Australian College of Nursing

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#26 WINTER 2019

KEEPING YOU INFORMED, CONNECTED AND INSPIRED

A lifetime of nurse leadership

Ruth Zionzee RN RMN OHNC FACN (DLF)

Empower nurses to improve abortion care

Lydia Mainey MACN

Time to talk, period.

Erica O' Donoghue MACN

WOMEN'S HEALTH

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Australian College of Nursing

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WOMEN'S HEALTH

Australian College of Nursing

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We love to see member submissions in *The Hive*. If you're interested in having your submission considered for publication, please see our guidelines and themes at **www.acn.edu.au/publications**.

For enquiries or to submit an article, please email **publications@acn.edu.au.**

ACN publishes The Hive, NurseClick and the ACN eNewsletter.

President's report

PROFESSOR CHRISTINE DUFFIELD FACN
AUSTRALIAN COLLEGE OF NURSING PRESIDENT

As with many countries, 90.3% of the employed nursing workforce is female but importantly, 39% in Australia are over the age of 50 (AIHW, 2016). The rate of part-time employment for women in all industries in this country is 68.5% (ABS, 2019). This statistic is slightly better in the nursing profession where 48.8% of employed registered nurses and midwives work an average of 33.5 hours per week (considered to be part-time), and this figure is 57.5% for enrolled nurses (AIHW, 2016). This under-employment reflects the many unpaid roles undertaken by women. Clearly anything which affects women's health will have a significant impact on productivity and workforce participation, and significantly for our profession, the capacity we have to provide care, either in paid or unpaid roles.

The leading causes of death and disability for women in this country include; dementia and Alzheimer's Disease (11%), coronary heart disease (10.7%), cerebrovascular disease (8.1%), lung cancer (4.4%), chronic obstructive pulmonary disease (4.3%), breast cancer (3.9%) and diabetes (2.9%) (AIHW, 2018). This is not dissimilar to the statistics for men. Women of course face other health issues including endometriosis, ovarian cancer and menopause, to name a few. However, the causes of death do not speak to many of the issues which can have a profound impact on the health and wellbeing of women and by extension, their families. Three receiving significant attention at the moment are domestic violence, poverty and homelessness.

Nurses should have high health literacy given our professional background and university preparation. That said it comes with a great responsibility: We are expected to know and role model healthy behaviours, but how healthy are we? In the UK, Blake et al. (2011) found that pre-registration nurses had a poor health profile, with low levels of physical activity, poor dietary habits, high levels of binge drinking and higher rates of sick leave. However, on a positive note, rates of smoking were lower (Blake et al., 2011). There are similar findings in the US. A large-scale prospective cohort study there has followed female resisted nurses (n = 77,782) aged 30–55 years for a period of more than 24 years. Of 8,882 deaths documented in this study a decade ago, 55% were linked to smoking, inactivity, poor diet and being overweight (Dam et al. 2008). More recently in the US, a cross-sectional study of 335 RNs found that more than half of participants were overweight or obese, 80.1% were sedentary for three or more hours a day, and almost half consumed less than the daily-recommended intake of fruit and vegetables (Ross et al., 2018).

> **"Nurses should have high health literacy given our professional background and university preparation."**

Australian nurses have a slightly better health profile. Compared to the general population we are more likely to meet dietary recommendations, and have lower rates of obesity and smoking but lower rates of physical activity (Perry et al., 2018). However, the burden of disease and disability amongst us is significant and leads to a higher intention to leave the workforce. Those intending to leave reported significantly poorer general health, took more sick days and were more likely to have been hospitalised in the previous 12 months (Perry et al., 2016). They were more often diagnosed with anxiety, were more likely to have experienced moderate-severe bodily pain, back pain, severe tiredness, indigestion, depression and poor sleep patterns (Perry et al., 2016). These findings do not bode well for the long term sustainability of our profession.

As women comprise the majority of the nursing profession, it is critical that we prioritise our own health and wellbeing to ensure we maintain a resilient workforce which supports, and is responsive to, the specific health needs of women and girls.

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Hello!

Welcome to the Winter edition of the Australian College of Nursing's quarterly member magazine, *The Hive*.

ADJUNCT PROFESSOR KYLIE WARD FACN
AUSTRALIAN COLLEGE OF NURSING CHIEF EXECUTIVE OFFICER

Michelle Obama said a few years ago, "Communities and countries and ultimately the world are only as strong as the health of their women." There's a lot of power in these words, I'm sure you will agree. But let's stop and think for a moment: how many mothers, wives and daughters do you know who really look after their mental, physical, spiritual and emotional health? How many nurses – who spend most of their time caring for others – care for themselves? And as nurses and nurse leaders, what role do we have to play? Those are the issue we address in this edition.

In **Empower nurses to improve abortion care**, **Lydia Mainey MACN** discusses the complexity of abortion in the context of social issues like domestic violence, sexual coercion and financial hardships and the impact these have on women undergoing abortion. More importantly, she touches upon why nurses, who boast a range of clinical skills and understand this, need to be provided a greater scope of practice to allow them to provide more comprehensive pre-, during and after abortion care.

The first step to care – of any kind – is to talk about the issue. This is especially true in the case of sexual health.

In **Understanding Female Genital Mutilation (FGM)**, **Marie Jones MACN** urges health professionals to 'ask the question' instead of waiting for affected women and girls to talk about it, especially since they may not even know they've undergone FGM. In **Time to talk, period**. **Erica O'Donoghue MACN** puts the spotlight on another reproductive health issue: menstrual pain and why we don't – but must – discuss it. We often tend to brush period pain off without realising that it warrants a conversation, simply because not all pain is 'normal'. Health professionals especially need to make this distinction between normal and abnormal pain by asking the relevant questions instead of dismissing it or making light of someone's condition.

In **Migrant women and motherhood**, **Dr Ruth De Souza FACN** talks about caring for new mothers from varied cultural backgrounds and highlights the vital role nurses play in creating a safe and supportive environment for them. As Australia becomes more diverse, it is essential nurses are aware of their responsibilities to provide culturally safe care.

In **A lifetime of nurse leadership**, the ever-effervescent **Ruth Zionzee RN RMN OHNC FACN (DLF)** talks to us about her challenging yet inspirational journey as one of the pioneers in the field of occupational health nursing, paving the way for nurses in this area today. Ruth's impressive 38-year-long stint in the profession is indicative of the importance of occupational nurses' active engagement with the wider community and we're glad that she is an invaluable part of ACN as it has evolved over the years.

Speaking of nurse leaders, please join me again in congratulating this year's Trailblazer Award winner **Nikki Johnston OAM MACN** and finalists **Professor Jeanine Young FACN**, **Professor Sandy Middleton FACN** and **Linda Campbell MACN** who talk about their passion for the profession and their work towards dramatically improving the quality of health and aged care in Australia. As always, we are proud to support nurse leaders who are constantly working to transform our country's health care system and I hope they will inspire you, just as they inspire me.

Nursing Now Australia launch

ACN Nursing & Health Expo Melbourne

LET'S RAISE THE PROFILE OF NURSING

ACN is proud to be the lead organisation for Nursing Now Australia and were honoured to officially launch the campaign at Doltone House in Sydney on 9 April. The launch was attended by high profile VIP guests, including Lord Nigel Crisp, Co-Chair of Nursing Now.

Nursing Now was established by the World Health Organization and the International Council of Nurses based on the findings of the triple impact report. The report concluded that as well as improving health globally, empowering nurses would contribute to improved gender equality and stronger economies. Nursing Now aims to empower nurses to take their place at the heart of tackling 21st century health challenges and maximise their contribution to achieving Universal Health Coverage.

We have partnered with the major nursing organisations in Australia to develop the Nursing Now Australia Challenge. Each month, counting down to the 200th anniversary of the birth of Florence Nightingale in May 2020, we are encouraging nurses to engage in activities to raise the status and profile of our profession. By participating in the monthly challenges you will get a chance to win one of two $100 Visa gift cards each month. If you complete six or more monthly challenges you will also be entered into the major prize draw! Head to **acn.edu.au/nursingnow** to download your copy of the challenge calendar and get started.

SUPPORTING A REWARDING CAREER CHOICE FOR MEN

Nursing is a lucrative and worthwhile occupation for those who identify as male. Despite this, numbers of male nurses in our profession remain low. Our 'Men in Nursing' initiative seeks to reverse this trend by emphasising the many benefits a career in nursing can offer for males. The initiative encourages men currently in the nursing profession to share their journey and experiences. These stories will be compiled into an eBook to be released later this year. If you want to share your story, it isn't too late to contribute! Stories should be between 400-1,000 words in length and sent to **publications@acn.edu.au**.

ENEWS GOES MONTHLY

From June 2019, you can expect our eNewsletter to appear in your inbox on the last Friday of every month. The monthly eNews will be the place to catch up on all that is happening in our tribe and features engaging content on topics like upcoming events, scholarship opportunities and the latest education courses. It will also contain a welcome from our CEO Adjunct Professor Kylie Ward FACN and highlights from our NurseClick blog! Be sure to spread the word with your friends and colleagues within the ACN membership.

2019 NURSING AND HEALTH EXPO

We would like to thank all those who attended our annual Nursing and Health Expo in Melbourne on 27 April 2019. The event was a resounding success with over 5,000 nursing students having the chance to discuss career opportunities with industry experts and attend a range of informative educational seminars. A photo album from the day is available on our Facebook page. We are already looking forward to next year's event so keep an eye out on our website for more information as it comes to hand!

BREAKFAST CELEBRATES NURSES ACROSS THE GLOBE

Our annual National Nurses Breakfast was another big hit in 2019. The breakfast, which is held to mark International Nurses Day, celebrates the incredible efforts of nurses all over the world. Thank you to all those who organised an event at their workplace, university or community centre. We loved seeing the photos of all the amazing food! ACN would particularly like to thank HESTA for their support of the event and we can't wait for next year's celebrations.

HOW WE'VE BEEN GETTING NURSESTRONG

We are incredibly passionate about looking after the health and wellbeing of our profession. That's why we launched NurseStrong last year, to give nurses an opportunity to enhance their health and fitness in a safe and supportive environment. In 2018 we gave over 1,000 nurses around the country the opportunity to participate in an online HIIT (High Intensity Interval Training) program. Over the past months we introduced two new NurseStrong initiatives based on your feedback.

To motivate nurses to engage in low impact exercise we partnered with the Heart Foundation to run the Active April Walking Challenge. NurseStrong participants were encouraged to track their daily steps using the Heart Foundation Walking app. Together we clocked up an impressive 18 million steps! Special shout out to Amy Fifita MACN (Undergraduate) and Lily Ward for winning the Active April challenges. We encourage you to continue using the app and aiming for 10,000 steps per day.

In May we moved from an emphasis on physical fitness to mental wellbeing to bring you Mindfulness May. Thanks to Mindful Innovative Actions (MIA) the first 500 nurses that registered received complimentary access to the eight-week Stress Less, Live Well mindfulness program designed for nurses by nurses. If you missed out and would like to learn more about mindfulness you can register for a course with MIA via miaonline.com

Stay tuned for more exciting NurseStrong initiatives to come. Keep an eye on the hashtag #ACNNurseStrong on social media and download our motivational calendar from acn.edu.au/nursestrong to stay inspired and receive updates about NurseStrong.

ACN SNAPS

At ACN, we love getting out and about with our members and the wider nursing community! If you attend an ACN function or event, make sure you share your snaps with us through our social media platforms!

Remember to use our membership hashtag #ACNtribe

Kazuma Honda MACN with Professor Ikuko Sakai (Director of Interprofessional Education Research Centre, Chiba University Graduate School of Nursing, Japan)

ACN Nursing and Health Expo 2019

Hellyer Community Nursing Service held their International Nurses Day bake off

Adjunct Professor Kylie Ward FACN laid a wreath at the Nurses and Midwives Wreath Laying and Remembrance Ceremony at the Australian War Memorial on May 7. She is pictured with Dr Carolyn Stapleton FACN, Professor Karen Strickland MACN and Ms Marina Buchanan-Grey MACN.

Nursing Now Australia launch

POSTED

MORE Start a conversation with other Fellows and Members on ***neo*** at **neo.acn.edu.au**

DR MADONNA GREHAN MACN
HISTORIAN

WOMEN'S HEALTH – A BROAD CONCEPT

"It's a significant document to guide women's health policy in the next decade."

One of the earliest government policies aimed at improving the health of women was the *Maternity Allowance Act 1912* (Cth), a five pound payment to married and single women who had given birth, to cover the cost of a trained attendant. The White Australia policy applied at the time, however, and some women were excluded from the policy under Section 6(2) namely: Aboriginal women, Pacific Islanders, Papuans and Asiatic women.

For much of the 20th century, women's health policy focused on stages in the female reproductive cycle from puberty to pregnancy and birth and menopause. The latest policy document launched by the federal government in April 2019, the *National Women's Health Strategy 2020–2030*, positions women's health as a much broader concept.

The reproductive life cycle remains integral, of course, but it's combined with maternal and sexual health to form one of five priority areas for government. The other four areas are:

- Healthy ageing with a life course approach
- Chronic conditions and preventative health
- Mental health
- The impact of violence on women and girls

Accepting that there's no 'average' woman in Australia, the plan is underpinned by a principles-based approach and without the discrimination that applied in 1912. The 2020–2030 plan acknowledges that the health of women is not simply about the physical body but multi-factorial. For example, some dynamics recognised as influencing women's health are literacy, education, living conditions, poverty, culture and stigma. This strategy is the product of substantial community, consumer and professional input. It's a significant document to guide women's health policy in the next decade.

***The National Women's Health Strategy 2020–2030* is available at: www.health.gov.au/internet/main/publishing.nsf/Content/national-womens-health-strategy-2020-2030**

MS LAURIE BICKHOFF MACN
EARLY CAREER NURSE

WOMEN DIE BECAUSE THEY AREN'T MEN

It has been argued that medicine has a gender problem, that the medical system, diagnosis and treatment is skewed towards males. Consider the following:

- 50% of women are misdiagnosed following a myocardial infarction (Dusenbery, 2018).
- In six out of 11 types of cancer, it takes longer to diagnose women compared to men (Samuel, 2019).
- If you're a man, a diagnosis of Crohn's disease will take about a year. If you're a woman, that time increases to 20 months (Kiesel, 2017).
- Women presenting to ED with acute pain are less likely to be prescribed an opioid analgesic but more likely to be prescribed a sedative or anti-anxiolytic than their male counter-parts (Bilock, 2018).
- It takes on average six to ten years for a diagnosis of endometriosis (SpeakENDO, 2019).

When you look at the research, we cannot deny our health system has an issue, one that has persisted long after 'hysteria' as a diagnosis was supposedly relegated to the history books.

Women experience pain and disease processes differently to men and their symptoms are often considered 'atypical'. However, for the 50% of the population that are female, these presentations are the norm, not the exception. Medications that work effectively for men may not have a corresponding result for women, and vice versa, yet gender specific data analysis of medication trials remains a rarity.

How can the nursing profession help? Our critical thinking and clinical reasoning skills are vital in recognising and helping close the gender disparity in health care. Our profession has a strong foundation of person-centred care and patient advocacy and both are needed to ensure women are heard and their health concerns addressed correctly. Our nurse educators, academics and researchers need to acknowledge the issue and reflect on how they can integrate gender specifics into their work.

Nurses have a long history of leading change in health care. This issue will take determination and perseverance to overcome and the nursing profession has proved many times over that we have both. Nursing can be the driving force that sees the quality of women's health care improve.

