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Welcome

Carmen Morgan FACN, President of ACN

It is my pleasure to welcome you to the September edition of NurseClick.

As we shine a spotlight on primary health care for Community and Primary Health Care Nursing Week: Nurses where you need them (September 21-27), Community Care Nurse Manager Debra Gilbertson explores the value of critical reflection in community nursing. Thank you to all the nurses and supporters who have contributed to the week and helped to raise awareness of the important role of nurses in our communities, in not just direct care but illness prevention and health promotion. With the increasing number of people delaying or refusing lifesaving vaccinations for themselves and their children, the role of the nurse as an advocate also becomes increasingly important. In her article, ‘Immunisation advocacy in an era of vaccine hesitancy’, ACN Nurse Educator Sara Peterson discusses the impact of this worrying trend and how community health professionals are in the best position to communicate the importance of immunisation to their patients.

Next up on ACN’s busy calendar is our annual signature event, The National Nursing Forum, where we are looking forward to bringing together nurses from across Australia and around the world to network and share ideas. We will also be celebrating the release of the ACN centenary commemorative trilogy, The History of Australian Nurses in the First World War, at the Forum, where author Dr Ruth Rae will be signing copies of the books. For this edition of NurseClick, Ruth has given us a special glimpse into the family connection that set her on a 30-year journey of researching Australian nurses who served in, ‘A life changing journey: Researching and writing the Trilogy’.

ACN regularly seeks experienced and enthusiastic members and fellows to represent us on a wide variety of working groups and advisory bodies. Our representative on the Northern Adelaide Local Health Network governing council, Brenda Wilson, shares her experiences in our Representation Q&A. Another important way our members contribute to ACN is through participating in online consultations and surveys. ACN’s policy team recently consulted members on The Nursing and Midwifery Board of Australia’s review of the current National competency standards for the registered nurse. In the article, ‘Active interest in the review of nursing standards for practice’, policy team member Nastassia Hanson-Murphy outlines the important feedback our members have contributed to this review and the key recommendations put forward as a result.

I hope you enjoy the issue and don’t forget to share your Community and Primary Health Care Nursing Week event photos and spread the word on social media using the hashtag #nurseswhereyouneedthem.
Member news

**EBSCO CPD resources and support now available to all members via 3LP**

ACN members can now access the EBSCO databases via 3LP. This new member service will benefit all nurses looking for research and CPD support and resources.

Members can access the EBSCO Discovery Service, EBSCOhost Web, and the new Nursing Reference Center Plus, which has been specifically designed for nurses.

To access these exciting new resources, simply sign in to 3LP and follow the link on the Literature Search tab.

If you have any questions regarding EBSCO or need your 3LP login reset, please contact the membership team on 1800 061 660 or membership@acn.edu.au.

**Back issues of NurseClick, The Hive and Collegian available via 3LP**

All members can now access back issues of ACN publications via the 3LP portal.

Catch up on any articles you might have missed or find an article relevant to your research or studies. Simply log in and click on the ACN Publications tab.

For more information please contact Membership on 1800 061 660 or email membership@acn.edu.au.

**Are you interested in building your leadership skills?**

The Leadership@ACN program is comprised of a series of workshops, seminars and courses designed to help you develop your skills, confidence and ability to take a leadership role in health care. This evidence-based, practical program is tailored specifically to be relevant and useful at all stages of your career.

Register your interest at acn.edu.au/leadership to receive email updates as more information becomes available for the Leadership@ACN programs in 2016.

**Share your story or research with ACN**

We’re looking for member submissions for our upcoming editions of The Hive and NurseClick.

If you have a research piece, clinical update, personal reflection or profile piece that you’d like to share, we are eager to hear from you.

If you’re interested in having your submission considered for our upcoming publications, please see our publishing guidelines and send your complete article to publications@acn.edu.au by Monday, 14 October 2015.

**Nurse leaders are found at all levels of the healthcare system**

**Nurses are leaders in patient care**

View the new Leadership@ACN video.
The concept of critical reflection first emerged in In Focus dilemmas I have encountered over the last 20 years (Simpson & Courtney 2002). Some techniques used for reflection include journaling, debriefing sessions, diarising, clinical supervision, reflective essays and examining case histories (Cotton 2001).

By critically reflecting, an RN may view a scenario in a completely different way, which can translate to taking an alternative course of action. Bringing issues to the conscious level is a major step in personal and professional growth (Yoder-Wise 2011).

**Personal experience**

Having trained in a hospital in the 1980s, my nursing education was very much geared towards employment in the hospital environment. However, a one day placement with a district nurse changed the course of my career forever. I thoroughly enjoyed visiting clients in their own homes, and found working and thinking independently to be invigorating. The RN had the ability to spend time with her clients, liaise with their family and offer holistic care, focussing more on wellness than illness.

Six years post-graduation, and after working in varied nursing environments around the world, I was offered the opportunity to work as a community nurse. The timing was right; I had gained the necessary skills and training to be an exceptional community nurse. I had excellent communication skills, had worked with different multicultural groups, had experienced working with clients with acute and chronic health problems and had confidence that I could work independently – all the qualities necessary to fulfil the position, or so I thought.

Three different clients come to mind when I reflect on the changes and growth I have made both personally and professionally. Three different clients, similar nursing needs, similar environmental concerns, identical hoarding behaviours but with different outcomes. Mr B was referred to my service for wound care and management of a chronic ulcer by his local doctor. On arrival at the client’s home my immediate impression was that the yard was a little untidy in comparison with other houses in the street. I was met by Mr B at the front door and welcomed inside. I was totally overwhelmed by the internal environment of the house; I feared he may have seen through my poker face and realised that I was appalled by his living conditions. Piles of rubbish and clutter were stacked almost to the ceiling, covering all of the floor space, with the exception of narrow pathways allowing access to other areas of the house.

