW Chief Nursing Officer from 2002 to 2003.

Joan's thirst for knowledge was insatiable and she undertook many years of study, including Operating Theatre Management, Diploma in Nursing Administration, Bachelor of Health Administration and Master of Science and Society.

In June 1993, Joan received a Member of the Order of Australia award. Sydney University also conferred the title of Adjunct Professor in recognition of her work between the service and academic sectors.

Joan was a very active member of many nursing and health organisations. She was awarded life membership in the NSW Operating Theatre Association in recognition of her 22 years of very active involvement, including seven terms as President. She was a very important part of the formative years of the association that enabled it to grow into a strong and influential organisation. Her enthusiasm and leadership impacted on many nurses over those years.

Joan was also a longstanding fellow of NSW College of Nursing (NSWCN)/ The College of Nursing (TCON) and the Royal College *of* Nursing A*ustralia*. From 1965 to 2004, Joan was very active in the NSWCN (and TCON) including many years as an elected member of the Council/Board, also holding executive office over various years as Senior and Junior Vice-President, Secretary and Treasurer and several terms as President.

Joan's involvement with the Australian Council on Healthcare Standards (ACHS) is legendary – 34 years in total, including nine years post retirement. She was totally committed to quality health care and was always a champion of the ACHS accreditation process.

Joan was a Nurse Surveyor from 1979 to late 2013 and a Preceptor for 14 years from 1985 to 1999. These roles were two of the many in which she mentored so many nurses and others that have gone onto become very influential people.

Joan was first appointed to the NSW Nurses Registration Board in 1987, initially a member then Deputy President, and then ultimately President in 1990 – a position she held for more than a decade and history will record Joan as the longest-serving nurse President of the Board. Joan was very committed to the work of the Board and its importance in the development of processes to inform the profession and, in particular, of the regulatory responsibilities which nurses and midwives face in daily practice. Underlying that was always the interests of public safety.

Joan gave over 100% of effort in everything she did and was a very influential leader and incredible mentor to many.

DR FAITH MAHLEAH JONES

By Kay Plymat FACN

Dr Faith Jones, former Head of the School of Nursing at Cumberland College of Health Sciences at the University of Sydney, died in June in California. Faith was a Fellow of both the New South Wales College of Nursing (1986-1998) and the Royal College of Nursing Australia (1986-2006).

In 1985, Faith was recruited to Australia from Chicago to head the School of Nursing at Cumberland College. During a period of immense change in higher education, Faith's leadership helped the School develop strong and innovative programs, particularly at the Master's and Doctoral level.

Faith had a particular interest in transcultural and international nursing, and was instrumental in getting the School of Nursing designated as a WHO Collaborating Centre for Nursing Development in Primary Health Care in 1988. Faith was also appointed to the WHO Executive Committee for Nursing Education, and helped to develop higher education for nurses in Hong Kong, Singapore, Bahrain, Malaysia, the Philippines and other Pacific Rim countries. In January 1994, Faith helped lead the School of Nursing at Cumberland into a merger with the Faculty of Nursing, creating a unified nursing presence within Sydney University.

Faith was born to Welsh missionary parents in Yunnan Province, China. In 1939, the pending Japanese invasion hastened the family's return to Cardiff, Wales, where they survived the bombing of their home during World War Two. In 1953, her family immigrated to Chicago, USA, where Faith completed her BSc in Nursing at Wheaton College, and her RN certificate at West Suburban Hospital in Oak Park, Illinois.

Faith then went to Britain where she qualified as a midwife, and practiced midwifery in the East-end of London and rural Wales. Returning to Chicago, from 1965-1977 Faith designed and administered a program to prepare inner-city students in practical nursing. In 1971 she received an MA in Education from Roosevelt University, and in 1977 a Doctorate in Education from Loyola University. Teaching and administrative positions followed at the University of Illinois and Rush University.

Faith's passion was seeking justice and acting on behalf of people in need worldwide. She saw nursing education as a way to fight for a better life for women. She maintained a strong religious faith, and served as an ordained elder at St. Stephen's Uniting Church in Sydney. Upon retirement from the University of Sydney in 1999, she earned an MA in Theology from United Theological College in Parramatta.

Faith had a great sense of adventure, and enjoyed travel. She visited Antarctica three times, went rafting through the Grand Canyon and had frequent trips to Africa and Asia. She was an opera enthusiast and choral singer, and served as a Patron of the Welsh Society in Sydney. In 2006, she returned to the USA to be closer to her family, and until her death resided at Mount San Antonio Gardens Retirement Community in suburban Los Angeles.