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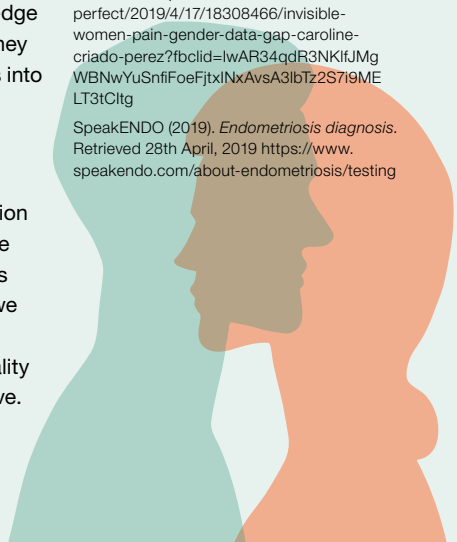

MS TOMICA GNJEC MACN
CLINICIAN

PREVENTATIVE HEALTH AND THE NATIONAL WOMEN'S HEALTH STRATEGY 2020–2030

One of the identified priority areas of the National Women's Health Strategy 2020–2030 is preventive health. The report discusses and suggests "a life course" approach to health with increased awareness and primary prevention of chronic conditions, symptoms and risk factors in women and girls (Australian Government, Department of Health 2018).

An opportunistic interface for contact with young women and girls is the acute health setting. Health professional interactions with young women can be sporadic and unplanned. Brief interventions can easily be employed and may include dissemination of relevant health information and local support services available (e.g. Headspace – a national online and phone support service for young people) and the use of mobile health apps (e.g. 'Healthyminds' and 'Happify') to assist with achieving goals and tracking health progress.

> **"An opportunistic interface for contact with young women and girls is the acute health setting."**

As a gatekeeper to health services it is imperative to welcome and continue to encourage an open line of dialogue and information sharing with our young women to explore any unaddressed concerns at all points of health contact.

It is important that we as clinicians aim to embed a positive health journey to empower young women to better prevent illness and drive their own health care needs (Australian Government, Department of Health 2018).

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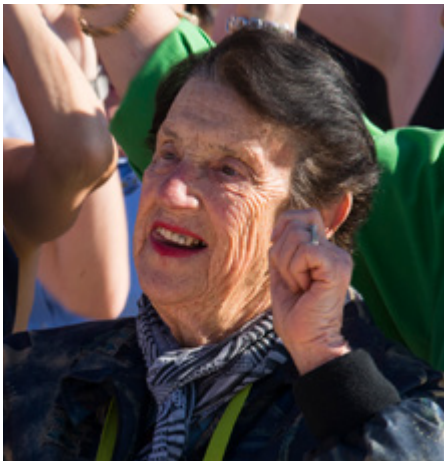

DISTINGUISHED LIFE FELLOW: RUTH ZIONZEE

A lifetime of nurse leadership

Dora Ruth Fairchough Zionzee RN RMN OHNC FACN (DLF) (Ruth) is a passionate nurse leader who has had a resounding impact on our profession and organisation throughout her distinguished career and into her retirement.

During her time as an occupational health nurse and through her ongoing involvement with the Australian nursing community, Ruth has seen the health care industry evolve and transform into what it is today. “The rate at which technology is advancing places the nursing professional of today between rapid advances of science and the realities of patient care,” Ruth says.

Ruth learned the realities of patient care almost 70 years ago when she commenced her nursing career. Prior to this, Ruth worked at Lever Brothers in Balmain, Sydney. “Three years in an office environment at Lever Brothers gave me a good background to work practices and how to interact with people,” Ruth says.

But for Ruth, nursing was her true calling. Despite her father saying “no daughter of mine is going to be a nurse,” she left Lever Brothers and joined the first intake at the Preliminary Training School at Balmain Hospital in 1950. The school was revolutionary at the time as it was the first of its kind to offer nursing students six-weeks full-time training prior to commencing in the wards. It was also the first to offer male nurse training.

Ruth started at the school with six other nursing students and they had a lot of fun together as they embraced a very full and practical training experience, guided by highly regarded tutors. “We were all in superb spirits during training but once into the wards, a totally different world evolved. ‘Pretending’ and ‘make believe’ became reality, and the scope for confusion was considerable.”

Despite the steep-learning curve, after four years of working with a close-knit team, most of whom became life-long friends, Ruth completed her training with flying colours in 1954. At the graduation ceremony, she received the Silver Medal for Proficiency, an award never given before or since. “If you were to ask my fellow trainees about this award, I suspect they’d say it was for telling risqué jokes every day!” she says.

Soon after training, Ruth decided to train as a midwife at the Royal Hospital for Women in Paddington – where she came third in her cohort. Her first job as an industrial nurse was at Ira L & A L Berk Car Manufacturers in 1956, where she provided first aid to employees and was paid 12 pounds per week. After two years, Ruth returned to Lever Brothers as an industrial nurse. “Suddenly, I was back at Lever Brothers, with a different hat on. I was running an exceptionally busy health centre looking after 1,600 employees.”

At Lever Brothers (later renamed Unilever), Ruth saw, and contributed to, the transformation of nursing and health care delivery in an occupational setting. “I was fortunate to be on the ground floor to see the changing role of the industrial nurse to the preventive role of occupational health nurse, assisting in making the workplace safer,” she says.

Over the years, the occupational health service expanded enormously. When Ruth first commenced in her role, a part-time doctor visited daily for an hour. By 1962, a full-time occupational health physician was appointed to the service. The following year, she got an assistant, Ruth Betts, to help with her increasing workload. Ruth (Betts) was interested in pursuing a nursing career and stayed for two years before leaving to commence her training. She was replaced by an enrolled nurse aid.

For Ruth, a turning point in her career occurred in 1969. That year, Mary Blakely SRN SCM OHNC had given the oration for the NSW College of Nursing about the speciality of occupational health and the nurse’s role within it.

At the time, Mary was the President of the Royal College of Nursing and National Council of Nurses of the United Kingdom, as well as the Principal Nursing Advisor of Unilever UK. When she heard that Ruth had worked in the industry almost 12 years without a post-graduate certificate in occupational health nursing, Mary pushed for her to be given this opportunity (an opportunity that she had previously requested from management).

The next year, she was enrolled into the Occupational Health Nursing Certificate course run by the NSW College of Nursing. Ruth excelled again, gaining first place in the class and graduating with a high distinction in 1970. Impressed by her achievements, Unilever appointed her to junior management as a senior nursing sister the following year. “The key to the executive (male-domineered) washroom almost!” Ruth says.

Over the years, Ruth’s accomplishments paved the way for today’s nurses. One way in which she did this was when she was called upon as an expert witness for the equity pay rise in the industrial court in 1974. Proceedings took place over a week and the outcome brought about a very reasonable salary increment, in line with the Public Hospitals Award rate. This was an enormous breakthrough in occupational health at the time.

In 1981, Ruth was appointed Principal Occupational Health Nurse for Unilever. She headed a staff of five nurses and two enrolled nurse aids based in Sydney, as well as four full-time nurses in Melbourne. She frequently travelled between both cities and often lent her expertise to conduct interviews, write job descriptions and work practice manuals, as well as other high-level duties.

Ruth undertook further education in the 1980s, studying Applied Human Physiology for Nurses at the Sydney Technical College in 1986 and Ergonomics Fundamentals at the

> **“Over the years, Ruth’s accomplishments paved the way for today’s nurses.”**

NSW Institute of Technology in 1984. In 1988, she retired after 38 years in the industry.

Upon reflection on her fruitful career, Ruth emphasises the importance of occupational nurses actively engaging with the wider nursing community. “Preventative work, without a doubt, doesn’t have the urgency or glamour of curative or therapeutic work. To some extent, it must be sought,” Ruth says. “Opportunities have to be seen and taken.”

“Working as a sole nurse in isolation and away from the general stream of curative nursing, the support I received from my colleagues and nursing organisation cannot be over emphasised.”

Nor can her contribution to our professional organisation as it stands today. Ruth is a Distinguished Life Fellow who has been an invaluable part of the Australian College of Nursing (ACN) as it has evolved over the years. She has never missed a forum nor an oration since 1969, and is a crowd favourite amongst delegates with her endless enthusiasm and daily joke. “I remain positive and enthusiastic in retirement,” Ruth said. “I am especially interested in ACN and attend forums regularly. I am inspired by advanced nurse leadership and nurse education within the industry. It’s so important for nurses to belong to their respective professional organisations.”

In retirement, Ruth’s zest for nursing and life in general has remained strong. She walks daily, takes a weekly Zumba class and regularly plays tennis. Ruth also loves ballet and attends several performances every year. She continues to impart wisdom to the younger generation and embodies the very essence of what it means to be a nurse. For Ruth, “the nursing spirit is the essence of healing and caring for sick and injured people”.

“Try to be the best nurse you can be and always respect the team you work alongside. In this journey, don’t ever think that you know it all!”

Looking forward – the future is in the past

When I think about the future of nursing, several key phrases come to mind: ‘marching on’, ‘change is history’, ‘prevention is better’, ‘controlling our destiny’, ‘growth and development’, ‘focus on the future’, ‘leadership prevails’, ‘teamwork’ and perhaps most importantly, ‘widening horizons’. By reflecting on our past and honouring the fundamentals of nursing care, we can widen our horizons and expand the future of our profession.

Back in 1970, I was required to write a ‘short’ 1,500-word essay on the history of nursing to be accepted into the Occupational Health Nursing Certificate course at the NSW College of Nursing in Glebe. I spent weekends at the state library, researching the story of Florence Nightingale, the founder of modern nursing.

My essay must have been satisfactory, as I was accepted into the course; I suspect one had to have a reasonable understanding of nursing history prior to commencement. Our shared history and Nightingale’s legacy is as relevant and recognised today, as it was back in 1970.

Just recently, the Florence Nightingale Medal was posthumously awarded to a young South Australian nurse who was killed in the London Bridge terror attack, while attending to the wounded. It was an act of bravery not unlike Nightingale’s efforts in the Crimean War, gaining her prominence for her care and treatment of the wounded.

Although much time has passed since and the role of technology in nursing has evolved significantly, we still return to the basics: care and treatment of the wounded. Nurses still provide hands-on care, whether this involves dressing wounds or bathing patients (infection control in nursing has been around since the 80s!).

In my role at Unilever, I had the privilege of introducing occupational health to student nurses, who would spend one full week on duty with me. Most days, I would treat at least 50 patients, and had to complete annual medical reports that involved taking a person’s temperature, pulse, height, weight, blood pressure, urinalysis, and haemoglobin — it was a busy, busy time!

When a student joined me on duty, I’d always ask them, ‘What do you think about nursing?’

Most answered, ‘What do you mean?’ or ‘I’ll get through.’ They were young.

During the course of the week, I would always strive to inform each student of the basics of caring for the sick and injured. I trust they learnt this from me and took this knowledge away with them, while their chosen nurse education course continued.

When it comes to the nursing profession, the future is in the past.

AUTHOR

RUTH ZIONZEE RN RMN OHNC FACN (DLF)

EMPOWER NURSES TO IMPROVE ABORTION CARE

A few months ago, Queensland added itself to the list of other Australian states (barring NSW) that decriminalised abortion. The historic law reform put into the spotlight a topic usually engulfed by stigma and politics – both for nurses who work in abortion care and the women receiving it.

One in four Australian women will have an induced abortion in their lifetime (Scheil et al., 2017); for many the decision to have an abortion can be complex, and made in the context of social issues such as domestic violence, sexual coercion or financial hardship. Most of these women will be cared for by a nurse during their patient journey. Many nurses who work in this area view it as rewarding work, and with the reform comes an opportunity for the profession to review the role of nurses in this area and highlight the possible future direction of abortion care across the country.

The role nurses play

Induced abortions have probably always been performed in Australia. Until the late 1920s, many women performed their own abortions or sought the assistance of lay-midwives (Baird, 2013). Nurses formally became involved in abortion care after the practice was legislated under the various State's criminal codes and moved into the health system.

Today, abortion is a safe, straightforward procedure which can be done via surgery or through the administration of medications. The most recent national report found the majority of the 80,000 abortions recorded annually take place in private clinics (AIHW et al., 2005). Nurses from other clinical areas (such as sexual health and primary care) often facilitate women's access to these centres. There is optimism that law reform will increase abortion access in the public system and in general practice and therefore more nurses may become familiar with abortion care.

The law on abortion

The Federal and State governments legislate abortion in Australia and take conservative approaches to the scope of nurses. It is legal in all states and territories for registered and enrolled nurses to assist with abortions, including the administration of abortifacient medication and assisting in theatre with the surgical procedure (when performed within the requirements of the law) (Children by Choice, 2019). The nursing role tends to focus on assessment of the woman, preparation for the abortion, and assistance with the procedure and aftercare.

Although some abortion facilities allow for nurses to deliver contraceptive implants and intrauterine devices, nurse practitioners are unable to provide medical abortions such as Mifepristone – one of the medications used in medical abortions – as it is restricted by the Therapeutic Goods Administration and must be prescribed by an authorised medical practitioner (Department of Health, 2012).

Similarly, surgical abortions must be performed by trained medical practitioners. In countries such as the USA, the UK and many developing nations, extended practice nurses are permitted to prescribe abortion drugs, perform surgical abortions and manage post-abortion complications (Berer, 2009).

Better skills equal better care

Nurses who provide abortion care work across a range of services such as primary practice, stand-alone abortion centres, operating theatres and afterhours call centres. They have a sound understanding of the female reproductive system, induced abortion methods and post-abortion care. They must have a host of clinical skills in their toolkit.

Not only do they demonstrate strength in clinical assessment and health history taking, they are also able to identify and act on risk factors such as domestic violence. Sound sexual health and contraception knowledge is also essential, as is the ability to undertake women-centred counselling around these topics. They have a good understanding of the medications used in abortion and provide clear education on their use, effects and side-effects. Additionally, nurses who care for women undergoing surgical abortions must also have a knowledge of the perioperative patient journey.

Going beyond patient care

Most nurses who work in abortion care understand that the pathways to access abortion are imperfect and can be stressful to the woman. Thanks to roll-out of education programs from organisations such as Children by Choice, they are also beginning to understand that women often seek abortions in the context of domestic violence and reproductive coercion, cases that then prompt them to sensitively adapt their care to meet the needs and experiences of the individual.

Some nurses reveal that they try to develop a quick rapport with the woman allowing sensitive information to be shared, comprehensive care to be given and outcomes to be evaluated.

Empowering nurses to do more

Comprehensive abortion care (CAC) is the gold-standard of abortion service delivery and could be a model of care that Australia moves towards in the future (Dawson et al., 2016). CAC is a women-centred integrated and decentralised services approach that focuses on preventing unwanted pregnancies, reducing complications after abortion, and attending to other issues affecting the women.

The nurse's role in this model of care is quite broad and differs from what's currently provided by most abortion services in the country. For example, in countries that practise CAC, nurses lead many medical termination services, and some countries allow extended practice nurses to perform surgical aspiration abortions.

Extending the nurse's scope allows those who work in rural and remote locations to provide services to their communities reducing the need for women to travel. Integration of abortion services with other services such as family planning and domestic violence will require nurses working in this space to collaborate with other professionals such as social workers.

Abortion is not a fringe obstetric issue. It is a safe, legal and straightforward procedure that many women will – and have the right to – choose. Providing nursing care to women undergoing abortion is a rewarding experience where the skills and art of nursing intertwine. More nurses may have the opportunity to work in this area, and with a greater scope of practice, as legislation continues to change and abortion care moves towards comprehensive care.

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AUTHOR

LYDIA MAINEY MACN

“The abortion law reform in Queensland will hopefully act as a catalyst in extending the scope of nurses' role beyond patient assessment, assistance and aftercare.”

YOUR HEALTH, YOUR RIGHT

Our bodies are trying to communicate with us, but are we listening?

Women's health is a vast subject, and yet something that women themselves pay little attention to. Our bodies, right from the time we're born, are constantly undergoing major changes. Puberty, pregnancy, childbirth, menopause and so on. These changes don't just affect women physically, but mentally and emotionally too, and often bring with them women-specific illnesses or health issues.

As a woman, I know the way I choose to live my life affects my health, directly and indirectly. I want to live a life where I am not only healthy, but I feel 'well'. To do this, I consider my health status from a holistic approach and look at every area, i.e. physical health, mental health, level of vitality, relationships, family life, personal life and work life. All these aspects of life are intertwined with what I eat, how I exercise, what I do for self-care.

Proactive versus reactive

What I've observed in my time working as a nurse is that women tend to have little consideration of their health status until an illness or ailment comes to their attention, like acute or chronic pain, extreme period pain, a diagnosis of endometriosis, polycystic ovaries, a tumour, a sexually transmitted disease – the list could go on.

