thehive

#2 WINTER 2013

Australian College of Nursing

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is dying

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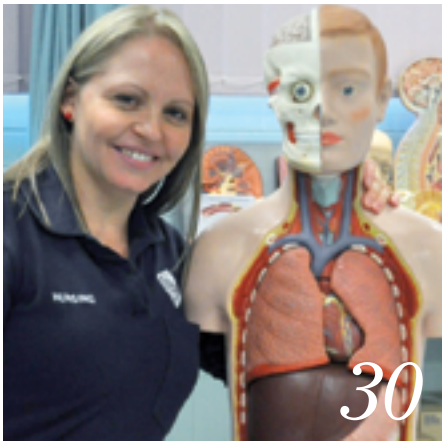
#2 WINTER 2013 (Jun–Aug)



COVER STORY

REGULAR

SPECIAL FEATURES

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FEATURES

PUBLISHING DETAILS

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Editors
Adjunct Professor Debra Thoms FACN (DLF) and Jackie Poyser

Editorial coordinator
Keren Nicholson

Editorial assistant
Phoebe Glover

Design
Nina Vesala

Publisher
Australian College of Nursing
1 Napier Close, Deakin ACT 2600
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Cover
Laura Turnbull, RCNA Scholarship Grant recipient, with a colleagues son.

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WELCOME FROM THE CEO

ADJUNCT PROFESSOR **DEBRA THOMS** FACN (DLF)

"ACN recently celebrated the successful launch of the new ACN brand with a generous helping of cake."

Both the Sydney and Canberra offices of the Australian College of Nursing (ACN) recently celebrated the successful launch of the new ACN brand with a generous helping of cake. The two office communities were united through the use of Skype and it was great to acknowledge all the hard work from staff across the organisation.

Among the innovations of ACN, we drew upon feedback and looked at the way our members engage with one another and the profession, both geographically and based upon their professional interests. In this edition of *The Hive*, we formally introduce to you our new engagement structures which draw upon the commonalities of our members to foster professional networking, debate and support.

Again, we showcase the diversity of our membership in this edition. Ann Dewey, an aged care nurse and mother, describes the road to being endorsed as a nurse practitioner; Margaret Boyes and Marg McLeod share their recent trip to India in *Observing and learning at the Holy Family Hansenorium*; and Meagan Shannon gives us insight into the role of a Skin Integrity Clinical Nurse Consultant.

We have also included in this issue, a showcase of the recent recipients of the 2012–2013 ACN Grants and Awards, introduce members who have received national accolades and we remember those who have helped to lay the foundation for ACN. Our membership truly consists of nurses of the highest calibre.

ACN MEMBERSHIP ENGAGEMENT STRUCTURES

Since the establishment of ACN, significant emphasis and consideration has been given to strengthening our membership engagement structures.

ACN has drawn upon the success of the existing structures consisting of Chapters, Faculties and Networks, along with feedback from members, to foster the development of new structures that provide opportunities for greater member engagement.

The new structures recognise the differing levels of interests and varying expectations for participation within our membership and have been designed to better support member networking opportunities in nursing practice and policy issues. These levels will be supported in two main areas of engagement; at a geographical level and a specialty level.

With the implementation of these new structures, ACN is confident that members will be afforded increased opportunity to network, undertake professional development, bring forward views and issues from a range of perspectives and communicate with each other on a range of levels.

Ultimately, our strength comes from the participation of and support from our members. We believe that these enhanced structures will enable ACN to better utilise the diverse nursing perspectives within our membership base and better equip us to effectively advocate to governments on issues directly affecting the nursing profession.

ACN supports nurses throughout all stages of their career and with your support and involvement, will remain the voice of influence for nurses throughout Australia.

For more information on ACNs Membership Engagement Structures, please visit our website ***www.acn.edu.au/engagement*** *or email* ***engagement@rcna.org.au***

REGIONS

The structure of ACN Regions provides opportunities for all members to network, focus on state issues related to health and nursing, and to facilitate continuing professional development opportunities for members locally. The following table presents the list of ACN Regions under the new structure.

> WESTERN AUSTRALIA

1. Kimberley – Pilbara
2. Goldfields – Midwest
3. Perth
4. WA South West

> NORTHERN TERRITORY

5. NT North
6. NT South

> SOUTH AUSTRALIA

7. SA Far North
8. SA North/West (York/Eyre Peninsula)
9. Adelaide Metro/SA South
10. SA Far South/East (Mt Gambier)

> QUEENSLAND

11. QLD Far North
12. QLD Central
13. Brisbane
14. QLD West
15. QLD South

> NEW SOUTH WALES

16. NSW North
17. Sydney Metro
18. Sydney West
19. Sydney South/Illawarra
20. Hunter Valley
21. NSW Central/Far West
22. NSW South

> AUSTRALIAN CAPITAL TERRITORY

23. Canberra & Regional ACT

> VICTORIA

24. Central & South Gippsland
25. Melbourne
26 Geelong
27. Murray/Goulburn
28. Victoria South West

> TASMANIA

29. TAS North
30. TAS South

COMMUNITIES OF INTEREST (COIs)

The structure of COIs has been developed for members seeking to engage primarily in a networking capacity to explore practice and policy issues relevant to their area of professional interest. The COIs allow greater access to the breadth of experiences within the ACN membership base, to inform members of latest research, innovations, and practice. The following table presents the COIs that exist in the new structures.

- > RURAL NURSING AND MIDWIFERY
- > COMMUNITY AND PRIMARY HEALTH CARE
- > HEALTHY AGEING
- > MOVEMENT DISORDERS AND PARKINSON'S
- > DISASTER HEALTH
- > EDUCATION AND RESEARCH
- > ADVANCED PRACTICE
- > LEADERSHIP AND MANAGEMENT
- > LEGAL AND ETHICAL ISSUES
- > HISTORY
- > CHRONIC AND COMPLEX
- > ADOLESCENT AND YOUNG PEOPLE
- > ACUTE CARE SERVICES

CONGRATULATIONS TO THE 2012 ACN GRANT RECIPIENTS

In 2012, the Royal College of Nursing, Australia and The College of Nursing's grants and awards were consolidated into ACN Grants and Awards. Here, we feature the recent recipients who have demonstrated a significant commitment to the advancement of the nursing profession, exceptional leadership, innovation in research, and persistence in professional development. ACN would like to congratulate our 2012 recipients.

ANNIE M SAGE GRANT
JULIA MORPHET MACN

Grant awarded for postgraduate research studies – *Transition to specialty practice programs in Australian emergency departments; analysis of effectiveness and cost*

Julia has a Master in Nursing (Education) and is a passionate emergency nurse, with a keen interest in the professional development of emergency nurses. She is the Vice-President of the Victorian branch of the College of Emergency Nursing Australasia, and is the national education co-chair.

Julia also coordinates the Master of Nursing (Emergency) program at Monash University.

FLORENCE NIGHTINGALE GRANT
CHIUNG-JUNG WU MACN

Grant awarded for postdoctoral studies – *Improving cardiac rehab delivery mode using eHealth approach for better life*

Dr Wu is a lecturer at the School of Nursing and Midwifery, Institute of Health and Biomedical Innovation, Queensland University of Technology. Her research interests evolved from over 16 years' clinical experience in the coronary care unit where she observed differences in the progress of cardiac patients with diabetes. Her post-doctoral studies have continued to make a significant contribution to promoting self-management for patients with coronary heart disease and diabetes.

RCNA RESEARCH GRANT
PROFESSOR LINDA SHIELDS FACN

Grant awarded for post doctorate/research studies – *Family-centred care in cystic fibrosis*

Professor Shields is a Professor of Nursing – Tropical Health and Director of the Tropical Health Research Unit, a partnership between James Cook University and Townsville Hospital and Health Service, and Honorary Professor, School of Medicine, The University of Queensland. Her research includes health in tropical regions, family-centred care, paediatric perioperative nursing, and the history of nursing. She holds a higher doctorate – Doctor of Medicine, PhD and Master's degrees from The University of Queensland, International Nurse Researcher Hall of Fame, Sigma Theta Tau International.

BEQUEST FUND FOR RESEARCH
ELISABETH JACOB MACN

Grant awarded for postgraduate research studies – *Australian registered and enrolled nurses: What's the difference?*

Elisabeth commenced work at Monash University in 2008 as a lecturer in nursing and currently coordinates a satellite nursing school. Elisabeth has been a registered nurse for over 20 years in both rural and metropolitan hospitals. She has experience as a unit manager, graduate coordinator, clinical educator, postgraduate educator and clinical nurse, practicing in medical, emergency and intensive care wards. She has developed an interest in the experience of clinical placements for nurses, transition to graduate nurse, workforce development and chronic health issues.

RURAL NURSING AND MIDWIFERY FACULTY GRANT
AMARJIT SINGH MACN

Grant awarded for continuing professional development – Maternity emergency care course

Amarjit has been practising in the field of emergency nursing for more than 20 years and has been working as a casual nurse in the emergency departments of Northern Health and Western Health in Victoria for many years. Being a casual nurse has given him the opportunity to venture into other areas of nursing such as remote and rural nursing, perioperative nursing, and in day medical units amongst many others.

JOYCE WICKHAM MEMORIAL GRANT
SARAH BURSTON MACN

Grant awarded for doctoral studies – *Evaluation of a transforming care initiative*

Sarah has worked extensively in acute nursing in both Australia and the UK. Currently she is Assistant Director of Nursing-Education Programs for the Gold Coast Hospital and Health Service and is an Adjunct Senior Lecturer at the School of Nursing and Midwifery, Griffith University. She has experience in advanced clinical, management, research and education positions. Her current role focusses on entry to practice, transition to professional practice and continuing education.

NSW NURSES RESEARCH GRANT
SCOTT BRUNERO MACN

Grant awarded for postgraduate studies in (clinical) nursing – *Mental health care in general hospitals*

Scott is a Clinical Nurse Consultant in mental health liaison nursing, at the Prince of Wales Hospital, Sydney and has been in mental health nursing for over 20 years. Scott is a PhD student at Sydney University researching the provision of mental health care in general hospital settings using a grounded theory approach.