Inspection of other rooms revealed the same status; the kitchen was encumbered with all manner of debris and the bedroom shambolic, with the exception of one small area where the client obviously slept. Showering was impossible as the shower and bath were full of possessions and Mr B had resorted to washing himself at the basin.

This was my first encounter with hoarding syndrome, an obsessive-compulsive disorder, which is defined as collecting excessive quantities of poorly usable items of little value, failing to discard items and difficulty organising tasks (Valente 2009). Hoarders acquire and cannot dispose of worthless items and clutter leading to functional impairment, indecisiveness, perfectionism, procrastination and diminished coping (Valente 2009).

My immediate instinct was to decline home visits to Mr B and request that he visit the district nursing office to have his wound care attended, or return to his local doctor. I informed Mr B that I would be unable to attend home visits until he cleared at least one room that would be usable, citing workplace health and safety (WHS) regulations as my excuse. Mr B stated that he couldn’t clean out a room, as his council wheelie-bins were both full, being located somewhere inside the house currently covered with piles of rubbish.

Thinking I was being helpful, I phoned the local council to obtain additional bins for the client. I arranged for Mr B to visit the office the next day, where wound care would be attended and negotiated to attempt a home visit the following week - only to find the newly acquired wheelie-bins inside the house, full of old newspapers and magazines. Retrospectively, I should have felt honoured that this gentleman invited me into his home. I should have rejoiced with him when his wound healed but I couldn’t overcome the sense of failure, in that this gentleman would continue to live in what I considered to be squalid conditions.

The next time I encountered a client with hoarding syndrome I was able to draw on these reflections and improve on the care provided. Mrs S, a 78-year-old widow, lived alone in an old weatherboard house, in which she had resided for 55 years. She was referred by her local doctor for wound care to a chronic leg ulcer. On home visiting, I found the central corridor that ran from the front to the rear of the house had yellowed newspapers stacked continuously from floor to ceiling.

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Throughout my career, I have endeavoured to examine and critically reflect upon my performance as a community RN. I have always found the exercise of critical reflection empowering and endorse its use to my colleagues from novice to more advanced practitioners.

On this occasion, I accepted the surroundings and found a way to safely attend to the wound care. I negotiated with Mrs S to attend her wound care on the front veranda, which was uncluttered and screened to ensure privacy. On each visit, Mrs S would bring a basin of warm water and a clean towel from the house so that I could bathe her leg prior to redressing the wound. I provided a sealed container for storage of the required wound products to ensure they remained clean.

Over the following months, as wound healing progressed I earned the trust of Mrs S and she disclosed the reason for the hoarding. Her husband had disappeared during active service in the Second World War and his body was never found. From the time her husband left to go to war, Mrs S had bought a variety of newspapers to keep informed of events, as she did not own a radio at the time. She continued to do this after being notified of her husband’s disappearance until the present day, feeling unable to discard the papers as she felt they represented a connection to her husband. This was to be an ‘a-ha’ moment – enabling a better understanding behind the causes of hoarding syndrome.

Many years later, and now a Nurse Manager, I was asked to intervene and provide support to a nurse encountering similar issues with a new client to our service. The client required wound management and resided in an extremely cluttered environment making it difficult to perform the required care. There was no provision for attending staff to wash their hands or store required wound care products. The immediate reaction of the visiting RN was to delay care until a thorough spring clean was attended and the house met minimum WHS standards.

I spent time with the RN, who was new to community nursing, to discuss the client’s rights to live as they choose and not enforcing our own standards upon them. I asked her to research hoarding syndrome and told her of my own experience and reflections. I attended a joint visit, and asked the client if we could relocate some of her possessions to another area, in order to have a small area cleared where we could provide the assistance required. We adapted our practice to suit the environment while maintaining best practice and abiding by policies that governed our work.

On a subsequent visit, the client confided to the RN that she had been in a concentration camp during the Second World War, during which time her entire family had died. Her only possession during this time was the clothing she wore; these were reduced to rags over the years she was interned. At the end of the war she migrated to Australia and met her husband. Since his death, she had been unable to throw anything out, fearing that one day she would again have nothing. On learning this, the staff involved became more accepting and caring towards the client.

Conclusion

The primary health care philosophy that directs the practice of community nurses is founded on principles of equity and social justice (World Health Organization, 1978). It is this philosophy, supported by a holistic approach, which underpins community nursing practice to ensure that all people, including marginalised and isolated clients, obtain equitable care (Rose & Glass, 2006).

Throughout my career, I have endeavoured to examine and critically reflect upon my performance as a community RN. I have always found the exercise of critical reflection empowering and endorse its use to my colleagues from novice to more advanced practitioners. I am committed to the continual development of my colleagues and myself in the field of community nursing and I thank the district RN, who unwittingly, almost 30 years ago, led me to this rewarding nursing specialty.

References


Get Involved

This week is the inaugural Community and Primary Health Care Nursing Week. Hosted by the ACN Community and Primary Health Care Community of Interest (COI) Advisory Committee, the campaign aims to raise awareness of the current and potential contribution of community and primary health care nursing and its impact on the health and wellbeing of individuals and the community.

It is not too late to get involved in this national initiative. There are a range of activities that ACN is encouraging nurses and the broader community to become involved in throughout the week:

1. Download and read the Community and Primary Health Care: Nurses where you need them eBook, a collection of short stories submitted by community and primary health care nurses across the country.