So, the questions I'm asking are:

Why don't we make conscious efforts to live well so that we can feel well most of the time?

Why, despite being the most intelligent species on the planet, are we the only ones who knowingly choose eating or drinking habits that have an adverse effect on our health?

Most importantly, why are we reactive rather than proactive? Why wait until an ailment becomes a reality to cure it?

Of course, we cannot compare the life of a human to that of a wild animal; however, we have to consider that although we can speak multiple languages, build skyscrapers, create jobs and run an industrial world, we still sacrifice our health, unlike any other creature.

Mind and body awareness

I know I like to examine what things in life are good for my body and what aren't. In doing this, I choose what I need from a connection to my body; I don't do it just because everyone else is or because it's common knowledge.

Every woman has a different body. What's healthy for me needn't be right for someone else. The amount of exercise I need may vary from what another woman needs. The only way to know is for each woman to develop a relationship with her own body and allow its intelligence to inform her. If you're wondering how, think about it: Have you noticed there are certain foods you eat that make you feel bloated, trigger a reaction such as a stuffy nose or a phlegmy throat, give you a heartburn, or increase your weight?

These symptoms are your body's intelligence that's trying to tell you what's working for it and what is not. Paying attention to my body means eating foods I know nourish my body, eating enough but not too much, exercising gently and regularly, going for walks and resting when I'm tired. Over time, you will find that if you respond to your body's cues, it heightens your sense of wellbeing too. A healthy body is the first step towards holistic wellness.

Wellbeing through engagement

For humans, social engagement is just as important for nourishment as food. I know that the way I speak and engage with others has an impact on my sense of wellness. Have you noticed that you feel drained after talking to a particular person or about a specific subject? On the other hand, you always end up feeling good when you have a great conversation or just a fun gossip with a friend. Having conversations that lift you and others is vital for a more holistic health approach.

On top of my own experience of what it's like to truly love your body, as I study disease concepts and pathophysiology as an undergraduate registered nurse, it only increases my appreciation for the human body, and I can say that my body is more intelligent than I am. Our bodies are always communicating with us. If we listen, we can prevent illnesses. If we choose to ignore the signs, they will eventually stop us in our tracks, forcing us to deal with the problem.

As women rise and claim their rightful place as leaders in health care and leaders in communities, they must also declare their right to love their bodies again with no reservation! Taking the lead on one's health is one of the most inspiring forms of empowerment women can have. When this becomes the new normal, who knows what the illness and disease statistics will be?

AUTHOR

ARIEL YOKOTA

UNDERSTANDING FEMALE GENITAL MUTILATION

Nurses can play a crucial role in providing care to girls and women who are victims of FGM

My interest in the area was sparked over 20 years ago when I began caring for women affected by Female Genital Mutilation (FGM). I have worked as a nurse/midwife at The Royal Women's Hospital in Melbourne for over 30 years, in a variety of areas such as antenatal/postnatal, birth centre and special care nurseries/outpatient clinics. Currently, I work as an Associate Nurse Unit Manager in the Emergency Department, and I also coordinate the African Women's Clinic (AWC) in the Women's Health Clinics. The AWC is a nurse/midwife-led clinic.

What is FGM?

"Female Genital Mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, UNICEF, UNFPA, 1997).

FGM is known to be practised primarily in African, Middle East and Asian countries. Although outlawed in most countries, it continues to exist. "It is estimated that more than 200 million girls and women alive today have undergone FGM in the countries where the practice is concentrated. Furthermore, there are an estimated three million girls at risk of FGM every year. The majority of girls are cut before they turn 15 years old" (WHO 2019).

FGM is a criminal offence in Australia, and it's illegal to take a girl/woman from Australia to perform FGM on her. Maximum penalties range between seven and 21 years of imprisonment.

The World Health Organization (WHO) classifies FGM in four types. Type 1 is partial/total removal of the clitoris, Type 2 is partial/total removal of the clitoris with partial/total removal of the labia minora. Type 3 is infibulation (partial /total removal of the clitoris/labia minora and the sewing together of the labia majora allowing a small opening to pass urine and menstrual fluid). Type 4 is pricking/cutting/piercing/cauterisation of the genitals.

Effects of FGM

FGM, primarily a cultural practice, is seen as a rite of passage to ensure the woman's chastity before marriage, fidelity within marriage, and "being clean" as the clitoris in some cultures is seen as unclean. It has no health benefits, and can result in short-term consequences such as infection, bleeding, pain, distress, urinary retention and death. Long term effects include ongoing pain, scarring, abscesses, recurrent infections (particularly urinary), fertility complications, dysmenorrhoea, dyspareunia, inability to have penetrative sex, psychological distress, post-traumatic stress disorder and complications during pregnancy and birth (WHO 2019).

FGM is a violation of the child's human rights as well a form of discrimination against women (WHO 2019).

Nurses need to "ask the question"

In my experience, affected women are very unlikely to discuss their condition. Instead, they wait for the health professional to ask if they have experienced FGM. By not asking 'the question', we can miss important information, which can be detrimental to their care, especially if they are pregnant.

In the AWC, my co-worker Sarah Robson (also a nurse/midwife) and I see women of all ages, about half of whom are pregnant. They may be requesting help with complications from FGM, getting married (or are married and cannot have intercourse) and requesting de-infibulation, or they may be pregnant and need to know how FGM will affect their pregnancy and birth.

Language, sensitivity and respect are of utmost importance. For example, "I see you were born in Sudan/have come from the Middle East/lived in Ethiopia, have you been affected by traditional cutting?" Reassure the woman that any information is confidential. She may also not disclose information if accompanied by a partner or family.

In Victoria, workers at FARREP (Family and Reproductive Rights Education Program), which was set up in 1997, support health professionals. They are mainly from backgrounds where FGM is practised, and support and educate affected communities.

This practice can have long-lasting effects on physical and mental health of affected women, and as nurses, we not only have a duty towards their care but also to educate them and advocate for their wellbeing.

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AUTHOR

MARIE JONES MACN

MIGRANT WOMEN AND MOTHERHOOD

Why a 'one-size-fits-all' type of perinatal care can't work for migrant women

Motherhood is, for most, a joyous experience. The journey, however, isn't without its challenges. The weeks immediately preceding and following birth can take a toll on a woman's emotional and physical wellbeing.

Add physical and cultural dislocation – specifically those faced by migrant women – to that equation and the difficulties magnify. We spoke to internationally-renowned nurse leader Dr Ruth De Souza FACN, about the vital need for culturally safe maternal health care and how nurses can play an important role in creating a safe environment for migrant mothers.

How is maternal health in migrant women different?

For migrant women who are having a baby it's often their first encounter with the new health system. For them, it's literally a new life. Taking care of a newborn, finding their footing in a new culture and wrapping their heads around a new health care system can be overwhelming, especially when it's done without familiar rituals and support. Consequently, motherhood can become daunting and stressful.

What has been your experience in the area of maternal mental health?

After working in mental health for 10 years, I worked on a postnatal ward where I thought there might be opportunities to make a difference to women and their families. The reality of the situation was a bit different. I realised that many of the routine practices could make new migrant mothers feel unsafe and unsupported. The 'factory-like' process of treating every woman in the same way was deeply problematic, although it appeared benevolent.

I realised that some of the gaps were related to the difference in how birth is viewed in different societies. In countries like New Zealand, a maternal body is portrayed as being strong, capable of caring for the newborn without any outside help. However, in many cultures, childbirth is seen to make a woman's body more fragile and vulnerable, requiring that the mother be nurtured and cared for before she can take care of the baby all by herself.

For example, it was a ward practice then to administer an icepack near the perineum to soothe the area after birth. But for many women from other parts of the world, it is thought that women should be given warm foods. In some cultures, being exposed to cold or draughts can result in lifelong illnesses and vulnerability.

I noticed how 'institution-centred' and task focused that particular ward environment was rather than being family friendly. I think that the individualistic focus of much care is a problem also when we think about how the transition to parenthood is something that a whole family and extended family experience.

When did you first realise that this was an issue waiting to be addressed?

There were a lot of issues around communication and models of care. In one instance during my time on the post-natal ward, staff couldn't get access to an interpreter and so, proceeded to ask the woman's child to ask his mother about the lochia on her sanitary pad.

In another, as a nurse on the maternal health team, I visited a Sri Lankan woman and asked about problems she was experiencing. The woman replied that she didn't want to talk about her problems, instead she wanted help with washing clothes and cooking meals! It made me realise how the dominant model in mental health was oriented toward 'talking therapies' and for women who were looking for practical support, there was little I could offer. In many of these families, the partners are away all day at work. Some women are lucky enough to be able to get their family members, others weren't, and had to fend for themselves.

These scenarios made me reflect on the effectiveness of cultural safety. A framework for care was developed by Māori nurses to address health inequalities among Indigenous people. It was embedded in the curriculum, but I wondered if nurses were able to apply it in practice and whether it was effective for working with migrant populations. This led me to do a Masters by research looking at the experiences of birth for women from Goa and then a PhD where I spoke with nurses and mothers from Palestine, Iraq, India, Korea, China, the USA, Australia and South Africa. My current work explores how migrant mothering is being transformed through data and all things digital.

Do you think the landscape in Australia has changed, as far as cultural safety and maternal health care go?

Yes, it has. For starters, a framework for competency standards was launched for clinicians in January this year. It's titled *Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds*. Several Australian organisations came together with Migrant and Refugee Women's Health Partnership to help clinics deliver culturally responsive care to women from migrant and refugee backgrounds. It recognises that migrants can be indicators of a nation's health and that their health care, in turn, needs to consider several factors such as gender, migrant experiences, socio-economic status, etc. There's also been a consultation about cultural safety by the Australian Health Practitioner Regulation Agency (AHPRAH) and cultural safety is now incorporated into the code of conduct for nurses and midwives.

You've indicated that caregivers, to provide care to women from different cultural backgrounds, must consider their knowledge incomplete.

Nurses and health professionals are socialised to believe that they know all the answers. The truth is, sometimes they do, sometimes they don't. There are some issues where there is a clear question and a clear answer. But when we are working with people who are culturally different from us and negotiating relationships, it's more complex and there can be several answers. Therefore, we must concede that we know little about the patient – so that we ask them questions about them, questions that are relevant and informative, questions that will help us treat them better. At the same time, it's important to be respectful and kind.

What challenges do you think nurses face in providing culturally-responsive care?

Education and leadership are very important in providing care, especially in the case of migrants. None of us knows everything. We encounter new, unfamiliar situations all the time. What we need is to work in partnership with experts and at the same time, recognise our own limitations.

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AUTHOR

DR RUTH DE SOUZA FACN

COMPETENCY FRAMEWORK DOMAINS

A set of optimal cultural responsiveness competency standards for clinicians in all health care settings (Migrant and Refugee Women's Health Partnership, 2019, p.11)

Clinical Expert: Clinicians understand, and respond to, the diversity of individual characteristics and experiences, and ensuing barriers, as part of the provision of quality and safe person-centred and family-focused care to people from migrant and refugee backgrounds.

Communicator: Clinicians adopt effective communication practice to support people from migrant and refugee backgrounds in understanding and making informed decisions about their health, and to facilitate the provision of quality and safe care.

Collaborator: Clinicians work effectively with health care professionals and other relevant professionals, including with interpreters as members of a health care team, to provide timely, quality and safe care to people from migrant and refugee backgrounds.

Leader: Clinicians engage with their clinical and non-clinical colleagues and lead by example to contribute to the development of culturally responsive organisational and systemic processes that facilitate the delivery of accessible and equitable care to people from migrant and refugee backgrounds.

Health Advocate: Clinicians recognise barriers to access to health care experienced by people from migrant and refugee backgrounds and contribute to improving their health access by supporting enhanced health literacy and health system literacy in migrant and refugee communities.

Scholar: Clinicians are committed to providing evidence-based care, maintaining awareness of linkages between cultural diversity and population health, and facilitate sharing of information and knowledge to promote cultural responsiveness in the provision of care to people from migrant and refugee backgrounds.

Professional: Clinicians maintain culturally responsive practice as an integral part of the provision of quality and safe health care, ethical conduct, and adherence to professional standards.

A UNIQUE APPROACH TO WOMEN'S HEALTH

A wrinkle reduction laser technology is paving the way for improved vaginal health

> "The laser creates a controlled wound, which then regenerates into new, healthier tissue."

When Nurse Practitioner and Adjunct Associate Professor Elissa O'Keefe MACN started her journey into the specialty of sexual health in 1993 and then expanded her career to follow her other passion – skin health in 2010 – little did she know that within less than a decade her interests would intersect in a most unusual way.

Back in 2015, Elissa and her colleague Dr Uche Menakaya FRANZCOG, within days of one another, independently approached the National Health Co-op (NHC) in Canberra looking for new opportunities. As a nurse practitioner, Elissa wanted to expand the scope of her primary health care practice. To her, the NHC was a "unique model of co-operative, multidisciplinary primary health care with 10 practices in the ACT and region". "The patients essentially 'own' the Co-op and by default are your boss. This upside-down approach appealed to me as did the enhanced opportunity of access for all to quality health care at an affordable price," she explains.

Uche wanted to set up a specialist women's health clinic in Canberra that introduced the new concept of advanced gynaecological ultrasound for the early diagnosis of endometriosis. And so, the duo set out to establish a unique partnership, the Junic Specialist Imaging and Women's Centre (Junic).

As far as she is aware, their model of care, i.e. a nurse practitioner and medical specialist co-located within a primary health care multidisciplinary team, is

unique in Australia and possibly the world. “The benefits are enormous. We are able to refer the women we see for ongoing cost-effective multidisciplinary care that is bulk-billed while the doctors, physiotherapists, psychologists and dietitians are able to refer women in to us too.” They also accept referrals from outside of the NHC.

Elissa and Uche share the care of women at Junic and see women and girls as young as 12. They specialise in endometriosis care but also see women who are pregnant, those with fertility issues and the variety of gynaecological issues that present across the lifespan. Elissa is clear that she is not a midwife. “The women who are pregnant are aware that I am not a midwife and are cared for as private patients by Dr Menakaya. They are linked in to the midwife program at Calvary Hospital in Canberra as soon as they are able.”

A success story of this collaboration is the significant improvement in the quality of life for the women who receive an early diagnosis of endometriosis using the advanced gynaecological ultrasound. This often cuts years off the time from the onset of symptoms to an intervention. Sadly, the average length of time in Australia is currently 11 years (As-Sanie et al, 2019). Women with endometriosis are provided with bespoke, complex clinical care that can include the management of abnormal vaginal bleeding, chronic pain, acute exacerbations of pain, fertility, fatigue, depression and anxiety, and relationship issues.

Uche and Elissa are now pioneering Australia’s first 3rd generation vaginal laser at Junic. Called diVa, it is a dual wavelength laser that treats both the vaginal mucosa and the lamina propria. The technology and published results enable an evidence-based approach to the use of lasers in women’s health. This is where Elissa’s two worlds merged. “Who would have thought that years of women’s health experience and the skills and knowledge I gained resurfacing acne scars and facial wrinkles would translate to treating women’s most intimate areas?”

The diVa is a resurfacing laser, a type of laser that’s been used safely in dermatology for a very long time for remodelling scars and other skin abnormalities and the principles are similar. “It can treat the whole length of the vagina and the vulval area and deposits thousands of pinpricks of light into the tissue essentially creating a controlled wound. These areas then regenerate to create new, healthier tissue.”

Women generally have three treatments four to six weeks apart and then one each year for maintenance. The procedure is quick, affordable, has no down-time and is comfortable. The vaginal laser technology can be used to treat:

- Mild to moderate urinary stress incontinence
- Vaginal relaxation syndrome postnatally
- Vaginal dryness, burning and/or itching
- Painful intercourse
- Scar tissue softening and reduction
- Recurrent UTI
- Lichen sclerosus
- Abnormally high vaginal pH

Elissa and Uche have a rigorous assessment process and are undertaking research on women’s outcomes that they hope to publish late next year. “Unfortunately, vaginal laser is being done by unqualified people in some beauty parlours and cosmetic clinics, and I am very concerned about people with no women’s health experience doing these procedures.”