CENTAUR NURSES GRANT
SOPHIE JONES MACN

Grant awarded for postgraduate research studies – *The epidemiology of post thrombotic syndrome following the use of central venous lines in paediatrics*

Sophie is an Anticoagulation Clinical Nurse Consultant and a Cardiac Clinical Nurse Specialist at The Royal Children's Hospital, Melbourne. Sophie has conducted and published nurse-led research in the areas of paediatric cardiology and haematology, recently examining quality of life for children requiring warfarin therapy. Sophie is involved in the education and mentorship of nurses in research and evidence-based nursing at the Royal Children's Hospital and The University of Melbourne.

RCNA SCHOLARSHIP GRANT
CALEB FERGUSON MACN

Grant awarded for postgraduate studies – *Stroke prevention in atrial fibrillation: barriers and enablers to Thromboprophylaxis*

Caleb is a registered nurse with a clinical background of stroke nursing and a PhD candidate with the Centre for Cardiovascular and Chronic Care at the University of Technology, Sydney. Caleb's research focusses on atrial fibrillation and stroke prevention. He hopes that his research will assist in understanding factors why patients may not initially receive thromboprohylaxis or adhere to prescribed therapies.

RCNA SCHOLARSHIP GRANT
LAURA TURNBULL MACN

Grant awarded for postgraduate studies – *Structured education and support for undergraduate nurses at The Royal Children's Hospital*

Laura is the Nurse Educator for the Undergraduate Nurses at The Royal Children's Hospital Melbourne. Laura has over 10 years of experience in paediatric nursing and is currently completing her Masters in Advance Practice Nursing. Laura is passionate about supporting and educating undergraduate nurses as they transition from the role of student nurse to registered nurse.

THE SUL STUART-FRASER SCHOLARSHIP
LUCIANA LO MACN

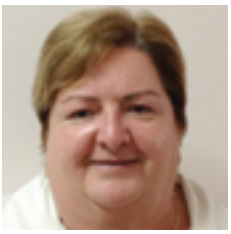
Grant awarded for postgraduate studies – ACN Graduate Certificate in Perioperative Nursing

Luciana studied and worked as a nurse in Malaysia and came to Australia to complete her postgraduate studies. After completing a Master in Nursing at the University of Technology, Sydney she fell in love with Australia and decided to stay. Now, working at a private hospital in the northern suburbs of Sydney, she has been working as a scrub/scout since becoming a registered nurse and loves the perioperative environment.

THE SUL STUART-FRASER SCHOLARSHIP
HANNAH SATISH MACN

Grant awarded for postgraduate studies – ACN Graduate Certificate in Perioperative Nursing

Hannah has been nursing for 21 years, mainly in South India. Her speciality was cardiothoracic nursing, and she worked in ICU for 10 years. She has experience in post-op wound care, education of patients undergoing artificial valve replacement and managing their coagulation levels and always looks for new specialities to learn. Since moving to Coffs Harbour, she has developed a passion for perioperative nursing.



THE "OLLIE" NURSE PRACTITIONER SCHOLARSHIP
KAREN GLAETZER MACN

Grant awarded for continuing professional development – Adolescent and Young Adult Palliative Care topic, Flinders University

Karen was the first nurse in Australia to be endorsed as a nurse practitioner in the specialty of palliative care, in 2003. She has an academic appointment with the School of Medicine, Flinders University and has postgraduate qualifications in oncology, bioethics, palliative care and a Master of Nursing (Nurse Practitioner). Her special interest areas include mental health, the disability sector and motor neurone disease, for which she coordinates a consultancy service for people in South Australia.

MARGARET Y WINNING QUEENSLAND NURSING SCHOLARSHIP
CHRISTINA PARKER MACN

Grant awarded for postgraduate studies – *Identification of early predictors of non-healing venous leg ulcers and development of a risk assessment tool*

Christina is a registered nurse and PhD Candidate in Queensland University of Technology's (QUT's) wound healing research team and is currently in the final year of her studies. Christina has been involved in a variety of projects within QUT's wound healing team, working as a research assistant and project officer. Christina was inducted into the Sigma Theta Tau International Honor Society of Nursing in 2012.

MARGARET Y WINNING QUEENSLAND NURSING SCHOLARSHIP
JANE O'BRIEN MACN

Grant awarded for postgraduate studies – *The benefits of a self-management telephone based intervention for promoting exercise and healing rates for venous leg ulcer patients*

Jane is a Senior Research Assistant and Doctor of Philosophy student in the Institute of Health and Biomedical Innovation at Queensland University of Technology. Jane is an RN and Accredited Exercise Physiologist with more than 10 years' experience in hospital and community settings and has been working on research projects relating to chronic wound management and exercise and older adults.

THE MAYLEAN JESSIE CORDIA SCHOLARSHIP
JULIA SACHMACINSKI MACN

Grant awarded for continuing professional development – Graduate Certificate in Critical Care Nursing

Shortly after becoming a registered nurse, Julia discovered a passion for critical care nursing. She is seeking to further develop her knowledge and skills in this field, in pursuit of excellence.

ACN Grants and Awards

Closed 10 June 2013

Applicants who have recently applied for the 2013 round of ACN Grants and Awards will be notified of the outcome of their application in October 2013, and will be featured in an upcoming issue of *The Hive*.

NATIONAL SUMMIT ON FEMALE GENITAL MUTILATION

BY KATHLEEN MCLAUGHLIN FACN, ACN EXECUTIVE MANAGER, MEMBER RELATIONS

In December 2012, the Gillard Government made a promise to boost community awareness and educational campaigns, and review Australia's legal framework in an effort to stop the practice of female genital mutilation (FGM) (DoHA 2012). Prime Minister Julia Gillard asked the Hon Tanya Plibersek MP, Minister for Health, to coordinate the Government's effort to end the practice of FGM and support those affected.

On 7 April 2013, representing ACN, I joined a range of stakeholders including government, health and legal professionals and community representatives at a National Summit hosted by the Australian Government at Parliament House to discuss possible approaches to address FGM in Australia.

Whilst there has been a significant amount of work undertaken to date in various jurisdictions, a commitment to coordinated action was affirmed at the Summit. This call to action has stemmed from the identification of cases in recent years; higher migration from communities where FGM is common; and following Australia's commitment to the United Nations General Assembly resolution in December 2012 to intensify global efforts to end FGM (DoHA 2013b). FGM has, in certain communities, become established practice, passed down through generations to become cultural tradition (DOHA 2013a).

Summit discussions commenced with a call by a young woman affected by FGM for respect for girls and women affected by the practice of FGM and to protect them from any associated stigma. This call was repeated throughout the day ensuring a focus was maintained on the perspective and experiences of the girls and women.

Dr Comfort Momoh, a midwife in England who specialises in the study and treatment of FGM and established one of the first Well Women's Clinic in the UK, dedicated to caring for women affected by FGM, was an international guest at the Summit. She shared with summit participants her experience and knowledge on a number of key issues related to developing action against FGM. Dr Momoh is also Vice-President of the European Network on FGM and other traditional practices and has worked as an adviser to the World Health Organization on the issue of FGM.

Summit discussions focussed greatly on the vital role of community participation, empowerment and action in ensuring that FGM is not practised in Australia, and that support is provided to women and girls in Australia affected by FGM. The role of the education sector, and health professionals, in identifying girls and women who have been affected by FGM or are at risk of suffering FGM was highlighted, as was the role health professionals play in supporting these girls and women. Nurses and midwives have a major role in providing informed, culturally sensitive care and support, which may include specialist physical and mental health care and social support.

The importance of professional development for health professionals had been previously raised by ACN with the Government and was reiterated at the Summit. ACN is pleased that the Government has acknowledged the need for education and training for health professionals to support effective and non-discriminatory services for women with complex FGM health needs by making a commitment through targeted Commonwealth grants to build on existing clinical resources and guidelines.

Minister Plibersek called for Summit participants to refocus and double current efforts to protect and support those affected by FGM (DoHA 2013a). A National Compact on Female Genital Mutilation was agreed at the Summit and supported by ACN who is committed to action in our areas of influence.

Department of Health and Ageing 2012, *Gillard Government to Act on Female Genital Mutilation in Australia*, viewed on 16 April 2013, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-tp-tp111.htm

Department of Health and Ageing 2013a, *National Summit on Female Genital Mutilation – Minster for Health – Speech*, viewed on 16 April 2013, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr13-tp-tpsp09042013.htm

Department of Health and Ageing 2013b, *National Summit on Female Genital Mutilation – Media Release*, viewed on 17 April 2013, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr13-tp-tp027.htm

Pictured above: Representatives and participants of the National Summit on Female Genital Mutilation

THE OTHER SIDE OF THE COT RAILS

BY PAUL FOOKES FACN, CLINICAL NURSE ADVISOR, ROYAL AUSTRALIAN ARMY NURSING CORPS

Paul Fookes

“In reflecting on my practice from the other side of the cot rails, it has been crystalised in my consciousness that as expert practitioners, we must participate in continued learning to be relevant in the workplace.”

I was admitted to a mixed surgical ward in a hospital in a large country town for exploration of lower leg wounds. This was my first admission for more than a minor procedure so the opportunity arose to reflect on my own practice as a nurse and feelings as a patient – to observe, feel, question, contextualise and review my values and perceptions. I have post basic qualifications in mental health and perioperative nursing, and also a strong interest in quality system management and mentorship. I’ve also previously developed a model for mentorship for new graduates in the perioperative environment and presented papers on the subject. This admission provided me with an ideal opportunity to reflect upon my experiences as both a nurse and a mentor. It was from this vantage that my journey of exploration began.

