CRANA plus
improving remote health

Issue 125 | April 2022

magazine

the voice of remote health

Aboriginal and Torres Strait Islander readers are advised that this publication may contain images of people who have died.

Contents

Editorial
Editor: Denise Wiltshire
Journalist: Sam Richards
Journalist: Rosemary Cadden

Design and production
Graphic designer: Alison Fort
Printer: Newstyle Print
Distribution: 7,900 copies

For marketing/advertising enquiries, or if you have a story you would like to share, please contact marketing@crana.org.au

CRANA plus
improving remote health

Head Office:
Unit 2, 189–191 Abbott Street,
Cairns QLD 4870 Australia
Phone: (07) 4047 6400
Website: crana.org.au

About the Cover: The late nurse and midwife Ray Wyeth near Wingellina, WA, in 2016, soon after he started working for Ngaanyatjarra Health Service. Full article on page 26. *The image was taken by his wife, Jennie.*

From the CEO

Dear CRANAplus Members and Friends,

We have welcomed in the new year, and once again, it is shaping up to be a roller coaster ride! I hope that your connection with the CRANAplus community makes the ride a little smoother and that you resonate with the positive stories and experiences featured in the magazine.

We enjoyed reading your feedback in our recent member survey, specifically 'why you stay in the job.' Everyone working in remote and isolated Australia has a unique story to tell, and our recently launched Podcast series features member experiences of working out bush. It is available on all major podcast platforms – search for 'CRANAcast'.

Safety and security have long been a focus of CRANAplus. But sadly, we are hearing that the impacts of the pandemic have exacerbated safety concerns in the remote and isolated health workforce.

CRANAplus recognises that the continuity of vital health services is inextricably linked to staff feeling safe and secure in their work and communities. We believe that increasing the safety and security of the remote health workforce requires further urgent attention from government, employers, and communities. Our advocacy work ensures that your concerns are heard at the state and federal level.

We are deeply committed to supporting the workforce. We have a range of resources for those preparing to work remote and those currently working in remote and isolated areas. Head to our website to view.

Finally, I am delighted that we can now share the date and location of our 2022 CRANAplus conference, scheduled for 4–6 October 2022 in Adelaide. It feels like it has been such a long time since we have come together face to face. I hope to meet many of you in person at the conference. It will be a fabulous opportunity to celebrate the work that you do.

Warm regards,

Katherine Isbister
Chief Executive Officer
CRANAplus

LIKE US ON facebook
facebook.com/CRANAplus

CRANAplus acknowledges the Traditional Owners and Custodians of the land, waters and sky, and respects their enduring spiritual connection to Country. We acknowledge the sorrow of the past and our hope and belief that we can move to a place of equity, partnership and justice together. We acknowledge Elders past, present and emerging, and pay our respects to the cultural authority of First Peoples.

From the Deputy Chair of the Board

Here we are well into 2022 and two years of dealing with the pandemic. Health professionals right across Australia are exhausted, worn out by the pressure and expectations of the community and the ever-changing guidelines and mandates. This is even more so in remote areas, where our amazing remote health practitioners and clinic staff deal with everything, mostly by themselves. It looks like a bleak picture, and many might say it is indeed a perilous time for remote health and the communities they serve.

However, there are rays of hope and glimmers of better days ahead. Many remote health practitioners do what they do because they care and want to make a difference. They want to provide health care in settings where few practitioners desire to work, and to support remote communities to deal with the arrival of the pandemic in their area, as well as all the other aspects of health care that still need to continue. Their relationships with residents of remote communities and other isolated settings are critical to getting correct evidence-based health messages heard, understood, and acted upon. These and other positive threads must not be forgotten or ignored among the flood of negative social media and mainstream media coverage of our sector. Individual successes may indeed be small, but together they make a huge difference to the lives of people in remote Australia.

CRANAplus is proud to educate, support and represent remote health practitioners right across Australia. There are many people who make CRANAplus work, including the voluntary Board of Directors, the highly skilled and dedicated management and leadership team, the committed and hard-working employees of the organisation, the many outstanding volunteers who help to facilitate the face-to-face courses, and of course the members who believe in and support CRANAplus. I say a heartfelt "Thank You" to every one of you and feel immensely proud to be a part of something that really matters, the remote health sector.

John Wright
Deputy Chair
CRANAplus Board of Directors

First Peoples

Being an AHP during the pandemic

Geoffrey Ganambarr from the Marthakal Homelands Health Service (pictured right, with Health Manager Jannie Kraayenhof) has been an Aboriginal Health Practitioner for 11 years. His challenging role involves being the first point of contact and providing health care over distances and during the Wet, but he finds a way, even during the pandemic.

From its base on Elcho Island in Galiwin'ku in the Northern Territory, the mobile Marthakal Homelands Health Service provides care to the Yolngu People over an area of 15,000 km^2.

Among the community, behind the wheel of a 4WD, or in a plane travelling to the distant corners of the Homelands, you are likely to find Geoffrey Ganambarr, who has been an Aboriginal Health Practitioner for over 11 years.

Geoffrey is multilingual in traditional Yolngu Matha languages and acts as a first point of contact for Yolngu People seeking health support.

"It was hard in the first place, but it's easy now," Geoffrey explains of his career so far. "A lot of experience now.

"I came here when I married my wife. She's from here. I came from Milingimbi [Island]. I was here for long years when I was young."

The work is demanding at the best of times, but the pandemic has increased the difficulty.

As we talk on the phone in January, Galiwin'ku has just gone into a seven-day lockdown due to COVID-19 cases in the region. Health services are temporarily limited to medications and emergency.

"We are locked down at the moment and will be opened next week," Geoffrey continues. "People are frightened. We didn't have this virus before.

"It's not happened here before. It just comes and goes. People can't go back to Darwin for a weekend."

Fortunately, Geoffrey and the team did everything they could to limit the risk beforehand.

"We had some people come in from Darwin and they explained to the people about this COVID-19," Geoffrey says, remembering back to a few weeks ago. "Then they understand, and they came into the clinic and asked for a vaccination.

"During COVID vaccinations I worked in the clinic, helping them last week. When the people come through, they see me first. I take temperatures and then they go off and see the nurse for a vaccination."

This year's wet season has added to the complexity: "Wet season, like biggest rain. We can't go and fly to the Homelands, the mainland. We stay in the one place. We drive alright, here. Visit Homelands around here."

As Geoffrey points out, there are many benefits for nurses if they decide to work for the Marthakal Homelands Health Service. Together, Nurses and Aboriginal Health Practitioners can achieve great things.

"It's a good opportunity for them to come here, and get more experience, get experience from us," he says.

"When the visiting nurse can't understand, we explain to them. We speak Yolngu Matha, and we explain to them.

"We follow a recall system. Then we know who the people are and take the nurse to those people."

Health Manager at Marthakal, Jannie Kraayenhof, says that by employing Aboriginal Health Practitioners like Geoffrey, the service empowers nurses to do what they do best.

"Having a local person who is the first port of call – for me that is an important standard to set in all Aboriginal communities," she says.

"They speak the language, it's their culture, their people – if anyone's going to understand each other, it's going to be these mob."

If you are interested in working for Marthakal Homelands Health Service as an AHP, a nurse, or a GP, you can email Jannie at health.manager@marthakal.org

Let's CHAT about Dementia

The Let's CHAT Dementia research project is set to drive research-informed best practice dementia care for Indigenous Australians living in rural and remote areas. Dallas McKeown, who is a member of the Indigenous Reference Group, discusses the project's progress.

Twelve Aboriginal Community Controlled Health Services (ACCHSs) from regional and remote Victoria, New South Wales, North Queensland and Western Australia are currently participating in the Let's CHAT (Community Health Approaches To) Dementia in Aboriginal and Torres Strait Islander Communities project, conducted by The University of Melbourne.

The collaborative project aspires to improve the detection of cognitive impairment and dementia, the quality of dementia care in the primary care context, and the quality of life of older people and their families, by co-designing a culturally responsive best practice model and rolling it out in the health services of the project's ACCHS partners.

Dallas McKeown, Director of First Peoples' Strategies at CRANAplus, is a member of the research team and a representative on the Indigenous Reference Group, which advises on data collection activities, resource development and the implementation of the best-practice model of care. She has been providing advice and input into the project and has provided presentations to ACCHS staff and other stakeholders regarding cultural determinants of healthy ageing.

Gidgee Healing in Mount Isa, north-west Queensland, is a project participant and in late November the Cairns-based team lead by Dr Eddy Strivens, a Chief Investigator of the research project, undertook a range of project activities including:

- Six-monthly audits of 150 client files to identify current practice regarding assessment, detection, and management of cognitive impairment, dementia and dementia risk.
- Comprehensive Geriatric Assessments (CGA) of clients identified through the audit process as having cognitive/memory concerns. These patients will then be reviewed every six months through the life of the project. For each client, two controls matched on age and gender, are also assessed.
- GP workshops and staff workshops.

CRANAplus continues to support the research project and envisages that it will have an impact on policy development and program implementation in rural and remote areas in the forthcoming years.

More information about the project can be found at medicine.unimelb.edu.au/school-structure/medicine/research/lets-chat-dementia-research. ●

Let's CHAT staff and participants in Mount Isa, left to right: Dr Yvonne Turner; Rebecca Casey and Dell Burgen (Injilinji Aged Care); Dr Eddy Strivens; Linda Muller (Bluecare); Rachel Quigley (JCU); and Dallas McKeown.

Long line of achievers

Vicki follows her mother and aunt in being recognised with an OAM.

Vicki O'Donnell, a Nyikina Mangala woman from Derby in Western Australia, is the third person in her family to receive the OAM for community work. Here she talks about the influence of her family and her passion for Aboriginal community health.

When Vicki first heard she had been nominated for the Order of Australia Medal (OAM) this year, she thought it was a scam.

"I am a humble person, I just do the work," she says. "It's true I may have been the voice for Aboriginal primary health in the Kimberley, but there is a whole team of people behind me doing a lot of the work... This medal is for all the teams I've worked with."

Vicki, who has worked as a strategic leader in Aboriginal Community Controlled Health (ACCH) for nearly 20 years, received her OAM for her involvement in Indigenous affairs and Indigenous health in the Kimberley and across the state. She comes from a long line of family members who speak up and are the voice for their community.

Her mum Elsa Archer received the OAM four years ago for services to the community, and her aunt Carmel Moore, her dad's sister, received it about 20 years ago for her involvement with the CWA. Her dad, who died at 57, was involved in the Shire, speedway and many community clubs.

"I put it down to my upbringing," says Vicki, whose dad was Aboriginal, her mum non-Indigenous. She learned over the years to speak up for herself, for Aboriginal communities, for Aboriginal health, to become a voice, to make a mark.

"We've a way to go, but we've come a long way," says Vicki.

> "We are now at the table with a voice that is heard – but there are still occasions we have to knock at the door, and loudly, to point out that we are here."

With a Diploma business degree, Vicki's working life began in WA State Health and then with Aboriginal Affairs. She then became CEO of Derby Aboriginal Health Service for 12 years and has been the CEO of the Kimberley Aboriginal Medical Services (KAMS) in Broome for the past seven years.

KAMS provides advocacy and services to member services, across 15 remote clinics. 80 per cent of clients are Indigenous.

"I've always had a passion to work in this field, to try and give back and provide advocacy for health for Indigenous people," says Vicki, who is proud of the comprehensive approach of the Aboriginal Community Controlled Health Service (ACCHS) which began in Redfern in NSW over 40 years ago, and came very soon to WA. Broome was the first in the Kimberley. ▸▸

"We were in front providing comprehensive primary health care which is all about wellbeing as well as acute illness," says Vicki.

"When you go into a state health system, it is still very much that you are treated for what you are there for.

"In the Aboriginal system, it is about your whole health and wellbeing, with follow-ups and referrals. We have strong links and partnerships with mainstream health services who are now taking advice from us, learning from our definition of health care.

"It is a model where the doctor, the nurses and the Aboriginal Health Workers are all equally important. I think it works well and the non-Indigenous health workers who work in our system are also strong believers.

"It's a primary health care and prevention system that works to prevent clients going into hospital, that enables people who are not well to be managed at home."

Vicki is delighted to see that the ACCHS has grown to have a voice of its own.

"Seeing young people move into managerial roles, that's something you wouldn't have seen before," she says.

"It's important to back our young leaders and their decisions, and my view is, if a mistake can be corrected, it's not a mistake."

"Every person should have the opportunity to manage. If you don't get that opportunity, you don't get the experience.

"We have some young leaders in their 20s, and older leaders in their 30s, and we need to support them all, help them step onto the ladder and climb."