2. Hold an event to share readings from the Community and Primary Health Care: Nurses where you need them eBook. You could hold a social gathering, lecture, informal networking or any other type of event. Register your event with ACN to get your town or city on the map of community and primary health care nurses across Australia.

3. Wear an orange scarf or t-shirt during the week to show your support of community and primary health care nurses.

4. Spread the word! Join the conversation on social media to help us raise the profile of the week #nurseswhereyouneedthem.

Find out more about Community and Primary Health Care Nursing Week at: www.acn.edu.au/primaryhealthcarenursingweek2015
Active interest in the review of nursing standards for practice

By Nastassia Hanson-Murphy

The Nursing and Midwifery Board of Australia (NMBA) has commissioned Southern Cross University to review and revise the current National competency standards for the registered nurse and produce new Registered nurse standards for practice. The NMBA’s first round of consultations in February 2015 invited key nursing and midwifery organisations, including the Australian College of Nursing (ACN), to read, comment on and propose changes to each section of the draft standards.

In May 2015, the NMBA released the revised second draft standards for public consultation. The purpose of the consultation was to engage the profession in reviewing the draft standards to inform further development into their final stages. During this consultation, ACN involved and actively engaged the membership to inform ACN’s response to the NMBA.

The final draft version of the Registered nurse standards for practice is expected to be available for NMBA review and consideration by end of October 2015.

A substantial member response

The draft standards will have a direct professional impact on all registered nurses, making it an important consultation for the profession. To gather its members’ views, ACN made a survey available that allowed members to contribute their feedback on the draft standards.

The volume and quality of responses ACN received indicated members’ enthusiasm and commitment to safe and quality health care, and provided a large body of advice to inform ACN’s response to the second consultation of the draft standards.

What members had to say

The feedback ACN received from its members was divided in terms of the functionality of the draft standards. Many members supported the more contemporary and concise revised draft standards, claiming they were more user-friendly and easier to apply to assess and evaluate performance. However, other members stated that many of the standards were too broad or vague to provide adequate guidance to individuals and organisations. Some members considered the standards not adequately stress some of the key components of nursing, such as person-centred care, collaboration and the epistemology of nursing.

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A key concern that many members raised referred to the lack of reference to integrated and collaborative practice in the draft standards. Members suggested that in order to promote collaborative practice, consideration should be given to criteria relating to such practice, including fostering awareness of other therapeutic and professional practice relationships.

Other common feedback received from ACN members suggested that the draft standards could benefit from having a stronger focus on leadership, mentoring, and wellness and health promotion. There was also concern that the language of the draft standards did not appropriately reflect nursing as a disciplinary way of thinking.

All members’ views were carefully considered in the development of ACN’s final submission to the consultation.

ACN’s key recommendations

ACN believed that the second draft standards constituted an improvement on the first draft. However, based on members’ feedback, ACN provided a range of recommendations to the consultation. ACN advised that the standards required further development, including that practicing and demonstrating person-centred care could be given greater emphasis across the standards.

ACN stressed the need to place greater emphasis on integrated and collaborative practice. As stated in the members’ feedback, collaborative and integrated models of practice are an essential part of providing holistic nursing care. Nurses do not work in isolation; they give and receive advice and exchange views with other health services and health professionals to support better health outcomes for their patients. For this reason, ACN recommended more specific references to collaborative and integrated models of practice to affirm nurses’ collaborative practice.

Thank you

The policy team thanks all members who contribute to our work for their effort. The team not only welcomes hearing members’ views, but also relies on this information to ensure its policy analysis and proposals are well anchored in the real world of care delivery.

Expert knowledge provided by members ensures ACN’s submissions are well informed, reflect contemporary practice and take account of local health care environments. Members are consistently helpful in providing evidence and a greater understanding to ACN on the breadth of professional, practice and system issues, and the policy team gains valuable information from every conversation and survey response.
ACN has partnered with Dr Ruth Rae to produce a commemorative trilogy which details the important contribution of Australian nurses who served in the First World War. Here, Ruth Rae shares how The History of Australian Nurses in the First World War boxed set came to be

By Ruth Rae, FACN, PhD

It was my mother's fault; this 30 years of research and writing about Australian nurses who served in the First World War. In 1983, my mother had just moved to Queensland and my family (me, my husband and two daughters) were visiting. I distinctly remember mum, me and my eldest daughter, Jenna, having our photograph taken. After the photograph was taken, mum went inside and brought out a non-descript plastic bag, which contained old books/scattered photographs and postcards. 'I have been carting these around for more than 20 years,' said mum. 'They are the rest of my father's diaries and letters from Gallipoli. You take them because I know you will look after them.'

A simple enough statement which changed the course of my professional life from a nurse who was passionate about aged care nursing to that of a researcher and writer. The bag contained what we historians refer to as 'primary sources'. I did not realise it at the time but it was historical gold. However, keep in mind that in the 1980s, the First World War was not commemorated the way it is today. Specifically, the collection consisted of six diaries (volumes 9-14), 214 photographs, 20 letters (three of which were incomplete) and 30 picture postcards. Nothing was in order and the only oral history I had to go with it was that my maternal grandfather, Fred Tomlins, gave them to my mother before he died when I was about four years old.

The documents became all important to me in November 1987. My mother died suddenly (aged only 63 years) and my grief was acute; her claim that I would take care of the contents of the plastic bag took on a new dimension. I was very fortunate that cousins of my mother, who I had never heard of before, became aware that I was retyping the diaries and putting the documents in some semblance of chronological order. My great uncle Will's daughter, Joan Wheeler, was a family historian and together we typed and typed and typed (500,000 words). My mother’s grandmother, Gretta Tomlins, was a key person in this history because she was not the writer of these documents but she was the keeper of the documents. I never knew her, of course, but in the first book of the trilogy, From Narromine to the Nile, you can gain a real sense of who she was and what she went through as the mother of 11 children in outback NSW in the late 1800s and early 1900s.