We often hear of hospital horrors, uninformed gossip or media built stories. I, at times, also held the perception that the delivery of health care could often appear to be mechanical, punctuated by busyness. What I was now experiencing as a patient was very different from this perception. My observation was that the nurses were humanistic in their delivery of care. I saw a consistently high standard of care delivery, cohesive teamwork, interest in work and a good balance between the art, science and spirit of nursing (Price 1960). As a strong advocate of the importance of mentorship in the workforce I also gained great satisfaction in seeing that, without exception, each nurse checked that their nursing colleagues were ‘doing OK’. I was seeing mentored practice both vertically and horizontally and team cohesion. It was like the general whirring of ingredients in a blender – they all went around, each separate but not separated, contributing to a cohesive mixture of care.

In reflecting on my practice from the other side of the cot rails, it has been crystalised in my consciousness that as expert practitioners, we must participate in continued learning to be relevant in the workplace. We must nurture junior practitioners not only in the clinical areas but all areas of life; ensuring that we pass on the lessons taught to us by our mentors so we can assuredly guarantee our transposition to the other side of the cot rails when the time comes. I’ve always held the strong belief that early education and mentored practice can be built on to achieve excellent returns as practitioners and as individuals; my positive experience on the ‘other side of the cot rails has now firmly solidified this belief.

Price, A L 1960, *The Art, Science and Spirit of Nursing,* W.B. Saunders Company: St. Louis MO

Author acknowledgements: Thank you to Professor Vicki Parker for her mentorship in the development of this article and Liz Kepreotes and Anna-Maree Shaw for additional suggestions on writing style and content. This article is an extract from a longer article.

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A DEAR FRIEND OF AUSTRALIAN NURSING:

remembering Donna Diers

BY PROFESSOR JILL WHITE AM FACN, DEAN, FACULTY OF NURSING AND MIDWIFERY, UNIVERSITY OF SYDNEY, NSW

Professor Jill White

Recently, Australian nursing and midwifery lost one of its best friends and mentors. The Annie Goodrich Professor Emerita Donna Diers lost her battle with cancer on 24 February 2013, Yale-New Haven Hospital. Donna had been a good friend to Australian nursing for nearly 30 years, having first come to speak about diagnosis related group (DRG) based funding information for hospital data systems. Her fascination with data systems was derived from her ongoing passion for making the work of nurses visible and to establish a science base for and from nursing practice.

It was on one of these early visits that I was privileged to meet Donna and to begin what was for me, a very important and enduring friendship. At the time, I was Dean at the University of Technology, Sydney (UTS) and we were beginning the ambitious journey of a professional doctorate in nursing and one in midwifery. Donna was publically recognised as having revolutionised graduate education in the United States and she came to UTS to help us with the very early doctoral schools, engaging robustly with our growing distinction between nursing and midwifery. This distinction was not something which was part of her largely North American experience and therein lay some of the most wonderful, thoughtful, and deeply respectful intellectual struggles one would ever be privileged to be part of.

Appointed Dean at Yale University, Connecticut in 1972 as a Masters prepared youngster only in her 30s (a position she held until 1985), Donna had never felt she had the opportunity to undertake her doctorate, and had felt this was a gap in her achievements. As it happened, UTS offered the PhD by publication and it seemed the perfect fit for Donna. So under the supportive supervision of Professor Jackie Crisp and Professor Judith Donoghue, Donna began a journey of interrogating her vast array of published works to decide which she would put forward as the body of work that had contributed to nursing and about which she could write a cogent exegesis.

The reason for the existence of the modern hospital is to provide nursing care. Nursing is two things: the care of the sick (or potentially sick) and the tending of the entire environment within which care happens. These two sentences capture the content of my original contributions. – Excerpt from exegesis.

Needless to say, the outcome was a flawless piece of work, and Dr Diers graduated in 2002. She was then struck with a problem – one is expected to publish from one's doctorate, but how? Her solution was brilliant and a further gift to us all. She wrote a book – *Speaking of Nursing: Narrative of Practice, Research, Policy, and the Profession* – which locates the major

“ Donna managed to say elegantly the things that I struggle to articulate about nursing. She became a literary heroine of mine and over the years the most oft-quoted of all nurse writers in my papers, speeches and teaching. ”

pieces of published work within their political, social and professional contexts and tells of the speeches that were often the precursors to the published works (Diers 2004). It is a great read and certainly should be compulsory reading for any nursing graduate programme.

I was privileged to be asked by Donna to write the Australian foreword. This forward captured my debt to her:

Early in my nursing academic career in Australia I came across the words of Donna Diers. Donna managed to say elegantly the things that I struggle to articulate about nursing. She became a literary heroine of mine and over the years the most oft-quoted of all nurse writers in my papers, speeches and teaching.

This literary association began with ‘Nursing as Metaphor’, as I struggled to find words to explain nursing to non-nurses in the new university environment for nursing in Australia. Quickly the association moved to clinical scholarship, as I wrestled with the lack of relevance to practice of so much of the early Australian nursing research. Donna’s constant emphasis on the need to move the focus of research from the worker to the work struck a strong chord. When policy became my passion it should have come as no surprise that Donna’s words were there, accessible, pithy, intelligent and interestingly at a tangent to the contemporary nursing discourse. I loved it, but have been challenged to imagine an area of nursing one could traverse that Donna had not already thought about, talked about, and written about (Diers 2004, p. xiv).

In 2010 Donna was named by the American Academy of Nursing to be a Living Legend; an honour that moved her most profoundly as she was a most humble woman.

Sadly, I was unable to attend the Yale memorial service for Donna on 23 April 2013. Associate Professor Donna Waters, our Associate Dean Research at the University of Sydney represented me and indeed all our Aussie colleagues at Donna’s memorial service.

In her address in the Battell Chapel at Yale, Donna Waters said:

Donna had a connection with Australia and New Zealand going back 30 years, and while I can’t claim to know everyone she ever met, I did contact some of our mutual friends in case there was something in particular they wanted me to say.

I started to notice a bit of a pattern to their stories…they went something like this…

I first met Donna in (insert place and year). She had come to speak on (nursing, DRGs, workforce, workload, PhDs, research, nurse practitioners…). She gave a fabulous presentation at the (conference, workshop…). I had to push through people in the breaks to make sure she got a (break/drink/lunch/dinner…), then they inevitably finished with – AND SHE HAS BEEN A FRIEND EVER SINCE.

Our dear friend, we will all miss you and nursing will miss you but we are so privileged to have your words forever.

For those of you reading this and wondering who is this person of whom we speak so fondly, may I suggest you do yourself a really big favour and read at least two of Donna Diers’ published works. I suggest that you read *Nursing as Metaphor* and more recently her oration from 2002 given in the Great Hall of the University of Sydney for the then NSW College of Nursing, entitled simply *Finding Nursing*.

She would love to know you were reading her work for the first time.

Diers, D 2004, *Speaking of Nursing: Narrative of Practice, Research, Policy, and the Profession*, Jones and Bartlett Publishers, Sudbury Mass.

Fagin, C & Diers D 1983, ‘Nursing as metaphor’, *New England Journal of Medicine*, vol. 309, no.2, pp. 116-117.

Diers, D 2002, ‘Finding Nursing’, *Fiftieth Annual Oration,* The NSW College of Nursing.

THE FINAL HURDLE:

nurse practitioner folio submission

BY ANN DEWEY MACN, CLINICAL COORDINATOR/ AGED CARE NURSE PRACTITIONER, SAN CARLO NURSING HOME, VIC

The role of a nurse practitioner (NP) is not new but one that continues to evolve. For this aged care nurse, the journey to NP has been long and one in which the final hurdle is yet to be faced, folio submission. For those unfamiliar with this mammoth but necessary task, it is the development and submission of a body of evidence to be presented to the Australian Health Practitioner Regulation Agency (AHPRA); our nursing professions registering authority and the means by which suitability for registration is decided (National Board 2012).

My road toward registration to become an NP began many years ago.

After 15 years in intensive care, I transitioned to residential aged care as a result of increasing personal demands from four young children. A part-time local job seemed a logical way of maintaining nursing skills whilst juggling family commitments. In a world where coincidences never cease to amaze, the interview, now 10 years ago, was performed by an old colleague who herself had changed career paths. Over a short time frame a casual position as a registered nurse (RN) progressed to that of Clinical Coordinator; the position I hold today.

Over the next few years it became apparent that I had inadvertently entered an area in which my previously learnt assessment skills were utilised on a daily basis. The RNs I encountered were interested in extending their knowledge but required guidance, encouragement and they desired further options of study, often seeing themselves as overworked, undervalued, but on the whole, completely dedicated. My job became my career again, and I like to believe it was here I developed a passion for improving the care standards delivered to elderly Australians.

Through support and friendship of colleagues and senior management, my opportunity to learn and develop gerontological skills arose repeatedly, through courses, seminars, conferences and finally, after having attained an RCNA Department of Health and Ageing scholarship, a Master in Nursing.

I was keen to remain a clinical practitioner throughout my career; attaining recognition at the most senior of positions seemed a logical progression. My day-to-day job in an area with no in-house medical support and frequently deteriorating residents, often resulted in the demonstration of the nursing skills required of an NP.

Undertaking assessments, liaising with health practitioners, GPs and hospitals face-to-face and by phone was a daily occurrence. Ensuring residents retained active input into their health journey was integral to my own practice and an ideal I still strive to instil in others.

The NP aged care position I aspired to, has an enormous body of literature supporting the improvements in care for elderly residents that result from its existence. Waiting times for initiation of basic pharmaceutical interventions will potentially be reduced, transfers to emergency departments possibly prevented in some scenarios by timely initiation of specific actions, and residents will be assessed quickly and invited to be involved in their own care. With the qualification of NP, my own autonomy would be enhanced whilst retaining the ability to collaborate with medical and allied health colleagues.

So in 2012, with advanced standing for previous study granted, I commenced the clinical internship component of the Master of Nursing (Nurse Practitioner) and currently await final results prior to submitting my evidence folio. I should state that the

“My own folio has served as a reminder as to how much I have learnt, in both classroom and clinical settings; how many supportive and brilliant colleagues I have met, how many fascinating people I have cared for, how my skills have developed and how I am more competent as a nurse.”