Vicki is also proud that KAMS is now the provider of all renal services in the Kimberley, winning the tender last year.

"We have a great partnership with the WA Health Service," she says. "We are bringing home dialysis to more people, treating 160 people a week.

"Our aim is to slow down Stages 1 to 3 and to target prevention by advocating investing in environmental health – that means better housing, better-placed rubbish tips, food security... That focus would help greatly with a number of other illnesses too, including diabetes and cardio-vascular.

"The fact is, you get sick for a reason."

A study has shown that primary disease, according to the World Health Organisation definition, was the reason why most Aboriginal people spent time in hospital over a period of a year in WA, costing the state $14 million.

"Governments need to focus on the front end," says Vicki, "dealing with overcrowding, for example, and spending money on all those environmental issues, rather than the bricks and mortar of new hospitals."

Vicki is also proud of the COVID-19 response from ACCHS.

"We led the way in WA," she says. "In the Kimberley, we were on the front foot at the very start, dealing with 22 cases, the highest figure in any region. And we have continued to be proactive.

"Even before the WA government, with the latest wave, we were putting in orders for vaccines, for RATs, for masks and making plans."

Vicki believes the Kimberley region has been successful because of its ability "to work well as a sector, share information to avoid overlap and repetition, get the messages across to our mob to be safe."

"We did the same with action to promote the vaccine and, with the latest outbreak, we will be prepared as well as we can be. There will always be issues to be ironed out, but we will work as well as possible with whatever happens."

Legitimising Yarning

Photo: bennymarty – stock.adobe.com

Have you been invited to participate in a yarning circle? If not, what are your expectations? CRANAplus' Dallas McKeown asks us to consider what it means to be involved in the process and to identify our strengths and opportunities to learn.

The terms 'yarning' and 'yarning circles' are applied in many situations. For many First Peoples, these words evoke a welcome sense of déjà vu, bringing to mind the terms 'culturally appropriate' and 'consultation'.

Yarning is a culturally safe way to connect, exchange information and share stories and experiences, that respects and utilises First Peoples' world views.

A commonly used tool in health-based research with Aboriginal and Torres Strait Islander Peoples, yarning prioritises lived experiences, creates a telling space[1] and provides a channel for Indigeneous participation in research that infuses traditional cultural knowledge[2].

It allows Aboriginal and Torres Strait Islander participants to frame and generate new research areas and research priorities.

It respectfully allows Indigenous participants to divulge information in a respectful, self-determined way; it is inherently reciprocal, allowing transfer of appropriate knowledge between participant and researcher[3] as they journey through memory and lore to better understand the research's topic or purpose.

Types of yarning

Professor Dawn Bessarab and her colleague Dr Bridget Ng'andu identified four discrete yarning types in their research: social, research topic, therapeutic and collaborative yarning.

- Social yarning may involve news, humour, advice or gossip. Research is not discussed; however, social yarning creates rapport and trust, and is therefore a precursor to other types of yarning.
- Research topic yarning involves information gathering through a purposeful conversation addressing the project's fundamental questions, grounded in storytelling.
- Therapeutic yarning follows the sharing of personal, emotional and potentially traumatic stories and memories; the researcher adapts to the role of listener, affirming the experience and supporting the participant.
- Collaborative yarning involves discussing the research project or ideas related to the research. It may involve exploring similar ideas or explaining new concepts.

In summary

Yarning is conducive to a First Peoples' way of doing things. It allows First Peoples to retain authority of their knowledge[4] and is therefore a key aspect of a First Peoples research paradigm. It cuts across the formality of a person's identity as a researcher and demands human to human interaction, where both parties are knowers and learners in the process[5].

When next asked to conduct a 'yarning circle' or participate in a 'yarn', consider where you are in the process.

References

1. Williams, ST, (2007). Indigenous values informing curriculum and pedagogical praxis. Thesis Manuscript. Deakin University.
2. Bessarab, D. Ng'andu, B. (2010). Yarning about yarning as a legitimate method of Indigenous research. International Journal of Critical Indigenous Studies 3(1): 37–50.
3. Dean, C. (2010). A yarning place in narrative histories. History of Education Review 39(2): 6–13.
4. Smith, LT. (2012) Decolonising Methodologies: Research and Indigenous Peoples (2nd rev. edn). London: Zed Books.
5. Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.

Photo: Trung Nguyen – stock.adobe.com

In Focus

End of an era

A facilitator on the CRANAplus REC Course since the very beginning, Rosemary Moyle continued to bring her wide-ranging experience to CRANAplus courses until 2021. As she hangs up the boots, Rosemary reflects on her favourite memories and how the REC course has evolved over time.

In 1997, CRANAplus received funding from the Australian Department of Health to develop and implement a pilot program of remote emergency care courses.

Rosemary Moyle's manager at Royal Flying Doctor Service (RFDS), Geri Malone, told her about the opportunity. She decided she'd "give it a go" and became one of the first facilitators to ever deliver a REC course.

In 2021, Rosemary delivered her final course for CRANAplus, an Advanced Life Support course in Adelaide which marked her 41st course since 2013, when the current method of record keeping was introduced.

Rosemary Moyle farewells facilitating.

Her longstanding involvement saw her deliver education in all Australian states and territories, and as far afield as Christmas Island.

What inspired Rosemary to facilitate for 24 years?

"I love being in clinics, hearing the stories," Rosemary says. "Meeting, face to face, people who I might have talked to on the phone before, or who were there when I went to pick up a patient [with the RFDS]. We could talk about that and how that turned out.

"I love the little outback communities and the people that work there. I remember we delivered a course up in north-western Australia once, and the people who were attending hadn't been to such a course before.

"We started talking about the ABCs – airways, breathing, circulation – and someone came up to me later and he said, 'you know, I've never heard of this ABC stuff before, but I'm going to remember that. That's good, I can remember ABC.' That sticks in my mind.

"I love the hospitality and the appreciation of the people in the bush," Rosemary continues.

"I know myself having lived in the country how difficult it is to get to the city sometimes. You've got to get a course, accommodation, time off work, time away from home. To be able to do it locally is so much better.

"We did a course in outback Queensland and one of the students was a lady who worked on a cattle station. She drove the truck in to do the course – a semi-trailer – because that was her mode of transport. I was in awe that she could drive down the main street and turn up that way.

"Also, I always learn something from the courses – something local, like a local treatment for, say, jellyfish stings," she adds.

"There are other places we've been where they've just had a bushfire or flood. Talking with the local staff about how they've dealt with that was quite a learning experience for me."

How has remote health changed over time?

"Education is more available nowadays," Rosemary says. "Staff are much more willing to partake in educational opportunities – they grasp them wherever they can.

"There are some very professional nurses out there that are very experienced, and they enjoy their jobs. They have to be quite resilient people with lots of other skills apart from working in clinical health care, such as driving a 4WD or changing a tyre. They might have to report on the weather or be the post office for that particular place.

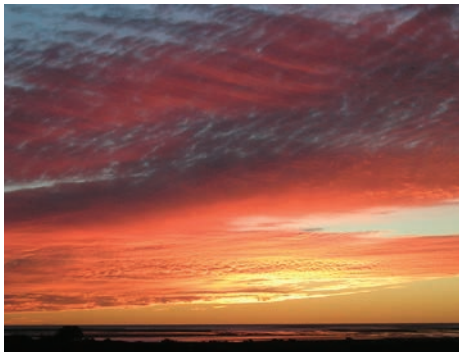
"Some places are very well equipped, and others hardly have anything at all to work with. However, I think that has changed quite a bit. [In the present day] it's much more standardised across the health services, which makes it easier for people to use equipment.

"[Remote health] still has its challenges," Rosemary reflects. "There are still staff shortages, there's still burn-out, there's still a lot of things that come up to make people less resilient, I suppose – but they're the salt of the earth Australians, I think, out there working." ▸▸

How have REC courses changed since the 1990s?

"Courses were organised differently [back then]," Rosemary says, with a laugh. "We used to have the old pen and paper, and printed notes and lectures, and a class-room type situation.

"There's a bigger group of facilitators now, many from varying backgrounds.



A memorable Broome sunset after a REC course.

"At the beginning, we had to write our own lectures, and what you brought to them depended on what sort of background you had. Now, they are standardised and formal, so it stops that variance in knowledge.

"Over time the emphasis has become less on lectures and more on practice... We try to make it as much fun as possible. I think people enjoy less emphasis of sitting in a classroom; they enjoy the hands-on, and the ability to chat to each other in small groups.

"CRANA has grown," Rosemary says in conclusion. "It's offering more than it ever did in the past, and it is adjusting to the needs of the climate of health. Whether it be COVID, or working safely in a community, CRANA ventures across all of that."

The CRANAplus Education Team extends a heartfelt thank you to Rosemary Moyle for her longstanding commitment and valued contributions as a Facilitator.

Singing from the same song book

A stalwart in the remote nursing policy space, Heather Keighley joined CRANAplus as Senior Policy Adviser in December 2021. She discusses policy issues affecting remote area nursing, collaborating with like-minded organisations, and putting remote nursing on the agenda.

Late last year, longstanding CRANAplus Member and regular Conference Panellist Heather Keighley FACN AFACHSM CHM BN RM MIHM joined CRANAplus as Senior Policy Adviser, bringing her passion and wide-ranging experience to CRANAplus' advocacy.

She has worked as a Health Workforce Executive for Northern Territory PHN, Chief Nursing and Midwifery Officer for the NT, is the Chair of the Australian College of Nursing's (ACN's) Rural Nursing and Midwifery Faculty, a Board Director of ACN, and a Council and Board Member with the National Rural Health Alliance.

She's also an ACN Fellow, an Associate Fellow for the Australian College of Health Service Managers, and a Research Fellow at Flinders University.

What policy issues are on Heather's radar?

Number one is the lack of an established pathway for nurses preparing to go bush.

"At the moment, we're working with the Deputy National Rural Health Commissioner on a National Nursing Framework around what remote and rural generalist nursing looks like, and from there developing a pathway," Heather says.

"Our goal is national consistency around remote and rural nursing – what the preparation is, what's required to effectively and safely work in a more autonomous way with the right training, education, thinking and values.

"CRANAplus does a fantastic job, but within the system, employers don't have sufficient senior, experienced remote area nurses to provide support for clinicians, and the level of mentorship and supervision required for early career transitions into remote.

"Universities have programs and educators and do a great job as well but are outside the actual service delivery system.

Above left: At the Australian College of Nursing 2016 National Nursing Forum Speed Leading Session. Above: With Professor Roianne West at the CATSINaM 2021 Back to the Fire Conference in Darwin.

"Within the service delivery system there needs to be more cognisance and recognition of the supports required for early career nurses to practise safely and support Aboriginal health improvement and Aboriginal health staff.

"With a higher Indigenous population in rural and remote areas, these issues cannot be separated from Closing the Gap."

Heather also identifies workforce availability as a key policy consideration exacerbated by the mobility limitations imposed by COVID-19.

"How we address that shortage is a vexed question," she says.

"How do we put systems and processes in place, so nurses are positioned to deliver evidence-based best practice in a remote context when there's limited staff and an increased workload due to COVID, vaccinations and public health measures?

"That issue is for employers, but CRANAplus can still put its mind to the question, insofar as it relates to prioritisation, self-care and resilience."

How is CRANAplus advocating for RANs?

CRANAplus' advocacy includes representation on steering groups, committees and boards, attendance at forums, meetings with politicians, and development of position papers, submissions, and research (often related to investigations being conducted by Government), Heather explains.

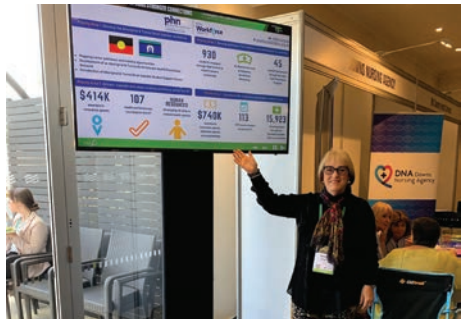
"To give just one example, [CRANAplus CEO] Katherine and I are on the board of the National Rural Health Alliance," Heather explains. "We bring that remote and rural area nursing lens to those meetings and make sure our issues our raised.

"Part of my role is to be across current Government positions, policy and stance, and the likelihood of success of possible solutions," Heather continues.

"It's understanding particular issues, examining them, and documenting them, so that when an opportunity arises, you're ready with material and ideas to start advocating for what is required."

Thanks to her connections in the remote health sector, Heather is well positioned to strengthen CRANAplus' collaborations with like-minded organisations.