Gretta endured the First World War from her family wheat property in Narromine (NSW) where she wrote to two of her sons, Fred and later Will who were members of the Australian Light Horse Regiment. However, it was while reading Fred’s diaries I became aware that another family member, her eldest child, a daughter, Jessie, also served overseas in the Australian Army Nursing Service (AANS). I was a qualified nurse and had no idea that civilian trained nurses, nurses who trained under similar conditions to me, joined the AANS once they had completed their finals.

They made the transition from civilian nursing to military nursing with one focus: their soldier patients. Their soldier patients were young men, their own age, who were from their home towns, their brothers, their brother’s mates, their cousins and their prospective husbands.

Jessie went to Egypt with the blessing of her parents to look after her brothers in case they were wounded. She was very keen to go but I did not know any of this from Fred’s documents; I needed primary sources from Jessie. Many family members knew that Fred’s contribution to the war was important and they were aware of his documents but it was not until Jessie died, aged 93 years, that her family came upon letters she had written during the war. They were found in a back shed on her rural property and most of them had been written to her mother, Gretta.

I now had 110 original letters in the collection and the more I read, the more I wondered why the nurses’ history was missing from the enormous number of military books published every year. Jessie’s daughter, Dorothy Rowe, allowed me to use her mother’s letters to answer this question, which was the foundation of my PhD thesis (University of Sydney, 2001). I used copies and the originals were returned to Jessie’s family. Later, Jessie’s diary was also found and this was copied and details have been incorporated into From Narromine to the Nile. The original collection

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that my mother gave me has been donated to the State Library of NSW (The Tomlins Collection) and I have edited the diaries and the letters which are now published as ebooks (The Price of Peace and To all at home … letters from a Lighthorseman).

However, as we know, one thing leads to another and it was during my research into one Australian nurse who served overseas that I became aware of the many others who had fascinating stories.

There is no official history of the AANS during the First World War. There is an official history of the Australian Army Medical Services. The three volumes which constitute this history include interviews of 128 AANS nurses conducted by Matron (Adelaide) Maud Kellett. These were taken after the armistice and prior to their return to Australia from England in 1919. A further 137 nurses’ narratives that relate to this period were collected by the official historian.

The narrative of Matron Alma S. Bennett, 34th Welsh General Hospital (34 WGH) at Deolali in India, provides an example of the variable motivators resulting in Australian nurses omitting important information. The narrative and the missing data is the foundation of the chapter on AANS service in India in Scarlet Poppies and stimulated debate about the limitations of primary sources to historical research.

This research reinforced in my mind the fallibility of memory and the tendency of some individuals to cull unpleasant experiences from official interviews or narratives. Interestingly, it was a letter home which alerted me to this piece of our nursing history. Nurses were often comfortable in writing to their loved ones about important historical events which they believe to be nothing more than gossip; in the case of the incident at the 34 WGH – which I recount in Scarlet Poppies – it was much more sinister.

During the many visits to hospital archives throughout Australia and New Zealand, I have occasionally had some remarkable luck. Such was the case when I travelled to Woodman’s Point recreational centre near Fremantle, Western Australia, in search of the four graves of our colleagues who died there during the 1919 influenza pandemic. During that time, Woodman’s Point was a quarantine station. I finally found the graves, which is a story all of its own, but there was no reference to the individual nurses who worked there and what they endured. Given I live in New South Wales and am an independent researcher (which means self-funded), the trip to Western Australia was disappointing at this level but very useful for other research that was used in Scarlet Poppies. However, I went home via South Australia and then Victoria, where I visited the Royal Melbourne Hospital archives.

In a glass case was a tiny diary – the size of a notebook – it belonged to Susie Cones. I looked her up in my database and realised she had served on the ship Wyreema in 1918. I became very excited because I thought she may have served at Woodman’s Point; and she did. I copied her diary which describes the harrowing conditions at this quarantine station including the conditions under which four civilian trained nurses died, two of whom still lie in the scrub of this recreational park, and that fills me with sadness.

Scarlet Poppies was my furor into the neglect of the AANS by the army. However, I came out the other side of this research realising it was not only the nurses who were being ignored by history, but the casualties for whom they cared. Shell shock, lack of antibiotics, level of training of nurses, anaesthesia, surgery, rehabilitation, allied health, dietetics are all areas of research and development which took place during the 1914-18 war and in the immediate aftermath. Great strides were made, so I needed to research this and simultaneously uncover the professional and social history of the women who joined the AANS. I did this by writing Veiled Lives.

Each of the books took, on average, four years to write. Meanwhile, I had kept a record of any information I found about a nurse who served in the war because there was no definitive list. The Australian War Memorial (AWM) and other authors had differing lists. I wanted to know about the nurses who were unable to join the AANS and paid their own fare to England where they joined the Red Cross, private nursing units or the British/US/French nursing services.

The nominal roll is an important adjunct to the trilogy of books because it has been nearly 20 years in the making, since preparing for my PhD thesis. My research into every book brought more and more details of individual nurses who served their country but are still unknown to our countrymen; for that matter many are still unknown to us; their colleagues.

Jessie Tomlins trained at the Sydney Hospital from 1912-16 under conditions which were not dissimilar to how I trained at The Parramatta Hospital from 1974-78. Her first postgraduate experience was in the 14th Australian General Hospital (14 AGH), Cairo, caring for war casualties following the Battle of Romani and later, Beersheba; one of these casualties being her little brother, Will. Apart from the fact they were my relatives, Jessie was my professional antecedent. Her history is my history.

