Australian College of Nursing

the hive

#34 WINTER 2021

KEEPING NURSES INFORMED, CONNECTED AND INSPIRED

FREE EDITION

NURSING WHERE IT IS NEEDED

THE TRUE POWER OF COMMUNITY NURSING
Kitty Hutchison MACN

WORKFORCE SHORTAGE OR A SUPPLY ISSUE?
Adjunct Professor Alanna Geary FACN & Dr Craig Phillips MACN

THE BEAUTY OF BUSH NURSING
Anna Flynn MACN

+MORE INSIDE

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

ACN publishes The Hive, NurseClick, ACN eNewsletter and Collegian.

CELEBRATING NURSES ON INTERNATIONAL NURSES DAY 12 MAY

Every year on 12 May, the world honours nurses everywhere for their selfless work, dedication to the profession and compassion for everyone they care for.

In a world that continues to be affected deeply by the COVID-19 pandemic since March 2020, nurses continue to provide care in the face of unimaginable difficulty with grace and resilience. To recognise their hard work and contribution, we encouraged them to observe a day of self-care by hosting or participating in the Australian College of Nursing (ACN) National Nurses Breakfast on International Nurses Day (IND).

We loved seeing you getting together with your peers to take this day for yourselves and celebrate each other.

Festivities began early at a special ACN Breakfast event at Lake Burley Griffin, where our staff and members were joined by ACT Minister for Health Rachel Stephen-Smith and our valued Corporate Partner HESTA.

To add to these celebrations, we were extremely proud to have the ACN flags once again flying over the Commonwealth Avenue Bridge. In a special first, the National Carillon was lit up for the week to acknowledge the pivotal contribution of nurses to the health and wellbeing of our communities.

Adjunct Professor Kylie Ward FACN with nurses at Royal Prince Alfred Hospital in Sydney Local Health District and students from UTS Health for an interview with Studio 10 on IND

Nurses all over Australia participate in the ACN National Nurses Breakfast 2021 on International Nurses Day. Thank you for sharing your photos with us!

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NEW ON neo

Welcome to NEW ON ***neo***. In every edition, we will bring you the most engaging and popular discussions and debates from ***neo***, an exclusive platform through which our members can showcase their expertise, seek advice from experienced nurse leaders and contribute to discussions shaping the Australian health care landscape.

Here are the top three discussions on ***neo*** this month.

Registered, persecuted, annihilated. The Sick and the Disabled under National Socialism. Free Brisbane exhibition, lecture and film program
–By Dr Darren O'Brien MACN
Topic: Discussion on the exhibition that took place at the Royal Brisbane and Women's Hospital Education and Conference Centre.

Confusing question on registration renewal
–By Darren Jacob MACN
Topic: Seeking opinions on the nursing registration renewal questionnaire.

Some great info on imposter syndrome and what to do about it
–By Debra Pittam MACN
Topic: An article and video resourced shared by Debra regarding the conversation about imposter syndrome and how to overcome it.

Join the conversation via **neo.acn.edu.au** or download the ***neo*** app!

NURSE CONTRIBUTION TO THE RURAL HEALTH RESEARCH AGENDA

Nurses in rural areas are well positioned to contribute to rural health research aimed at redressing health inequities in these communities