"CRANAplus will continue to work in concert with the Australian College of Nursing, Australian Primary Health Care Nurses Association, the Australian College of Nurse Practitioners, Australian Nursing and Midwifery Federation and other leadership groups on professional policy issues," she says.



Opposite page, from top: CRANAplus 2017 Conference in Broome with NT Senior Nurses; Left to right: Paul Stephenson Former CRANAplus Chair, Heather Keighley as Acting Chief Nursing and Midwifery Officer, NT Department of Health, Stuart Moseby and Tanja Hirvonen Centre for Remote Health; In Darwin 2019 with Dr Paul Worley then National Rural Health Commissioner and NTPHN Board Chair Dr Andrew Bell and then CEO Nicki Herriot. This page, from top: 2017 International Congress of Nurses in Barcelona with Qld CNMO and current Deputy Rural Health Commissioner Adjunct Professor Shelley Nowlan and then NZCNMO Dr Jane O'Malley; CRANAplus Conference in the Hunter Valley presenting a poster on NTPHNRWANT Workforce support.

"If we all sing from the same song sheet, we are more likely to be effective, and there are many issues that chart across all those different areas of nursing.

"Often, you get around the policy table and people aren't talking about nursing. They're talking about health more generally – about doctors, about allied health.

"A bit like your Mum, nurses are often taken for granted a little bit in the system. Yet we're always there and we'll always work hard and do everything we can."

However, collaboration between peak bodies is a cause for optimism, Heather says. Our joint efforts are set to place remote and rural nursing on the agenda more forcefully than ever before.

She says in conclusion: "I have heard more advocacy and discussion of the issues affecting remote and rural nurses in recent months than I've heard throughout the decades I've been in the remote health space." ●

A strong and continuing advocate

Kathryn Zeitz, an avid sponsor of the CRANAplus scholarship program to fund remote placements for health students, has fond memories of discovering the existence of our organisation back in 1998.

A former Board Member of CRANAplus in a time of significant change and a Fellow of CRANAplus since 2016, Kathryn has maintained a strong connection with the organisation over the years.

"Even though I have no remote background in a traditional sense, I am fully committed to the work of CRANAplus," she says, "and will always be a strong advocate for the organisation."

Kathryn commenced her nursing career at Flinders Medical Centre predominately as a Registered Nurse in Accident and Emergency. Because of her background in emergency care and as a volunteer ambulance officer, Kathryn applied for a role in 1998 to help develop a Remote Emergency Care (REC) educational program for CRANAplus.

"It was the first program specifically for the remote setting. There was nothing like it at all in those days," says Kathryn.

"I hadn't heard of CRANAplus until that moment. What struck me most was that nurses in remote settings were working at the top of their licence, doing procedures that nurses in other settings are still not allowed to do. I was and still am so impressed.

"We were doing some very advanced skills in those programs, skills such as infusions for babies, chest drain insertions and intubations.

"To this day, you won't find city nurses doing these procedures, but we had to have them in the curriculum because this range of skills in remote settings is life-saving. If they're not done, if no-one is available because of distances, people die."

Kathryn ran the first four pilot REC programs – in Broome, Port Augusta, FNQ and Alice Springs – and has since been a facilitator of courses across the country.

Again, in 2002, she reviewed the Remote Emergency Care program, and is proud the courses being provided by CRANAplus "still [feature] elements we set up in the very early days."

Kathryn, who completed her PhD thesis in clinical nursing at the University of Adelaide in February 2003, joined the Board in 2011 and served for six years during a period of significant organisational growth.

"It had been a very small organisation when we ran the first courses," she says.

"When I joined the Board, it had grown, and it grew even more in every area: the services provided to members, the funding opportunities they have established, and the support now provided to the rural and remote sector in general."

Opposite page, from top: The CRANAplus Board in 2015 (Kathryn top left); Kathryn and Monica Frain being inducted as CRANAplus Fellows. This page, from top: Kathryn speaking at the CRANAplus Conference in 2014; Kathryn Zeitz.

During her time on the Board, Zeitz Enterprises, a business run by Kathryn and her cardiologist husband who does a lot of rural and outreach work, began sponsoring remote placements for health students through the CRANAplus program.

"We both see a huge benefit from encouraging students to do clinical placements in rural and remote settings, for many reasons," Kathryn says.

"While the placements are important for the students' education and experience and help to attract people to work in rural and remote settings, I believe the placements also play a significant role in advocacy.

"Even if the students don't go on to work in these rural and remote settings, the experience makes them much more compassionate and understanding when they get that phone call from a remote practitioner, because they are aware of the work the health workers do out there and the limitations they work under."

With a diverse career in acute hospital operational management, Kathryn has been Executive Director Clinical Governance at Central Adelaide Local Health Network for three years. She is both an Adjunct Associate Professor with Flinders University and Clinical Associate Professor for The University of Adelaide and has been a member of St John Ambulance Australia, in a voluntary capacity, for 30 years, most recently joining their Australian Board. ●

Building clinical reasoning in a less critical environment

Days spent gaining skills in venepuncture, arrhythmias, and wound care. Nights spent enjoying the Territory's best chicken wings and cooling down in the local swimming pool with friends. Charles Darwin University Nursing Student Kundai Chimhau remembers her expectation-defying Tennant Creek placement.

I did my final year nursing placement at Tennant Creek hospital. The placement was over four weeks and was the first remote placement I ever completed.

A week into my placement I found myself looking forward to knocking off work and enjoying the tranquillity of the outdoors in the early morning hours or over the weekend. I was fortunate to be housed with three other students from Adelaide who were also as curious about Tennant Creek as I was, so we shared not only a love for fitness but a desire to learn as much as we could about Tennant Creek.

Between nature walks at nearby Lake Mary Ann or the Tennant Creek Telegraph Station about 5km out of Tennant Creek, and selecting from a wide range of arts, crafts, fashion, and cuisine at the fortnightly local markets at the town centre, there was always something to do.

Although the weather was sometimes unforgiving, with temperatures as high as 41 degrees, it was not enough to deter us from unwinding after work. We soon found a local public pool and a local gym where we could sign up for the duration of our placement and "pay as we go" for a swim.

The nurses at Tennant Creek Hospital were an absolute delight to work with. They were supportive and patient with us. The educator, John Wright, was exceptional in accommodating our needs. Based on our requested skills needs, he allocated us in at least two different wards, and we benefited from individualised placements.

Above: Exploring around Tennant Creek. Opposite page, from top: Kundai and colleagues; Cooling off in the afternoons; Walking at Tennant Creek Telegraph Station; Sharing a meal with friends.

Prior to attending this placement, I expressed to John that I was keen to practise more venepuncture, and better understand arrhythmias, wound care, and wound management. Based on my needs, he placed me in the Emergency Department as well as the GP clinic. I also got a chance to pop into the COVID-19 clinic.

The beauty of Tennant Creek hospital is that all the wards and clinics are under one roof, so if you are curious about anything, there is always an opportunity to access any clinical area of interest to you. There is also more time to learn at Tennant Creek Hospital because even though the hospital treats short-term illnesses and injuries, with critical cases being transferred to Royal Darwin Hospital, Alice Springs Hospital or Royal Adelaide Hospital, most presentations are secondary to chronic conditions and thus as a student you get an opportunity to build on your clinical reasoning in a less critical environment.

At the end of each week, we took it upon ourselves to try out the restaurants in town and we had no regrets. My personal favourite was Sporties, largely because I just love chicken wings and they had a kilo for just $16; add a little buffalo wing sauce and we'll be friends forever. If you love your barramundi, schnitzel, pizza, or some Asian cuisine, you'll have all that in Tennant Creek, as long as you are keen to explore.

After a while, the days just seemed to fly by and before I knew it, the month was over and it was time for me to go back home and be someone's mum again. Tennant Creek allowed me the respite I never knew I needed. ●

This CRANAplus undergraduate remote placement scholarship was sponsored by HESTA.

Immersion in Emergency

Lucas Revell from Edith Cowan Uni reflects on his month in Esperance, spent consolidating his emergency nursing skills by facing new presentations – including septic shock and mastocytosis – and catching waves on his days off.

I attended my four-week-long stage-five nursing practical placement at Esperance Health Campus Emergency Department.

Straight off the bat this was my favourite placement to date, by far! I have equally fallen in love with Esperance the town, and emergency medicine as a field that I would love to work in for the future.

This placement opened my eyes to how a regional emergency department functions and what a fantastic job they do. I thoroughly enjoyed the hands-on learning and the independence I was granted by the staff there.

Esperance Health Campus is quite a small hospital without any particular specialty wards, which meant I was exposed to and learned from a multitude of patients of unpredictable demographics and clinical presentations.

I thoroughly enjoyed the goal-orientated approach of the ED and the interaction between registered nurses and medical officers to help solve problems.

I was able to consolidate my learning of the crucial A-E process when assessing patients in an emergency setting, which was great for my development as a student nurse. I got to witness my first cardiac arrest and resuscitation which was at first quite confronting, but it made me realise that this is the clinical environment that I want to excel in one day, in order to make direct positive impacts on people's lives.

I was exposed to and helped treat conditions that I have never seen before such as kidney rejection, septic shock, cardioversion, respiratory distress, pseudo seizures, mastocytosis and many more. I was also exposed to many mental health patients, often with suicidal ideation – again, a new experience for me. This was great for my learning on the common procedures of how to manage these types of patients.

I cared for paediatric patients for the first time, which was challenging, and from the experiences I had on this placement, I now identify this as an area I need to improve on to achieve my goal of becoming a competent emergency medicine nurse.

Learning the flexibility and potential benefits of working for WACHS or for agencies whilst working in the regions of Western Australia has motivated me to become a competent nurse one day for the regions of WA.

The CRANAplus scholarship has contributed significantly for me to be able to attend this placement and obtain the valuable clinical and life experience it has provided. The scholarship funds enabled me to afford the costly fuel and living costs of working in such a remote community, approximately 800km from home!

Top: On the runway with an RFDS plane. Above: Enjoying a surf.

I could not recommend attending regional WACHS clinical placements to other students more, considering the extent to which they have developed my sense of independence and confidence in delivering safe health care to rural communities. ●

This CRANAplus undergraduate remote placement scholarship was sponsored by HESTA.

HESTA

My Dearest Friend Cathy

Michelle Dowden recalls her wonderful Galiwin'ku Island colleague, Cathy Woods, who passed away in 2021 but who lives on in treasured memories of distributing ice-cream on Boxing Day and 3am debriefs after airstrip retrievals.

A movie featuring Nurse Practitioner Cathy Woods living and working in remote communities in Arnhem Land in the Northern Territory would portray her as "an outstanding human being who made things happen, saved lives and gave selflessly to all".

Michelle Dowden, who was manager of the clinic on Galiwin'ku Island when Cathy arrived there in 2008, says the movie would also be a sure-fire blockbuster, complete with love, romance, heartache, adventures, and twists.

"Cathy would have seen herself as a modest remote nurse who things happened to," says Michelle.

"In fact, she had clinical skills that could have matched the best medical specialist, her attention to detail in the kids clinic was nothing but outstanding and she was much loved by all Yolngu [people]."

Cathy died, aged 40, from liver cancer at the end of last year.

"She desperately wanted to get back to her beloved Arnhem Land," says Michelle. "Sadly this did not happen, but I can tell you for sure Arnhem Land never left Cathy.

"Shortly before she died, we recollected special times, many involving the airstrip, often at 3am after a long and complicated evacuation, perhaps involving a heart attack, serious infection or major trauma.

"The joy of seeing the plane take off and then us dropping all the Yolngu family members back home in the ambulance and finally having that well-earned coffee and a debrief that no-one other than a remote area nurse can appreciate.

"In our time together in Galiwin'ku, we shared many, many times, we shed tears and had lots and lots of laughs."

Tireless workdays driving around to deliver medications and make household visits, and joyous downtime simply cooking damper in the coals and having a cup of tea, walking in the cycad bush – that was the life that Cathy cherished.

One anecdote revolves around Christmas.

"It was Boxing Day and we both realised we had missed Christmas because it had been so busy at the clinic," says Michelle. "So we drove around the whole community giving out the icecream from the freezer.

"We would often reflect after a big day how much can happen. A birth, a death, a cranky client, a funny client, 20 flat tyres, a huge storm, a power outage, all in a day's work and then up all night for call."

Cathy, who trained at Deakin University and worked at St Vincent's Hospital in Melbourne where she originally came from, first went to Galiwin'ku around 2004 after her nursing training.

Opposite page: Cathy (left) and Michelle (right).
Above: Cathy and Michelle at Sydney Harbour Bridge.