Elissa points out that vaginal laser should never be done without a full pelvic examination, an ultrasound to exclude pathology if required, negative cervical cytology, exclusion of infection and pregnancy, ability to identify sexually transmitted infections and the skills to manage the unique needs of a woman who has a background of sexual violence.

Women are happy with their diVa results and report that their sexual partners are too. RealSelf, an international consumer website, reports that 98% of women say it’s worth it (RealSelf, 2019), while international clinical studies (Guarette, 2017) are showing improvements in Genitourinary Syndrome of Menopause (formerly called atrophic vaginitis) and dyspareunia. Elissa and Uche are beginning to see the same results consistently and after a year of treatments, have observed women returning for their annual maintenance treatment.

On the future of vaginal laser therapy, Elissa says, “I see it being restricted to clinicians who are medically trained to perform it such as doctors, nurses and midwives, and that non-health professionals will be excluded because they can’t be insured for it as it is too high risk. I also see that the cost-benefits will be such that it will attract a Medicare rebate.”

Cost analysis shows already that vaginal laser is cost effective compared to some HRT and can reduce the costs of continence products (Data on file Sciton Inc, 2018). Elissa is particularly interested in the subject of continence as a significant number of women are admitted to age care as a result of continence issues. Imagine reducing the burden of disease for these women and reducing pad costs and residential care.

There are studies underway in the European Union with regard to the effectiveness of vaginal laser as a treatment for prolapse and recurrent thrush and bacterial vaginosis, which the Junic team awaits eagerly (Preti, 2019). They understand that the addition of these indications will improve millions of women’s lives.

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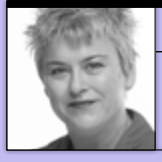

AUTHOR

ELISSA O’KEEFE MACN

TIME TO TALK, PERIOD.

Why it's important to discuss your menstrual pain

One of the most common gynaecological issues is period pain, with a 70–90% prevalence rate in Australia and similar incidences occurring across the world (Subasinghe, Happo, Jayasinghe, Garland, & Wark, 2016). This article explores the causes, variations and recognition of period pain and highlights the importance of becoming more comfortable about discussing menstrual issues.

Why does period pain occur?

Period pain or dysmenorrhoea results from cramping or spasms of the uterus, specifically the myometrium (the internal muscle layer of the uterus), before or during menstruation (Burnett & Lemyre, 2017; Chen, Shieh, Draucker, & Carpenter, 2018; Iacovides, Avidon, & Baker, 2015). It's classified as primary or secondary (Iacovides et al., 2015). Primary dysmenorrhoea is diagnosed when no underlying cause has been identified and usually begins in adolescence after establishing ovulatory cycles, whereas secondary dysmenorrhoea is diagnosed when an underlying cause is identified (Burnett & Lemyre, 2017; Osayande & Mehulic, 2014).

The latter may be caused by conditions such as endometriosis, adenomyosis, uterine myomas (fibroids), cervical stenosis or obstructive lesions of the genital tract (Burnett & Lemyre, 2017). Other causes of menstrual pain may also include ectopic pregnancy, pelvic inflammatory disease (PID) or infection, polycystic ovary syndrome (PCOS), ovarian cysts or abscess, endometrial polyps, interstitial cystitis, intrauterine devices (IUDs), adhesions or chronic pelvic pain (Bernardi, Lazzeri, Perelli, Reis, & Petraglia, 2017; Chen et al., 2018; Fallatah et al., 2018; Osayande & Mehulic, 2014; Stoelting-Gettelfinger, 2010).

Exercise caution until further investigations eliminate differential diagnosis of dysmenorrhoea, especially when the pain persists or symptoms worsen (Burnett & Lemyre, 2017; Osayande & Mehulic, 2014).

'Normal' and 'abnormal' pain

The difference between 'normal' and 'abnormal' period pain depends on the individual and their pain experience. Gender identity and cultural issues such as female genital mutilation (FGM) or menstruation myths must also be considered (Australian Government: Department of Health; Braddy & Files, 2007; Tan, Haththotuwa, & Fraser, 2017). Gaining self-knowledge in these areas is crucial to reduce experiences of discrimination, stigma or disadvantage.

'Abnormal' period pain could mean moderate to severe dysmenorrhoea leading to absence from school, work or a disruption in daily activities (Bernardi et al., 2017; Burnett & Lemyre, 2017; Chen et al., 2018; Fallatah et al., 2018; Osayande & Mehulic, 2014). However, those affected often believe that it is 'normal' and just get on with it. Some health care professionals still believe that period pain is 'normal', and it is very concerning when the issue is dismissed or undertreated (Burnett & Lemyre, 2017; Chen et al., 2018; Iacovides et al., 2015; Stoelting-Gettelfinger, 2010).

Monitoring period pain

Monitoring period pain and early initiation for referral to a gynaecologist to explore treatment options may be necessary (Burnett & Lemyre, 2017; Stoelting-Gettelfinger, 2010). One needs to ask specific questions when obtaining a medical history (Burnett & Lemyre, 2017), such as:

- At what age did your menstruation start?
- How long are your menstrual cycles (number of days per cycle)?
- Are your cycles regular or irregular?
- What types of menstrual products do you use (e.g. tampons, sanitary pads, a combination)?
- How frequently do you change these products (day/night)?
- At what point to you experience the pain in your cycle?
- Describe your pain (e.g. sharp, stabbing, aching, burning)?
- Where do you experience it? (specific location, any radiation?)
- Do you experience any other symptoms associated with your period pain?

The more commonly associated symptoms of period pain include abnormal uterine bleeding, heavy menstrual bleeding (menorrhagia), dyspareunia (pain associated with intercourse) and pelvic pain (Osayande & Mehulic, 2014; Stoelting-Gettelfinger, 2010). Additional symptoms may include nausea, vomiting, diarrhoea, bloating, fatigue, fever, headache and insomnia (Bernardi et al., 2017; Iacovides et al., 2015; Osayande & Mehulic, 2014).

Talking about period pain

To dispel the stigma around discussing period pain, it's important to build awareness and knowledge about it. Due to its high prevalence, you'll certainly know someone who's experienced it, including your patients. In my experience, those affected are often happy to talk about their experiences as it provides validation that not all period pain is 'normal'.

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ENDOMETRIOSIS: A NEW APPROACH

A new plan aims to build awareness around the condition and lead research hopeful towards a cure

> **“Estimated > 700,000 Australian women, girls and other individuals have endometriosis.”**

On 9 April 2019, the National Women's Health Strategy 2020–2030 was launched with $52.2 million of funding allocated towards keys areas such as ovarian cancer ($20 million), endometriosis ($10 million) and Aboriginal service providers ($9 million) (Liotta). The strategy has also highlighted the first ever blueprint, the National Action Plan for Endometriosis, to improve the treatment and understanding of endometriosis including chronic pelvic pain (Australian Government: Department of Health).

This is a new approach for endometriosis, especially related to building awareness, advancing health care services and leading research hopeful towards a cure. The momentum has been building for some time with more lasting changes occurring right here in Australia. The following key points are selective and not at all comprehensive; therefore, it is encouraged to review all references to seek further information.

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KEY ACTIVITIES

- Australian College of Nursing is developing an online endometriosis training module for nurses
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists is developing endometriosis clinical guidelines and online learning resources for medical practitioners
- Pelvic Pain Foundation Australia will deliver endometriosis, period and pelvic pain education for secondary schools in South Australia
- Jean Hailes is establishing a Clinical Research Network and social media awareness campaign
- EndoActive is to disseminate 25 evidence-based videos called ‘Shared Perspectives’
- Robinson Research Institute, University of Adelaide, will develop a digital health platform for endometriosis information, resources, treatment tool and research support

(The Hon. Greg Hunt MP)

KEY FACTS

- Estimated > 700,000 Australian women, girls and other individuals have endometriosis
- An average of 7 to 12 years’ delay between symptom onset and diagnosis
- Affects those from pre-pubescence to beyond menopause
- It is not normal to have severe pain with menstruation (dysmenorrhea)
- Up to one in three women with endometriosis have fertility problems
- Many individuals have no symptoms at all
- There is no cure

(Commonwealth of Australia, 2018)

KEY PRIORITIES

- Raise awareness to reduce diagnostic delay
- Provide education to break the cycle of under-recognition
- Provide clinical management and care in an effort to improve patient outcomes
- Connect services for all stages of care pathways and disease progression
- Support research through a national clinical trials network

(Commonwealth of Australia, 2018)

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ERICA O’DONOGHUE MACN

LET'S RAISE THE

PROFILE OF NURSING!

Nursing Now is an international awareness campaign which, in collaboration with the World Health Organization and the International Council of Nurses, aims to raise the status and profile of nursing around the world. The Australian College of Nursing (ACN) is proud to be the lead organisation for the Nursing Now Australia campaign.

The major nursing organisations in Australia have created a monthly challenge calendar to support the objectives of the Nursing Now campaign and count down to the 200th anniversary of the birth of Florence Nightingale on 12 May 2020.

This calendar will allow you to make a direct impact on the way our profession is regarded by other health care professionals, the media, governments and the community at large.

You will also be able to enter a competition to win one of two $100 Visa gift cards each month! Head to **acn.edu.au/nursingnow** to find out more.

MAY

Host an ACN National Nurses Breakfast or other event to celebrate International Nurses Day. Register via the ACN website **www.acn.edu.au/events**.

SEPTEMBER

Wear orange and organise an event to celebrate Community and Primary Health Care Nursing Week.

Register your event via the ACN website **www.acn.edu.au/events**.

JANUARY

Lead by example and tell us what you are doing about your health and wellbeing by sharing your photos on social media using the hashtag #ACNNurseStrong.

MAY

Tell us who your nursing role models of the past and present are by sharing your stories on Twitter.

JUNE

Include your title, qualification and membership postnominals in your email signature and social media bio. (e.g. Jane Smith BN, RN, MACN).

JULY

Give friends and family an insight into nursing by describing a day in your life during catchups or on social media.

AUGUST

Celebrate men who have chosen nursing as a career and profile your male colleagues in a public place at your work, in the local press or on social media.

OCTOBER

Speak to your organisation's PR team or nominate yourself as a media representative to ensure nurses are recommended as experts for media interviews.

NOVEMBER

Upload ACN's 'I love nursing' overlay frame onto your Facebook profile picture.

DECEMBER

Reflect on why you're proud to be a nurse and share your thoughts on Twitter. ACN will share your reflections in a blog on **NurseClick**.

FEBRUARY

Publicly recognise a nurse who excels in their chosen area by nominating them for an award, such as the **Health Minister's Award for Nursing Trailblazers**.

MARCH

Talk with local school kids, parents and teachers about what nursing is today and why it's a great profession to choose.

APRIL

Participate in the Nightingale Challenge by nominating a young nurse leader under 35 for a leadership program in 2020, such as the **Emerging Nurse Leader Program**.

Remember to use the hashtag #NursingNowAustralia when posting on social media.

Please refer to the Nursing and Midwifery Board of Australia's social media policy to ensure you are complying with your professional requirements when posting on social media.

Nursing now Australia

Australian College of Nursing

POLICY CHAPTERS: THE NEXT STEP

Creating toolkits and regulating workforce for nurses

This edition's update shares the progress of our Policy Chapters, outlining the goals and priorities for this year. The aim is to provide opportunities for nursing leaders and experts to inform change and guide future directions through collaboration.

Each Policy Chapter focuses on a specific matter, drawing on the specialised skills and expertise of members of ACN and external stakeholders who are all working with and influencing government and policy makers.

END OF LIFE CARE

POLICY CHAPTER CHAIR – DISTINGUISHED PROFESSOR PATSY YATES FACN

Distinguished Professor Patsy Yates FACN is the Policy Chapter Chair of ACN's End of Life Care Policy Chapter.

During 2018, Patsy, Dr Melissa Bloomer FACN as the Deputy Chair, and the members of the Chapter delivered two important policy documents. The first was a position statement that provided guidance about the implications of Voluntary Assisted Dying (VAD) legislation for nurses. The second was a White Paper titled Achieving Quality Palliative Care For All: The Essential Role Of Nurses.

The White Paper summarises the evidence relating to nurse-led models in the care of people with life-limiting conditions and identifies key areas for action by government and health system managers to ensure nurses' roles are optimised. The ACN Board has recently approved the release of this White Paper.

Their goal for 2019 is to build on these outcomes through a range of implementation strategies. For the White Paper, the Chapter has commenced development of a toolkit to guide the implementation of nurse-led models for care of people with life-limiting conditions. The toolkit will be aimed at funders, health service managers, and nurses looking to implement evidence-based nurse-led models themselves.

To address recommendations outlined in our VAD position statement, the Chapter will develop a proposal for funding to develop education programs specifically for nurses on the implications of VAD for our practice.

There is a lot going on in the area of palliative care policy at this time. A new National Palliative Care Strategy has been released, and a number of jurisdictions have inquiries underway into end of life care issues. The Chapter will continue to keep a watch on emerging policy developments and seek to influence these where appropriate.

WORKFORCE SUSTAINABILITY

POLICY CHAPTER CHAIR – PROFESSOR LEE BOYD MACN

Professor Lee Boyd MACN is the Chair of ACN's Workforce Sustainability Chapter.

In collaboration and consultation with Deputy Chair Adjunct Associate Professor Alanna Geary MACN and the Workforce Sustainability Policy Chapter members, these are the priorities for 2019:

1. Identify and approach key stakeholders at the national, international and organisational level (i.e. government, funders, CEOs, chief nurses, universities) to determine what nursing workforce data is currently being collected and what data sets exist at the national, international and organisational level to support nurse workforce planning.
2. Develop a Decision Framework (template/flowchart) to assist workforce planners with staffing decisions.
3. Develop a National Minimum Data Set (METeOR compliant; EBAs defined) to assist workforce planners with staffing decisions. Data will be used to demonstrate links between skill-mix, education level, NSIs, workplace culture, patient/nurse satisfaction, organisational costs, and capture workforce movements due to maternity and/or carers leave.
4. Prepare a scoping paper (1–2 pages) for publication, position statement, White Paper with recommendations and/or protocol (dependent on what the scoping review finds) by mid-October 2019.

CHRONIC DISEASE

CHILDHOOD AND TEENAGE OBESITY: THE NURSE'S ROLE

This year the Chronic Disease Policy Chapter will focus on the role of nurses in relation to obesity and young people.

In Australia, one in four children are classified as overweight or obese (AIHW, 2017) and ¾ of male teenagers and over 90% of female teenagers in Australia do not take the recommended weekly amount of exercise (WHO, 2015). Excess weight, especially obesity, is a major risk factor for cardiovascular disease, type 2 diabetes, some musculoskeletal conditions and some cancers.

As the level of excess weight increases, so does the risk of developing chronic conditions, which at a young age, has major implications for health and wellbeing into adulthood. The number of children diagnosed with Type 2 diabetes in Australia is increasing with around 400 new cases diagnosed each year (AIHW, 2014). The likelihood of developing serious complications like a stroke or amputation in their lifetime are greater than an adult who develops Type 2 diabetes (AIHW, 2014).

The Policy Chapter members are scoping out the international evidence on the effectiveness of nurse-led interventions and seeking case studies of good practice from around Australia. The evidence will inform the development of a toolkit for nurses in relation to key knowledge and interventions for practice. The work will culminate in the development of a position statement at the end of the year, highlighting the key areas of strengths, needs and recommendations.

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ACN BRISBANE REGION MEMBER PRIORITIES: RESULTS FROM A 2018 MEMBER SURVEY

Celebrate what we do best

The Australian College of Nursing (ACN) has established a network of state-based membership Regions which are guided by a Leadership Team. The Brisbane Region Leadership Team of Chris O'Donnell MACN, Rhonda Gartrell MACN, Melinda Hassall MACN and Ariela Rother MACN was formed in late 2017 and have actively engaged members through ***neo*** (ACN's online engagement platform), networking events and a member survey conducted in October 2018.

The aim of the member survey was to provide the Leadership Team with an understanding of the approximately 950 members in the Brisbane Region, their primary role, location, area of work and interests. Members were also asked to share the key areas they would like the Leadership Team to focus on and their vision for the nursing profession in the next 5–10 years. The survey was completed by 103 members. We would like to share the results with you and highlight how they will influence our Region moving forward.