WE WOULD LIKE TO TAKE THIS OPPORTUNITY TO REMEMBER ACN MEMBERS THAT HAVE RECENTLY DIED.

MISS MARJORIE CLARKE FACN (DLF) – NSW

MRS ALISON BALLANTYNE FACN – SA

MS PAM WRIGHT FACN – TAS

MRS JUDY FORREST FACN – NSW

UNE/COLEDALE'S STUDENT-LED CLINIC: AN AWARD-WINNING INITIATIVE UNDER THREAT

By Cynthia M. Stuhlmiller FACN

DEVELOPMENT AND OUTCOMES OF A STUDENT-LED CLINIC

In March 2013, University of New England (UNE) nursing students joined Professor Cynthia Stuhlmiller at the Coledale Community Centre in West Tamworth to develop a student-led clinic. The initiative, funded by a Health Workforce Australia grant, aimed to create clinical learning opportunities for students while serving a community with little or no access to health care. Clinical mentors, Joe Miller, Dr Alan Avery and Dr Adyta Menon from the Hunter New England Health (HNEH) mental health promotion unit, along with HNEH stroke care coordinator Rachael Peake, joined Stuhlmiller in her mission to enable students to conceptualise, develop and lead an integrated one-stop approach for health and wellness services.

Students began to engage the community through meet and greet barbecues, walk and talk fitness groups, women's health days, family fun days, and a variety of other health promotion activities. Today, the UNE/Coledale clinic serves more than 2,000 residents and is home to a wide variety of collaborative programs that involve partners such as HNEH, Walhallow Aboriginal Health Corporation, Tamworth Family Support Services, and Anglicare. Nursing facilitators Kristie Latimore, Di Knox, Helen Cameron and office manager Jodie Gaffney have joined the team since.

Data collected on all occasions of care indicates a reversal of life-threatening conditions, reduced burden of disease, and significant cost savings to community members and health services (Stuhlmiller & Tolchard 2015). While it is impossible to determine a dollar value on preventative care, screening or early detection, students have hosted health promotion events for thousands of people and screened well over 1,200 elementary school children detecting ear and eye problems of up to 33%. Follow-up data indicates an extensive downward trend of smoking and drinking of adults and improved school performance of children.

COMMENDATIONS

The clinic has received local, national and international attention as a model of integrated health and service learning, such as the Northern Inland Innovation Award Commendation and an international award for clinical innovation. One initiative deserves special mention; Founding students, now graduate nurses, Mary Anne Dieckmann, Raekeeta Smallwood and Jeremy Luke Hatfield began a campaign to prevent stroke and improve recovery. They discovered that the information available to community members was not appropriate for our regional Aboriginal population; Much had been written by Queenslanders with coastal themes. As is the mantra of the clinic, the question asked of students was, "So what are you going to do about it?" Thus became the birth of *Written for the Mob by the Mob,* a student-led community driven stroke education resource booklet under the guidance of stroke expert Rachel Peake and Aboriginal liaison Joe Miller. The stages for development included more than 12 months of consultation with key stakeholders, including members and elders from the Kamilaroi country, and another year of gathering stories of stroke survivors, art illustrations from Peel High School students, compiling the work and gaining feedback.

Soon to be launched, the booklet is already receiving acclaim, with Rachel a finalist for the 2015 National Stroke Foundation Care Champion Award and Mary a winner of the Excellence in Aboriginal and Torres Strait Islander Health Care award at the 2015 NSW Health Excellence in Nursing and Midwifery Awards. Evaluation of the project is the topic of Rachel's graduate thesis. She is undertaking a yarning research methodology to gain insight into the strengths and shortcomings of the approach taken to educational resource development.

SUCCESS, CHALLENGE, AND CALL FOR HELP

The student-led principles have been the key to success of the clinic. Residents have been drawn to the students because of their ongoing presence, involvement, accessibility, unlimited time to devote to each person and willingness to learn together and from each other. With the first years of students contributing to the clinic over months, they were able