She returned in 2008 and stayed until 2015, and then worked in Milingimbi for a couple of years before her diagnosis in 2018. All in all, more than 10 years working remote with Miwatj Aboriginal Health.

Like many non-Indigenous people who go to live and work in East Arnhem Land, Cathy was adopted into a family; a big part of her story, says Michelle. She always held the view that she lived, loved and worked with Yolngu. This meant an open house and an open heart.

"The adoption system is best described as a necessary requirement to place you in the complex system that is the Yolngu world," says Michelle. "Each rock, tree, animal and place is significant and has a relationship to you and those in your clan. Cathy understood this system.

"We lived in adjoining houses, elevated, louvred with ceiling fans and massive fragrant frangipani trees which provided glorious canopies outside, and we regularly popped over to each other's places to share a ginger beer, countless cuppas and many meals.

"Yolngu family were never left out if they happened to turn up at dinner time."

Cathy was a dedicated remote area nurse, says Michelle, and proud to become a Nurse Practitioner, coming top in her year.

She was instrumental in the follow-up of a group of children with a rare heart anomaly and helped many a researcher with fieldwork over the years.

"Her professional dedication was no more apparent," says Michelle, "than in her determination to attend professional development to maintain registration up until a year before she died."

In memory of Cathy, Michelle has had a star named in her honour: Wurrupa (ocean woman) "because she so deserves to be seen shining every night somewhere", Michelle says of her dearest friend. ●

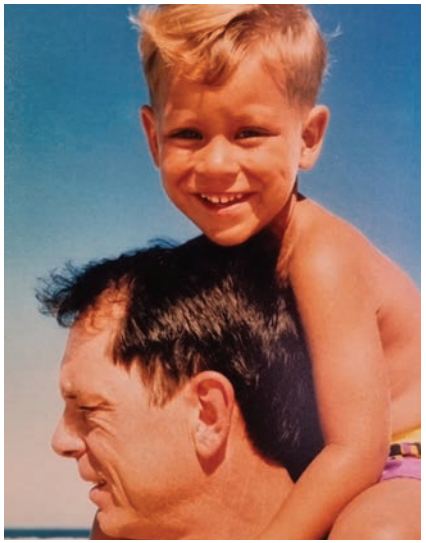
Remembering Ray Wyeth

On October 11 2021, Nurse and Midwife Raymond Clifford Wyeth tragically lost his life while working in an ambulance in Stanwell, Central Queensland, along with the patient he was caring for. Ray's colleagues share their dearest memories and reflect on his legacy.

In 1979, Ray and Jennie sat on the banks of the Bloomfield River in Far North Queensland with the Kuku Yalanji, Kuku Nyungul and Jalunji people.

These moments were a revelation to Ray, who had just completed his final nursing exams and made the bumpy journey to visit his partner near her workplace at the Wujal Wujal Aboriginal Community.

"When we get married," Ray said, "This is the nursing I want to do. I want to work with these folks."



Above: Ray with his son, Tim. Above right: Ray at Bloomfield River, 1979. Right: Ray during his nursing studies.

Commitments such as raising their son, Tim, took precedence, but Ray never lost sight of his goal, taking every opportunity to equip himself for service.

In the early 1980s, Ray could be seen in scrubs, training as a midwife at Royal Brisbane Women's Hospital, and later, walking down St Paul's Terrace, textbooks under his arm, during his Maternal and Child Health studies.

He subsequently worked at Maryborough Hospital, St Stephens Private Hospital, and Hervey Bay Hospital, until 33 years after that influential afternoon on the Bloomfield.

"In 2012 we resigned our jobs and ventured into this world of Indigenous health," Jennie says.

Ray's remote career began in Cherbourg, working for Barambah Regional Medical Services.

The Royal Flying Doctor Service

In 2013, Ray became a flight nurse with Royal Flying Doctor Service and operated out of Kalgoorlie, Derby and Port Hedland until 2016.

"Ray was a lovely bloke, very much a bushie," Senior Flight Nurse, Shane Miller, says. "He was down to earth, no airs or graces.

"He loved remote and rural areas of Australia... One of the pilots used to go out with him occasionally. They used to go camping, sitting by a campfire, having a yarn.

"He was just very relaxed. To be so relaxed, chilled, adaptable... In our work as flight nurses, you have to be extremely flexible because things can change in a matter of minutes."

Ray's passing was felt across the entire flight nursing sector, which is small enough for everyone to know everyone.

"There's only a small group of us – probably 100, 120 in the country," Shane says.

"From Kalgoorlie base to Ray's family, his wife Jennie, and his son Tim, we send our condolences, and we thank Ray for the time he spent with us."

When there were no patients onboard, Ray sometimes gazed out of the window at the desert below, Jennie says.

"Ray did what he called 'reconnaissance' flights over the state to decide where to work next," she says.

Ngaanyatjarra Health Service

In 2016, Ray found his next location – Wingellina, remote WA. As an RN, Jennie had worked near Ray previously; but in Wingellina, they worked together as RANs.

"Before sunset we would sometimes drive the few minutes to the tri-border of WA, NT and SA, where it was fun having dip and crackers in three states at the same time," Jennie remembers.

"Ray's main desire was to learn from the people, rather than teach them. He was keen to learn their traditional ways, their cultural lore, to listen, to talk, to befriend, and to assist in their health care needs.

"Ray consistently performed a service to others in need, whether this was a person, family, a community or a loved dog, and regardless of the time and effort.

"One time Ray was honoured to lead a funeral procession by driving the ambulance containing the coffin. On weekends he would take the children on adventures, or to a nearby community swimming pool.

"He had compassion, empathy, and conviction. He often delivered help, which was not without risks and cost to himself, and always without external gain.

"He was a caring father figure who encouraged the kids to come to the clinic after school and learn first aid. As a midwife he gained trust with mums-to-be, delivering positive outcomes." ▸▸

When Jennie returned to Queensland, Ray continued at Wingellina on a FIFO contract for two more years. Beverly Tysoe, Specialist Coordinator at Ngaanyatjarra Health Service, fills us in on the period until Ray's departure in 2019.

"Ray was a professional and caring person who will be fondly remembered by the people in Wingellina and by his co-workers at Ngaanyatjarra Health Service," Beverley says.

"At work Ray was a dedicated health professional who advocated for his patients and supported them in their health journey.

"In his spare time, he would often drive locals and visitors to water holes and landmarks.

"It was a pleasure and a privilege to have known and worked with Ray."

Ray's return to midwifery

Ray had joined nursing agency CQ Nurse in 2016. CQ Nurse tells CRANAplus that "Ray was a much-loved member of the CQ Nurse team, and he represented our organisation impeccably for five years... He continues to inspire us".

Through CQ Nurse, Ray obtained a contract at Biloela Hospital, where he crossed paths with former colleague Kerri Green, a midwife who knew Ray from Hervey Bay Hospital.

"If you understand that the term 'midwife' comes from the Old English: 'mid' meaning 'with' and 'wif' meaning 'woman', you will understand that Ray wore the title 'midwife' without a problem," Kerri says.

"The women he delivered care to, [quickly] loved and trusted him. The students he supported and his colleagues respected him and enjoyed his sense of humour. They cannot help but smile when remembering him.

"Most will be able to tell you an amusing 'Ray story' – some involving 'knitting' while supervising a student managing a labour.

"On a more serious note... Ray had the ability to deescalate the rising emotions of all involved while coordinating a calm approach to resolve [high stress situations].

"He did briefly consider giving up his Midwifery in 2018 but he made the mistake of accepting a contract in Biloela where a previous Midwifery Manager was already working. He was dobbed in as a 'midwife' and given a rapid re-entry... I was privileged to be that 'Midwifery Manager', colleague and friend.

"My life is richer for having known this incredible human being."

New acquaintances also awaited Ray in Biloela, such as Director of Nursing at Biloela Hospital, Tracey Hansen.

"What really stood out for me was the way in which Ray treated all the people he came in contact with," Tracey says. "He cared for his clients as if they were his family."

Ray was valued not only as a colleague but as a house-sitter, who enabled others to take much-needed leave while looking after their plants, cows and dogs.

"When Ray house-sat, he would open all the windows and let the fresh air in," Tracey says, before sharing an anecdote passed onto her by colleague Maria RN/RM:

"One day he was snuggled on the lounge when he felt a 'presence', only to find one of the chooks had come inside and nestled beside him. Even the chooks felt relaxed with him!

"Ray has enthused many of us to stretch ourselves and do things we really want to do but were never game."

Ray's younger colleagues, who encountered him during formative periods, echo this sentiment.

Ray was NUM on the postnatal ward at St Stephens Private Hospital when Lorraine Woods commenced as a midwife. She later worked with him at Hervey Bay.

"He was a caring, sensitive, and gentle man who had a passionate composure for women-centred care," Lorraine recalls.

"After a couple of years, he decided to work rural and remote which was a passion of mine but was never the right time.

Opposite page (left to right, from top): Ray onboard an RFDS plane; Ray and Jennie in Kalgoorlie, WA; Ray travelled far and wide with the RFDS; Fishing at Cape Leveque, WA, while with RFDS Derby in 2015. Above: Ray with Wingellina kids.

Above, from top: A Christmas feast at home, cooked by Ray; Ray climbing Mt Sonder in 2021; Ray's return to Queensland brought him closer to beloved destinations, including Fraser Island.

"His stories of his work were amazing."

Those stories inspired Lorraine and in 2021, she obtained a position as clinical midwife in Weipa.

"Once I made my decision [to head] rural and remote we were to have lunch with friends and workmates from St Stephens Private Hospital... Ray was tragically taken from us two days prior, which was devastating.

"I was so excited to tell him of my plans. [Then I felt], I will continue his amazing work with as much passion as he had."

Burning the candle

RFDS Doctor Nick Enzor; Steven Williamson, then-CEO of the Central Queensland Hospital and Health Service; Ray's former workmate and celebrant Fred Hampson; close friend Andrew Butkus; and Dr Tom Dunn, Maryborough RSL, all spoke at Ray's funeral.

Deputy National Rural Health Commissioner and Chief Nursing and Midwifery Officer, Queensland Health, Adjunct Prof. Shelley Nowlan, presented a Florence Nightingale Tribute, during which she asked all nurses and midwives to stand.

"40 to 50 per cent of the group that were present stood, not to mention the large number that joined online," Shelley tells CRANAplus.

"Ray walked the tracks that not many nurses and midwives do... Often, we get stuck in metro areas because there, life has ease of access, but Ray saw a different world within rural and remote – not just for nursing, but for his own growth and development, and contribution to communities.

"He was real, he was Ray... He brought his own personality, values, and beliefs to share them with community, valuing the community's culture and beliefs [in turn].

"He came without judgment, he came without condition, and he cared for their needs, whatever they might be – whether they were mental health, whether they were maternity – and

sometimes just to be an ear, to be a friend that was having a yarn at the local pub or local park.

"He is joined by a profession who mirror his values, his concerns for community, and the investment to continue to be better, to continue on with his study... [as] evidenced by his membership with CRANAplus.

"What we saw in Ray is a mirror image of what we all aspire to have as attributes and traits within his profession. Our admiration is one collegiality, one of: 'Thank you for burning our candle'."

The Ray Wyeth Early to Remote Practice Award

CRANAplus is offering the Ray Wyeth Early to Remote Practice Award for the first time in 2022. The award follows Ray's lead in encouraging and recognising an emerging remote health professional who demonstrates commitment and cultural safety. Read more about this award and others on page 70.

Ray's legacy

Jennie believes her husband's legacy can be one of inspiration.

"I hope in Ray's death, his life of caring and service is inspirational to any nurse willing to combat adversity in a remote setting, to develop courage and determination, and to overcome any obstacles in order to achieve better health outcomes for all Australians." ●

Top left: Badu Island, Torres Strait, at Christmas time in 2016. Left: Ray with his grandson. Above: Jennie, Ray and Tim.

Help our audience discover new opportunities. Advertise with us.

CRANA plus improving remote health

Magazine advertising rates

		One issue	2 issues (- 10%)*	3 Issues (- 20%)*
Full page	Type: 128mm W x 183mm H Trim: 148mm W x 210mm H Bleed: 154mm W x 216mm H	$2,240	$4,032	$5,376
Half page	Horizontal: 128mm W x 90mm H Vertical: 65mm W x 183mm H	$1,232	$2,218	$2,956
Third page	Horizontal: 128mm W x 59mm H Vertical: 65mm W x 121mm H	$840	$1,512	$2,016
Double page	Type: 276mm W x 183mm H (allow at least 5mm clear of type for central gutter) Trim: 297mm W x 210mm H Bleed: 303mm W x 216mm H	$4,256	$7,661	$10,214

Magazine colour insert

		15,000 single-sided	15,000 double-sided
Full size	Trim: 148mm W x 210mm H Bleed: 154mm W x 216mm H Artwork must be supplied	$1,500	$2,000

The CRANAplus Magazine is an A5 size periodic publication with a readership of 15,000 per issue across Australia and internationally. It reaches those who are passionate about remote health in Australia and provides a high-quality space for your advertising. In our content-rich publication, your message will stand out.