I do not know the 2,468 nurses listed in the nominal roll as well as I know Jessie but I know many of them, as a result of my research. I know the biographical details of the 40 nurses who died during the war and grieve for the fact that few of my professional colleagues know who they were. They were remarkable women. They were remarkable nurses.

The writing of the trilogy and the compilation of the nominal roll has been, in a way, my gift to them. They deserve recognition. They deserve their place in history. Dr Ruth Rae will be available for a book signing at the ACN booth at the National Nursing Forum between 10.45am and 11.30am on Thursday, 15 October.
A fascinating history of Australian Nurses in the First World War, the Australian College of Nursing Commemorative Trilogy was researched and written by Dr Ruth Rae. The three books detail the important contribution and valuable service that Australian Nurses provided, not only to the servicemen but to the ongoing professionalism of military and civilian nursing.

Includes: From Narromine to the Nile, Scarlet Poppies, Veiled Lives, plus the inaugural edition of the Nominal Role of Australian Nurses who served in the First World War.

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Click here to order your copy today
Immunisation advocacy in an era of vaccine hesitancy

By Sara Peterson, Nurse Educator for ACN’s Immunisation for Registered Nurses course

We are a population at the leading edge of the Information Age, with unbounded access to a wealth of knowledge. However, with this ease of communication comes misinformation. There has been an increase in the number of parents who have become hesitant to immunise their children due to misinformation from anti-vaccination groups. Due to the resultant vaccination hesitancy in our communities, we are starting to see an increase in the number of vaccine-preventable disease outbreaks.

There have been a number of stories in the media during the past few months regarding outbreaks of measles, influenza and pertussis. Most recently there was an outbreak of measles at the University of Queensland Brisbane campus, with 10 confirmed cases linked to the outbreak and more expected to surface.

Influenza media stories are also popular at the moment due to the peak of the influenza season. The Department of Health publishes periodic reports regarding influenza surveillance. So far in 2015, there have been 60 notifications of influenza associated deaths. The majority of deaths have occurred in the 85-year-old and above age group.

The most poignant and heartbreaking vaccine preventable death this year was the story of baby Riley who died of pertussis in Western Australia in March. Riley was four weeks old – too young to be vaccinated against pertussis.

Due to waning vaccination rates for pertussis in the community around baby Riley, this exposed him to the fatal illness.

Following the loss of Riley to pertussis, which could have been prevented if there was high herd immunity in the community, his family are now determined to eradicate the disease from Australia. They hope to raise awareness around the importance of vaccination to protect the vulnerable in communities.

Websites such as shotbyshot.org and chainofprotection.org both share the personal stories of individuals who have experienced vaccine preventable diseases, and the impacts that these diseases have on individuals and their loved ones. The most alarming part of these stories is that the diseases causing the infections and deaths are all vaccine preventable.

Vaccines save, on average, three million lives per year globally. However, in recent years, the number of people delaying or refusing vaccination has increased, despite the availability of vaccination services. This phenomenon is known as vaccine hesitancy.

The impacts of vaccine hesitancy are becoming evident with outbreaks of measles and pertussis within communities coinciding with an increased number of vaccination refusals in the same area. There are various reasons for vaccine hesitancy amongst individuals, such as complacency towards vaccine preventable diseases and the lack of confidence in vaccine efficacy.

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The high success rate of modern vaccines has resulted in a much lower risk of being exposed to potentially deadly diseases that were commonplace in the pre-vaccination era. As a result, complacency to vaccines has occurred as individuals focus now upon the vaccine side effects rather than the risk of the disease that the vaccine prevents. Confidence related to vaccine hesitancy covers a number of issues, such as trust of vaccines, concerns over vaccine safety, and trust in the health care professionals involved in all aspects of vaccination – from vaccine manufacture to administration.

The World Health Organisation states that, “Vaccines can only improve health and prevent deaths if they are used, and immunisation programmes must be able to achieve and sustain high vaccine uptake rates”. Immunisation advocacy refers to the act of publicly supporting, or actively making recommendations, regarding immunisation so as to ensure the protection of the public against vaccine-preventable diseases. Our role as health care professionals allows us the opportunities to make a positive impact to the lives of the people who are vulnerable to vaccine-preventable diseases through immunisation advocacy.

Immunisation advocacy also includes dispelling fears, addressing concerns and promoting the acceptance of vaccination via effective communication to individuals regardless of their vaccination stance. In order to effectively promote immunisation advocacy, it is crucial for health care professionals to build a rapport and gain the trust of the individuals in the community.

When advocating immunisation, firstly begin by respecting the individual’s opinion, and also consider other factors that may be influencing the individual’s decision not to immunise, such as religious beliefs, personal beliefs or their cultural background. It is important to listen carefully to the arguments against vaccination, explore the individual’s concerns regarding vaccination, and then tailor appropriate information to the individual’s level of understanding by providing a clear and logical explanation of the weaknesses in anti-vaccination arguments. Providing evidence-based resources from credible sources will help to enhance the understanding of vaccination for patients, especially patients who are vaccine hesitant.

The public look to health care professionals for guidance. In order to reassure the public and advocate vaccination, health care professionals must be able to clearly and honestly communicate the risks versus the benefits of vaccination to their patients.

As health care professionals, we are at the forefront of the fight against vaccine preventable diseases – we can make a positive difference to the lives of the vulnerable by ensuring that as many people who are eligible for vaccinations are immunised.