Who are our members?

The survey revealed the Brisbane Region membership covered a range of nursing roles.

STUDENT NURSES

Students comprise approximately 25% of our members, with almost 14% of survey respondents identifying themselves as students, highlighting ACN's significant investment in our future nurse leaders.

NURSES

Around 30% of respondents are registered nurses, with approximately 28% in positions of clinical nurse and clinical nurse consultants, 3% are Nurse Practitioners and enrolled nurses respectively. Approximately 7% of Brisbane Region member respondents hold dual qualifications of registered nurse/midwife.

A small number of respondents also indicated their positions as directors, nurse educators, nurse unit managers, administrative, informatics, academic, research or retired.

Where do our members work?

The survey respondents reflected recent data highlighting that Australian nurses are providing care in a variety of setting across acute care, community and primary health care, public health and management (Department of Health 2014).

Approximately 52% work in administration, universities, research and education.

Approximately 36% of respondents work in acute care settings; hospital ward, outpatients, operating theatre, maternity (midwives).

Approximately 33% work in community and primary health care settings such as community health, school-based youth health, mental health, alcohol and other drugs, general practice, aged care, residential care and palliative care.

What interests our members?

A number of topics and issues were of interest to members with almost 64% of respondents identifying clinical education – specifically regarding wound care, stomal therapy, continence, urology, cardiology, oncology, immunology, immunisation, diabetes and mental health. Around 50% of respondents recorded interest in career and mentoring opportunities and 30% in graduate programs. Other issues that our members stated as important to them were culturally diverse health care, law within the health care setting, health policy and leadership. This suggests that our nurses are considerate of the varied care needs of community members and are aware of the importance of structural and systematic issues related to the provision of safe and equitable care.

What do members want from the Brisbane Region?

Strong themes that emerged from answers to this question – from students to advanced practice nurses – included leadership opportunities, leadership to inform policy and networking events.

Leadership was a key theme throughout many responses. One student respondent highlighted the need for ACN Brisbane Region to create "awareness for students about the importance of leadership in nursing". Early introduction of leadership in education curriculum and professional development opportunities, demonstration of leadership by nurse managers, senior nurses, support and mentoring for students and early career nurses is required to ensure the sustainability and influence of our profession in health (Department of Health 2014, World Health Organization 2017).

Our members also feel that the Leadership Team should prioritise issues regarding policy, including development to inform key policy areas and evaluation, opportunities to support ACN position statements, offer research opportunities and develop research capacity. Facilitating networking events with other ACN Members, Fellows and Communities of Interest and professional development events were also overwhelmingly indicated by the respondents as additional priority areas for the Leadership Team.

To meet these goals, we plan to engage with local nurse leaders in clinical practice, education, academia and research to ensure that the members have access to professional development, networking opportunities and social events to support their varied interests and career stages.

What 5–10 year vision for the nursing profession do our members have?

Individual member's thoughts on their 5–10 year vision for the nursing profession ranged from broadening clinical skills, mentoring to assist with career progression and retention of nurses. Other key concerns for the future included workforce issues such as nurse to patient ratios, increasing professionalism, eliminating bullying and empowering nurses to be leaders in health policy.

We would like to highlight two interesting trends that emerged from answers to this question.

First, respondents believe the nursing profession needs to be adaptive to changing health needs and technological advances, whilst maintaining its focus on person-centered, culturally appropriate care that is responsive to community needs. These findings match the way the role of nurses in Australia is strengthening in diversity, complexity and innovation, requiring appropriate education opportunities and a responsiveness to digital technology. The 2014 Nursing Workforce Sustainability: Improving Nurse Retention and Productivity Report acknowledged that changes are being observed in the health of Australians, particularly in ageing and chronic disease, and that associated care planning, models of service delivery and technologies are required to support adaptive models of care (Department of Health 2014). These nursing attributes are also being acknowledged as critical for all nurses globally as we seek to improve health outcomes to meet international goals for universal health coverage (World Health Organization 2017).

The responses also highlighted the need for the nursing profession to publicise and celebrate its professional capabilities, broad ranging experiences, expertise, flexibility and adaptability to demonstrate nurses' capacity to enhance patient outcomes and support the health care system. These goals match those of the Global Nursing Now Campaign and the World Health Organization's announcement of 2020 as the Year of the Nurse & Midwife (Nursing Now, 2019). Both these initiatives strongly advocate for recognising the significant role nurses play in developing innovative models of holistic and person centred care and as leaders in policy that supports their practice.

It is fantastic to see the forward thinking of the engaged members of our Region and that they align with the strategic and global goals of our profession.

How will the Brisbane Region Leadership Team continue to support its members?

Responses from members have led to the planning of three networking events for 2019 in collaboration with local Community of Interest representatives. The importance of students in our membership and to our future workforce has been acknowledged and the Brisbane Leadership Team is engaging with student nurse groups to coordinate an event to support our student nurse members. We will continue to use ***neo*** to connect with members, post information on upcoming events and topics of interest that were highlighted in the survey. The Leadership Team looks forward to meeting existing member colleagues, potential new members and engaging with others through ***neo*** and at the 2019 networking events.

The ACN Brisbane Region Leadership Team would like to thank all members who contributed to the survey.

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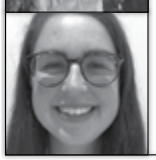
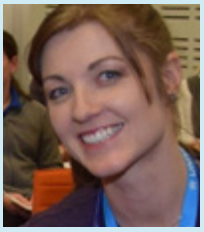


ARIELA ROTHER MACN

REPRESENTATION: INDEPENDENT HOSPITAL PRICING AUTHORITY, CLASSIFICATIONS CLINICAL ADVISORY GROUP

Higher nurse participation needed to effect policy changes



Professional representation is pivotal in influencing the health arena in Australia – and we look forward to keeping you across ACN's representation activities in *The Hive*.

Recently, we caught up with Kasia Bail MACN, our nominated member representing ACN in the Independent Hospital Pricing Authority's (IHPA) Classifications Clinical Advisory Group (CCAG).

What is the most recent work that has come out of the committee?

The CCAG is working on developing a framework for reviewing the disease classification system for hospitals. The purpose of the CCAG is to provide expert clinical advice to IHPA with respect to the development and refinement of the Australian Refined Diagnosis Related Group's (AR-DRG) Classification System. This includes the Australian modification of the World Health Organization's 10th revision of the International Statistical Classification of Diseases (ICD-10).

This particular committee is trying to design a format that will support the review of DRG classifications on an ongoing basis.

What are your main takeaways from this opportunity?

Participating in this committee has made me more aware of the cycle of submission dates and opportunities to request specific analysis and modelling to be conducted, in order to test assumptions built into the DRG system.

An important takeaway has been that this kind of committee has an obligation to maintain representation from key stakeholders. However, the nursing voice is missing from many of these conversations. It is essential that we build long-term understanding of the system of coding with generalist and specialist nursing input.

I have realised that nurses are not capitalising on opportunities to pitch well-timed, well-placed, well-researched and well-worded submissions to the policy landscape. We need more participation to better represent our volume and influence as the largest group of health professionals.

Are there any issues or benefits for the profession as a result of this committee?

This committee can help us identify when public consultations open, so we can mobilise the nursing community to put in suitable and timely submissions. This is how policy happens.

Why do you think this committee requires a nursing contribution?

With the ICD and DRG system, we collect a lot of patient data. However, this data does not reflect the functional status of patients; whether they are self-caring and independent or bed-bound and nurse dependent.

This deficiency has very real consequences for our profession, as higher dependence becomes an invisible cost borne by nursing staff and unattributed in costing models. Currently, this is only managed through complex algorithms using DRG coding based on medical data (rather than broader clinical data) that are difficult to critically appraise.

An additional risk is that if functional impairment is not measured, it will be missed. There is currently no financial incentive for hospitals to maintain or improve patient function (Madden et al., 2015). We need to measure more nursing-sensitive data points.

There are few care processes that reach patients without passing through the hands of a nurse (Jones, Hamilton, & Murry, 2015), and consequently, we are at real risk of receiving the majority of the blame for cost-saving systematic decision-making (Willis et al., 2016). There is no doubt that achievement of positive patient outcomes will be achieved through the most effective use of limited resources (Spirig et al., 2014). Unfortunately, as many nurses are unaware of what data is available, they are unable to perceive its usefulness (Roche, Duffield, Aisbett, Diers, & Stasa, 2012). We have to move on from determining efficiency based only on cost. IHPA knows that it is not cheaper if the quality is poorer, and additionally it is probably just shifting the cost somewhere else. DRGs are in Australia to stay, so it is wise for nursing to participate in making them meaningful for Australia's health care system.

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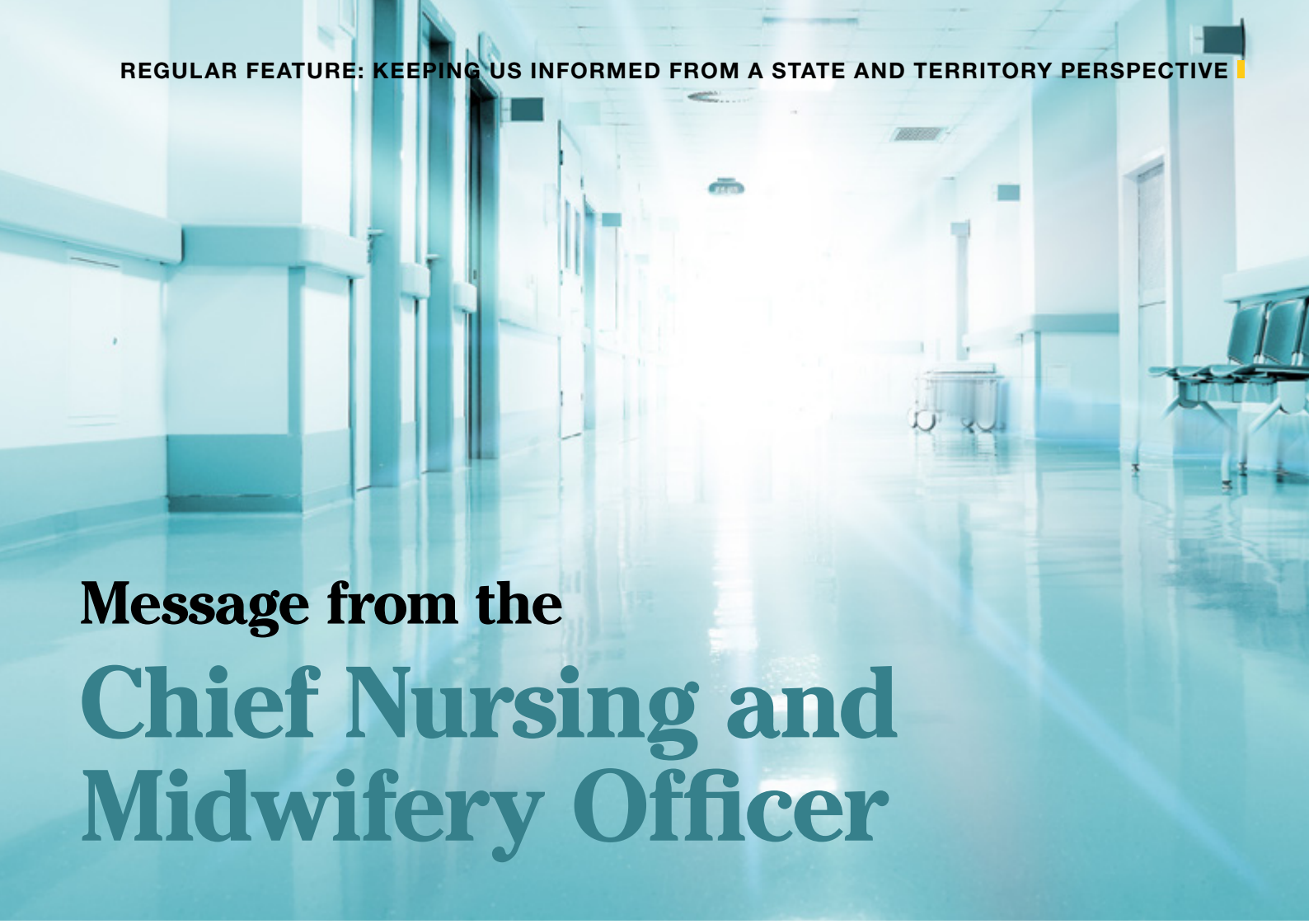

Message from the Chief Nursing and Midwifery Officer

TAS

ASSOCIATE PROFESSOR FRANCINE DOUCE MACN
CHIEF NURSE AND MIDWIFE TASMANIA

Over the past year, our team developed a professional practice framework that represents our vision for practice; where nurses and midwives feel valued and have a voice in the context of health policy and strategic planning. The Framework is designed as a 'Compass' to underpin and guide the way we work.

The Compass has created a discussion about how we harness the thinking of nurses and midwives and how this can inform and influence our work. To this end, we have developed the Engagement & Consultation Framework as the basis for connecting with our nurses and midwives, our partners and key stakeholders.

The Compass describes four domains as its points of reference; this embodies a philosophy of collaboration, transparency and accountability that aspires for excellence, and contributes to a culture of strong, sustainable and authentic working partnerships.

The key domains of the Compass (PERL) are

- **P**eople are our priority
- **E**vidence informs our practice
- **R**egulatory compliance
- **L**earning for life.

These domains have formed the foundation for engaging with our workforce through a range of levels appropriate to the specific piece of work at hand. The Framework describes five levels of engagement ranging from information sharing to workforce empowerment; each project/portfolio is assessed on merit.

The Compass and Framework are supported by our values of collaboration, integrity, passion and respect, ensuring the advice we provide is heavily informed by the experience of Tasmanian nurses and midwives working within the Department of Health and the Tasmanian Health Service.

Geri O'Rourke from the Office of the Chief Nurse and Midwife team joined me in presenting this work at the recent international ANCC Pathway to Excellence® Conference – *Igniting P.O.W.E.R* in Florida.

Our presentation highlighted how the Pathway to Excellence Standards has informed this work and their relevance across a range of professional contexts including non-clinical nursing teams.

What a wonderful opportunity to share our work internationally, to promote our beautiful island and Tasmania's fantastic nurses and midwives.

EDITOR'S NOTE

ACN is pleased to announce that Francine will be one of the keynote speakers at the upcoming National Nursing Forum (NNF) 2019 in Tasmania. To register for the NNF visit www.acn.edu.au/events.

COMMUNITY OF INTEREST: ADVANCED PRACTICE

The need for transformational leadership

Almost two centuries ago, with a lamp in hand and a passion for demonstrating the power of evidence-based practice, Florence Nightingale began the transformational journey of modernising nursing. In developing and professionalising nursing, she understood the critical foundation that was afforded by a strong base of education for delivering safe and quality health care. Furthermore, she understood that nursing should be responsive to the emerging needs of the patient and of the communities they serve.

> *"The most important practical lesson that can be given to nurses is to teach them what to observe … and to adapt to what they observe"* (Florence Nightingale 1860).

As we draw closer to 2020 and the 200th anniversary of Florence Nightingale's birth, now is the time to determine the emerging needs that lay before our patients and communities, and how we should respond, as a profession that carries a legacy committed to the notion of transformation.

Health and health care are facing substantial challenges on the horizon. Constrained funding, an ageing population, the scourge of chronicity, changing consumer expectations and the disruption of technological change all create drivers and opportunities for nursing to transform. The need for our profession to evolve is unquestionable.

As the largest contributor of health care to the population, the nursing profession must adapt or we won't continue to sustain the health of the communities we serve. This combined with a looming nursing workforce shortage, estimated by Health Workforce Australia to be about 85,000 by 2025 and 123,000 by 2030 (Health Workforce Australia, 2014), and health spending that is rising to unsustainable levels, means that transformation is essential if nursing is to continue to deliver high quality, accessible care to the people who need it at the right time and in the right place.

> *"Were there none who were discontented with what they have, the world would never reach anything better"* (Florence Nightingale 1860).