Publication Dates: April, August and December

Submission Dates: April (Issue 125) 14 February 2022, August (Issue 126) 13 June 2022 and December (Issue 127) 17 October 2022.

*Discounts apply to consecutive issues only. Corporate members receive further discount on these rates. Contact membership@crana.org.au for further information.
Magazine is printed in A5 format. Other advertising sizes can be negotiated. Rates are in AUD$ and are inclusive of GST. All artwork to be submitted by close of business on the published deadline date. All ads to be submitted in high resolution PDF format with trims and bleed, all fonts embedded and all colours converted to CMYK.

Corporate Members and Partners

2XM Healthcare is an Australian owned and operated Rural and Remote Nursing specialist. Based in WA our consultants have over 20 years' combined experience in the industry and have experience in supporting remote area clients and candidates in their searches. We are committed to developing high quality relationships and our mission is to support the R&R community as best we can. For all our up to date jobs, please visit www.2xmhealthcare.com.au or call (08) 6388 0700.

Affinity is a nurse owned and managed agency with in-house Clinical Educators providing your professional development. As a non-commission-based agency, we focus on finding the right match for you. Join today to experience the Affinity difference. www.affinitynursing.com.au

AMRRIC (Animal Management in Rural and Remote Indigenous Communities) is a national not-for-profit charity that uses a One Health approach to coordinate veterinary and education programs in Indigenous communities.
Ph: (08) 8948 1768 www.amrric.org

The **Australasian Foundation for Plastic Surgery (The Foundation)** is a not-for-profit organisation that supports quality health outcomes for those involved with Plastic Surgery, with a particular focus on rural and remote communities.
Email: info@afps.org.au www.plasticsurgeryfoundation.org.au

The Australasian College of Health Service Management ('The College') is the peak professional body for health managers in Australasia and brings together health leaders to learn, network and share ideas.
Ph: (02) 8753 5100 www.achsm.org.au

The **Australian Council of Social Service** is a national advocate for action to reduce poverty and inequality and the peak body for the community services sector in Australia. Our vision is for a fair, inclusive and sustainable Australia where all individuals and communities can participate in and benefit from social and economic life.

The **Australasian College of Paramedic Practitioners (ACPP)** is the peak professional body that represents Paramedic Practitioners, and other Paramedics with primary health care skill sets. ACPP will develop, lead and advocate for these specialist Paramedics and provide strategic direction for this specialist Paramedic role. Email: info@acpp.net.au www.acpp.net.au

The **Australian Indigenous Health*InfoNet*** is an innovative Internet resource that aims to inform practice and policy in Aboriginal and Torres Strait Islander health by making research and other knowledge readily accessible. In this way, we contribute to 'closing the gap' in health between Aboriginal and Torres Strait Islander people and other Australians. www.healthinfonet.ecu.edu.au

The **Australian Primary Health Care Nurses Association (APNA)** is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care. APNA is bold, vibrant and future-focused.

Benalla Health offers community health, aged care, education, and acute services to the Benalla Community including medical, surgical and midwifery.
Ph: (03) 5761 4222 Email: info@benallahealth.org.au
www.benallahealth.org.au

Central Australian Aboriginal Congress was established in 1973 and has grown over 45+ years to be one of the largest and oldest Aboriginal community controlled health services in the Northern Territory.

The **Central Australian Rural Practitioners Association (CARPA)** supports primary health care in remote Indigenous Australia. We develop resources, support education and professional development. We also contribute to the governance of the remote primary health care manuals suite. www.carpa.com.au

Citadel Medical provides innovative, technology and value driven custom health services, from pre-employment medicals to ongoing health care and support, to the mining and construction industries and provides expert service and holistic solutions to our clients. Citadel Medical delivers responsive and compassionate care that improves employee health and wellbeing while reducing risk, injuries and incidents for employers. Supported by an experienced, highly trained and well-respected team, we believe all remote clinical staff should be knowledgeable, experienced and approachable. Importantly, they should maintain a visual presence on-site, building rapport with employees and actively participating in site safety programs.

The **Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)** is the peak representative body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. CATSINaM's primary function is to implement strategies to embed Cultural Safety in health care and education as well as the recruitment and retention of Aboriginal and Torres Strait Islander People into nursing and midwifery.

Cornerstone are the medical matchmakers™. We are remote and rural nursing and midwifery recruitment specialists, with agency, contract and permanent roles in public and private sectors across Australia.

The **Country Women's Association of Australia (CWAA)** advances the rights and equity of women, families and communities through advocacy and empowerment, especially for those living in regional, rural and remote Australia. Email: info@cwaa.org.au www.cwaa.org.au

CQ Nurse is Australia's premier nursing agency, specialising in servicing remote, rural and regional areas. Proudly Australian owned and operated, we service facilities nationwide. Ph: (07) 4998 5550 Email: nurses@cqnurse.com.au www.cqnurse.com.au

CQ Health provides public health services across Central Queensland, in hospitals and in the community. CQ Health is a statutory body governed by our Board. We serve a growing population of approximately 250,000 people and employ more than 3,700 staff, treating more than 700,000 patients each year. The health service has a diverse geographic footprint, ranging from regional cities to remote townships in the west and beachside communities along the coast. Destination 2030: Great Care for Central Queenslanders is our long-term strategy, will shape the future of hospital and health care across our region and support our aim for Central Queenslanders to be amongst the healthiest in the world. For more information about CQ Health visit www.health.qld.gov.au/cq or follow us on Facebook @cqhealth

Downs Nursing Agency (DNA) was established in 2000 and is 100% Australian-owned and operated. Our agency understands both the lifestyle needs of nurses and the health care provider requirements. We are a preferred supplier for governmental and private health care facilities in Queensland. Contact us on (07) 4617 8888 or register at www.downsnursing.com.au

E4 Recruitment has launched a new division that is dedicated to securing Registered Nurses and Midwives contract opportunities in regional and remote Australia. Helping to ensure that every Australian has access to the health care and services that they deserve. https://e4recruitment.com.au/

First Choice Care was established in 2005 using the knowledge gained from 40 years' experience in the health care sector. Our aim to provide health care facilities with a reliable and trusted service that provides nurses who are expertly matched to each nursing position. www.firstchoicecare.com.au

Flight Nurses Australia is the professional body representing the speciality for nursing in the aviation and transport environment, with the aim to promote flight nursing, and provide a professional identify and national recognition for flight nurses. Email: admin@flightnursesaustralia.com.au https://flightnursesaustralia.com.au/

Flinders NT is comprised of The Northern Territory Medical Program (NTMP), The Centre for Remote Health, The Poche Centre for Indigenous Health, Remote and Rural Interprofessional Placement Learning NT, and Flinders NT Regional Training Hub. Sites and programs span across the NT from the Top End to Central Australia. Ph: 1300 354 633 http://flinders.edu.au/

Healthy Male is a national organisation that helps men and boys lead healthier lives by providing evidence-based, easy-to-understand information on men's health topics. They aim to make information available to everybody, regardless of gender, age, education, sexual orientation, religion, or ethnicity. Supported by the Australian Government Department of Health, Healthy Male collaborates with Australia's leading scientific and medical researchers to fill the gaps between preventive health, health promotion and education need as part of the National Men's Health Strategy 2020-2030. Everything Healthy Male does is designed to inform, engage, and create better lives for men and boys. Ph: 1300 303 878 www.healthymale.org.au

Health Workforce Queensland is a not-for-profit Rural Workforce Agency focused on making sure remote, rural and Aboriginal and Torres Strait Islander communities have access to highly skilled health professionals when and where they need them, now and into the future.

Heart Support Australia is the national not-for-profit heart patient support organisation. Through peer support, information and encouragement we help Australians affected by heart conditions achieve excellent health outcomes.

HESTA is the industry super fund dedicated to health and community services. Since 1987, HESTA has grown to become the largest super fund dedicated to this industry. Learn more at hesta.com.au

IMPACT Community Health Service provides health services for residents in Queensland's beautiful Discovery Coast region. IMPACT delivers primary and allied health care services, including clinical services, lifestyle and wellbeing support and access to key health programs.

Inception Strategies is a leading Indigenous Health communication, social marketing and media provider with more than 10 years of experience working in remote communities around Australia. They provide services in Aboriginal resource development, film and television, health promotion, social media content, strategic advisory, graphic design, printed books, illustration and Aboriginal Participation policy.

The **Indian Ocean Territories Health Service** manages the provision of health services on both the Cocos (Keeling) Islands and Christmas Island.
https://shire.cc/en/your-community/medical-information.html

James Cook University – Centre for Rural and Remote Health is part of a national network of 11 University Departments of Rural Health funded by the DoHA. Situated in outback Queensland, MICRRH spans a drivable round trip of about 3,400km (nine days).

KAMS (Kimberley Aboriginal Health Service) is a regional Aboriginal Community Controlled Health Service (ACCHS), providing a collective voice for a network of member ACCHS from towns and remote communities across the Kimberley region of Western Australia.

Katherine West Health Board provides a holistic clinical, preventative and public health service to clients in the Katherine West region of the Northern Territory.

The Lowitja Institute is Australia's national institute for Aboriginal and Torres Strait Islander health research. We are an Aboriginal and Torres Strait Islander organisation working for the health and wellbeing of Australia's First Peoples through high-impact quality research, knowledge translation, and by supporting a new generation of Aboriginal and Torres Strait Islander health researchers.

Majarlin Kimberley Centre for Remote Health contributes to the development of a culturally-responsive, remote health workforce through inspiration, education, innovation and research. Email: marjalin@nd.edu.au

Mater Misericordiae Ltd – Central Queensland is building a better, healthier future for our community by providing access to world-class hospital facilities, cutting-edge medical and surgical techniques, and unmatched specialist expertise. Our internationally acclaimed hospital network supports thousands of people each year and comprises hospitals in Southeast, Central and North Queensland. In Central Queensland, we have three facilities: Mater Private Hospital Rockhampton which has been supporting local health for over a century; Mater Private Hospital Mackay which has been providing excellence in clinical and pastoral care since 1927; and Mater Private Hospital Bundaberg, founded in 1946. Ph: 07 4931 3313 Website: mater.org.au

Marthakal Homelands Health Service (MHHS), based on Elcho Island in Galiwinku, was established in 2001 after traditional owners lobbied the government. MHHS is a mobile service that covers 15,000km² in remote East Arnhem Land. Ph: (08) 8970 5571 www.marthakal.org.au/homelands-health-service

Medacs Healthcare is a leading global health care staffing and services company providing locum, temporary and permanent health care recruitment, workforce management solutions, managed health care and home care to the public and private sectors. Ph: 1800 059 790 Email: info@medacs.com.au Website: apac.medacs.com

Medical Staff Pty Ltd specialises in the recruitment and placement of nursing staff, locum doctors and allied health professionals in private and public hospitals, aged care facilities, retirement villages, private clinics, universities, schools, medical surgeries and home care services including personal care and domestic help. Email: join@medicalstaff.com.au www.medicalstaff.com.au/ind

Mediserve Pty Ltd is a leading nursing agency in Australia that has been in operation since 1999. The Directors of the company have medical and nursing backgrounds and are supported by very professional and experienced managers and consultants. Ph: (08) 9325 1332 Email: admin@mediserve.com.au www.mediserve.com.au

Murrumbidgee Local Health District (MLHD) spans 125,243km² across southern New South Wales, stretching from the Snowy Mountains in the east to the plains of Hillston in the northwest and all the way along the Victorian border. www.mlhd.health.nsw.gov.au

Farmer Health is the website for the **National Centre for Farmer Health** (NCFH). The Centre provides national leadership to improve the health, wellbeing and safety of farm men and women, farm workers, their families and communities across Australia. www.farmerhealth.org.au/page/about-us

The **National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners Ltd (NAATSIHWP)** is the peak body for Aboriginal and/or Torres Strait Islander Health Workers and Aboriginal and/or Torres Strait Islander Health Practitioners in Australia. It was established in 2009, following the Australian Government's announcement of funding to strengthen the Aboriginal and Torres Strait Islander health workforce as part of its 'Closing the Gap' initiative. www.naatsihwp.org.au

The **National Rural Health Student Network (NRHSN)** represents the future of rural health in Australia. It has more than 9,000 members who belong to 28 university rural health clubs from all states and territories. It is Australia's only multidisciplinary student health network. www.nrhsn.org.au

Ngaanyatjarra Health Service (NHS), formed in 1985, is a community-controlled health service that provides professional and culturally appropriate health care to the Ngaanyatjarra people in Western Australia.