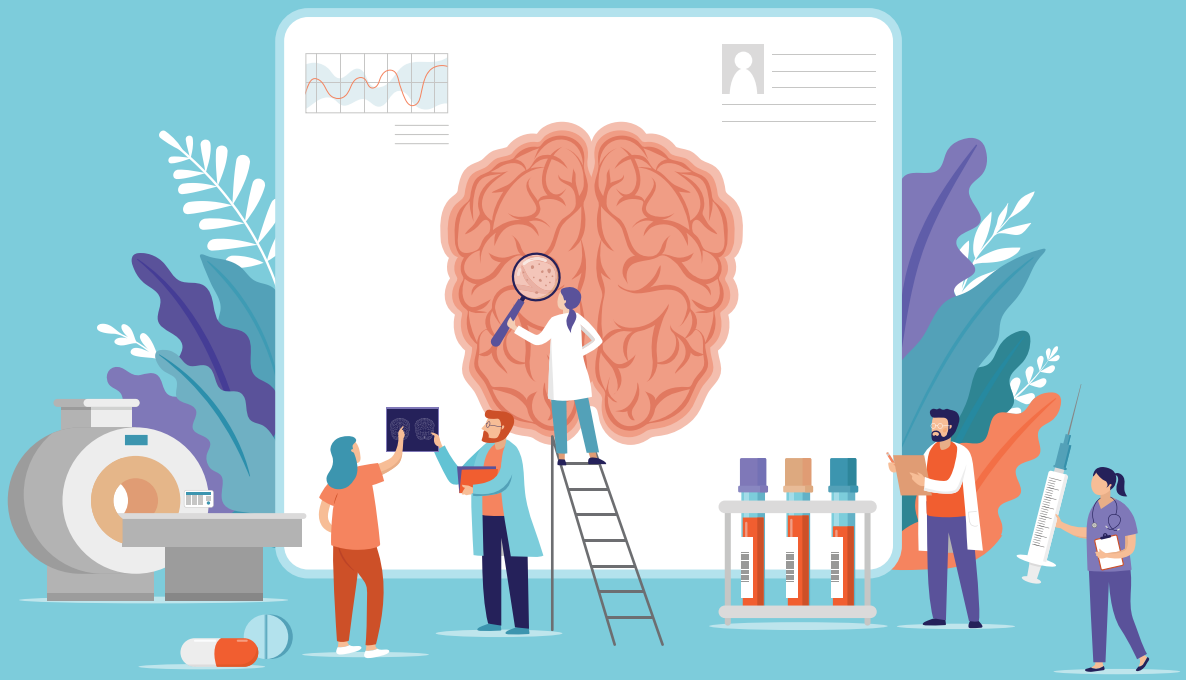
Nurses in rural areas are often characterised by their advanced practice skills, generalist clinical experience, expanded scope of practice and leadership in advocating for the needs of rural communities (Bish, Kenny & Nay 2012; Muirhead 2020). Consequently, they are well positioned to contribute to research seeking to improve the health and welfare of rural communities. This includes the need for rigorous research studies of nurse-led chronic disease prevention and management programs in rural areas, as supported by the Australian College of Nursing's (ACN) Position Statement, *The role of nurses in chronic disease prevention and management in rural and remote areas* (Australian College of Nursing 2020).

It is well established that rural communities experience a higher burden of chronic disease and risk factors for chronic disease, and poorer health service accessibility, when compared to metropolitan populations (Australian Institute of Health and Welfare 2017). However, there is little discussion around what pathways exist for nurses interested in contributing to rural health research redressing these inequities.

As a Registered Nurse, I developed an interest in rural health research during my nursing transition to practice year undertaken in rural New South Wales. Working in a rural community, the challenges of managing chronic disease and accessing health services (particularly metropolitan-based specialty health services) were apparent.

During this time, I commenced a Master of Public Health through distance education, which provided me with a toolkit for undertaking both qualitative and quantitative research, and furthered my understanding of health policy and population health. After working across diverse clinical settings, I grew more comfortable in my clinical skillset as a rural generalist nurse and sought opportunities to undertake research in my community. In 2016, I commenced in the position of Associate Research Fellow with Deakin Rural Health (Warrnambool, Victoria), a University Department of Rural Health (UDRH).

UDRHs have been pivotal in leading the rural health research agenda, and are well placed — both geographically and strategically — to grow the capacity of rural nurses and other health professionals to undertake research (Gausia et al. 2015; Humphreys, Lyle & Barlow 2018). Funded by the Rural Health Multi-Disciplinary Training (RHMT) program, there are now 16 UDRHs across Australia working towards the distribution of the health workforce in rural areas and undertaking locally responsive research to meet the needs of rural communities (Department of Health 2020).



> **“Although the pace of research can be slower compared to working clinically as a rural generalist nurse, there are many rewards.”**

The valuable contribution of the UDRH network to rural research was recently supported by a national evaluation of the RHMT program (Department of Health 2021). Recommendations for strengthening research in rural area through the UDRH network includes continuing to build the research capacity of local health professionals, including nurses (Department of Health 2021).

Through a UDRH, I have gained opportunities to further my skills in mixed methods research and systematic reviews, and collaborate with health services across a range of research projects. This led me to commence a Doctor of Philosophy (PhD) in 2019 evaluating an innovative Aboriginal community-developed and governed model of primary health care.

A PhD is just one research training program for nurses to gain research experience. Other pathways include undertaking an Honours program following completion of the Bachelor of Nursing or a Masters by research program. Rural nurses are encouraged to connect with a UDRH, university or health service research office to scope for opportunities to be involved in health research. They can also seek post-graduate scholarships.

Although the pace of research can be slower compared to working clinically as a rural generalist nurse, there are many rewards, such as contributing to changing clinical practice, influencing policy and supporting health services in meeting the needs of the communities they serve.

As the demand for health care and need for innovative models of care increases, the role of rural nurses in research will be imperative to improving health outcomes for rural communities.