Ann Dewey

learning has been a pleasure; finding time has been the challenge – although, I am not alone in being a working mum who is studying! Without the support of my Director of Nursing, facility board and the general practitioners who have established a collaborative mode of practice, I could not have achieved what I have to date. I would be remiss not to recognise the support of a particular GP who has acted as mentor, teacher and resource for much of the journey.

It is the content of this folio submission on which these years of work culminates. The certified material contained within constitutes documents supporting my personal nursing history and progression to application for acceptance to this senior clinical role, the nurse practitioner. It is designed to present evidence from multiple sources and to illustrate one’s capacity to meet the competency standards of an NP outlined by the Nursing and Midwifery Board of Australia. Integral to these standards is the ability to demonstrate dynamic practice, professional efficacy and clinical leadership (ANMC 2012).

This folio of information contains not only letters of support, master’s level educational certificates, a comprehensive CV and research experiences, but also documents outlining the specific scope of practice and health care setting for practice; demonstrating a candidate to be an expert in a field and, therefore, deserving of formal recognition.

Despite the hours of collation, periods of frustration and persistence required in sourcing support letters, certificates and finalising case studies, this exercise has proven an unexpected means of reflection. Reflective practice has for many years been recognised as an effective means to review personal progression and facilitate improvement (Jarvis 1992).

It is all too easy as we go about our working lives to forget why we as nurses do this job, why after all these years we continue to deliver the care, face the difficulties and relish the pleasures. My own folio has served as a reminder as to how much I have learnt, in both classroom and clinical settings; how many supportive and brilliant colleagues I have met, how many fascinating people I have cared for, how my skills have developed and how I am more competent as a nurse.

As my folio nears completion I look back over the past few years with optimism. I can honestly say that although it has been a long, and at times a challenging journey, it has also been worthwhile and rewarding – on both a professional and personal level.

Article acknowledgement: Debbie Deasey MACN, Network Editor, Nurse Practitioner National Network

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At the time of printing, Ann Dewey had recently received her endorsement as a Nurse Practitioner.

ENHANCING THE SCOPE OF PRACTICE FOR THE SKIN INTEGRITY CLINICAL NURSE CONSULTANT

BY MEAGAN SHANNON, SKIN INTEGRITY CLINICAL NURSE CONSULTANT, PENINSULA HEALTH, VIC

Meagan Shannon with the Low Frequency Ultrasound Debridement machine

The role of the Skin Integrity Clinical Nurse Consultant (SICNC) within Peninsula Health, Victoria is to support staff in the prevention and management of pressure injuries and to provide advice on skin assessment and wound care. The SICNC, like other clinical nurse consultants, is uniquely positioned to provide clinical expertise in their specialty area, education and leadership (Vaughan et al. 2005) and is supported by selected clinicians who have received extra education to take on the role of a Skin Integrity 'Portfolio Holder'; a position known elsewhere as a 'link nurse' or 'resource nurse' augments the role of the SICNC by providing peer education and advice in all clinical areas (Heals 2008). These support roles at the clinical level have enabled some significant changes to be made to the work of the SICNC; in particular extension of the current scope of practice of the SICNC to include the provision of Low-Frequency Ultrasound Debridement (LFUD) where clinically indicated. Following successful funding from the Department of Health in the 'New Technologies' grant round, Peninsula Health and three other selected public health services, were able to introduce this alternative treatment option for select patients.

LFUD is a technology which uses ultrasound waves to remove unhealthy tissue whilst sparing healthy tissue at the wound bed (Breuing et al. 2005). Normal saline is streamed through high frequency ultrasound waves to create cavitation, and this cavitation disturbs the tissue when applied directly to the wound. Unhealthy tissue is stretched and washed or suctioned away as healthy tissue is stretched and 'tipped' into an inflammatory process ultimately debriding and healing at the same time. The advantages of LFUD include improved safety, efficacy, resource utilisation, cost savings and new capabilities over existing practice and excellent wound bed preparation with antibacterial capabilities. This technology has been used in Europe for many years, but is still a relatively new technique in Australia. Despite the newness of this therapy, a recent review found that LFUD treatment was superior to existing care focussed on the chronic wound, and is a treatment option in trauma, pressure ulcers, burns, dehisced surgical, chronic ulcers and a variety of other wounds (Breuing et al. 2005).

For SICNCs in Australia, practices such as debridement and the use of topical anaesthetics, have long been recognised and addressed by extension to the scope of practice (Bryant-Lukosius, et al. 2004).

“LFUD is a technology which uses ultrasound waves to remove unhealthy tissue whilst sparing healthy tissue at the wound bed.”

Where previously this treatment could only be performed by a podiatrist, the aim was to have LFUD treatment similarly recognised as an ‘Enhanced Scope of Practice’ (ESOP) skill for the SICNC. Consideration for ESOP involved articulating the learning strategies, competencies, validated assessments and maintenance of accreditation of use for approval by the Peninsula Health Nursing Enhanced Scope of Practice Committee, and was an essential process to ensure there was appropriate governance for the introduction of this new technology into the SICNC’s arsenal of wound care. Significant consultation was also undertaken with key stakeholders, including plastic surgeons, vascular consultants, podiatry, pharmacy and the Director of Surgery in the development of this ESOP. Now approved, this extension to the SICNC scope of practice, combined with specialist training and assessment, and the development of associated policies and guidelines means that the SICNC is now more responsive to patient needs and able to provide another therapy which can assist in improving the patient experience, promote faster wound healing and also results in a decreased length of stay.

This enhanced scope of practice for the SICNC has resulted in greater job satisfaction, increased expertise and the opportunity for more interdisciplinary collaboration and the development of a robust professional link between disciplines. Patients also benefit from this change with another treatment option that contributes to greater patient satisfaction and decreased length of stay.

Article acknowledgement: Melissa Bloomer FACN, Network Editor, Acute Care National Network

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WHEN YOUR PATIENT IS DYING...

"Supporting less experienced colleagues through the provision of end of life care is essential to ensuring that patients receive appropriate care, extending to the patient's family."

BY MELISSA J BLOOMER FACN
PHD CANDIDATE, MONASH UNIVERSITY

BY PROFESSOR WENDY CROSS FACN
HEAD OF SCHOOL, SCHOOL OF NURSING & MIDWIFERY, MONASH UNIVERSITY

BY PROFESSOR MARGARET O'CONNOR FACN, VIVIAN BULLWINKEL CHAIR IN PALLIATIVE CARE NURSING, MONASH UNIVERSITY

BY PROFESSOR RUTH ENDACOTT
NURSE ACADEMIC, MONASH UNIVERSITY

Australia's population is ageing, and despite improvements in medical technology, many patients will die in the acute hospital setting. While Australia is ranked second in the world for 'quality of death' (Economist Intelligence Unit 2010), only a small proportion of patients who die in Australia are cared for in a specialist palliative care setting (O'Connor et al. 2007). For those who die in general hospital wards or in critical care areas, where the overall momentum is toward extending life, the quality of end of life care is dependent on many factors (Bloomer et al. 2011).

Clinicians may have a sense of failure associated with the death of a patient, particularly when resuscitative treatments or interventions are continued right up until death. Others describe their emotional and moral distress at continuing resuscitative care, even when they felt no hope that the patient would survive and a sense of powerlessness in not being able to change the focus of care to end of life care (Bloomer et al. 2011).

Despite its inclusion in nursing curricula, it was clear that not all nurses felt adequately prepared educationally or emotionally to provide care for the dying patient, which often extends to include caring for their family/loved ones (Bloomer et al. 2011). Knowing what to say, how to say it and how to provide the support the family/loved ones need is not innate. Previous studies have shown that nurses rely on mentoring and role-modelling to learn how to carry out this important work (Bloomer et al. 2012). However in the context of acute hospital wards, where patient acuity is high and the pace is fast, facilitating this kind of supported learning can be very difficult.

For the family, death of a loved one can be equally difficult. When resuscitative care continues, this may create a false sense of hope that death can be denied or delayed, and then when death does occur, it can be harder to accept. Studies suggest that the seriousness of the situation is often not clearly articulated by clinicians who often find it difficult to talk about death or dying. Many rely on euphemisms; others avoid talking about the topic altogether (Bloomer et al. 2011), leaving the family 'in the dark', unprepared and without the opportunity to say goodbye.

How the family are cared for after a death is also important work that often goes unrecognised. Families may be in shock, grieving and in need of support. When the death occurs after hours, and support personnel such as social workers or pastoral care are not available, it is usually the nurse who is responsible for family care (Bloomer et al. 2012 & Stuart et al. 2010). While it is already well known that the families of patients who are critically ill or die, may suffer long lasting psychological effects as a consequence of their experience (Pochard et al. 2005), it is important to talk with the family, give them time, space and privacy to be with their deceased loved one, and facilitate specific cultural or religious needs or rituals that may be important. It may be impossible to foresee exactly what is needed, but families will appreciate it if clinicians make an effort to meet their needs.

Caring for a dying patient is a challenge, particularly when they are being cared for in an acute hospital ward where the focus is on resuscitation and cure. For those who are less experienced at this aspect of nursing work, it can also be difficult emotionally. Supporting less experienced colleagues through the provision of end of life care is essential to ensuring that patients receive appropriate care, extending to the patient's family.

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20 THINGS YOU MAY HAVE MISSED AT UNIVERSITY BUT WISH YOU HADN'T!

BY MANDY WALKER MACN, REGISTERED NURSE, BUNBURY REGIONAL HOSPITAL, WA

Mandy's article, 'Do you remember?' was featured in the March 2012 edition of the RCNA publication, 'Connections'. It was a personal letter to herself about her student experiences on placement. Mandy has now been a registered nurse for almost 18 months. During this time she's discovered that whilst her university training prepared her in many ways, there was still so much to learn.

1. Your patients' business is your business. I used to feel awkward asking patients personal questions but then I realised they expect me to ask, and it's in my best interest to. I once asked a lady, "Can I ask you a question?" to which she replied, "Yes, I've had my bowels opened" and I said, "Oh that's good but that wasn't what I was going to ask!"