References


California Immunisation Coalition 2015, Shot by shot, California, viewed 11 September 2015 <http://shotbyshot.com>

National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases 2012, Chair of protection, Sydney, viewed 11 September 2015 <http://www.chainofprotection.org>

MacDonald, N.E. 2015, ‘Vaccine hesitancy: Definition, scope and determinants’, Vaccine, vol. 33, no. 34

The National Nursing Forum: We look forward to welcoming delegates to Brisbane

ACN is excited to be welcoming National Nursing Forum delegates to Brisbane in just a few weeks. Now in its third year, The National Nursing Forum will bring together nurses from across Australia to learn, network and share ideas with their colleagues and peers. The Forum theme, Advancing nurse leadership, aims to inspire and engage nurses who play a critical role in delivering health services to the community.

Key highlights of this year’s Forum include:

• Nearly 50 topical nursing presentations across two and a half days
• Two hour intensive workshops with leaders from the nursing profession
• The opportunity to attend the prestigious HESTA Australian Nursing Awards Dinner which will be held in conjunction with the Forum on Thursday evening. Awards for Nurse of the Year, Team Innovation and Outstanding Graduate will be presented on the night. It will be an evening of celebration and dancing!


Congratulations!

ACN would like to congratulate the following members, who have been awarded a delegate registration scholarship to attend the 2015 National Nursing Forum. The scholarships are proudly provided by Boehringer Ingelheim.

• Alexa Jefferson
• Anna Nolan
• Anne Smith
• Emma Matthew
• Heather McMahon
• Jodi Harms
• Nancy Arnold
• Suzanne Basford

Hurry, registrations close 9 October 2015

With thanks to our major Forum partners and sponsors

Indigenous Health Scholarships

Puggy Hunter Memorial Scholarship Scheme

Open 14 August 2015
Close 12 October 2015

Click here to apply

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Many single subjects to study anywhere, anytime.

See our postgraduate studies handbook for more.
Upcoming CPD short courses @ACN

Complimentary places are available for NSW Health employees (NSW Health short courses only).

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<td>8 Oct 2015</td>
<td>Assessing and managing vascular access devices</td>
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<td>14-15 Oct 2015</td>
<td>Clinical assessment for nurses</td>
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For more information and to view the full CPD calendar, visit [www.acn.edu.au/cpd](http://www.acn.edu.au/cpd)

ACN Refresher program – commencing February 2016!

ACN recognises the need to support nurses moving back to acute clinical environments, or those wishing to refresh their fundamental knowledge of acute nursing.

In 2016 ACN will be offering an online refresher program for nurses already on the national register and looking to reconnect with acute care work.

The course will consist of self-paced modules to support your learning needs.

Further information coming soon to our website or email [customerservices@acn.edu.au](mailto:customerservices@acn.edu.au)
Which committee/working group are you representing ACN on?

I am the ACN representative on the Northern Adelaide Local Health Network governing council. This network includes:

- Lyell McEwin Hospital
- Modbury Hospital
- GP Plus Health Care Centres and Super Clinics
- Sub-acute and mental health services.

What led to your interest in this area?

There are at least two reasons I was interested in becoming a member of the council:

1. Experience: I have a long history of holding senior management roles in health over many years, including Executive Director of Nursing, Flinders Medical Centre and Chief Executive, Cancer Council SA, a position I held for just over 12 years. I thought my skills could be valuable to the council.

2. Giving back: The northern suburbs have a high proportion of low SES (socioeconomic status) people living in the area. When I was growing up I spent part of my school years living there. As a result of this, I have a keen interest in making sure the health services delivered are of a high standard. I am astounded every day by the outstanding service the nurses and doctors deliver. The data presented regularly to the council reflect this.

What is the most recent work out of the committee/working group and what were the major items discussed?

The role of the council is to receive a performance report every two months from the Chief Executive across the health services listed above. In particular the CEO reports statistics and data on a range of areas that reflect performance.

Health statistics data contains historical data on health risk factors, mental illness, population groups, the performance of hospital and health care services, safety and quality and public health.

These performance data include up-to-date information on a range of hospital data, including elective surgery waiting times, notifiable disease information and specific data on cancer, pregnancy, births, breast screening, cervix screening and immunisation coverage.

Transparency of performance of the northern area health system is achieved by releasing the Emergency Department (ED), the Inpatient (IP) and the elective surgery dashboards.

The ED Dashboard includes information on the number of patients within the EDs, the number of treatment areas available, waiting times, arrivals, discharges and patient types.

The IP dashboard includes information on the number of patients within each inpatient area or clinical unit of the hospitals plus other information on average length of stay, bed numbers, discharges and patient types, and includes information on elective surgery waiting list activity in major metropolitan and 27 country hospitals.

The ambulance service dashboard includes information on the average ambulance clearance times, and the number of ambulances that were at hospitals for 30 minutes or more in the last three hours.

At our last meeting, the council had the pleasure of meeting in an Aboriginal facility which houses people from the country having treatment in metropolitan Adelaide. This service enables Aboriginal people to live in Adelaide while undergoing treatment. They are able to complete their treatment and as a result have better health outcomes.

Can you please highlight any issues/benefits arising for the profession as a result of this committee/working group?

The benefits of having a nurse on council are:

1. Understanding the complexities of the issues presented and discussed

How important is this ACN representation opportunity to you or how has this opportunity benefitted you and/or your career?

There are definitely personal benefits from being a council member and I was pleased to learn that my application to ACN was successful and was later approved/accepted by the Health Minister who signs off on the recommendation from ACN.

It provides me with a lot of personal satisfaction to be able to give back to the health service in South Australia (from an arm’s length), which I have always been very passionate about.

It also provides some opportunity for me to continue to remind people that “prevention” (tackling smoking and obesity etc.) is as important for the health of individuals as service delivery in hospitals.

If the problems such as obesity and smoking are not tackled now by government (and our profession), in addition to providing good health services, we will not be able to afford health care in the future.