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AUTHOR

HANNAH BEKS MACN

THE BEAUTY OF BUSH NURSING

The bush was always an undeniable addiction. But working as a nurse in the bush is what opened up an amazing adventure for me

I look at the magnet on the fridge. It says, 'Year of the Nurse and Midwife 2020'. I graduated in 1984. I think back on my career: What have I achieved in my 36 years of nursing? What have I contributed to the profession? The strong women who brought me up, instilled in me that we are all equally deserving of care, irrespective of background, geography and social circumstance.

Shared experiences encourage other nurses to see the value of diversity and flexibility, and to be where we need them — in our indigenous communities and supporting remote farming families. After all, they are the ones hardest hit by nursing shortages. According to Australian Government Department of Health (2020) workforce data, there are nearly 345,000 nurses registered in Australia. Less than 1.0% are in very remote areas, where the working week is long and the average age of a nurse is 47.

The bush is an undeniable addiction, probably due to my upbringing. I am a dairy farmer's daughter. My mother was a nurse, who had to leave the profession when she married. One of four kids, we got cows in and helped milk them if Dad was late. We drove cattle and dipped sheep. We chopped wood and the heads off chickens. My father suggested nursing to me. Perhaps I was to finish what my mother started. Dad knew that nursing at a university was a happening thing, he was a forward thinker.

In 1986, I tasted remoteness for the first time. Alice Springs Airport was a tin shed that appeared more like a bus stop than an airstrip. I was sent to Mantamaru (Jameson) in Western Australia. A single sister station in one of the most remote communities in the country. I had limited midwifery skills. The clinic was a small, shipping container. There were no telephones, only a radio connected to Victor Juliet Yankee (VJY) Darwin; 6 Charlie Xray November was my call sign. The red button was for emergencies and if pushed, everyone cleared the airway.

I ran a clinic for a community of approximately 300 people. I had no clue what I was in for. I adopted a joey, I dealt with chronic disease and domestic violence. Tribal fighting was common and petrol sniffing was out of control. I had never heard of rheumatic heart disease. But I coped. And that is what nurses do.

Friends asked me to go to Gapuwiyak in North East Arnhemland — an unknown entity for most — in the early 90s. Nurses came and went. They missed their lattes and felt lost without the on-ground support of a doctor, and with limited phone access and regular power outages. There was a lot to learn.

One moonless night after getting bogged (I was not the driver), my nursey mate Deb and I walked 42 kilometres. We walked

> “I had no idea what I was in for.
> But I coped – and that’s what nurses do.”

all night, ran hand-in-hand through a river with a known crocodile, shared a cordial bottle as a pillow and found help with the road crew manager at five in the morning. We learnt to tell people where you are going.

In 1992, I attended the launch of the Central Australian Rural Practitioners Association (CARPA) manual, a little handheld bible of potential medical mayhem. We began the first e-health, documenting clans and skin names. I trained my first health worker and she is still there today.

Local challenges were tough. I delivered babies in the clinic and over the radio. We endured death in the community and learnt about payback. We buried the elderly and too many young people. I still remember the day my heart sank, the day I buried my first paediatric trauma case. That was the tipping point. There was little support for nurses then and I was burning out. I had spent eight months on call for 24 hours a day, with no relief.

I left and completed the outstation pilot program at Oenpelli. I spent countless nights on the roof of the troop carrier, tucked in my swag, at the mercy of the mosquitos but away from the crocodiles. Driving was thwarted by the wet season: getting bogged, winching myself out and looking like a half-drowned sewer rat. I fished Saratoga with the locals.

Unlike the boar that had gone to the water’s edge and had its last drink not five metres from where I was sitting, I avoided becoming lunch. A 15-foot crocodile called black Eric lived (and probably still does) in an adjacent lagoon. Tourists about to swim did not want to heed my warning, until we saw the tail of the monster on the opposite bank. I was privileged to regularly sit under rocky ledges and admire the artwork and the sun setting over the wetlands. I remember thinking then: ‘What an earth am I doing here?’

Returning to the city left me lost.
The truth was, I yearned for the bush.
I found workplaces stifling and I was just a pair of hands. Often, as an agency staff, I was treated differently and as though I had little knowledge. I knew how untrue that was and the challenges that I bestowed upon myself would one day reward me.
I needed to go back to where I was needed.

Now, 25 years later, after two farms, three kids, one divorce, over 25 workplaces, I am a nomad. I work in midwifery with kind, strong women, a friendly emergency department, and an incredibly supportive agency. I am gaining confidence again and returning to where nurses are most in need — the beloved bush.

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AUTHOR

ANNA FLYNN FACN

How ethical leadership translates into positive health outcomes

Exploring the correlation between respectful culture and quality of patient care in health organisations

Health care organisations are increasingly embracing values-based health care and incorporating values-based recruitment, and core values are perceived to be central to the operationalisation of visions and missions. A scanning exercise across health care organisations shows a recurrent value of respect, and one must ask what this means in terms of nursing leadership.