Clinic co-researchers on the steps at Toomelah

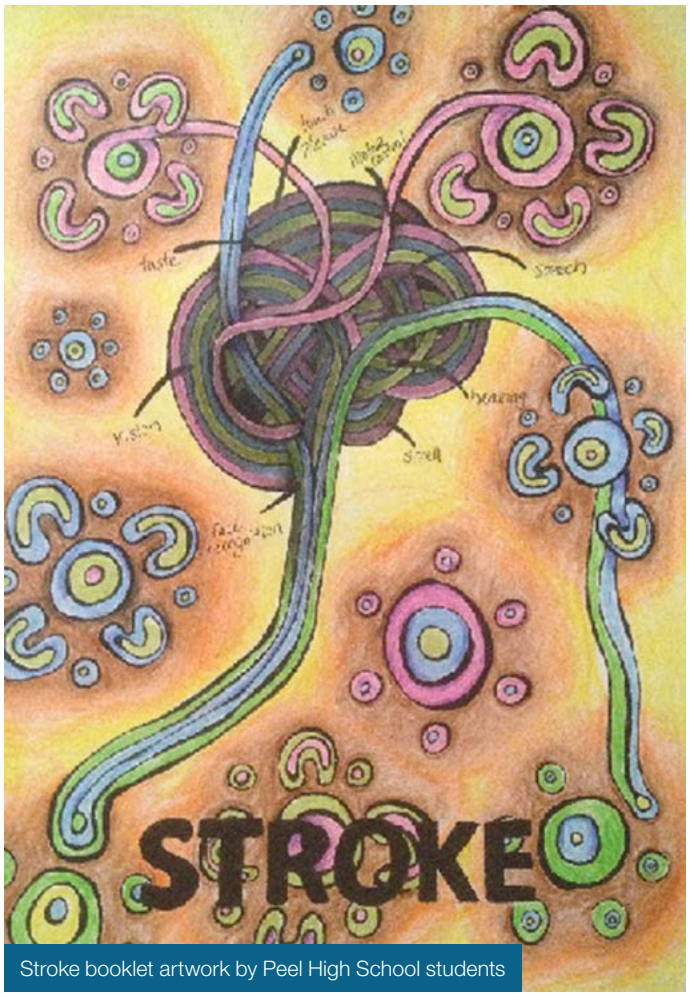
to develop community engagement and leadership skills, relationships with community members and come to appreciate the intrinsic value of all people and their right to high quality health care. With this extended time, students immersed themselves to explore and address the social determinants of health, apply principles of primary care, coach residents to achieve health goals and develop socially responsive health promotion programs. The student vision, based on coming to know Coledale priorities, was determined through extensive communication with residents, community groups and health personnel. As a student reflected:

"This meant that in the first few weeks of trying to engage with the community, the students and I shared countless cups of tea and coffee, stories, humour and good will with anyone who walked through the centre doors. This seemingly simple, yet effective task was our keystone to developing a clinic that was responsive and appropriate for this particular community. Such conversations allowed us to respond to the needs for birth certificates, vaccinations, drug and alcohol services, homeless support, domestic violence counselling, child and adolescent engagement and an overwhelming demand for a general practitioner. At first glance, the development of such a free-range, organic clinic was no simple task, yet, these demands were not excessive. To me, they sounded like basic human rights."

Sadly I report that with a change of curriculum to align with the prevailing Australian nursing student block placement, the unique and powerful student-led aspects of the clinic are currently under threat. With only a two- or three-week clinical experience, students are not able to obtain the aforementioned skills or create and execute programs. Rapid student turnover has created noticeable service gaps, eroded care continuity, and undermined the rich collaborative learning opportunities that require time to unfold. As one GP stated, it has become "*medical tourism.*"

“The student-led principles have been the key to success of the clinic. Residents have been drawn to the students because of their ongoing presence, involvement, accessibility, unlimited time to devote to each person and willingness to learn together and from each other.”

Adam Marshall, MP; with Cynthia Stuhlmiller, Barry Tolchard and Joe Miller receiving the 2014 Northern Inland Innovation award



Stroke booklet artwork by Peel High School students

So while this article is aimed to celebrate the accomplishments of the clinic experiment, it is calling for nursing educators and health service managers to provide the evidence of value that supports client experience and student learning in a block placement of two to three weeks in primary and chronic disease settings, especially in underserved populations. I believe the future of health care resides in nurse-led integrated health and social services in community settings and our students deserve the opportunity to chart that future. As a student said, the “*UNE/Coledale Student-led Clinic highlights the ability for such community projects to support the future of health care through utilisation of young leaders and innovative ideas.*”

The achievements of the clinic have been a tribute to the students and community it serves. As Mary receives her honour this month, I am reminded of her words:

“No matter the area of study, it is the right of passage that students are often regarded as the lowest person in any industry. It is often seen that apprentices and trainees are the bottom of the ladder and are required to take direction from those above them, which of course includes almost everyone. If an opportunity presents itself where a student is able to direct the flow of culture in a workplace, and give themselves over to a community, it is without doubt something to behold and bear witness to.”