The dilemma for governments is always about finding additional spend for preventative health, when the costs of treating people are so high.
The latest from the Australian Institute of Health and Welfare

Half of Australians in residential aged care suffer from dementia

A new web report looking at aged care services shows that people in residential aged care have higher rates of dementia than the estimated prevalence rates for their age. ‘In the general population, 3% of people aged between 65 and 74 are thought to have dementia, but some 43% of people in permanent residential aged care in the same age group had a diagnosis of dementia,’ said AIHW spokesperson Justine Boland.

For more information, read the Residential aged care and home care full report.

1 in 5 Australians affected by multiple chronic diseases

About half of all Australians have a chronic disease, and around 20% have at least two, according to new data. The data covers eight chronic diseases: arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes and mental health conditions.

For more information, view the media release.

In the news

World news

Screening pregnant women for chlamydia would be ‘cost effective’

A new study analysing the cost-effectiveness of incorporating chlamydia screening into routine antenatal care for pregnant women between 16 and 25 found that screening could avoid much larger costs of managing complications of undetected chlamydia, such as neonatal pneumonia and pelvic inflammatory disease.

Read more.

Getting closer to universal flu vaccine

Researchers say they are closer to developing a vaccine to give life-long protection against any type of flu, after promising trials in animals. Two separate US teams have found success with an approach that homes in on a stable part of the flu virus.

Read more.

Wearable devices being used in drug trials

What began as an aid for athletes and dieters to track their movements is quickly becoming a critical tool for medical researchers. By outfitting trial participants with wearables, companies are beginning to amass precise information and gather round-the-clock data in hopes of better understanding whether a drug is working.

Read more.

Nurse-led walk-and-eat intervention may improve outcomes for patients with esophageal cancer

A nurse-led walk-and-eat intervention is feasible and effective to preserve functional walking capacity and nutritional status in patients with esophageal cancer undergoing neoadjuvant chemoradiotherapy, according to a recent study published in the journal The Oncologist. Results showed that those who received the intervention had a 100-metre less decline in walk distance than control patients, 3kg less decrease in hand-grip strength, and 2.7kg less reduction in body weight.

Read more.

New drug treatment offers cancer hope

New research, funded by the Irish Cancer Society, is testing a new type of drug, copanlisib, which is being trialled on women who have HER2-positive breast cancer, which tends to spread more quickly than other types. Research scholar Naomi Elster said the drug, when used in combination with regular therapies, acts as a “signal blocker” in cancer cells which may halt the spread of the disease.

Read more.

Continues on next page
**National news**

**Receivers of flu vaccine less likely to have heart attack**

A study by University of NSW researchers has found that people who have been vaccinated against influenza are 29 per cent less likely to have a heart attack – representing a greater protective effect than ceasing smoking and nearly as much as taking statins.

Read more.

**Who cares for nurses’ health?**

A study of 5000 NSW nurses presents a good news-bad news story for health managers and governments grappling with the policy challenges of caring for an ageing population. Frontline nurses reported a high level of job satisfaction, an important indicator of quality of care and intention to remain in the workforce, but they also reported a host of health symptoms and diseases.

Read more.

**National immunisation register coming**

A new immunisation register for adults is expected to use text messages to remind people when their next vaccines are due in a bid to combat complacency among the time-poor. Disease experts predict having a “whole of life” register covering recommended vaccinations from newborns to the elderly will be up and running in 18 months and boost immunisation rates in Australia.

Read more.

**Bullying, sexual harassment by surgeons widespread, report finds**

Experts who investigated discrimination, bullying and sexual harassment by surgeons are “shocked” at the scope of the problem. The Royal Australasian College of Surgeons (RACS) on Thursday apologised for the behaviours, accepting in full the recommendations and draft report of the Expert Advisory Group (EAG).

“These behaviours have been too long tolerated and have compromised the personal and professional lives of many in the health workforce,” said RACS president Professor David Watters.

Read more.

**SA researchers develop stroke alert blood test**

Adelaide researchers have developed a simple blood test to alert people they are at imminent risk of a stroke. The breakthrough – if all goes according to plan – will fundamentally change treatment of a condition affecting about 50,000 new people a year at an annual cost of around $50 billion.

Read more.

**Organ donation shortage: NSW hospital uses recycled and diseased kidneys for dialysis patients**

The critical shortage of organ donations in Australia has led doctors at a New South Wales hospital to use the recycled and diseased kidneys of cancer patients. The John Hunter Hospital in Newcastle have been quietly transplanting the kidneys into dialysis patients since 2008 with great success.

Read more.

**No Jab No Pay laws leading to parents abandoning conscientious objection of vaccinating their children**

The number of conscientious objectors in NSW has dropped since the announcement of the Federal Government’s No Jab No Pay laws, which will see parents who refuse to vaccinate their children lose family tax benefits and child care rebates as of next year. Immunise Australia Program figures from the June quarter show the number of parents who refuse to vaccinate their children dropped by more than 500 in NSW.

Read more.

**AIDS cases stable, other STIs on the rise**

A new report card on Australia’s sexual health is a mixed bag, with AIDS infections stable but gonorrhoea and syphilis on the rise. The number of Australians contracting HIV has stabilised but about a thousand people a year are still returning positive tests.

Read more.
Diabetes NSW Update

A multi-disciplinary approach to managing diabetes

Medical intervention alone is no longer considered sufficient to manage diabetes, and, as with any chronic disease, a multi-disciplinary approach is considered best practice. Members of that team include the general practitioner (GP), practice nurse, allied health professionals and endocrinologist (if required).