Without substantial transformation from within the profession, we risk an alternative where increasingly limited resources result in more care rationing and tough decisions on who receives nursing care and who doesn't.

Enabling nurses to work to their full scope of practice is critical to the delivery of sustainable and effective health care. It seems incredulous that a workforce the size of nursing would be operating in a hamstrung manner and ignoring skills that could be used to the benefit of all. But time and time again, despite a mountain of evidence, many nurses work well below their skill level and are very wastefully underutilised. Stephen Duckett of the Grattan Institute contends that among the key barriers to enabling full scope of practice for nurses are culture, tradition, funding models and vested interests (Duckett, S., Breadon, P. and Farmer, J. 2014).

> *"What cruel mistakes are sometimes made by benevolent men and women in matters of business about which they know nothing and think they know a great deal"* (Florence Nightingale 1860).

So how does nursing evolve and overcome the powerful inertia of resistance to change that abounds in not only our profession but the entire health care system? How do we capture the clarion call for transformation that Florence Nightingale first sang in the 1800s?

Like Florence, most health care roles were born in the days of the horse and buggy, and change is long overdue. The challenge for nursing is to embrace this need for change and to drive it as the leaders of health care that we are.

So how do we meet the challenge? How do we use the available evidence to transform? Can advanced practice shine a light on the full scope of practice required to enable transformation of our profession to meet the emerging needs of the communities we serve?

> *"Rather, ten times, die in the surf, heralding the way to a new world, than stand idly on the shore"* (Florence Nightingale 1853).

The Australian College of Nursing (ACN) is the pre-eminent and national leader of the nursing profession. As such, we hold at our foundation the commitment of advancing nurse leadership and practice to enhance the health and health care of all Australians. In response to the need for clarity around

> **“Were there none who were discontented with what they have, the world would never reach anything better.”**
>
> **FLORENCE NIGHTINGALE 1860**

the notion of advanced practice, ACN developed a Community of Interest (COI). The purpose of this COI is to explore the contribution that nursing can make, if it is unleashed and operating to full scope of practice; utilising the full extent of evidence, education and training available to deliver optimal care. As Florence Nightingale said:

> *“So never lose an opportunity of urging a practical beginning, however small, for it is wonderful how often in such matters the mustard-seed germinates and roots itself”*
> Edward Tyas Cook (1914, p. 94).

In the COI’s first few meetings, which were anchored by a very effective brainstorming session at the 2018 National Nursing Forum, some clear challenges became apparent that needed to be tackled:

1. There is a clear need for ACN to champion what the advanced practice/expert nurse looks like in terms of definition and professional clarity. This should support the evidence base and be aligned to the Australian context.
2. What tools does a nurse need to be an advanced practice/expert nurse? What continuing professional development? Self-development? Coaching or mentoring? Clinical supervision? How do we enable excellence using advanced practice as both a guide and a goal?
3. What does the progression from the graduate nurse to advanced practice nurse to nurse practitioner and beyond look like? Do we need to reconsider the notion of clinical versus management versus education versus research siloes in nursing? Should there be clear pathways for the advanced practice/expert nurse to work across all of these siloes?
4. The need for a White Paper on advanced practice which explores the issues facing the communities we serve and mapped a course for the nursing profession to evolve and reform to tackle these issues.

The chief strength of any community of interest lays of course with its membership. Over the last 10 months we have built a membership of more than 500 strong. With it, has come a richly diverse group of opinions and expertise; the critical ingredients required to help inform and shape the important discussions needed to develop policy around advanced practice. Ultimately, if we wish to empower nurses and nursing, and stay relevant to the tasks that need to be delivered, we as a COI must first listen.

This means that how we engage with our members and stakeholders is particularly important and to this end, we have heard you want flexibility. We understand that your time is valuable, and we won’t be asking you to dial in to a tele or videoconference to contribute to the group. Instead, we want to give you the flexibility to connect on your own terms. We engage across ***neo***, email and even Twitter. We want to use posts and newsletters to communicate with you and to hear your views.

Where to from here? As Florence Nightingale said:

> *“I think one’s feelings waste themselves in words, they ought all to be distilled into actions and into actions which bring results”*
> Edward Tyas Cook (1914, p. 94).

As a COI, we are focused on tackling the four challenges that have been laid before us. The one thing that was abundantly clear from listening to our members and stakeholders is that you want action, and we are singularly focused on delivering on that mission. The second message is that we need a clear road map for change to guide our focus and attention on the journey ahead. Finally, and perhaps most importantly, we have heard the message that you want us to be bold; it’s clear to us that our patients, our communities and our profession deserve nothing less.

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AUTHOR

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LEADERSHIP: FOR A HEALTHIER TOMORROW

Meet the Health Minister's Award for Nursing Trailblazers Finalists 2019

The Australian College of Nursing (ACN) collaborated with the Hon Greg Hunt MP, Minister for Health, to present the inaugural Health Minister's Award for Nursing Trailblazers in April 2019. The award celebrated and acknowledged the extraordinary contribution nurses make to the Australian health care system and gave much needed recognition to the leaders of our profession. We spoke to the three finalists, all of whom are outstanding high achievers in their specialist fields and have been influential in dramatically improving the quality of health and aged care in Australia.

Trailblazer Finalist
PROFESSOR JEANINE YOUNG FACN

For her work on uniting cultural practices and safe sleep environments for Indigenous Australian infants

For Professor Jeanine Young FACN, her mother, an intensive care nurse, was the inspiration that drove her towards the profession. To her, nursing is a profession that challenges her and helps her make a measurable difference to people's lives.

This, combined with her interest in advocacy and working with families and children, is what translated into her work with Aboriginal and Torres Strait Islander families, particularly Indigenous Australian infants. Jeanine built upon her general nursing experience by completing midwifery, neonatal nursing, and paediatric and child health qualifications, working in all these settings before completing a doctoral degree.

She was awarded for her work on the Pēpi-Pod Program, which is an innovative and culturally acceptable strategy to reduce risk of shared sleep environments for Aboriginal and Torres Strait Islander families. The program focuses on a practical solution that allows parents to keep their baby close during the night which they value, whilst providing a safer sleep environment; achieving both support for parents and protection for baby. Additionally, it reduces the smoking-bedsharing interaction which significantly increases risk of infant death.

"The program, which started in Queensland, has now been taken up in over 30 communities around Queensland; there are a couple of ongoing trials in several other Australian states, the UK and in Texas in the US," says Jeanine. "We started off with five of our services as part of the research trial and within two years grew to 25, so to keep up with the demand once maternal and child health services started to take up the program was the biggest challenge."

The team has recently commenced a population-based study in collaboration with the Queensland Paediatric Quality Council, which will allow them to evaluate the effectiveness of the program in the reducing infant mortality in the regions where it was implemented. At the same time, they will continue to monitor the program effectiveness on the primary outcome of infant mortality. In New Zealand the Pēpi-Pod and Wahakura Programs have been associated with a 29-36% reduction in all cause infant mortality. Jeanine collaborated with New Zealand's Change for Our Children and Queensland Aboriginal and Torres Strait Islander stakeholders to co-design a program suitable for Queensland.

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Trailblazer Finalist
PROFESSOR SANDY MIDDLETON FACN

For her contributions to evidence-based nursing care for stroke patients

Sandy Middleton FACN was always been interested in health, so choosing nursing as a profession was the most logical choice for her. Sandy's focus is to conduct evidence-based implementation research projects for bettering health outcomes and to encourage nurses to pursue a career in research.

Sandy has led the Quality in Acute Stroke Care (QASC) Program, comprised of multiple, multidisciplinary collaborative research projects conducted over a period of 14 years. The seminal trial published in Lancet in 2011 found that facilitated implementation of nurse-initiated protocols used in the first 72 hours following stroke to manage fever, raised glucose levels and swallowing difficulties (the FeSS Protocols) significantly decreased death and dependency 90-days post-stroke. A follow-up study found this effect was long lasting with 20% longer-term survival post-stroke.

Subsequently, her team successfully translated this intervention into all 36 NSW stroke units, and is now running a project to help implement the protocols across 300 hospitals in 14 European countries. An independent economic evaluation found that if only 65% of the eligible Australian population received care in line with this research, there would be a $281 million, 12-month saving.

The challenges, Sandy explains, were obtaining enough funding for the research and finding ways to support the clinicians to adopt evidence-based nursing care. The Trailblazer Award, she says, acknowledges over 14 years of collaborative research and recognises "how nursing protocols used in stroke can impact on those hard endpoints of death and dependency".

She adds, "We don't have enough young nurses entering the research career pathway. Examples of high quality research showing that nurses and nursing care make a difference to patients may encourage nurses to pursue a research career."

Sandy and her team are currently exploring the feasibility of 'QASC Global' – a translational study to demonstrate further improvements and sustainability of the FeSS intervention within Australia, and upscale the intervention into other hospitals internationally. To date, 75 hospitals in 27 non-European countries have signed formal expressions of interest to implement the FeSS Protocols and be involved in QASC Global. Importantly, this research will advance the science of implementation research and provide a model for translation of other nursing care practices beyond stroke.

Trailblazer Finalist
LINDA CAMPBELL MACN

For her work leading a blood management program for primary joint replacement patients

When her younger sister was unexpectedly hospitalised, Linda Campbell MACN had the opportunity to witness firsthand how a dedicated nurse could make a significant difference to her sister's recovery and her own wellbeing. The experience propelled her into nursing and her personal interest in blood management combined with her background in Post Anaesthesia Care and Transfusion Medicine led to her recruitment to the Patient Blood Management (PBM) position at Sir Charles Gairdner Hospital (SCGH) in Perth in 2012.

Linda leads the blood management program for primary joint replacement patients. The program employs a proactive approach of improving blood counts before major surgery that involves significant blood loss. By optimising Hb and iron stores pre-op, patients can recover their own Hb post-op, avoid chances of blood transfusion and improve recovery. The program has also reduced demand on donor blood as well as joint replacement transfusion rates.

The most rewarding aspect of her work has been ensuring accessible care to patients, no matter where in WA they live. "Creating networks with outer metro/rural health care organisations and GPs has provided the key to this. I find it very satisfying when the GP pre-empts PBM for the 'next' major surgery patient or a NP from a rural area phones me for anaemia management advice. It confirms that providing education does pay off. Audit results demonstrated PBM assessment rates of 99% and 100% for elective joint replacements," she says.

Linda adds, "We care for our patients, we're scientists, humanitarians and I guess the Trailblazer Award just puts it all together in one."

For the last few years, the team has been collecting data regarding transfusion rates and length of stay. Their current goal is to assess how PBM is affecting specific patient groups, and as WA's referral centre for Sarcoma, the team is particularly looking at this group of patients. They are collaborating on this project with the Sarcoma CNC, Orthopaedic waitlist nurse and SCGH research staff, with the aim of publication.

LEADERSHIP: TRAILBLAZER 2019 WINNER

A better life – and death

Trailblazer 2019 winner Nikki Johnston's unique model empowers both health care workers and families to improve living and dying for older Australians

For as long as I can remember, I wanted to be a nurse. My mum worked as a nurse at Monavale Hospital and in my family nursing is a highly-regarded profession.

In the 1990s, I was working at St Vincent's Hospital in the area of bone marrow transplant, caring for people who had haematological conditions like leukaemia as well as solid malignanices and HIV/AIDS. In this role, I came to the realisation that people were dying badly. It was sad and confronting for me as most of the patients that I cared for were young and there was a lack of preparation for those who were dying. Clinicians were not identifying dying and this led to missed opportunities to ask questions like "What matters most to you now?", talking about the process of dying, what their end of life wishes were and because curative treatments distracted clinicians, patients and families often didn't get to say goodbye to each other. People died in hospitals, whilst having curative burdensome treatments. In this situation, death can only be seen as tragic and unexpected. If dying is recognised, normalised and planned for outcomes are much better for the dying person, their families and the staff looking after them.

I chose to move from acute care into specialist palliative care and over the last five years my work has been about improving living and dying for older Australians in residential aged care. This population is one of our most vulnerable. More than 50% of residents are no longer able to speak for themselves as they live with dementia and other neurodegenerative disorders. It is important to advocate for this group that's easily hidden from the rest of the community.

Specialist palliative care is not consistently on offer across Australia and older Australians living in residential aged care often miss out. Inequity of access to specialist palliative care needs to be addressed urgently, as does upskilling the aged care workforce so that they have the skills and knowledge to do this work well.

I am driven to improve access, quality of life and the quality of death for older people living and dying in residential aged care. This includes residents having better connections with their families and to spiritual care and relief from pain and suffering in their last months of life. It also means that death becomes a normal expected part of life so that we can recognise it and plan for it. Residents without a plan in place often have multiple avoidable transfers to hospital in their last months of life with no benefit.

Recently released data from the Australian Institute of Health and Welfare (AIHW) reveals that "people aged 65 and older, who make up about 15% of Australia's population, account for almost half of all patient days" (Duffin 2019). This is affecting the workflow and capacity of the staff working in aged care facilities, and the flow-on effect is on staff working in hospitals also.

The nursing profession makes up the largest component of the palliative care workforce (AIHW 2019), which should come as no surprise as nurses work in almost all health care settings across the country. As such, it is as a nurse that I believe I was able to gain the unique perspective and insight into how we can ensure people receive the physical, emotional, social and spiritual care they deserve. As a nurse, I have also realised the true potential of a nurse working to their full capacity within their scope and how it can make true difference in patient outcomes.

To overcome barriers to access of specialist palliative care in residential aged care, we developed and tested a new model that integrates Specialist palliative care into residential aged care. We call our model 'Palliative Care Needs Rounds'. Our pilot proved that regular Palliative Care Needs Rounds helped staff identify residents most at risk of dying without an adequate plan in place.

Plans were then made including anticipatory prescribing for end of life increasing access to medications that are needed to keep people comfortable. Staff are mentored and supported by a specialist palliative care clinician – in our case a nurse practitioner. The intervention improved staff confidence in discussing death and dying with families and planning for symptoms and goals of care at end of life. Residents were more likely to experience a better-quality death including better symptom control and advance care planning. They were more likely to die in their preferred place of death. Participation in the study also saved a substantial amount of money in reduced hospitalisation.

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> **"Clinicians were not identifying dying and this led to missed opportunities to ask questions like "What matters most to you now".**

As a single mother with three kids, I started my studies to become a Nurse Practitioner (NP) and I'm proud to say that I was the first Palliative Care Nurse Practitioner (PCNP) in Canberra and I have now been involved in five PCNP positions being created in the Territory. I knew that being the first PCNP wouldn't be easy as I was breaking new ground and I was a woman working in an acute hospital promoting better dying when cure is what is often valued in acute care.

There are many experiences throughout my career that have helped me to strengthen my practice. As I was the first PCNP, I looked to my medical colleagues for mentorship and guidance and I am grateful for their teaching and support. One 'aha' moment was when I realised that I don't work in the medical model and that I was able to influence and change the system so that people didn't miss out. NPs are in a perfect position to collaborate with research teams to create and test new innovative models of care.

Through successful clinical research we have been able to influence governments, both local and federal, to change policy and provide funding for our model of care. It has been very exciting to be leaders who can change clinical practice for the better. If the health system isn't meeting the needs of a particular group, NPs notice and have the capability to change the way they provide care so that people don't need to fit into a system – the system fits around them.

Our work could not have come at a better time. Australia is currently facing an ageing population that is living with a range of chronic illnesses of varying levels of complexity with over one in seven Australians being aged 65 or over (AIHW 2018). On top of this, unlicensed health care workers – who are an extremely valuable part of the workforce but have not received any formal qualifications – make up 70% of the residential aged care workforce; meanwhile the number of registered nurses (RNs) had fallen from 21% in 2003 to less than 15% (Mavromaras 2017).

Our model integration of specialist palliative care into residential aged care is a solution for upskilling the workforce and increasing access. We need to take out the hierarchy in health systems and ensure that everyone who works in residential aged care – from nurses to care workers and activity officers – are valued. It is crucial that we come together as a team. I am an NP and I work with care workers, registered nurses and team leaders. We have different levels of education and we are all equally important when it comes to caring for those in their last months of life. We all do work that's valuable – we just do different jobs.