Author details

Cynthia Stuhlmiller is a Professor of Rural Nursing, University of New England, Armidale

References

Stuhlmiller, C. M., & Tolchard, B. 2015, ‘Developing a student-led community health and well-being clinic in an under-served community: Collaborative learning, health outcomes and cost savings’, *BMC Nursing*, vol. 14, no. 32, DOI: 10.1186/s12912-015-0083-9

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UPDATE FROM THE NMBA

The Nursing and Midwifery Board of Australia (NMBA) continues to lead nursing and midwifery regulation in Australia. The NMBA helps protect the public and provides leadership to nurses, midwives and students through responsible, evidence-based regulation in accordance with the National Registration and Accreditation Scheme.

Over the past year the NMBA has reached many important milestones.

Various registration standards and guidelines were developed and reviewed during the year, and will be implemented in the coming year, including five mandatory registration standards across both nursing and midwifery professions.

For nursing, three standards were developed and reviewed:

- registration standard endorsement as a nurse practitioner
- registered nurse standards for practice (formerly called competency standards), and
- enrolled nurse standards for practice.

In addition:

- there was improved engagement with nurses, midwives and the general community through public consultations and surveys on important workforce matters
- the NMBA collaborated with the Australian Nursing and Midwifery Accreditation Council (ANMAC) to set accreditation standards
- over 3,000 registration applications were processed under a new model for assessment of internationally qualified applicants seeking registration to practise in Australia
- the online experience for NMBA registrants and website visitors was improved through:
  - quicker and easier renewal of registration
  - a dedicated section for internationally qualified nurses and midwives, and
  - a streamlined suite of updated web documents, including factsheets, guidelines and position statements.

Nursing and Midwifery Board of Australia

RE-ENTRY TO PRACTICE POLICY EFFECTIVE FROM 1 SEPTEMBER

The NMBA's revised policy for re-entry to practice came into effect from 1 September 2015. This policy provides information for nurses and midwives who do not meet the *Recency of practice registration standard* and wish to re-enter practice.

The NMBA has also introduced **provisional registration** for nurses and midwives who are no longer registered and are applying to re-enter practice as a nurse or midwife. Nurses and midwives who fall into this category can now apply for provisional registration.

Under the National Law, there is a mandatory requirement for applicants for registration and renewal of registration to meet the NMBA's requirements on the nature, extent, period and recency of any previous practice.

More information and the revised policy are available on the NMBA website.

ENGLISH LANGUAGE SKILLS REGISTRATION STANDARD POLICY

The new version of NMBA's English language skills (ELS) registration standard took effect from 1 July this year.

To provide additional guidance on Pathway 5 of the revised ELS registration standard, the NMBA has approved an English Language Skills (ELS) Policy that also commenced on 1 July 2015.

Section 38 of the National Law requires the NMBA to develop and recommend to the Australian Health Workforce Ministerial Council (the Ministerial Council or health ministers), registration standards about the English language skills necessary for an applicant for registration in the nursing and midwifery profession to be suitable for registration in the profession.

The ELS registration standard states that all applicants, including internationally qualified applicants, who seek initial registration in Australia, must demonstrate that they have the necessary English language skills.

REVISED CRIMINAL HISTORY REGISTRATION STANDARD TOOK EFFECT FROM 1 JULY 2015

The revised Criminal history registration standard, common to all health professions' National Boards and approved by the Ministerial Council, took effect from 1 July 2015.

The revised shared criminal history registration standard makes very minor amendments to the old standard and is expected to have minimal impact on nurses and midwives. No changes have been made to the factors NMBA will take into account when considering an applicant's or registrant's criminal history.

When a nurse or midwife first applies for registration, the NMBA requires the applicant to declare their criminal history in all countries, including Australia. All registered nurses and midwives must inform the NMBA if they are:

- charged with an offence punishable by 12 months imprisonment or more, or
- convicted or found guilty of an offence punishable by imprisonment in Australia and/or overseas.

When nurses and midwives renew their registration they must disclose any changes to their criminal history.

KEEP IN TOUCH WITH THE NMBA

Engage with the NMBA by visiting www.nursingmidwiferyboard.gov.au for:

- registration standards, codes, guidelines and FAQ
- monthly NMBA meeting communiqués
- quarterly newsletters, and
- regular public consultations.

For enquiries:

- lodge an online enquiry form.
- address mail correspondence to: Dr Lynette Cusack RN, Chair, Nursing and Midwifery Board of Australia, GPO Box 9958, Melbourne, VIC 3001, or
- call 1300 419 495 (from within Australia) or +61 3 8708 9001 (for overseas callers) for registration enquiries.

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