Nganampa Health Council (NHC) is an Aboriginal community-controlled health organisation operating on the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in the far north-west of South Australia. Ph: (08) 8952 5300 www.nganampahealth.com.au

NT Dept Health – Top End Health Service Primary Health Care Remote Health Branch offers a career pathway in a variety of positions as part of a multidisciplinary primary health care team.

The Norfolk Island Health and Residential Aged Care Service (NIHRACS) is the first line health service provider for the residents and visitors of Norfolk Island. Norfolk Island has a community of approximately 1,400 people on Island at any one time and is located about 1,600km north-east of Sydney. Ph: +67 232 2091 Email: kathleen.boman@hospital.gov.nf www.norfolkislandhealth.gov.nf

NT PHN incorporating **Rural Workforce Agency NT** is a not-for-profit organisation funded by the Department of Health. We deliver workforce programs and support to non-government health professionals and services. Working in the NT is a rewarding and unique experience! www.ntphn.org.au

Palliative Care Nurses Australia is a member organisation giving Australian nurses a voice in the national palliative care conversation. We are committed to championing the delivery of high quality, evidence-based palliative care by building capacity within the nursing workforce and, we believe strongly that all nurses have a critical role in improving palliative care outcomes and end of life experiences for all Australians.

The **Remote Area Health Corps (RAHC)** is a new and innovative approach to supporting workforce needs in remote health services, and provides the opportunity for health professionals to make a contribution to closing the gap.

The **Red Lily Health Board Aboriginal Corporation (RLHB)** was formed in 2011 to empower Aboriginal people of the West Arnhem region to address the health issues they face through providing leadership and governance in the development of quality, effective primary health care services, with a long-term vision of establishing a regional Aboriginal Community Controlled Health Service.

At **RNS Nursing**, we focus on employing and supplying quality nursing staff, compliant to industry and our clients' requirements, throughout QLD, NSW and NT. Ph: 1300 761 351 Email: ruralnursing@rnsnursing.com.au www.rnsnursing.com.au

The **Royal Flying Doctor Service** is one of the largest and most comprehensive aeromedical organisations in the world, providing extensive primary health care and 24-hour emergency service to people over an area of 7.69 million square kilometres. www.flyingdoctor.org.au

Do you work in a rural or remote health care facility? Is it difficult to go on leave due to a team member shortage? You may be eligible for Australian Government-funded support to help alleviate the pressure of finding a temporary replacement. Our program officers will recruit, screen and place highly experienced locums. We arrange and pay for the locum's travel and accommodation. Your health care facility only pays for their hourly wage, superannuation and any applicable taxes for the duration of your leave period. Are you interested in becoming a locum? For every rural and remote placement, you receive complimentary travel and accommodation, and an incentive allowance of $150 per working day and a $100 per day meals allowance. Ph: (02) 6203 9580 Email: enquiries@rurallap.com.au www.rurallap.com.au

Rural Health West is a not-for-profit organisation that focuses on ensuring the rural communities of Western Australia have access to high quality primary health care services working collaboratively with many agencies across Western Australia and nationally to support rural health professionals. Ph: (08) 6389 4500 Email: info@ruralhealthwest.com.au www.ruralhealthwest.com.au

SHINE SA is a leading not-for-profit provider of primary-care services and education for sexual and relationship wellbeing. Our purpose is to provide a comprehensive approach to sexual, reproductive and relationship health and wellbeing by providing quality education, clinical, counselling and information services to the community.

Silver Chain is a provider of primary health and emergency services to many remote communities across Western Australia. With well over 100 years' experience delivering care in the community, Silver Chain's purpose is to *build community capacity to optimise health and wellbeing.*

Southern Queensland Rural Health (SQRH) is committed to developing a high quality and highly skilled rural health workforce across the greater Darling Downs and south-west Queensland regions. As a University Department of Rural Health, SQRH works with its partners and local communities to engage, educate and support nursing, midwifery and allied health students toward enriching careers in rural health.

Sugarman Australia specialises in the recruitment of nurses and midwives, doctors, allied health professionals and social care workers. We support clients across public and private hospitals, not-for-profit organisations, aged care facilities and within the community. Ph: (02) 9549 5700 www.sugarmanaustralia.com.au

SustainHealth Recruitment is an award-winning, Australian-owned and operated, specialist recruitment consultancy that connects the best health and wellbeing talent, with communities across Australia. It supports rural, regional and remote locations alongside metropolitan and CBD sites. Ph: (02) 8274 4677 Email: info@sustainhr.com.au www.sustainhr.com.au

The Nurses' Memorial Foundation of South Australia Limited. Originally the Royal British Nurses Association (SA Branch from 1901) promotes nurse practice, education and wellbeing of nurses in adversity. It provides awards in recognition of scholastic achievements, grants for nursing research, scholarships for advancing nursing practice and education, and financial assistance in times of illness and adversity. nursesmemorialfoundationofsouthaustralia.com

Tasmanian Health Service (DHHS) manages and delivers integrated services that maintain and improve the health and wellbeing of Tasmanians and the Tasmanian community as a whole.

The Torres and Cape Hospital and Health Service provides health care to a population of approximately 24,000 people and 66% of our clients identify as Aboriginal and/or Torres Strait Islander. We have 31 primary health care centres, two hospitals and two multi-purpose facilities including outreach services. We always strive for excellence in health care delivery.

WA Country Health Service – Kimberley Population Health Unit – working together for a healthier country WA.

Faced with the prospect of their family members being forced to move away from country to seek treatment for End Stage Renal Failure, Pintupi people formed the Western Desert Dialysis Appeal. In 2003 we were incorporated as **Purple House (WDNWPT)**. Our title means 'making all our families well'.

Your Fertility is a national public education program funded by the Australian Government Department of Health and the Victorian Government Department of Health and Human Services. We provide evidence-based information on fertility and preconception health for the general public and health professionals. Ph: (03 8601 5250) www.yourfertility.org.au

Your Nursing Agency (YNA) is a leading Australian owned and managed nursing agency providing high-quality health and aged care workers and support since 2009. Operating across regional, remote, and capital cities, YNA provides highly skilled registered nurses, enrolled nurses, specialist nurses, midwives, care workers and support to private clients, community and in-home programs, government agencies and hospitals. Including supplying all essential home care services to residents living with a disability. Email: recruitment.regional@yna.com.au Head to www.yna.comm.au for more information.

Support

Our direction in 2022

The first three months of 2022 have been very busy for the Mental Health & Wellbeing team. Our primary focus has been developing new infrastructure for the Bush Support Line and our other services. It is now time to take a breath, review our achievements, and look forward to what is on offer in the near future.

Mindful Mondays continue to receive very positive feedback, with a subscriber base of over 2,700 that continues to grow.

We consistently receive feedback that topics shared in Mindful Mondays are relevant and contemporary.

In addition, subscribers have often noted they've received articles with meaningful messages just at a critical moment:

"Can't tell you just how much I highly regard Mindful Mondays. It's like having a trusted, reliable, and very wise friend in my pocket that I can access PRN!! Thank you so much!"

If you are interested in joining the Mindful Monday movement, head to crana.org.au/mindfulmonday to subscribe. We are always happy to receive your feedback and suggestions for exploring topics. Scan the QR Code (left) to provide your suggestions or feedback.

At no other time in recent history has it been more important to take a moment to reflect on our wellbeing, plan to look after ourselves, and recognise, take action and adjust what is no longer working for us personally and professionally.

A few people shared with me at the start of 2022 that, after an opportunity to have a long break over December and January, they returned to work, reflecting on the balance in their lives.

They reassessed what was important during that time, committed to retaining that calm, and ensured they made changes to allow regular opportunities to recharge and reflect. But unfortunately, most front-line health workers did not have that luxury.

Those discussions clarified how exhausted and fatigued people were with or without realising it.

If you are struggling and need help to connect with what changes you might make or to recognise fatigue, or need support from someone familiar with the unique challenges of working in the rural and remote health sector, then call the Bush Support Line. It is free, confidential, and available 24 hours a day on 1800 805 391.

In the last six months of 2021, the Mental Health & Wellbeing team delivered 29 wellbeing workshops, tailoring them to the local audience and their needs.

Most popular was our short, 20–40 minute 'Wellbeing Reset', where front-line staff take whatever time they can afford to connect with methods of staying well, in mind and body, as a health worker. If you would like a tailored workshop at your facility, drop us a line at wellbeing@crana.org.au. These tailored workshops are offered free online or face to face, travel permitting.

"One of the best lectures was self-care by CRANAplus Mental Health and Wellbeing. It is one of the most important elements about working bush, and we don't talk about it enough. Thank you for including that."

Course Participant

The Mental Health & Wellbeing team has also been working on new workshop content and resources since the start of 2022.

The new online course, 'Critical Conversations', will soon be available, providing support for dealing with trauma in the workplace and expanding online content so you can listen or watch wherever you are. Stop by at our webpage for further details. ▸▸

Meet the Mental Health & Wellbeing Team

Cath Walker
Educator, Consultant Psychologist

Kristy Hill
Education and Resource Manager

Mary Jackson
Mental Health Educator

Nicole Jeffery-Dawes
Senior Psychologist

Stephanie Cooper
Bush Support Line Manager

Tracy Shepherd
Administrative Support

I would like to welcome students and the emerging rural and remote health workforce to CRANAplus Mental Health and Wellbeing Services. Whether you embark on a rural/remote placement, return home to the bush, start your career, or are an experienced health worker taking up a temporary or permanent role in a remote community, we have resources to support you. The Bush Support Line is available 24/7, and we have helpful information on how to be prepared for your adventure on the CRANAplus website.

The Mental Health and Wellbeing service continues to evolve, as does the changing landscape of our personal and professional environments. Thank you for your contribution, ongoing support, and connection to the people and communities you work for and with. We value your feedback on how we can better support you to stay well and look forward to hearing from you.

Pamela Edwards
Executive Director
Mental Health & Wellbeing Services
CRANAplus

Moral injury and the COVID-19 pandemic

Have the pressures of the COVID-19 pandemic forced you to do things at work that go against your moral principles? You may be experiencing moral injury and its symptoms of guilt, anger, and detachment.

As health care workers across Australia move into their third year of managing the COVID-19 pandemic, we have never been more grateful for their courage, resilience, sacrifices and persistence.

You are noticed and appreciated.

Despite their incredible strength and resilience, they are understandably exhausted from the relentless uncertainty, stress, trauma and grief. Many health workers have experienced numerous and continuous traumatic events which will, in many instances, negatively affect their psychological wellbeing.

In this ever-changing environment, many health care workers are facing situations that have the potential to be morally challenging, stressful and result in ongoing moral injury.

Moral injury has emerged in the health care discussion quite recently because of the difficulties and challenges health care workers and health care systems face in the context of the COVID-19 pandemic.

What is moral injury?

Moral injury is described as the 'psychological, social and spiritual impact of events involving betrayal or transgression of one's own deeply held moral beliefs and values occurring in high stakes situations'[1].

It was first described in the early 1990s, by US psychiatrist Dr Jonathan Shay when he began using the term "moral injury" to describe a particular kind of trauma he observed in the Vietnam veterans he was treating[2]. Moral injury occurred, he believed, when soldiers had been involved in events that contravened their deeply held moral convictions.

The literature describes two broad types of moral transgression events:

- Moral wrongdoings that involve people doing or failing to do things themselves
- Being exposed directly or indirectly to wrongdoings on the part of someone else (betrayal, or bearing witness to wrongdoings)[3].

Moral injury and COVID-19

Moral injury has been observed in health care workers who have faced situations that do not allow them to deliver care in the way they have been trained (that is, to help people and do no harm), such as when there are insufficient hospital beds, and insufficient equipment or access to equipment.

It has also been observed in health workers who have been forced to decide who receives life-saving treatment and who does not.

They may have had to prevent family members from being at the side of a dying relative or to follow clinical directions they felt were unethical. When health workers experience these situations, it can lead to moral injury.

What are the symptoms?

Phoenix Australia describes the symptoms of moral injury to include feeling:

- Guilt or shame that you can't do what you think is right
- Anger towards an organisation, which is then projected onto people close to you
- Lowered self-esteem and the feeling that you're not doing a good enough job
- Detachment from personal relationships or relationships with colleagues
- Questioning your career choice
- Not wanting to go to work[1].