2. When IV cannulas are in difficult places or hard to access, it can be easier to connect a J loop, which makes intravenous administration so much easier for you and less painful for the patient.

3. Ask for help and be aware of your limits. The majority of people won't mind if you ask for help but everyone will mind if you do something wrong and didn't ask for help.

4. Never underestimate your need to respect samples – blood, urine, sputum and faecal. Do not discard them until you are sure it's ok to do so. I threw out a urine sample that was meant to be part of a 24 hour collection, which then meant the entire process had to be started again, delaying treatment for the patient.

5. Never take a needle out of a vial until the vial is empty, unless you want a spray of medication all over your face and shirt.

6. I know it's not always possible but it's polite to wait for your colleagues and walk out of the ward after a shift together.

7. If a blood pressure reads abnormally on an automatic sphygmomanometer, take it manually and try both arms unless otherwise contraindicated.

8. If your patient has a low SpO2 (oxygen saturation) reading, consider the factors that can contribute to a low reading: hypothermia, hypotension, poor peripheral perfusion. Also, look at the heart rate displayed on the oximeter. The SpO2 reading should only be considered accurate if the heart rate on the display matches the patients' actual heart rate.

9. A flower on the pillow beside a person who has passed away seems to look softer than one placed on their chest; however, it's very important when caring for a patient who has died to be guided by what the family might want. Remember, the care you provide is not just for the patient but their family also.

10. If something doesn't seem quite right – it probably isn't. Always pay attention to that little voice that says, "Hey, that dose seems high," or "I'm sure that patient looks greyer now than they did at the start of the shift." Far better to check and have it be for no reason, than not to check, have something go wrong and know it might've been prevented if you'd investigated further.

11. Never underestimate the power of a warmed blanket for someone who can't sleep.

12. If you notice your patient coughs a lot when sipping fluid, ensure they are sitting upright and consider undertaking a swallowing assessment; coughing can indicate compromised swallowing ability.

13. If your post-op patient's pulse is elevated, the two most important things to consider are the wound site (they may be bleeding), and your patient's pain.

14. You are super and you are a nurse, however you are not expected to be 'super-nurse'. You must 'wee' at least once per shift!

15. Before calling the on-call doctor to report vital observations outside normal parameters, check to make sure that the parameters have not been modified for this patient; saves an embarrassing conversation and apology.

16. When you have emptied a catheter drainage bag, close the seal properly – and then check again. This two-second double check is going to be a whole lot better than a 10 minute clean-up of urine!

17. When you put medications back into the drawer after dispensing them in a medicine cup, use the opportunity to check the medication packet again to make sure it is the right one.

18. When feeding via nasogastric tube, if the liquid won't run through the syringe, use the plunger to get it started, liquid will flow through easily afterwards.

19. Remember oral care for the fasting patient, not just those who are unconscious or palliative.

20. Medications and observations are really important – but patients will remember whether or not you introduced yourself at the beginning of the shift, offered them a warm blanket, a drink of water, or helped them brush their teeth.

Article acknowledgement: Melissa Bloomer FACN, Network Editor, Acute Care National Network

OBSERVING AND LEARNING AT THE HOLY FAMILY HANSENORIUM

BY MARGARET BOYES
NURSING LECTURER, AUSTRALIAN CATHOLIC UNIVERSITY, ACT

BY ASSOCIATE PROFESSOR MARG MCLEOD FACN
ASSOCIATE HEAD OF SCHOOL, CHARLES STURT UNIVERSITY, NSW

In January 2012, we spent five days observing and learning at the Holy Family Hansenorium in the Tamil Nadu state in the south of India. The Hansenorium has been one of the mainstays of care since 1955 for people with Hansen's disease (leprosy), and more recently for people with HIV/AIDS and tuberculosis. Our group of five, from the Canberra campus of the Australian Catholic University (ACU), consisted of two nursing students, one social work student and two nurse academics (the authors). We were to learn that health care in rural India is diverse, challenging, and clinically and culturally holistic. Our group of Australian academics and students found that it includes: growing rice and milking cows; theatre scrubs with sterile sandals; and that confidentiality (as we know it) is not part of the picture.

The Hansenorium is a community care centre in every respect. The care of people affected by HIV/AIDS includes: inpatient management of acute episodes; community outreach; health promotion of safe sex and AIDS prevention in schools and villages; vocational help, such as the women's weaving workshop and the specialist boot-maker; childcare so that people can attend programs and appointments; and residential care for children orphaned by HIV/AIDS or tuberculosis. Many adults are both patients and long-term residents of the Hansenorium, and it was evident that they find a level of acceptance and freedom there from the stigma of HIV/AIDS and of the disfiguring wounds of Hansen's disease.

The students reflected that they will carry the experience with them for the rest of their professional and personal lives. One nursing student linked the Hansenorium's strong sense of community with the underpinning theory of holistic care, and noted the ways in which both can promote well-being and hasten recovery. The other watched a woman debriding and dressing the wounds that result from Hansen's disease. She noted that the woman was herself a long-term patient recovering from Hansen's disease, and was trained to carry out this painstaking daily procedure for others. We were to see many such examples of patients finding a vocation at the Hansenorium. The two nursing students and one of us were also privileged to be present at a caesarean birth. The procedure was similar to those observed in Australia, but there were minor differences, including routine vigorous suctioning of the baby using a mouth-operated suction catheter. For the students, the birth was a highlight of the journey.

Both Australian nursing students tried to find out more about the herbal and homeopathic treatments prescribed by the doctor to patients with migraines, skin disorders and coughs. They were observing a medical model that treats the symptom more than the cause, and a culture that expresses distress by somatising it.

We were shown the four bed 'de-addiction centre to salvage alcohol and drug addicts'. On admission, the patient is first given intravenous fluids. This is followed up with a program of counselling in Tamil. We sat in on a session, and each patient's history was told to us in English. There was no apparent effort at privacy, or consent by the patient to include us as observers. To the contrary, we saw nothing to suggest that confidentiality was an expectation. Indeed, the Hansenorium's website proudly displays photos of children affected by HIV/AIDS, and we did not have a sense of anything but a willingness by patients to include us. After all, we were, as one nursing student noted, in a culture in which 'it takes a village to raise a child'.

The social work student spent time with a Tamil social worker during the day and in the evenings with the elderly women in the Hansen's disease ward, chatting, laughing and listening to music. The student wanted to learn more from the Tamil social worker, about his role in health education in schools. He told her that HIV/AIDS prevention was still a struggle, and that he had to impart some of his educational messages when the teacher was out of the room.

“Many adults are both patients and long-term residents of the Hansenorium, and it was evident that they find a level of acceptance and freedom there from the stigma of HIV/AIDS and of the disfiguring wounds of Hansen’s disease.”

We all experienced the desire to understand more deeply how and why something was happening. We wanted to learn from the Tamil student nurses what their goals and hopes were. We listened to an old man with Hansen’s disease, who told us his story about a life of struggle. We watched a senior social worker teaching two male students in Tamil and realised that the social worker was, in fact, scolding the students for not wearing ties on a home visit. We had few regrets or disappointments.

After our time at the Hansenorium, we reunited with the rest of the group from the Canberra campus – students and leaders from the ACU School of Education who had been observing and teaching in Tamil Nadu primary schools. They, too, described a transformative experience.

We then flew to Kolkata, where we visited the ‘Mother House’ – the home and base of operations of the late Mother Teresa, and the site of her tomb. We saw the room where she lived and conducted her affairs for much of her life, and all of us felt the serenity of the community’s chapel. Soon afterwards, we visited the Daya Dan House, which cares for children with profound physical and developmental disabilities. There, nuns and a band of international volunteers worked in crowded conditions with few resources to provide their care. Returning to our digs after this excursion, most of us reflected and fell silent.

At the end of our three-week trip, we took a couple of days to be tourists in Delhi and Agra before heading home. Everyone who travelled to India on this immersion journey knew that it changed them in a number of ways. We all knew we had grown from the experience, and that this growth would guide our professional lives in the future.

To learn more about the Holy Family Hansenorium visit:
www.holyfamilyhansenorium.org/activities.php

Photos: Linda Norris (social work student); Associate Professor Marg McLeod; Margaret Boyes; Heidi Welsh (nursing student); and Ashley Maher (nursing student). All members of the group were working or studying, at the time, at ACU.

Teaching laboratory at the Holy Family Hansenorium, India.

Woman with Hansen’s disease weaving material to raise funds for the Holy Family Hansenorium

ADVANCED HEALTH DIRECTIVES AND ENDURING POWERS OF ATTORNEY

BY TAMMY COPLEY MACN, REGISTERED MIDWIFE, QLD

"However, in order to comply with patient's express wishes it is imperative that health care providers do understand the nature and intent of these documents…"

Throughout Australia there are both common law and legislative provisions for adults with legal capacity to give directions about the health care they will receive when they no longer have the requisite decision-making capacity. For example, in Queensland it is possible for those eligible to complete an Advanced Health Directive (AHD) and an Enduring Power of Attorney (EPOA) for this purpose. Indeed, as the population ages and the number of older patients presenting to health care agencies with a number of co-morbidities increases, the use of these advance notice documents is growing.

Few health care professionals have an in-depth understanding of these documents and the power they confer. However, in order to comply with patient's express wishes it is imperative that health care providers do understand the nature and intent of these documents, their legal status and what is required for them to be valid documents. This article briefly discusses the criteria for a valid AHD and an appointment of an EPOA based on the law valid in Queensland.

The Advanced Health Directive

An AHD is a legally binding form where an adult of 18 years of age or more can record decisions regarding their future health care should they reach a point where they can no longer make these decisions for themselves. In executing an AHD the person must demonstrate an understanding of a number of matters including that the directive is only operative when they do not have capacity, that they can revoke the directive at any time, and that they understand the effects of each of the directions created in their AHD. There are also certain formalities in executing the directive, for example, that the document is in written form, signed by the person creating it and that it is witnessed by either a Justice of the Peace (Qualified), Justice of the Peace (Commissioner for Declarations), lawyer, or notary public over the age of 21 years, providing that none of these specified witnesses are involved in the care of the individual. Furthermore, it is necessary for a doctor to sign a separate certificate that states that at the time of creating this AHD the person appeared to have the necessary capacity to make it.