The Credentialled Diabetes Educator (CDE) plays a unique role within this team by moving beyond the traditional discipline-specific roles and delivers the full spectrum of diabetes self-management and self-care behaviours using a highly specialised set of skills.

The role of a CDE?

A CDE is a health care professional who has met the standards set by the Australian Diabetes Educators Association (ADEA) to provide specialised, comprehensive education and support to people and their families living with diabetes. To become a CDE requires the completion of a postgraduate certificate in diabetes management, coupled with 1800 hours of clinical diabetes education practice and a comprehensive portfolio to demonstrate a high level of expertise and skillset. Of the approximate 1170 CDE registered nationally, the majority are registered nurses.

CDEs work in a variety of settings covering the full spectrum of diabetes management, from clinical consultations to international research. CDEs can be found in public and private hospitals supporting inpatients, community health centres for outpatients, private clinics, not-for-profit organisations, such as Diabetes NSW and JDRF, and research and clinical trials, such as Hunter Medical Research Institute (HMRI). There are also specialist fields, such as children and adolescents, gestational, Type 1 and pregnancy, pump therapy, Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities.

Challenges for CDEs

Two challenges CDEs face are commonly held perceptions within primary care arenas and the current referral system to access a CDE. With the shifting of diabetes management (and funding) from acute care to primary health, a new culture has developed, whereby “comprehensive” diabetes management can be interpreted as completing the diabetes annual cycle of care, which is often provided solely by the GP and practice nurse. It is not uncommon for a person with diabetes to have a significant excursion from their diabetes care plan (including abnormal biochemical markers, evidence of complications, deranged blood glucose levels and psychological distress or “burnout”); and a referral to an endocrinologist is considered with little regard for the skills and self-management tools a CDE could have provided. CDEs provide an integral role in diabetes support, education and management throughout the course of a person’s life with diabetes. Unfortunately, the role of a CDE remains misunderstood by some in primary healthcare.

Secondly, access to a CDE is reliant upon a GP referral to local diabetes services – generally a community health centre, outpatient clinic at a hospital, or a private educator, using the Chronic Disease Management Plan (CDMP). This CDMP is limited to five visits shared amongst a number of allied health professionals, including podiatry. For many other allied health professionals, options for some reimbursement via their private health insurer exist. However, presently there are very few private health insurers that recognise CDEs. This can result in a significant financial challenge, especially when a private CDE is the only option in some regions.

CDEs make a positive contribution to the health and wellbeing of people living with diabetes, with their specialist knowledge and experience. Their main value is in their ability to empower individuals using a client-centred self-management approach.

What is the role of a practice nurse?

Practice nurses are at the forefront of patient contact as they sit within the local general practice. This means they are ideal conduits of providing key diabetes management messages and education as they have regular contact with people living with diabetes (or at risk of type 2 diabetes) attending the practice.

PNs are also able to determine if a referral to an allied health professional would be beneficial to the individuals they are seeing and can, through the GP and the CDMP arrange for referral under the team care arrangements or to the local public hospital diabetes education service.

Diabetes NSW offers several activities or events that offer upskilling of diabetes management knowledge for PNs. If interested, please contact events@diabetesnsw.com.au
Revision of the re-entry to practice policy introduces new pathway back to practice

A revised policy that provides a new pathway towards general registration for nurses and midwives returning to work after an extended break has been launched by the Nursing and Midwifery Board of Australia (NMBA). In effect from 1 September, the revised policy for re-entry to practice introduces provisional registration for nurses and midwives who wish to return to practice but don’t meet the NMBA’s recency of practice requirements.

Under the National Law, there is a requirement for applicants for general registration to meet the NMBA Recency of practice registration standard. The purpose of this requirement is to make sure that registrants have undertaken sufficient recent practice to demonstrate competence in their professions.

Balancing public assurance with the need to enable workforce mobility without losing experience from the professions, provisional registration enables nurses and midwives to safely return to the professions under supervision or by completing a re-entry to practice program. This provides valuable support for individuals returning to practice and ensures professional competencies meet current NMBA requirements.

After successfully completing a period of supervision or participating in a re-entry to practice program, provisional registrants are eligible to apply to move to general registration.

The revised policy affects non-registered and non-practicing nurses and midwives with a lapse of practice between five and 10 years, but is not applicable to students or first-time registrants. Applicants with more than a 10-year lapse and some applicants with sole qualifications may still apply for provisional registration but will be subject to case-by-case consideration.

When a person who has not practised for a period of between five and 10 years applies for re-entry to the profession, the NMBA’s relevant state board or committee will make the decision to direct the applicant to either an NMBA-approved period of supervised practice (Pathway 1) or an NMBA-approved re-entry to practice program (Pathway 2).

Each application for provisional registration is decided on its own merits incorporating three key elements to ensure national consistency in decision making: professional competence, confidence, and capability. The main underlying principle for re-entry decisions is the safety of the health practitioner to practise in the profession.

Supervised practice is a period of practice under Level 1 and Level 2 supervision that is required to demonstrate competence to practice. Nurses and midwives who apply for provisional registration and undertake Pathway 1 to return to practice are responsible for arranging a supervision placement that meets the NMBA’s requirements. They must also submit a practice plan, as explained in the supervised practice guidelines.

Supervised practice must take place in a health setting that provides clinical experience placements for education providers delivering NMBA-approved programs of study leading to registration as a nurse or midwife.

The NMBA has published a range of information to provide guidance to nurses and midwives wanting to return to the professions. This includes the:

- Re-entry to practice policy,
- Recency of practice registration standard
- Fact sheet on re-entry to practice, and
- Supervision guidelines for nursing and midwifery.

For more information, go to the NMBA website at www.nursingmidwiferyboard.gov.au.