On a positive note, it is important to recognise that while some people exposed to moral stressors may experience significant distress and injury, others may experience post-traumatic growth. With this growth, people can take new meaning from their experiences and live their lives in a different way. This may include an improved appreciation of life, improved relationships with others, and increased personal strength[4].

Strategies to prevent or reduce the impact of moral injury

Experts are advocating the need to prioritise a range of preventative and early intervention strategies to reduce risks and maximise protective factors for workers. As a result, Phoenix Australia has collaborated with the Canadian Centre for Excellence – PTSD to develop a *The Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury*[1].

This Guide provides organisations and individuals with an understanding of moral injury and outlines an approach to manage and mitigate the risk of moral injury amongst health care workers. It makes a range of practical recommendations including:

- At the organisational level, it recommends policies to guide difficult ethical decisions; monitoring levels of exposure to trauma and staff wellbeing; and establishing peer support programs to address moral injury and provide accessible mental health and wellbeing support for frontline workers.
- At the team level, it recommends promoting a strong sense of shared purpose and strong leadership; encouraging open, empathic leader-led team discussions, demonstrating positive coping skills, and encouraging peer and social support.
- And at the individual level, it suggests supporting workers to learn about moral stressors and moral injuries; promoting self-care both within and outside of work, and seeking professional support if needed[1].

Photo: dmytro_khlystun – stock.adobe.com

If you need to talk things through with someone, you can contact the Bush Support Line on 1800 805 391 anytime to have a confidential chat with one of our psychologists.

Thank you for all that you do.

Kristy Hill
Manager Education and Resources
Mental Health & Wellbeing Services
CRANAplus

References

1. Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre for Excellence – PTSD (2020). *Moral Stress Amongst Healthcare Workers During COVID-19: A Guide To Moral Injury.*
2. https://insightplus.mja.com.au/2021/28/moral-injury-in-clinicians-concerning-in-covid-19-war/
3. Litz, B.T. and P.K. Kerig, Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications. Journal of Traumatic Stress, 2019. 32(3): p. 341-349
4. https://www.apa.org/monitor/2016/11/growth-trauma

Refresh and reset

A collaboration between Stephanie Cooper, Bush Support Line Manager, and Dr Nicole Jeffery-Dawes, Senior Psychologist (who live on opposite sides of the country), this article revisits the core principles of mindfulness. Are you embodying them all, or could you be more mindful?

Our new look Mindful Monday email newsletters are in full swing and we're thrilled to have received positive feedback. You can check out our library of weekly articles and see the new design at crana.org.au/mindfulmonday.

Over the past 12 months, we have had numerous new subscribers (thank you!) and would like to refresh the basics of mindfulness for everyone.

Mindfulness, in a nutshell, is about choosing to accept the things you cannot change (such as miseries, ailments and failures) and committing to changing the things you can (following the 'right' chain of actions and changing for the better). It's also about being present enough to make those helpful choices.

For example, have you ever been driving somewhere, reached your destination, and had no memory of how you got there? Did you wonder if you even used your turn signals? When we experience something like this we are not being 'mindful'; we are running on autopilot, getting lost in our thoughts and forgetting that we need to be present in the now.

Research into mindfulness has found benefits including increased emotional regulation and focus, stress reduction, reduced rumination, improved memory, inter and intrapersonal benefits, more job satisfaction and less emotional exhaustion. Mindfulness not only subjectively reduces stress, depression and anxiety and increases overall health and wellbeing, but differences can even be observed in functional neuroimaging methods. It can literally change the way our brain functions.

The benefits of mindfulness can also be experienced at any time in life using age-appropriate strategies. For example, certain strategies are employed in schools to support learning and behaviour, whilst other strategies are used by workplaces to decrease stress and improve awareness.

Photo: Leah-Anne Thompson – stock.adobe.com

Photo: Deirdre – stock.adobe.com

The key principles of mindfulness are:

- **Non-Judging:** Notice how often you judge your experiences as good, bad, or neutral (not interested). In mindfulness, we try taking the stance of an impartial witness to our own experience. Rather than judging it, we take a step back, pay attention to it with a mindset of compassion and kindness, and notice how we relate to the experience. Don't think of a situation as 'good' or 'bad'; it just 'is'.
- **Patience:** This is about being patient with the process and patient with yourself. A butterfly will emerge from its chrysalis in its own time, and our understanding of things will also occur in its own time. However, learning to be patient takes time in itself and will only be achieved through repetition.

You may notice your mind wandering, to thoughts such as "what should I have to do next" or "what's for dinner". When you notice this, bring yourself back to the 'here and now' and remember that you are strengthening this new habit every time you do it.

- **Beginner's Mind:** Look at everything as though it is for the first time. Think about how children live in the 'here and now' and notice the little details of what we see as the ordinary. Take the perspective of a curious scientist who has never seen or experienced this before. Perhaps remember a time when you were studying and thought, "Wow! How cool is that!"
- **Trust:** Develop trust in yourself and your feelings. If something doesn't feel right, honour that feeling or intuition. We may make mistakes along the way, but it is better than constantly looking outside of ourselves for guidance. It's also about placing your trust in the practice of mindfulness, which has a large amount of scientific research to support its efficacy.
- **Non-Striving:** Think about how much time and energy we put into 'purpose' or the need to achieve a goal by competing and comparing. When we do this, we judge ourselves and our actions by other people's standards (also a judgement) and stop focusing on ourselves.

- **Acceptance:** This refers to allowing things to be as they are without wishing they were different or trying to change them. Some things just 'are', and we need to come to terms with accepting them. Often this acceptance is preceded by emotion-filled periods of denial and anger. Still, these periods are sometimes required to 'shift' us to a place of being more conscious of how we are responding. Some people find it helpful to say to themselves, "It's unpleasant, but I can accept it" or "I don't like this feeling, but I can make room for it". In the words of Wonfor, "When we are not resisting, we are not creating our own suffering".
- **Letting go:** Some thoughts are helpful; others are not so helpful. Our minds can 'hook' us into getting caught up in our thoughts about difficult events which can lead to unhelpful behaviours, such as ruminating on them. By letting go of unhelpful thoughts, we 'unhook' ourselves from these thoughts and their associated behaviours.
- **Gratitude:** On our journey through life, we are often on automatic pilot. We take the miracle of life for granted: that our hearts are beating, we continue to breathe, and our amazing body is functioning at this moment. Having an attitude that includes gratitude can increase objective measures of physical health and increase our sense of subjective wellbeing.
- **Generosity:** When we give attention and time to others, it expands our sense of connectedness. However, this gift needs to start with ourselves. Be generous when it comes to giving yourself gifts such as self-acceptance or time for self-care. Practise sitting with the feeling of being deserving enough to receive them and accept them without obligation.

In our Mindful Monday articles, we discuss using mindfulness principles in relation to different circumstances and give you practical examples and strategies to incorporate into everyday life.

If this sounds helpful to you and you enjoyed this article, we encourage you to subscribe to our weekly email updates at crana.org.au/mindfulmonday.

The principles above are not a set of instructions to follow but rather a way of 'being' and looking at life, experiences, and situations. It should not be forced and instead come from a place where you are paying attention and living in the present.

Are there areas highlighted above you can focus some time on to improve your mindful presence and connection with the world around you, starting today? When doing this, be kind and gentle and remind yourself that it takes time and practice just like anything else you learn.

Take care,

Dr Nicole Jeffery-Dawes
Senior Psychologist
CRANAplus

Stephanie Cooper
Manager, Bush Support Line (Psychologist)
CRANAplus

References

- American Psychological Association (2022). Accessed 31 January 2022 at https://www.apa.org/monitor/2012/07-08/ce-corner
- Davis, D.M., and Hayes, J.A. (2011). What are the benefits of Mindfulness? A Practice Review of Psychotherapy-Related Research. Psychotherapy, 48(2), p198-208
- Hulsheger et al, (2012). Benefits of Mindfulness at work: The Role of Mindfulness in Emotion Regulation, Emotional Exhaustion, and Job Satisfaction. Journal of Applied Psychology.
- Kabat-Zinn, J (2013). Full Catastrophe Living. Bantam.
- Keng, S-L., Smoski, M.J. & Robins, C.J. (2011). Effects of Mindfulness on Psychological Health: A Review of Empirical Studies. Clinical Psychology Review 31(6) p1041-1056

Educate

COVID-19 safety on CRANAplus courses

Deputy CEO and Executive Director of Education, Amelia Druhan, outlines CRANAplus' COVIDsafe protocols for course delivery. Designed to keep the workforce and vulnerable communities safe, these relate to venue choice, PPE, vaccination requirements, refunds, and more.

With 2022 well underway, so too is the busy schedule of course delivery for the CRANAplus Education team. We continue to adapt, flex and find new ways to meet the needs of our course participants and overcome the impediments imposed by COVID-19. Those of you who have been on one of our face-to-face courses recently will already be familiar with our COVIDsafe planning and protocols. With the emergence of more transmissible variants and the 'opening up' of the country, we have added further precautions.

A comprehensive COVIDsafe Plan is completed for each face-to-face course, inclusive of measures taken before, during and after courses to reduce the risk of exposure and transmission of the virus.

All state/territory public health requirements are met as a minimum, but in many instances are exceeded out of an abundance of caution.

Some features of our COVIDsafe Plan include:

- Venue bookings with providers that have their own COVIDsafe plan in place and can accommodate physical distancing protocols
- A requirement for evidence of up-to-date COVID-19 vaccination status for participants and teaching teams
- Mandatory exposure/risk screening and declaration upon entry to course
- Ample PPE provisions and protocols, including appropriate face masks provided daily by CRANAplus. Face shields are available where required or preferenced by those in attendance
- Regular sanitising and cleaning of equipment throughout the skills stations
- Maximising ventilation of rooms and offering catering and breaks outdoors (venue and weather permitting)
- A full refund policy to support participants needing to withdraw from course due to matters related to the pandemic.

All CRANAplus Course Coordinators travel with a supply of rapid antigen tests (RATs) available for use on course as required.

So as not to further disadvantage an already stretched workforce managing a high degree of unpredictability, we continue to offer full refund policy to support participants needing to withdraw from courses due to matters related to the pandemic.

We understand everyone's need for reassurance at this difficult stage of the pandemic.

If you would like further information about our COVIDsafe Plan and our protocols please don't hesitate to contact our team; everyone is well-placed to assist you.

I take this opportunity to thank all staff, volunteers and participants who help so willingly and capably to ensure we do everything we can to limit transmission of COVID-19 on courses.

This is a true expression of the values of CRANAplus and our mission to protect vulnerable populations and communities. ▸▸

While keeping our courses as safe as possible is a preoccupation for us right now, we are simultaneously moving forward with other important work. On the following page, you can read about our new Triage Emergency Care (TEC) course.

The innovative mode of delivery, including online modules, (expert-led) discussion sessions, practice opportunities and case studies was designed in partnership with the sector.

Registrations have been taken up quickly for the first release.

No doubt related to the pandemic going into a third year, we continue to see increasing demand for our Mental Health Emergencies (MHE) course.

This course has been adapted and is now offered both online and face-to-face; offering choice to participants who are finding it difficult to travel at this time.

Our comprehensive review and update of the flagship Maternity Emergency Care (MEC) course is progressing on schedule and is led by a vibrant and creative team. Maternity clinical excellence, consideration for the remote and isolated contexts and best-practice learning design are the central tenets driving the review, which you can learn more about on page 61.

In the next edition of this magazine we will share news of a new short course in development for Aboriginal and Torres Strait Islander Health Workers/Practitioners.

Walking with us in the development of this course is Executive Director of First Peoples' Strategies, Dallas McKeown. The new course will be called 'Mirii'; the documented Yuwaalaraay word for star. Stay tuned!

Wishing you, your family and your community safety and wellbeing.

Amelia Druhan
Deputy CEO and Executive Director of Education
CRANAplus

Improve your triage competency, online

Photo: manonvanos – stock.adobe.com

CRANAplus recently launched Triage Emergency Care Online, a scheduled online course that makes triage competency attainable to remote health professionals who are affected by COVID-19 restrictions or wanting to save on face-to-face course attendance.

Following the successful release of the Mental Health Emergencies (MHE) Online Course, CRANAplus has commenced its very first Triage Emergency Care (TEC) Online course this March.

TEC Online is a scheduled course held over a period of eight weeks across set dates. It features the same content as our traditional face-to-face triage courses but is delivered fully online.