The person creating this document has the opportunity to state both treatments that they would consent to and those they would refuse if they were still able to make and communicate their own decisions. Hence they can give directions on how they wish their care to be handled in the event that they become terminally ill, incurably ill, or irreversibly ill, in addition to directions on how they would want emergency situations handled with respect to artificial ventilation, CPR or enteral feeding to keep them alive.

There are limitations on the AHD which are particularly restrictive in Queensland. For example in cases where the AHD indicates a refusal of life-saving treatment, it must satisfy a number of conditions before it can be relied upon. These include that the person:

- must have a terminal illness or other condition that is irreversible or incurable and in the opinion of two doctors will lead to the person's death within a year
- is permanently unconscious
- is in a persistent vegetative state
- has an illness or injury of such severity that there is no reasonable prospect of recovery, to a point that life sustaining measures would no longer be necessary (White, McDonald & Willmott)
- has no reasonable prospect of regaining capacity that would enable them to make their own decisions about health care.

Clearly an AHD cannot authorise illegal behaviour and so whilst good palliative care provisions can be supported, any actions that could be construed as intentionally causing the death of the person cannot.

Ideally once a valid document has been created the patient would ensure that any relevant next of kin, their treating practitioner

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and any person appointed as a surrogate decision-maker would be informed of its existence and intent. It is important that these people are aware of the existence of the AHD and where the original can be accessed.

Enduring Power of Attorney

The second form creates an EPOA. The word 'enduring' refers to the documents status as continuing, that is; it continues to confer the power delegated in circumstances where the donor of this power has lost their legal capacity to make decisions. The formalities of such an appointment need to be satisfied, including the completion of the relevant document, by the donor of the power and the EPOA accepting the role, duly witnessed by the prescribed witness. Once established, the EPOA may only make decisions regarding the donor's health care when they are no longer able to and can only make decisions that are consistent with the donor's recorded wishes. Should the adult who has appointed the EPOA regain the ability to make their own decisions, the EPOA's power ceases.

Both the AHD and the EPOA can be revoked at any time by the adult who created them.

Decision pathway

When a competent adult patient comes into a health facility, the staff are legally bound to obtain their consent for and respect any refusal of treatment offered. However, if the person is not competent, health care staff are obliged to address a series of considerations in order to provide treatment that would be lawful and not infringe upon that person's rights. For example, it is important for the health practitioner to make a reasonable effort to ascertain if there are any particular circumstances where a patient would refuse treatment, such as those who might for religious reasons refuse a blood transfusion. It would also be prudent where possible to determine if the person has enacted an AHD, appointed an EPOA or if they have a statutory appointed guardian in place. In the absence of these 'surrogate decision-makers', the law in all jurisdictions except the Northern Territory has made provisions for a 'default decision-maker'; in Queensland this is referred to as the Statutory Health Attorney.

In Queensland, the Statutory Health Attorney has the power to consent to and refuse treatment. This includes the refusal and withdrawal of life-saving treatment as long as the treating medical practitioner believes this is consistent with good medical practice (White, McDonald & Willmott).

Although there may be some increase in the use of these documents, they are still largely under-utilised by the adult population in Australia. Together, they create an opportunity for an adult of sound mind to have some control on the decision-making processes that could be employed to manage their treatment in circumstances where they are not able to communicate their wishes. It would be useful for health professionals across Australia to become familiar with the legislative and/or common law provisions of their jurisdiction regarding surrogate decision-making opportunities so that they are able to recognise a valid document versus one that has flaws within it and cannot be relied upon.

The above information is based on Queensland state law and further information can be sought from the Department of Justice, Queensland. Nurses in other states and territories should check with their Department of Justice for information specific to them.

Fact sheets are available from the Department of Justice and Attorney General, Queensland. In Queensland, the above forms can be found at newsagencies, stationery stores and bookshops for a nominal fee. They are available online at www.justice.qld.gov.au free of charge.

Tammy Copley is a Justice of the Peace (Qualified), State of Queensland.

Article acknowledgement: Associate Professor Linda Starr FACN, Network Editor, Legal National Network

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CLINICAL REFLECTION:

the importance of therapeutic relationships

BY PATRICIA FOX MACN, ACN EMERGING NURSE LEADER, 3RD YEAR NURSING STUDENT, QLD

"Although therapeutic relationships, and the many associated benefits, had been covered in theory during my undergraduate degree, this was the first time I had witnessed the effectiveness of it in practice."

During a clinical placement I had the opportunity to do a surgical follow-through with a patient. I was very excited about this as I had been hoping to see the inside of a theatre.

I went down to admission and met my patient, Margaret*. She was in her mid-sixties and was having a knee reconstruction performed. Margaret was with her husband but was clearly apprehensive and very quiet however; she agreed to have me tag along for the day. Once we were alone I started to talk to Margaret about day-to-day activities and she showed quite an interest in my nursing studies. We had a lot of time to talk prior to surgery and I started to build a rapport with her. By the time Margaret was taken to theatre we were well acquainted. From a practice perspective, I was also able to assist the anaesthetist with the spinal block and other pre-surgery requirements.

I observed Margaret's surgery, which took over two hours, and gained a new appreciation for why orthopaedic patients can be in a lot of pain post-surgery. I escorted Margaret back to recovery where I was introduced to the recovery nurse, and we waited for her to wake up. When Margaret opened her eyes the first thing she said was "Oh, you are still here." Once the recovery nurse was happy with Margaret's progress we transferred her back to the ward, I helped to get her settled and remained with her, performing her post-op observations, until it was time for me to go home.

The next day I was on another ward but I called in to see Margaret after lunch. She was in good spirits and pleased to see me. She invited me to sit down and we had a big chat about the previous day. She thanked me so much for looking after her and said she felt like she had received the royal treatment by having a constant 'presence' with her all day. It was at this point that I truly appreciated the importance of establishing therapeutic relationships with every patient. Although therapeutic relationships, and the many associated benefits, had been covered in theory during my undergraduate degree, this was the first time I had witnessed the effectiveness of it in practice.

While reflecting on the day I was thinking about how many different hospital staff Margaret had been in contact with during her stay: administrative staff; admissions nurse; anaesthetist; anaesthetic nurse; surgeon; recovery nurses; ward nurses; and a physiotherapist. However, I was her only constant and was therefore able to provide her with continuum of care. I understand this is not a service we have the luxury or time to offer to every patient, but we do have the ability to make the time we do have with our patients count. This experience highlighted to me that building therapeutic relationships is not just rewarding for my patients, but rewarding for me. I think every nursing student and nurse should strive to achieve this whenever possible.

**Name has been changed to maintain privacy.*

Pictured above: Patricia Fox on clinical placement

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Australian College of Nursing

NURSE ROUNDING:

an innovative falls prevention strategy for acute care?

BY CAROLINE AYERS MACN, REGISTERED NURSE, RYDE HOSPITAL, NSW

Caroline Ayers

Falls are the most common adverse event associated with hospital admission in Australia, and have serious consequences for individuals and the health system, resulting in higher costs, increased length of stay, and greater likelihood of discharge to long-term care (Choi et al. 2011). At the same time, it is difficult to engage nursing staff in falls prevention programs, due to workload pressures and 'checklist fatigue'. Frequent, scheduled nursing rounds may minimise inpatient falls, whilst improving holistic care.

The evidence for nurse rounding

Nurse rounding (NR) is a formal process incorporating hourly or two-hourly nursing assessments of each patient's requirements. In Britain, the National Nursing Research Unit (NNRU) (2012) considered the evidence for NR, and reported improvements in patient outcomes, specifically pain management and falls prevention (NNRU 2012). However, the authors highlighted the lack of randomised controlled trials in the area (NNRU 2012).

Despite the lack of high level evidence, an initial quasi-experimental trial conducted by Meade et al. (2006) focussed on nurses or nursing assistants visiting patients hourly to enquire about pain, toileting and comfort. In addition, staff offered further assistance as required, and advised that they would visit again in 60 minutes (Meade et al. 2006). Hourly rounding significantly reduced patient falls ($p=0.01$), compared to both usual care and two-hourly rounds (Meade et al. 2006). After 12 months, study sites reported a 60% reduction in falls (Meade et al. 2006). Another study reported that on a British medical ward, patient falls were reduced by 34% with the introduction of NR (Mason 2012). Researchers noted that NR encouraged nurses to focus on bedside care, achieving improved outcomes without increased staffing (Mason 2012).

Nurses' roles in minimising patients' risk of falls cannot be underestimated. Nurses provide 24 hour intimate care and play a crucial role in assessing and addressing patients' falls risk factors, as well as communicating patients' status and requirements to the health care team (ACQSH 2009).

Implementing a rounding protocol

Encouraging nurses to focus on bedside care through NR may reduce the likelihood that patients undertake risky activities. During rounding, the nurse may provide re-orientation as required, whilst ensuring that personal belongings, sensory and mobility aids, call bells and telephones are accessible. Enquiring about toileting is likely to minimise incontinence-related falls, whilst providing opportunities for education about safe mobilisation.

In an acute care setting, an hourly rounding protocol could provide a low cost, low technology strategy to reduce falls, whilst encouraging quality, holistic care. A four 'p' process is commonly employed, where after introducing themselves and performing scheduled interventions, the nurse enquires about patients' positioning, personal needs, pain and placement of personal items, whilst informing the patient that the same process will occur again at the next scheduled time (Halm 2009 & Bartley 2011 cited in NNRU 2012).

Article acknowledgement:
Raymond Chan FACN, Network Editor, Research National Network

“...the array of existing quality improvement initiatives may result in ‘checklist fatigue’, where clinicians perceive falls prevention programs as placing further demands on their time, for few observable gains.”