How does ethical leadership with a focus on respect influence performance and create a positive performance culture? What does respect mean in terms of leadership; what would this look like, and what is the impact on staff and patients alike? Answering these questions requires an exploration of the correlation between a respectful culture and health care outcomes.

Health care leadership is complex and compounded by an ever-changing environment including population growth and demand for service, increasing technological advances, societal expectations, environmental impacts and the culture of health care organisations (Park, 1997). Leadership should approach respect in an all-encompassing way that includes staff, patients, families, consumers and health care providers. Therefore, through the essence of leadership, one must embrace the core value of respect in engagement with everyone interacting with the health service.

To effectively navigate this labyrinth, a leadership team needs to adopt multi-modal methods with flexibility based on timely, continual and open feedback to ensure service provision is respectful and value based. The services must be carefully designed through integrative models of care to meet the needs and expectations of all involved.

Leadership within health care organisations has a direct effect on staff performance, which influences quality care and the safety of the patients (McFadden, Stock & Gowen III, 2015). It is timely to explore the links between values-based leadership and performance ranging from safety, quality, satisfaction and engagement, as well as the growing pressure on financial integrity.

The senior leadership team must role model without fault, and set the standard and expectations for values-based interactions, providing a person-centred approach, hence instilling a culture whereby staff are engaged and able to be key players in the change agenda (McGrath, Bennett, Ben-Tovim, Boyages, Lyons & O'Connell, 2008).

It is essential that organisational leadership embraces a collaborative multi-disciplinary team approach. The complexity is in identifying and working with the sub-cultures within the organisation, such as professional groupings (for e.g. doctors, nurses or allied health professionals) or specialty sub-cultures (for e.g. emergency department or paediatrics). These sub-cultures need to approach interactions with other groupings by focusing on the provision of person-centred care, by putting the patient at the centre of discussions and decision-making.

Therefore, the core values must be upheld across each sub-culture; it needs to become the daily expectation and interaction. Practically, however, there exist operational restraints such as clinical 'ownership' for each stage of the journey or the who-funds each-aspect.

Defining culture is difficult, however, it relates to the organisation's attributes or its character, and there are definitive links with culture and performance (Scott, Mannion, Davies, & Marshall, 2003). Clinical governance through a shared value integrates these different cultural and individual factors to provide an underpinning person-centred approach to the structures, accountability and effective leadership at all levels.

Therefore, a multi-disciplinary multi-departmental team can:

- Provide clinical leadership
- Approach problems as a team
- Focus on the patient in decision-making processes
- Embrace processes to monitor for safety concerns, quality concerns and overall performance (McGrath et al., 2008).

> **“Ethical leadership can guide health care professionals to make value-based decisions for patients, thus enhancing the quality of care and patient safety, which are essential performance measures for a health care organisation.”**

McGrath et al (2008) purport that one of the most complex challenges associated with this leadership approach is in sustainability and maintenance. Through transformational leadership approaches, sustainability is possible through the constant enthusiasm of each leader, and recruitment of new staff based on a value-based recruitment process and this will assist in the long-term sustainability of values into the future.

Hence, organisational culture requires a two-way relationship with timely, open and transparent communication between the leaders and staff to ensure long-term impacts on quality, safety and performance.

An ethical leadership style will provide a significant organisational foundation in creating an ethical culture that reflects the mission and values of a health care facility, guide the behaviour of health care professionals and help them make value-based decisions for the best interest of the patients. This helps enhance the quality of care and patient safety, which are essential performance measures for a health care organisation (Wong & Cummings, 2011).

The question central to this discussion is why having organisational leadership that respects individuals and a leadership structure designed to role model this underpinning value, can inherently result in improved performance. Research explains organisations with employees who identify with the value offer a strong commitment and will continue to be employed long term and aid through role modelling (Shi-Chi, Jen-Chia & Ya-Ling, 2012).

This study reports strong interactional requirements between the culture and the organisational commitment, and this can influence staff’s attitudes and instill in them a strong obligation to uphold the commitment to the patients and the organisation.

Effective, accessible and transparent leadership is critical to the success of the health sector through its impact on staff, and subsequently patients. A transformational leader, who inspires and empowers staff, can impact the daily performance of the team by creating a sense of belonging and focus on respecting the person at the centre.

In doing so, the actions and conversations have an amended focus which will have a positive impact on the organisational performance.

The underpinning strategy is to develop a leadership culture that promotes and supports everyday safety measures (Jencks & Wilensky, 2010). Leaders in health care facilities must commit to creating and maintaining a culture of safety which will ensure that suitable standards are developed for operational excellence, attraction, recruitment and retaining staff, and creating a productive and positive culture.

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