It is a great privilege for me to do this work and to be able to care for those in their last months of life. I have been very fortunate to have had these opportunities, working with driven people across various health settings who value care and compassion so highly, and who have allowed the Palliative Care Needs Round model to come to fruition. We suggest funding the model across Australia as it is affordable and effective.

I strive to help the vulnerable and advocate for equality and equal access for every person. Nurses are patient advocates meaning that they will advocate on behalf of their patient's best interests when they aren't able to for themselves. When a person and their family is empowered to prepare plans for their end of life, the entire community benefits from having those last wishes fulfilled and ensuring that there is time to say goodbye.

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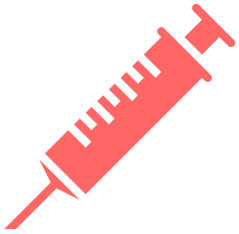
IMMUNISATION: OUR ROLE



ACN supports nurses to meet immunisation needs of Australian adults

Infectious diseases like smallpox and diphtheria were much feared causes of death up until about the middle of the 20th century. In an attempt to prevent contracting these deadly infections a form of vaccination was used as long ago as the 16th century in India and the 18th century in Turkey (Royal Society for Public Health, 2018). A huge scientific breakthrough occurred in 1796, however, when the famous experiment of Edward Jenner not only gave the world the process of vaccination but also the word itself. The folklore of the time was that an infection with cowpox protected against smallpox. Jenner decided to test this belief so he inoculated James, a young boy, with the cowpox virus, and subsequently with the smallpox virus. The result was that James did not develop smallpox so Jenner had not only shown that a virus could be transmitted from one person to another but that immunity was also possible with that transfer process (The Jenner Institute, 2019). The Latin word for cow is *vacca* so Jenner called the process he had invented, vaccination (Science Museum, 2019).

Since then, vaccines have been developed for many infectious diseases such as measles, mumps and influenza. Where a vaccine exists, that infectious disease has come to be called a vaccine preventable disease. As the name suggests and as Jenner showed, vaccines can either prevent the person suffering from a vaccine preventable disease, or if infected, the symptoms are less severe (*National Immunisation Handbook*, 2019; *National Immunisation (NIP) Schedule* 2019).

In the 1950s, Australia implemented a system of vaccinations for children. That system has now evolved to become an internationally recognised immunisation program offered throughout Australia. It is funded by all levels of government and is available across the life span. As a result, Australia has experienced a marked reduction in the incidence of vaccine preventable disease with subsequent improvements in the overall health of the population (*National Immunisation Strategy for Australia 2019-2024*).

Australia has also participated in the collaboration between nations spearheaded by the World Health Organization (WHO), which has led to the eradication of infections like smallpox and the near eradication of other debilitating infectious diseases such as polio (WHO, 2018). We need to be ever vigilant, however, as the immunity afforded by vaccines is not always lifelong. For example, in 2019, Australia experienced an upsurge in the incidence of measles as a result of under-vaccinated travellers either returning to Australia or visiting Australia from measles infected areas (New South Wales Government, 2019). Measles is a highly infectious disease, not a harmless disease of childhood. One example of the potentially harmful consequences of measles is Roald Dahl's story of his daughter Olivia. In 1962, at the age of seven, Olivia died from measles encephalitis, following which Dahl became an impassioned advocate for the benefits of childhood vaccinations against this vaccine preventable disease (Roald Dahl, 2018).

So what is the current and future role of the Australian College of Nursing (ACN) in all of this?

It is important for nurses to be aware that it is a requirement of the Nursing and Midwifery Board of Australia (NMBA) that all nurses promote and advocate for the positive benefits of vaccination and immunisation programs: to do otherwise is in breach of the licence to practice granted by the NMBA (*Professional Standards: Professional Codes and Guidelines,* 2018; *Position Statement: Nurses, midwives and vaccination*, 2016).

As part of its commitment to nursing, ACN has formed an expert Working Group of ACN members with expertise in vaccine delivery and immunisation advocacy. The role of the group is to assist ACN in the development of a Position Statement and a Discussion Paper on the topic of immunisation so that the ability of the nursing profession to meet the immunisation needs of adults in Australia and its NMBA obligations is facilitated and enhanced. It is anticipated that both the Position Statement and the Discussion Paper will be released in the winter of 2019.

In addition, ACN is authorised to deliver the *Immunisation for Health Practitioners course* under the newly approved *National Immunisation Education Framework for Health Professionals* (Australian Government, 2018). Completion of the course extends a nurse's scope of practice so that he or she can safely deliver vaccines and advocate for immunisation programs. ACN also offers immunisation updates at a variety of venues in regional, rural and metropolitan areas.

As the pre-eminent professional nursing organisation, ACN is committed to advocating on behalf of nurses so that their unique insights can contribute to quality health care environments for the benefit of the Australian community. Given that vaccination is a proven means of improving health, ACN is expanding its immunisation advocacy activities nationally and internationally, with the aim of enhancing the ability of nurses to deliver vaccines and promote the positive benefits of immunisation programs.

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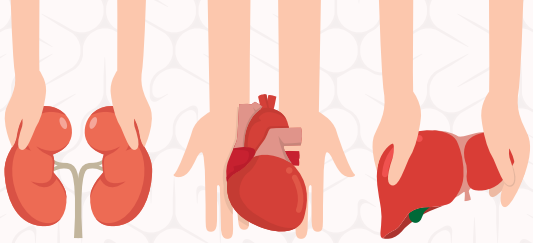

CONTINUING PROFESSIONAL DEVELOPMENT: ORGAN AND TISSUE DONATION SERVICES

Taking a step in a new direction

Leigh McKay, Education Coordinator with NSW Organ & Tissue Donation Service, hopes that comprehensive workshops on organ and tissue donation will boost nurses' confidence to work in the area and consequently make it an accepted part of every end of life discussion with families.

Why did you decide to become an educator for the NSW Organ and Tissue Donation Service?

I've been privileged to work in the Organ & Tissue Donation sector for over 20 years. In my early years as a Donor Coordinator on the Central Coast and in Northern Sydney I worked closely with health professionals in emergency department, intensive care unit and operating theatre to identify and manage potential donors and support their families. I then transitioned into a State Donor Coordinator role which provided me with a broader view of facilitating the donation process across NSW and the ACT.

Around eight years ago, I received a new opportunity to be an Education Coordinator within the donation sector. Education was an important aspect of my prior roles and I had previous experience as an educator at the NSW College of Nursing, so I decided to further hone my skills in education and training in this sector. Although I miss working with staff at the bedside and families during the donation process, it's great to have this opportunity to share my experience and learnings with others.

What do you love most about being an educator?

I am extremely fortunate to work in a dynamic field that is supported by a dedicated and committed team of health professionals.

Over the last 20 years, there have been significant changes in organ and tissue donation and transplantation; early identification and referral of potential organ and tissue donors, consenting practices, extended eligibility criteria of potential donors, transplantation advances and improved outcomes, to name a few.

It has been an incredibly interesting time to work with our donation network staff and health professionals at the bedside. I have been involved in the development of national and state workshops and innovative resources (simulation sessions with actors and DVDs) to nurture and help others to develop skills in communication, awareness of organ and tissue donation for transplantation and the Family Donation Conversation. It has been rewarding, both professionally and personally.

What is the most challenging aspect of being an educator?

Organ and tissue donation remains a relatively rare event for health professionals, so it is difficult for those working at the bedside to keep the possibility of organ and tissue donation at the forefront of their minds when death has occurred or is impending. Also, as a state-wide service, we need to ensure that our regional hospitals and colleagues have the skills, knowledge and support should the donation opportunity arise.

There are still many misconceptions surrounding organ and tissue donation in the community as well as among health professionals. My role is to ensure that we provide education to health professionals where organ and tissue donation may occur and the general community to ensure that these misconceptions are addressed and debunked.

How do you ensure that?

Providing forums, workshops and in-services will go some way in increasing awareness for health professionals. We have a Professional Education Package that has an introductory awareness program for critical care nurses, social workers and pastoral care; and advanced workshops for doctors and donation staff that lead the donation conversation with families.

In addition, the Australian College of Nursing is holding two different one day CPD workshops: the first workshop is an introductory general awareness workshop for any nurse interested in organ and tissue donation for transplantation. The other is specifically for peri-operative nurses. Both workshops include the personal experience of a donor family and a recipient, which provides an opportunity for participants to appreciate this unique perspective.

How does the course empower nurses and enhance their personal and profession development?

In organ and tissue donation for transplantation: latest statistics, legal perspectives, donation process, emerging technologies and transplant outcomes. It is our aim that participants will increase their knowledge in this area which will build their confidence to work within this space.

Although it's not an objective of our workshops, I believe participants may also be able to consider organ and tissue donation as a personal decision.

What do you want to achieve in future?

Whilst we have come so far in the last 20 years, I would like to see that organ and tissue donation is a normal and accepted part of every end of life discussion with families. By ensuring that health professionals are well supported by current knowledge and skills, my aim is for them to continue their vital work with donors and their families.

Finally, I remain committed to reviewing and reflecting on my practice and continuing my personal and professional development.

On a professional note, register for upcoming organ and tissue donation CPD courses in September and October.

On a personal note, to register your organ and tissue donation decision, visit donatelife.gov.au.

ETHICS MATTERS: ISSUES IN NURSING AND WHY THEY COUNT

Introducing ethics and philosophy matters

Welcome to the first edition of what is to be a regular feature in *The Hive: Ethics Matters.* Since this is the first time the column appears, it outlines the reasons for choosing *Ethics Matters* as the title. It also gives a brief description of ethics and philosophy and how they inform the style of this column. Subsequent columns will be less theoretical however, as they will identify issues of concern to the profession, clarify them, and suggest ways of thinking about them. The overall aim is to enrich your practice by promoting reflection on aspects of nursing which will then inform your actual practice.

In the Western philosophical tradition, ethics has long been a part of philosophy. The registered nurse and philosopher Steven Edwards has given what he calls a "nutshell" definition of nursing philosophy as "the examination of philosophical problems as these bear upon, or are raised by nursing theory and practice" (Edwards, 2001, 14). With the advent of so called modern nursing, ushered in by Florence Nightingale, the image of nurses as having a religious vocation became firmly entrenched. It was the religious teaching of the time that gave ethical guidance to nurses. As nursing evolved however, and became a profession, it drew on existing philosophical thought to develop what came to be called nursing philosophy. At much the same time, nurse scholars began to develop nursing ethics, for example, the very influential theories of caring in nursing (Benner and Wrubel 1989) and more recently virtue ethics (Sellman, 2011).

As Edwards suggests, this column aims to identify current problems arising from practice where practice is defined very broadly so that it includes not only clinical practice but also education, research and management or leadership. The problems for discussion will be identified using the litmus test of what 'matters' to the profession at the present time. The word matters has many meanings in the English language and two of those meanings will be used here: what is of concern to the profession (what matters), and how that issue may be analysed (its subject matter).

The title *Ethics Matters* was chosen for this column because it includes analysis of problems that matter to the nursing profession and how those problems can benefit practice when the methods of philosophy are applied. Those methods can be summed up as clarification of a problem and a deep analysis of the same problem which will uncover new or innovative ways of thinking ethically about it and so, inform practice.

Ethics is not only a recognised part of philosophy, it is also intrinsic to what nurses 'do' because all nursing actions are other directed. Nursing actions are inherently ethical as their intention always is to provide more benefits than harms. It is not an easy matter sometimes though to determine what will benefit the most or what will harm and whether any harm justifies the benefits. An ethical analysis is intended to determine the directions to take in those circumstances, and the profession's code of ethics is meant to provide guidance in that endeavour.

The International Council of Nurses *Code Of Ethics For Nurses* (2012) is one of the professional practice standards promulgated by the Nursing and Midwifery Board of Australia. The code requires nurses to "maintain competence by continual learning" and to "think about how you can apply ethics

> **“It is not an easy matter sometimes though to determine what will benefit the most or what will harm and whether any harm justifies the benefits.”**

in your nursing domain: practice, education, research or management” (International Council of Nurses, 2012, 3 & 5). The aim of this column is to encourage ways of thinking about nursing matters, which, when acted upon, benefit by creating quality practice environments. That contribution applies whether the practice environment is by the bedside, in an educational context, when conducting research or importantly, when the practice environment is management or leadership. Accordingly, *Ethics Matters* aims to encourage a deeper thinking about ethics and so take ethics beyond the bedside to all the other environments where nurses practise their profession.

To apply ethics in the manner *Ethics Matters* aims to do, it is helpful to provide a brief description of how philosophers develop knowledge and how they approach problems. Philosophers use research evidence (or data) from other disciplines as well as their own so that they can identify, clarify and inform the nature of problems. Ethics, as part of philosophy, does the same thing, that is, it draws upon available research evidence to clarify the exact nature of a problem and its relevance (or not) to particular contexts. Once the problem is identified and the exact nature of the problem clarified, it is analysed so that arguments can be developed in support of a particular position. The arguments then become the reasons for taking one stance over another and their worth is assessed according to their validity: are they logical, for instance? Others may disagree with the reasons and in turn, they will then develop their own arguments (or justifications) using the same processes of clarification and analysis. Further debate takes place until agreement is reached that one or other argument is the most robust so that comes to be accepted as the best way to justify actions. So when thinking ethically and acting on that basis, there must always be reasons offered for taking one stance over another.

All of us have opinions and beliefs about various aspects of our lives, but when we are acting in our professional capacity, there needs to be a justifiable reason for acting or not acting. In the ethical realm of practice, the codes of ethics are intended to guide decision making in that regard. The methods of philosophy provide the intellectual structure for turning personal opinions or views into professionally appropriate actions. *Ethics Matters* aims to provide you with the means of thinking about and developing those justifications as they apply to a particular problem. The Spring edition of *The Hive* will have an *Ethics Matters* column where this methodology is demonstrated.

If you have a nursing issue that matters and you would like it to be discussed and analysed then please email us at publications@acn.edu.au.

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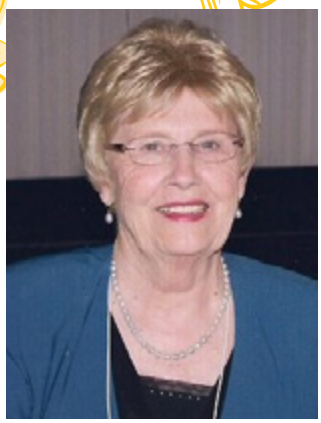

IN MEMORY:

Adjunct Associate Professor June Graham FACN

RN CM RICN Assoc Dip(N Ed) DNA (Nursing) MHA (UNSW) AssFACHSE
1941–2018

The Profession lost another great Nurse Leader in 2018.

June Graham had a long and successful nursing career in the Newcastle area remembered by her friends and colleagues as a fearless trailblazer who was always at the forefront; in a time when great changes were achieved in the nursing profession.

June had a wealth of experience in a variety of clinical settings including midwifery and intensive care as well as extensive experience in nursing education, administration, health services management and planning; development of new models of care and safety and quality programs in both the public and private sectors.

June was the Deputy Director of Nursing at the then Royal Newcastle Hospital from 1986-1994 following a period as an academic at the University of Newcastle. In 2000 June completed the Nuffield International Clinical Leadership Program at Oxford and Cambridge Universities, the focus of which was implementing clinical governance throughout diverse organisations.

June was the General Manager of Newcastle Eastlakes Sector of the Hunter Area Health Service and the Executive Officer Royal Newcastle Hospital and Port Stephens Health Services. She was extensively involved in the transfer of services to the John Hunter Hospital in 1992 and the commissioning of Royal Newcastle Hospital as a Bone and Joint facility. She held a range of management positions at John Hunter Hospital. June contributed to many nursing and health services working parties and committees throughout her career.

June was a Surveyor for the Australian Council on Healthcare Standards from 1999 where she provided strong leadership for survey teams.

June worked tirelessly for many years on the Committee of the Royal Newcastle Graduate Nurses Association holding the position of President for some years.

In 2003 June was made an Adjunct Associate Professor at the School of Nursing and Midwifery, Faculty of Health, University of Newcastle.