Engaging staff in a nurse rounding protocol

In acute care, large numbers of rotating staff care for an ever-changing array of patients. Time and resources are precious, and it can be difficult to engage individuals in practice change. In addition, the array of existing quality improvement initiatives may result in ‘checklist fatigue’, where clinicians perceive falls prevention programs as placing further demands on their time, for few observable gains. As a result, theoretically appropriate programs may be quickly derailed by the unwillingness or inability of staff to participate (Choi et al. 2011).

NR necessitates fundamental changes to ward routines, and Dix et al. (2012, p. 16) emphasised that “managers cannot assume that because NR focuses on fundamental care, it is easy to achieve.” Considering their initial rollout, Dix et al. (2012) concluded that implementation of NR must be carefully managed, specifically by using nursing leadership to champion the program, and ensuring staff are adequately trained (Dix et al. 2012). The UK’s NNRU (2012, p. 23) too, concluded that NR success requires “nurse leadership, staff training and accountability structures.”

In reality, engaging staff in practice change is challenging. In Somerset, nurses opposed NR, citing time constraints, and could not be engaged with the program despite high levels of patient satisfaction and reductions in adverse events (Dix et al. 2012). In response to concerns about time pressures, the Somerset project team advised nurses that 90% of rounds did not require any nursing interventions, whilst emphasising patients’ satisfaction with the regime (Dix et al. 2012). However, compliance with NR decreased after additional ward support ceased, and, during evaluation, nurses stated that they were less satisfied with the care they were able to provide under the regime (Dix et al. 2012).

Cultural factors may influence nursing engagement with rounding protocols. Nurses in the United States reported high levels of satisfaction with NR (Meade et al. 2006). On NR implementation in a medical/surgical unit in Philadelphia nurses expressed concern that NR would increase their workload. However, they concluded at the trials’ end that it allowed them more time during their shifts, whilst decreasing falls, fevers, pressure ulcer development and skin breakdown (Meade et al. 2006).

Promoting NR as a ‘one-stop-shop’ for improving nurses’ ability to provide quality care, whilst decreasing hospital-related adverse events, could encourage staff engagement. Further, NR should be used as an opportunity to reduce the administrative burden on clinicians through minimising paperwork associated with existing falls and pressure area prevention activities, and instead increasing time available for patient care.

Beginning with a program trial, ward staff could be engaged through education sessions, distribution of prompt cards, specifically designed rounding forms and access to NR ‘experts’. Practical assistance from project staff, working with ward nurses to implement NR would be crucial. Finally, program implementers need to address staff concerns, alter processes to suit local needs and evaluate program success.

Conclusion

Nursing staff, as providers of 24 hour bedside care, can play a crucial role in minimising patient falls. NR provides a structured, nurse-focussed approach to managing falls risk factors, including confusion and disorientation, lack of access to important items and mobility aids, risky mobilisation and incontinence. Further quality research, ideally randomised controlled trials, is required to determine if NR represents a time and cost-effective approach to reduce inpatient falls, whilst encouraging quality bedside care.

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LEADERSHIP CAPACITY BUILDING IN NURSING AND MIDWIFERY ACADEMICS

"Given the entrenched female-dominated gender dynamic that exists in nursing and midwifery academia, this gender-specific finding is especially salient for this current project."

BY DR JOANNE GRAY
REGISTERED NURSE AND MIDWIFE, ASSOCIATE DEAN (TEACHING AND LEARNING), UNIVERSITY OF TECHNOLOGY, SYDNEY, NSW

BY PROFESSOR DEBRA JACKSON
REGISTERED NURSE, PROFESSOR OF NURSING, FACULTY OF HEALTH, UNIVERSITY OF TECHNOLOGY, SYDNEY, NSW

BY DR KATH PETERS
REGISTERED NURSE, SENIOR LECTURER, SCHOOL OF NURSING & MIDWIFERY, UNIVERSITY OF WESTERN SYDNEY, NSW

BY DR SHARON ANDREW FACN
REGISTERED NURSE, PROFESSOR OF NURSING, ANGLIA RUSKIN UNIVERSITY, UK

BY ASSOCIATE PROFESSOR ELIZABETH HALCOMB FACN
REGISTERED NURSE, DEPUTY DIRECTOR OF HIGHER DEGREE RESEARCH, SCHOOL OF NURSING & MIDWIFERY, UNIVERSITY OF WESTERN SYDNEY, NSW

BY ASSOCIATE PROFESSOR YENNA SALAMONSON
REGISTERED NURSE, DIRECTOR OF ACADEMIC WORKFORCE, SCHOOL OF NURSING & MIDWIFERY, UNIVERSITY OF WESTERN SYDNEY, NSW

It has been recognised that nursing and midwifery academics face the same challenges as their colleagues in the clinical setting – an ageing workforce that requires a sustained and considered focus in order to plan for the future. A group of academics from the University of Western Sydney and the University of Technology, Sydney have been supported by funding from the Australia Learning and Teaching Council (now known as the Office of Learning and Teaching) to build and trial a program of leadership capacity building in nursing and midwifery academics.

The program combined face-to-face workshops, online activities, peer learning networks and academic mentoring. Building leadership capacity amongst early career nurse and midwifery academics will facilitate their career development, foster the development of communities of practice and enhance scholarly learning and teaching within the discipline.

Nationally and internationally, nursing is facing an acute shortage of suitably qualified academic staff (Andrew et al. 2009, Brendtro & Hegge 2000, deYoung et al. 2002 and Potempa et al. 2008). Possession of doctoral qualifications, widely viewed as essential for a career as a nurse academic, and inadequate numbers of nurse graduates from doctoral programs, coupled with pending retirements due to the ageing nursing workforce, have contributed to the acuity of the current situation (Berlin & Sechrist 2002 and Henshaw 2001).

The nursing and midwifery academic workforce is commonly drawn from the clinical practice environment (Andrew et al. 2010). This is considered to be the best place from which to recruit sessional and permanent academic staff, as recent clinicians bring to their teaching a wealth of clinical knowledge. Students, therefore, respond positively to these clinicians as they appreciate their expertise in the 'real world'; these new academics, whilst experts in their clinical areas, are novices in the academic environment. It is imperative to facilitate their academic career development that appropriate support strategies are provided.

The literature suggests that a positive work environment is essential to enhancing the "longevity of junior faculty" (Shepherd et al.

2001, p. 845). This is especially important given that the early years of academic life have been described as being stimulating and exciting, yet are also a period of intense pressure and significant growth, adjustment and disillusionment (Shepherd et al. 2001). In an academic context, job satisfaction has been demonstrated to be influenced by the institutional leadership and mentoring provided to staff (Bilimoria et al. 2006). Research has shown that female faculty, in particular, derived satisfaction in their work from internal relational supports (Bilimoria et al. 2006). Given the entrenched female-dominated gender dynamic that exists in nursing and midwifery academia, this gender-specific finding is especially salient for this current project.

In commencing this project, a reference group of experienced nursing and midwifery academics was established to provide critique and advice on the design of the study and study outcomes. This group has been an important part of this project and their collective wisdom has ensured that the project is relevant and credible for the participants. The project has resonated with many new academics from the two universities and has involved a range of developmental activities focussing on leadership development, and strategies for building and sustaining a satisfying and successful academic career. Over twenty new academic staff members have participated in the program, having attended four workshops, developed a relationship with a mentor, and accessed two online learning modules. A mixed methods framework of evaluation has been employed to explore the feasibility, sustainability and impact of the model. Analysis of these data is currently underway. The project is nearing the completion and early evaluation highlights the importance of initiating and sustaining a range of development and support opportunities for early career academics.

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A 10 WEEK SUMMER CLINICAL RESEARCH PROGRAM FOR AN UNDERGRADUATE STUDENT:

what are the potential outcomes?

BY JENNIFER MANN
CLINICAL NURSE, ROYAL BRISBANE AND WOMEN'S HOSPITAL, QLD

BY KALANA WICKREMARATNE
3RD YEAR NURSING STUDENT, SCHOOL OF NURSING AND MIDWIFERY, UNIVERSITY OF QUEENSLAND, QLD

BY RAYMOND JAVAN CHAN FACN
NURSE RESEARCHER, ROYAL BRISBANE AND WOMEN'S HOSPITAL, QLD

According to the Nursing and Midwifery Board of Australia (National Board) National Competency Standards, registered nurses (RNs) are required to practise within an evidence-based framework. Evidence suggests that RNs struggle to find time and have the appropriate skills to do and access research (Chan et al. 2010). There have been a lot of efforts that aim to rectify this issue. Amongst undergraduate nursing programs in Australia, there is a wide variation in how students are prepared to be competent evidence-based practitioners. In addition to the academic programs, some universities offer short-term research programs to allow participating students to gain hands-on research and evidence-based practice experience.

Here, we aim to describe our n=1 experience of a summer research program in an Australian tertiary cancer centre and the learning outcomes perceived by the research mentors and the undergraduate student.

This research program, offered by the University of Queensland, provided the student with an opportunity to work alongside two nurse researchers (the Chief Investigator and the Project Manager) on a research project over 10 weeks. The student received a scholarship of $1,000 from the university, for participating in this program. This program is extracurricular in that, it does not replace the required number of clinical contact hours for their registration. The student participated as a research assistant in a research project: a double-blind randomised controlled trial investigating the effects of two creams (Moogoo Udder Cream® vs Aqeuous Cream) for managing radio-dermatitis in patients with cancer (Chan et al. 2012, Chan et al. 2013). This project took place in Queensland's largest radiation treatment unit.

The learning outcomes perceived by the mentors and the student included increased knowledge, confidence and skills in a number of areas related to (1) research and evidence-based practice and (2) cancer care nursing practice. These outcomes correspond to a number of the *National Board Competency Standards for Registered Nurses* (see Table 1). After the program was completed, the student was appointed as a part-time research assistant for the project. This program was a positive experience for the student as well as the mentors. The perceived learning outcomes reported in this paper can potentially inform the development of a learning plan to maximise the benefits of such programs.