June distinguished herself as a nurse, educator and administrator in all of the positions she held. She was a mentor to many and an inspiration to all who worked with her.

She gave her all to her career for over 50 years.

Marie Curie and Pierre Curie

NURSING HISTORY:

A different perspective

Although I'm writing about the history of women's health, it's a topic I am only marginally informed about, so I have decided to take a different perspective.

The mental health of women is dependent on their social conditions, the way their lives work, and how they fit into their culture and society. I recently read Jane Caro's (2019) *The Accidental Feminist*, a book that gave me insight into the changes in women's lives in Australia from the 1950s. It talks about how women were raised to think that they were second-class citizens and that males must take precedence. I believe that this is as important as the physical health of women – after all, unless women can take their rightful place in society, their health is always going to suffer.

There's an old saying that goes, "Ginger Rogers did all the same steps as Fred Astaire but backwards and in high heels". In other words, it has always been more difficult for women than men to achieve great things and be recognised.

Hildegard von Bingen (1098–1179), a German Benedictine nun, one of the great writers, philosophers and doctors of her time (Slominsky & Kuhn, 2001) composed music that is still heard; her spiritual teachings are still influential, and she wrote extensively about treatments for a wide range of ailments for all, not just women. St Teresa of Avila (1516–1582), a Spanish nun at the time of the Inquisition, lived amid great turmoil and dominance of the male-driven church. Her written works influence people around the world even today.

Mary Wollstonecraft (1759–1797) wrote *The Vindication of the Rights of Women* (1792) in which she stated that women were not inherently inferior to men, rather, they could not access the same level of education (Taylor, 2017). Her daughter Mary Shelley (1797–1851), wrote *Frankenstein*; or, *The Modern Prometheus* (1818) (Bennett, 2014). She, too, was an early feminist.

Marie Curie (1867–1934) (Rogers et al. 2009) the only woman to win the Nobel Prize – twice – for her discovery of radium and its effects had to fight for her rightful place in a male-dominated scientific world. One can always discuss Florence Nightingale (1822–1910) (Baly & Matthew, 2011), but we do Nightingale a great disservice because the world sees her as "The Lady of the Lamp" while ignoring her invaluable input to statistics and epidemiology. The public relations around Nightingale promoted what was seen as her feminine side and ignored achievements considered too masculine for the feminine mind.

In culture, some women had a win. In Bizet's 1875 opera *Carmen*, one of the great love stories, Carmen refuses to bend to the masculinity of Don José, and instead takes life and love on her terms alone. Sadly, this ends in tragedy. Another quirky classic, the 1841 ballet, *Giselle*, teaches men not to take women for granted. The Willi are spirits of women who have died because of a man's dastardly deeds. When Giselle dies because she is badly treated by Prince Albrecht, the Willi make him dance until he drops (of course, being the gentle heroine, Giselle saves his life).

I could go on, but one thing is for sure: These women, like Ginger Rogers, achieved goals, beat the men, did them backwards and in high heels! Is women's health today any better because of their achievements? Caro's book is about resisting patriarchy and making sure that today's women won't have to dance backwards and in high heels. Their health depends on it.

The #metoo movement is a great example of that. We have seen a surge in awareness of domestic violence, rape in war, and the overt and covert abuse of women. It's relevant to some men too, but commonly, those on the receiving end of abuse are women, and it is great to see them coming out and screaming from the rooftops about how they won't put up with injustice anymore. To quote Caro:

> *… …perhaps it was always patriarchy's fatal flaw. No matter how much they held us back, no matter how many obstacles they put in our way, no matter how low our self-esteem or bitter our disappointments, they could not drain our brains out of our ears, or (totally) smash our spirit and our desire to participate in and contribute to the world. … Now, thanks to the efforts and determination and courage of countless generations of sometimes noisy, sometimes quiet, revolutionaries, most of us have found ways to put our brain, character and heart to good use.* (Caro 2014, Section 13, p18).

Women's health is in the good hands of the women of today.

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PROFESSOR LINDA SHIELDS MD PHD FACN

Board composition and election processes

Proposed amendments to our Constitution

In line with current best practice, the skills and competencies of Board Directors must support an organisation's mission, as well as ensure appropriate stewardship of its finances, risks and governance.

The Australian Institute of Company Directors (AICD) has raised the issue of Board composition and competence as a manageable risk in response to recent bad press relating to the Australian Banking Boards and the Australian Public Broadcaster.

To mitigate this risk, the AICD recommends that companies disclose their Board skills matrix in order to communicate to their membership the composition of skills, competencies and diversity they seek to achieve in their Board.

Recent media reports and the Australian Prudential Regulatory Authority (APRA) have emphasised the need for Boards to work harder to appoint Directors with comprehensive industry experience, while considering the skills of the Board as a collective. This has prompted the ACN Board to examine its own processes and review its existing governance structure to ensure it will meet the needs of the organisation into the future.

Our Constitution governs Board composition and election processes. Currently, the ACN Board comprises seven Directors who have been elected from the membership, as well as two Independent Directors selected by the Board. All Board appointments are for a four-year period and Directors can serve for two terms if re-elected.

In keeping with contemporary best practice, ACN's Board regularly reviews the competencies, experience and diversity required for Directors to fulfil their position successfully. Where necessary, Board Directors undertake skills development in order to acquire the skills identified as deficits.

Taking into consideration current best practice, as well as our future requirements as an organisation, the ACN Board has recommended an amendment to the Constitution. The proposed amendment is to develop a formal nomination and selection process for those interested in running as a candidate for the Board.

This process would involve a Nominations and Selection Committee developing criteria based upon the skills, competencies and experience identified in the Board Skills Matrix. This criteria would then be approved and adopted by the Board prior to each election cycle and published as part of the call for nominations.

The Nominations and Selection Committee would comprise up to five Board Directors who will not be standing for re-election. The committee would consider all nominations against the approved criteria and endorse candidates that meet the criteria for election. Following endorsement by the Committee, nominated Fellows and Members would stand for election under the current process.

A General Meeting of Members will be convened to consider the proposed changes in Sydney in July. The draft amended Constitution, Nominations and Selection Committee Terms of Reference, as well as the proposed nomination and selection criteria will be circulated along with the notice of the General Meeting. Proxies will be available for Fellows and Members who are unable to attend in person.

Reviews of a good read

SURVIVING THEATRES AS A NEW GRAD

Author: Cam Brown
Publisher: Xlibris AU
Published: 23 January 2019
Reviewer: ACN Publications Editor Neha Malude

A nurse for the last 28 years, Cam talks of her extensive experience working in theatres for 15 of those in her new book, giving the reader a glimpse of what working in a theatre is like.

Chapter by chapter, the author introduces the reader to all the aspects of working in a theatre – the different 'personalities' one needs to understand and deal with, what can go wrong and how to work one's way around it, how to navigate around the operating theatre (right down to details such as where you could stand so as to observe everything and yet stay out of people's ways to let them do their job without being a hindrance) – and more, exemplified with plenty of anecdotes which both entertain and inform.

The author also touches upon issues of workplace bullying and 'insider' tips and tricks to make the best of one's experience, and emphasises the importance of learning one's craft effectively. If you're a new nurse or postgraduate student hoping for a career in the OT, this book might just be the insiders view you're looking for.

NURSES, A STORY OF SEXUAL HARASSMENT: IN #METOO, STORIES FROM THE AUSTRALIAN MOVEMENT

Authors: Simone Sheridan and Ailsa Wild
Publisher: Pan Macmillan Australia
Published: 23 April 2019
Reviewer: ACN Communications Officer Rory O'Sullivan

In 2019, women all across the globe courageously took to social media to share their stories of sexual harassment and assault under the hashtag #Metoo. Sheridan and Wild's piece, which appears in a broader anthology of stories from the Australian #MeToo movement, shines the spotlight on the nursing profession by calling out the sexual harassment of female nurses.

The authors share the stories of three brave nurses, each of whom has been a victim of sexual harassment. These stories not only touch on the harassment itself, but the impacts the behavior has on the victims and the challenges they face when attempting to report their abuse in health care workplaces.

A number of powerful messages are woven throughout the article. **Under no circumstances** is sexual harassment of female nurses acceptable. No excuses justify this behavior. Nurses **deserve** better. They **deserve** to feel safe at work.

The article is a must-read that gives an issue long neglected the attention it deserves.

If you would like to submit a book or film review for publication in an upcoming edition of *The Hive*, please email us at publications@acn.edu.au

SHARE YOUR STORY WITH US

Thank you to all of our wonderful Fellows and Members who contributed to the 2019 Winter edition of *The Hive*.

The themes for the next few editions of *The Hive* are:

- Men's Health
- Artificial Intelligence and Innovation

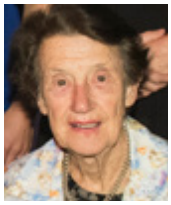
If you have a research piece, clinical update, profile piece or personal story to share that addresses these themes, please contact us at **publications@acn.edu.au.**

Thank you to all of our authors!

DR MADONNA GREHAN MACN
Women's health – a broad concept

LAURIE BICKHOFF MACN
Women die because they aren't men

TOMICA GNJEC MACN
Preventative health and the National Women's Health Strategy 2020–2030



RUTH ZIONZEE RN RMN OHNC FACN (DLF)
A lifetime of nurse leadership

LYDIA MAINEY MACN
Empower nurses to improve abortion care

ARIEL YOKOTA
Your health, your right

MARIE JONES MACN
Understanding female genital mutilation

DR RUTH DE SOUZA FACN
Migrant women and motherhood

ELISSA O'KEEFE MACN
A unique approach to women's health

ERICA O'DONOGHUE MACN
Time to talk, period.
Endometriosis: a new approach

CHRISTOPHER O'DONNELL MACN
Celebrate what we do best
The need for transformational leadership

RHONDA GARTRELL MACN
Celebrate what we do best

MELINDA HASSALL MACN
Celebrate what we do best

ARIELA ROTHER MACN
Celebrate what we do best

NIKKI JOHNSTON OAM MACN MACNP MPCNA
A better life – and dealth

PROFESSOR LINDA SHIELDS MD PHD FACN
A different perspective

Melanography Essentials

Melanography Essentials is a new course developed and delivered by the Australasian College of Dermatologists and MoleMap

Melanography skills are becoming a crucial element in the identification and subsequent treatment of skin cancers and skin conditions. Melanography Essentials course provides nurses and other health professionals with the relevant knowledge and skills in skin assessment and imaging which are required for competent and safe melanography practice.

This course is targeted at nurses or other appropriately trained health professionals who are interested in, or working in, the field of skin cancer imaging and wish to further their skills and knowledge in this area.

Melanography Essentials consists of eight online modules and two one day face-to-face workshops. It is facilitated by experienced melanographers and is delivered in a blended learning mode, so students will have access to online tutorials, discussion forums and videos of practical demonstrations as well as the practical face to face workshops. Study at your own pace in the eight self-paced online modules.

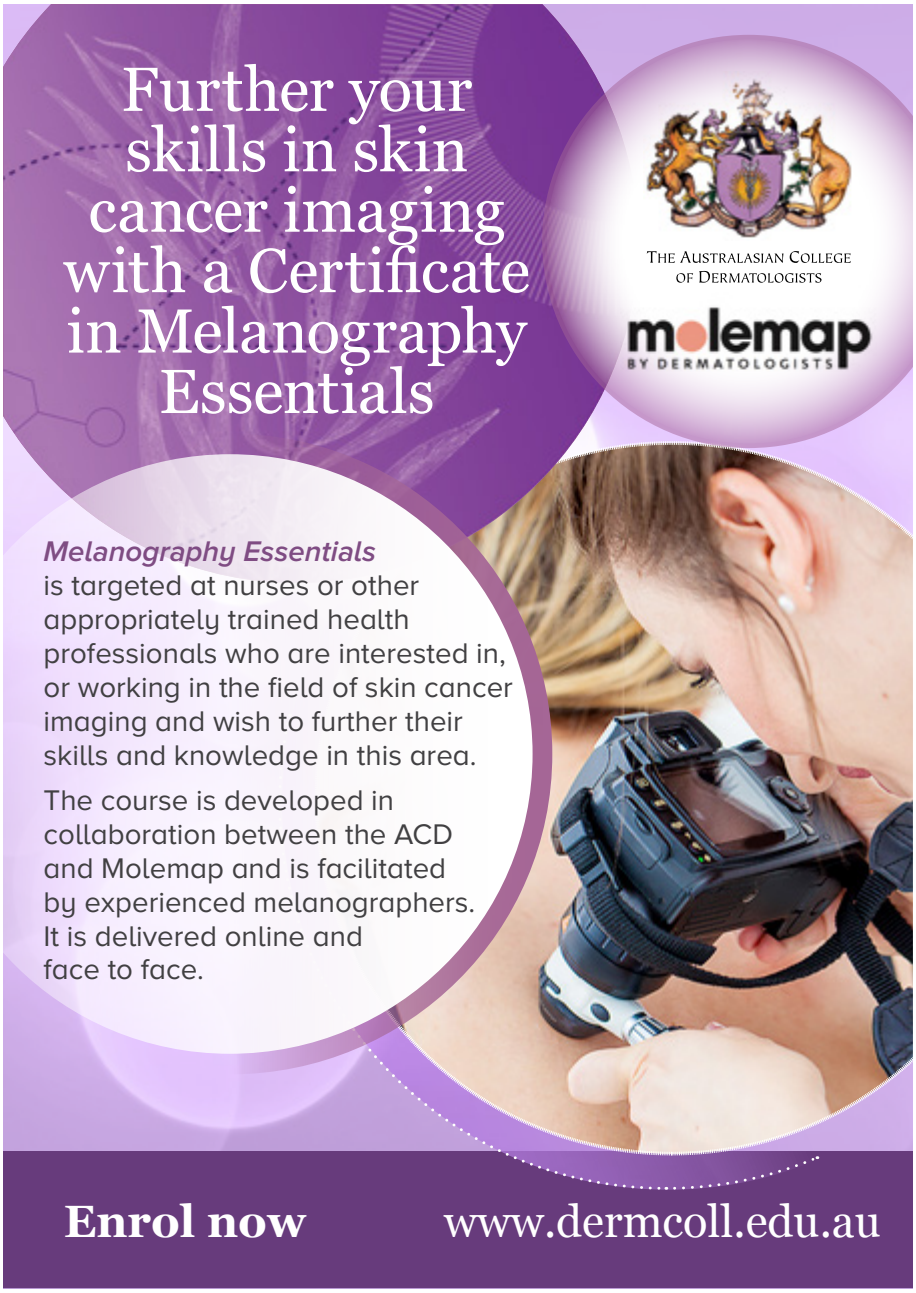
Melanography Essentials covers the following subjects:

1. **Anatomy and physiology of the integumentary system**
2. **Ultraviolet radiation**
3. **Lesion Recognition**
4. **Clinical assessment of lesions and dermoscopy**
5. **Melanography imaging procedures**
6. **Procedural guidelines for melanography practice**
7. **Safety, security and ergonomics in the clinic**
8. **Legal aspects of melanography.**

By completing the course you will learn to apply knowledge of skin anatomy, physiology and histopathology to melanography practice, describe skin cancer pathology and relate this to visible lesion features and explain the effects of ultraviolet radiation on the skin. Melanography Essentials provides education to patients about skin cancer and its prevention.

Students will conduct a thorough visual skin cancer assessment of a patient, learn to recognise skin lesions using clinical and dermoscopic criteria, accurately identify skin lesions that require photographic imaging for diagnosis and or surveillance and demonstrate competent skin photography skills. By the end of the course, they will be able to carry out total body and individual lesion photography in accordance with a quality standard, identify key elements for a melanographer to run a clinic efficiently and safely and outline legal consideration pertinent to melanography practice.

Registrations are now open for 2019 and numbers are limited. Any queries can be directed to **melanography1@dermcoll.edu.au**



SPECIALTY COURSE

Meets Immunisation Education Framework

Be an immunisation advocate

ACN's Immunisation for Health Practitioners 10-week online course meets the National Immunisation Education Framework for Health Professionals (2017). It is suitable for registered and enrolled nurses, midwives, pharmacists and other allied health workers.

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Monthly intakes available February – December
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