We suggest that careful consideration is required to prepare future RNs to be competent in practising within the evidence-based framework. While we are not suggesting that such a program is feasible for all students and is 'the solution', it is time for us to think out of the box and begin to innovate further in this space.

“Amongst undergraduate nursing programs in Australia, there is a wide variation in how students are prepared to be competent evidence-based practitioners.”

Table 1. Perceived learning outcomes for the student in the Summer Research Program

RESEARCH AND EVIDENCE-BASED PRACTICE	RELEVANT CORRESPONDING ANMC COMPETENCY STANDARDS	CANCER NURSING CLINICAL PRACTICE LEARNING OUTCOMES	RELEVANT CORRESPONDING ANMC COMPETENCY STANDARDS
Increased knowledge, confidence and skills include: › political awareness in the health care environment › understanding the importance of ethical guidelines › ensuring the adherence to ethical guidelines › understanding the importance of evidence-based health care › clinical assessment related to assessing eligibility criteria › using a computerised randomisation program › research data management › ensuring that the research conduct adheres to study protocol › ensuring informed consent is obtained.	1.1, 1.2, 2.1, 2.3, 2.4, 2.5, 2.6, 3.1, 3.2, 3.3, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 8.1, 8.2,	Increased knowledge, confidence and skills (non-cancer care specific) include: › professional communications among the interdisciplinary team › therapeutic communications with patients/family members (ensuring clarity and logical flow).	9.1, 9.2, 9.3, 9.4, 9.5, 10.1, 10.2, 10.3, 10.4,
		Increased knowledge, confidence and skills (cancer care specific) include: › cancer type, staging, anatomy, and the transitions along the cancer trajectory › types of anti-cancer therapy › skin toxicity assessment › topical treatment for skin complications › patient education › awareness of the role of the interdisciplinary team in cancer care.	2.3, 2.4, 2.5, 2.6, 5.1, 5.2,

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PRESTIGIOUS HONOURS

ACN is fortunate to be comprised of a number of nurses who excel in their work and are outstanding advocates for their profession, both in Australia and internationally. We are proud to feature the achievements of two such members.

GROUP CAPTAIN JENNIFER LUMSDEN CSC FACN

ACN would like to congratulate Group Captain Lumsden on her recent receipt of the Conspicuous Service Cross in the Australia Day Honours 2013 for outstanding achievement as Chief of Staff, Director General Health Reserves – Air Force and in developing the Military Critical Care Aeromedical Evacuation Capability.

DR JAN DESMA PRATT AM MACN

ACN would also like to offer our congratulations to Dr Pratt, as she received the recent honour as a Member of the Order of Australia (AM) in the Australia Day Honours 2013, for her significant service to child-health nursing through leadership in the area of professional development.

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TRUDE KALLIR AM FACN

1922 – 2012

BY JUDITH CORNELL AM FACN

Trude was a Foundation Fellow of the NSW College of Nursing (NSWCN), which was to become The College of Nursing (TCoN). Trude was an enthusiastic and committed member of TCoN and on the unification of RCNA and TCoN, Trude was one of two Foundation Fellows who transferred their membership to ACN.

After arriving in Australia from Vienna in 1939, Trude undertook the nurses' entrance examination before beginning her nurse training at the Prince Henry Hospital. After completing her training in 1945, she then went on to her obstetric training at the Royal Hospital for Women until 1946. As a double certificated sister she worked at Narrabri District Hospital and at the Eastern Suburbs Hospital before returning to the Royal where she remained working in outpatients until her retirement in 1956.

Trude was a student in the first Industrial Nursing Course run by the College and was subsequently admitted as a Foundation Fellow of the College at the 1952 Investiture of Fellows and was the holder of Badge # 7. In 1952 she was elected to the NSWCN Council and six months later was appointed as Honorary Treasurer; a position she held until 1955.

We are grateful for the life and work of Trude Kallir and her legacy lives on in the strength of ACN.

ANN WOODRUFF FRCNA (DLF)

1928 – 2012

Throughout her professional nursing career as a registered nurse and midwife, Ann made a sustained and distinguished contribution both nationally and internationally to nursing and education in Australia. Ann played prominent roles in the innovation and development of undergraduate and postgraduate curricula and courses.

Awarded the W. K. Kellogg Australian Nursing Fellowship in 1982, Ann provided strong leadership as nursing education moved from a hospital based program to the tertiary education sector.

ACN would like to formally recognise Ann's contribution to the nursing profession and to RCNA.

KAREN DRADDY MACN

1951 – 2013

Karen was a registered nurse and midwife who became an ambassador for nurses and midwives in Australia, seeking to mentor junior midwives and nursing/midwifery unit managers. Her involvement and membership in a number of associations representing nurses demonstrated her pursuit of nursing excellence.

A loyal and passionate advocate for equity, Karen was awarded the prestigious Pittwater Woman of the Year for her extensive community work.

ACN would like to acknowledge Karen's life-long dedication to the nursing profession.

New South Wales Nurses and Midwives Association, 2013, *The Lamp*, 11 February 2013

THE NATIONAL NURSING FORUM

Success through Synergy

In the centenary year of our national capital, ACN will be convening The National Nursing Forum for our members and the broader nursing community. The Forum will be held from 20–22 October 2013, in Canberra. The theme, *Success through Synergy,* not only draws on the unification of RCNA and TCoN, but recognises that in our practice we can be more successful when we work together, learn from each other and support each other.

MEMBER'S ONLY DAY

In acknowledgment of our member's commitment to ACN we will be holding a member's only day on Sunday 20 October. This day will feature:

- workshops which focus on identifying key priorities for ACN
- opportunities for members to meet the ACN President and Board, and network with colleagues who have similar interests
- discussion around representation and advocacy positions for ACN
- the ACN Annual General Meeting
- the inaugural ACN Oration, presentation of the 2014 ACN Emerging Nurse Leaders and admittance of ACN Fellows
- member only networking drinks.

This year's Forum will be all about 'moving forward' – both as a profession and organisation – and we would encourage all our members to attend, what is sure to be, a stimulating and relevant event.

PLENARY PRESENTER AND PANEL FACILITATOR

PROFESSOR PHILIP DARBYSHIRE

Professor Darbyshire is internationally recognised as a leader in nursing and health care research and practice development. He has presented over 100 keynote papers, seminars and workshops in 12 countries. He has a special passion for making research and systematic inquiry accessible and exciting and in using arts and humanities approaches to help nurses and health care staff develop a deeper appreciation of 'the patient's experience'.

For 13 years he led one of Australia's most successful practice-based research departments at the Women's & Children's Hospital in Adelaide, and has supported health and education organisations in Australia, New Zealand, UK, Norway, Ireland and Italy.

Professor Darbyshire is also a Professor of Nursing at Monash University, Adjunct Professor at University of Western Sydney and in 2012 he was voted 'Social Media Nurse of the Year'.

JULY – SEPTEMBER 2013

Continuing professional development calendar

JULY

11–12 Understanding team nursing and leadership
RN | Two days | 14 CPD hours | Brisbane QLD

17–19 Understanding mental health
RN/EN | Three days | 21 CPD hours | Orange NSW

18–19 Wound management
RN/EN | Two days | 14 CPD hours | Burwood NSW

19 Understanding dementia
RN/EN | One day | 7 CPD hours | Port Macquarie NSW

24–25 Physical health care in mental health
RN/EN | Two days | 14 CPD hours | Cairns QLD

25 Immunisation update
RN | One day | 7 CPD hours | Burwood NSW

25–26 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Burwood NSW

29–30 Palliative care
RN/EN | Two days | 14 CPD hours | Perth WA

31 Understanding dementia
RN/EN | One day | 7 CPD hours | Adelaide SA

Skills/knowledge required:
Beginner Intermediate Advanced

This course attracts no fees for employees of NSW Health.

AUGUST

8–9 Diabetes update
RN/EN | Two days | 14 CPD hours | Darwin NT

8–9 Pain management
RN/EN | Two days | 14 CPD hours | Alstonville NSW

9 Legal issues for registered nurses
RN | One day | 7 CPD hours | Brisbane QLD

15–16 Palliative care
RN/EN | Two days | 14 CPD hours | Griffith NSW

16 Perioperative anaesthetic nursing
RN | One day | 7 CPD hours | Adelaide SA

20 Pharmacology update
RN/EN | One day | 7 CPD hours | Alice Springs NT

22–23 Rehabilitation nursing
RN/EN | Two days | 14 CPD hours | Coffs Harbour NSW

22–23 Wound management
RN/EN | Two days | 14 CPD hours | Bendigo VIC

26–27 The deteriorating patient: clinical decision making
RN/EN | Two days | 14 CPD hours | Wollongong NSW

27 Day surgery nursing
RN/EN | One day | 7 CPD hours | Melbourne VIC

29–30 Wound management
RN/EN | Two days | 14 CPD hours | Burwood NSW

29–30 Orthopaedic update
RN/EN | Two days | 14 CPD hours | Townsville QLD

SEPTEMBER

5–6 Palliative care
RN/EN | Two days | 14 CPD hours | Hobart TAS

12 Day surgery nursing
RN/EN | One day | 7 CPD hours | Adelaide SA

12–13 Wound management
RN/EN | Two days | 14 CPD hours | Bunbury WA

13 Understanding dementia
RN/EN | One day | 7 CPD hours | Burwood NSW

13 Immunisation update
RN | One day | 7 CPD hours | Melbourne VIC

17–18 Nursing patients with an intellectual disability
RN/EN | Two days | 14 CPD hours | Burwood NSW

18–20 Clinical assessment: models of assessment and care
RN/EN | Three days | 21 CPD hours | Burwood NSW

19–20 Wound management
RN/EN | Two days | 14 CPD hours | Wagga Wagga NSW

20 CPD portfolio and competencies workshop
RN/EN | One day | 7 CPD hours | Brisbane QLD

20 ECG – introduction
RN/EN | One day | 7 CPD hours | Adelaide SA

26 ECG – introduction
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