"With COVID-19 affecting the delivery of some CRANAplus courses in 2021, particularly due to border restrictions, we gave some thought to what courses could potentially go to a purely online format," CRANAplus Remote Clinical Educator Nicole Smith explains.

"Delivering a course online counteracts some of the associated costs, such as travel and accommodation, and you can pretty much guarantee it will be delivered. The triage course definitely fits the brief for online delivery.

"We're not assessing clinical skills which are best delivered with face-to-face demonstrations and access to equipment.

"It's a knowledge-based course; it's about using your assessment skills to gather the information and assign your triage category, while also being mindful of communication, safety and what's going on around you.

"Within the course, we give you the links and the tools to then make your own decisions about whether you need to upskill [through something hands-on] or through other online courses. For example, there are references to the Remote Emergency Care (REC) course if you need to better understand how to do a primary survey."

The content is based on the Emergency Triage Education Kit as developed by the Australian Government, but like all CRANAplus courses, it is tailored to the rural and remote context.

"Basically, what we're giving you is an understanding of the Australasian Triage Scale and how to apply that to every person that presents to your clinic, whether it's regional, rural, remote or isolated."

"A lot of the scenarios are based in the rural and remote context. We refer to the facility as a clinic rather than an ED. We base scenarios on the fact you may not always be triaging in a clinic – you might triage out in community.

"We also incorporate some teachings from the REC, because, of course, remote and rural practitioners are not always just a triage nurse. After triage, they may then have to continue treating and managing the patient.

"If you've got clients coming in to visit the GP, because it's GP visiting day, or you've got pregnant women coming in to see the midwife because the midwife is visiting, but then you've got a sick patient who wanders into your clinic... This course is about helping that triage nurse, or nurse, to quickly distinguish who needs to be seen first."

The TEC Online course consists of five self-directed online learning modules, three online Zoom sessions, and an online discussion board for activities and reflection between Zoom sessions.

The Zoom sessions involve face-to-face questions, discussion about module content and group work on reflective activities/case scenarios centred on triaging and allocating a triage category.

Nicole says that group work "always helps with people being able to throw ideas around and to ask each other why they may do something as opposed to why they haven't."

Nicole acknowledges the vital contributions of the MEC and REC teams as well as the Mental Health teams in making this new learning opportunity a reality.

Having started with CRANAplus in 2021, Nicole brings a recent quality care background that has been influential in TEC Online's development.

"Part of my previous job was reviewing incidents and complaints, a lot of which were from and/or related to emergency departments."

"Many complaints related to how clients are treated, triaged, assessed and/or communicated with. That's certainly made me very conscious of the course content and how we have gone about putting this course together.

"It's essential the client gets timely access to care based on the triage assessment, and that they don't leave feeling like they weren't heard, listened to, assessed and most importantly, communicated with."

"If we always strive to do the best that we can with the knowledge, skills and resources that we have, we can only hope for the best outcome." ●

MEC course updates incoming

A recent survey of Maternity Emergency Care (MEC) course participants is guiding updates to CRANAplus' MEC Program. Using the feedback you provided, the Education Team are now busy updating the course, with a refreshed version set for release later this year, writes Michelle Price.

We are excited to announce we are undertaking a review of our flagship Maternity Emergency Care (MEC) program. As with any course in health care, the maternity emergency course (MEC) has undergone regular updates – five to be exact – since the initial course was designed in 2018 by Ree Dunn, Geri Malone, Sue Kildea and Sue Kruske.

Many innovative practitioners have been involved since then, producing and creating this program. Their work is greatly valued and the team plan to build upon the resources that they gathered over the years. It is imperative that CRANAplus continues to deliver up-to-date and current material.

Over time, feedback had indicated course participants wanted a change. To home in on how to best meet the needs of midwives and RANs, we sent a survey out to over 1,000 past participants and stakeholders. The results are in, and we are now aware of our audience's requests and needs. Thankfully, the background work that previous writers had done on the course created a fantastic foundation for the clinical experts to expand and update.

The team of subject matter experts (SME) consists of Leonie McLaughlin, Amy Shepard, Amanda Forti and Michelle Price as lead.

Student MEC, Adelaide.

They are currently nutting out the new layout and being guided by the CRANAplus learning and design manager, Julie Moran. Julie's ideas, framework and learning strategies are second to none, and with her design, our SME's content and a whole lot of passion and dedication, the course is expected to be more interactive and motivating than ever before.

This MEC (6th Edition) will feature the information and evidence-based education relevant to rural and remote nursing in Australia that CRANAplus is renowned for, but with an interactive and engaging format that will instill knowledge and create thought-provoking learning. Once the online modules are finalised, the work will start on the workshop restructure. This will ensure that the online modules and workshop complement each other beautifully to enhance hands-on learning, which is what the audience has demanded.

After the vigorous process of writing, designing and internal review is complete, the material will be reviewed by an external team. It is hoped that this will validate that what has been written is relevant and appropriate for the intended audience of rural and remote nurses and health care workers in Australia.

This will give the remote area nurses and other health care providers that attend these courses the absolute key skills they require to be able to provide care to pregnant women in rural and remote Australia, in conjunction with their maternity care providers. It is estimated that the modules will be complete by June 2022, with a trial course to be announced in the second half of 2022.

Michelle Price
Remote Clinical Educator
Midwifery Stream ●

Engage

Listening to your voice

The results of the 2021 CRANAplus Membership Survey are in. Find out why your colleagues stay remote, how COVID-19 has affected the workforce, and the advocacy priorities identified by our membership.

CRANAplus extends its appreciation to members who participated in our 2021 membership survey. Your continued feedback is essential to CRANAplus and informs development of our services, values, and areas of focus based on the issues of greatest importance to you.

Turn to the next page to see infographics of key survey data or read below for an in-depth overview.

Why members continue to work remote

One of the questions we asked was "What motivates you to continue working in remote or rural practice?" Your responses were varied, but the below answers express some of the most common themes:

"Love the challenges and autonomy remote has."

"Making a difference to the health of those living in a remote area."

"The country, the people, the lifestyle."

"Being a part of a small community."

"Being able to direct and be instrumental in the direction where the clinical care is going."

The ability to "learn new skills".

"The variation to work practices and the varied patients."

"The opportunity to be valued for the work I do."

"Knowing that the bush is on my doorstep."

"Being on Country."

"The challenges, complicated clinical presentations."

How COVID-19 impacted members

You also shared how COVID-19 had impacted you as a health professional. Here's just a few ways COVID-19 impacted respondents:

- Increased workload and work hours.
- Increased mental exhaustion and anxiety, including about catching the virus, and compounded by the fact it has been harder to see family and friends.
- Resulted in staff shortages and other staffing and employment issues.
- Restricted movements due to quarantine and border restrictions.
- Changed the role of staff (e.g., telehealth, vaccinations). For some, this was a positive professional development opportunity; for others, an additional burden on extreme workload.
- Made it necessary to dispel misinformation, while increasing the risk of aggression.
- Increased focus on infection control practices.
- Made it harder to access education and conferences, while making COVID-19 related education necessary.

How can the sector do better?

It was humbling to find that our members experience CRANAplus living its values (97%), and that you align most closely with our values of Safety, Integrity, and Respect.

You also told us that it is important that you are recognised, supported, and your voice is amplified and heard.

2021 CRANAplus MEMBER SURVEY

CRANAplus — improving remote health

CRANAplus FEEDBACK

- **95%** would recommend CRANAplus membership to colleagues
- **95%** consider CRANAplus membership is value for money
- **90%** consider CRANAplus courses are contextualized for health delivery in rural and remote contexts
- **95%** feel CRANAplus is on the right track representing and supporting the workforce

EXPERIENCE

- **47%** have worked in remote setting for more than 10 years. 21% for between 10 and 20 years and 26% for more than 20 years.

COMMUNITIES

- **31%** of respondents work in communities between 1,000 and 10,000 people
- **23%** work in communities between 500 and 1,000 people
- **30%** work in communities with fewer than 500 people

MOTIVATIONS FOR WORKING IN REMOTE OR RURAL PRACTICE

- The diversity, challenges and autonomy of working remote
- Making a difference to the health of those living in a remote area
- Advanced practice opportunity
- Making a difference to health outcomes
- The ability to learn new skills

COVID-19 HAS

- Increased workload and fatigue
- Limited or prevented travel to and from communities
- Disrupted breaks, leave and replacement staff
- Increased isolation from family and supports
- Increased focus on infection control practices including extended mask wearing

MENTAL HEALTH & WELLBEING SERVICES

- **91%** of respondents would recommend the Bush Support Line to a colleague or family member
- **62%** of respondents are aware of the new CRANAplus Mental Health & Wellbeing resources

WORKPLACE CONDITIONS IMPORTANCE

(combined 'very' & 'extremely')

- Educational preparation and skill maintenance **(85%)**
- Internet/email access in the workplace **(84%)**
- Having a fit for purpose workplace that is maintained **(84%)**
- Fatigue management **(79%)**
- On call demands **(78%)**
- Clinical support and referral networks **(76%)**
- Professional recognition **(74%)**
- Day to day workload **(74%)**
- Accommodation **(73%)**
- Internet/email access in the accommodation **(69%)**
- Remuneration **(67%)**
- Access to quality affordable food **(65%)**
- Access and egress into community **(59%)**

SAFETY & SECURITY

Whilst there have been some improvements, members report...

- Poor accommodation/infrastructure
- Threats to personal safety
- Damage to property
- Lack of practical policies
- Increased community violence
- Inadequate security measures

BENEFITS OF BEING A MEMBER

- Education
- Access to the Bush Support Line
- Networking and support
- Informing membership of issues
- Advocacy

MOST VALUED OPPORTUNITIES

(combined 'very' & 'extremely')

- Free online training/resources **(99%)**
- CRANAplus website **(99%)**
- Discounts on courses/conferences **(97%)**
- Weekly CRANApulse newsletter **(95%)**
- Dedicated member alerts for time critical events **(95%)**
- Quarterly magazine **(86%)**
- Scholarships and grants **(86%)**
- Annual Conference **(83%)**
- CRANAplus awards **(77%)**
- LINKS Mentoring Program **(72%)**
- Mindful Monday message **(67%)**
- Facebook/social media **(54%)**

Respondents valued:

"Belonging to an organisation that understands our work environment"

"That an organisation bigger than me has a voice for remote nursing in our government."

"The sense that someone is fighting for us at a higher level."

"Understanding us as a unique group of professionals (and) care givers!"

Your participation in the survey has affirmed our understanding of how important our advocacy is to members.

It's invited us to double down on our determination to advocate at all levels of government for positive change.

You told us that, for the sector to truly thrive, we would need to see:

- Improved staff security, including safer accommodation and never alone policies.
- Greater First Peoples engagement and employment.
- Meaningful action towards social determinants of health, such as improved Indigenous housing.
- More staff, greater staff retention, and flexible work arrangements.
- Adequate funding, including for education access.
- An established remote area nursing pathway, possibly including financial incentives.
- Increased workplace support, skilled management, and improved fatigue management.

Rest assured, that's not everything you identified. We value every perspective that was shared by members and will be using all your responses to help determinate our actions in 2022 and beyond.

Thank you for having your say

In conjunction with initiatives such as our Nursing and Midwifery Roundtable, these results help us to understand what we are doing well and to identify emerging priorities.

Our education courses continue to operate with COVID-safe plans and protections in place, with innovative solutions to keep them as accessible as possible.

Staffing, retention, and the need for skilled management and leadership continue to be a significant conversation across national industry forums. Workforce challenges, exacerbated by the COVID-19 pandemic, have been tabled at national and jurisdictional forums and meetings.

CRANAplus continues to provide supports and resources addressing self-care, professional development, and career pathways.

Our Bush Support Line acknowledges that staffing and retention are significant factors impacting our rural and remote workforce and our team of psychologists support health professionals with contextualised strategies and resources.

In conclusion, thank you for your continued commitment to rural and remote health. It's fantastic to have you as part of the CRANAplus community.

We take this opportunity to encourage you to make the most of your full membership benefits and to really maximise the supports and resources available to you through CRANAplus.

Katherine Leary
Executive Director of Corporate Services
CRANAplus

Let's not fail our New to Remote

Short-lived attention to workplace safety for nurses and midwives in remote settings is nothing new. If Registered Nurse Kellie Kerin, the NT Indigenous representative on the CRANAplus Nursing and Midwifery Roundtable, has anything to do with it, State and Federal authorities, health services and nursing agencies will be forced to finally act.

"Even before the pandemic, safety issues were recognised as a most pressing and urgent priority facing remote health," says Kellie.

"Health workers face unacceptable workloads, chronic lack of resources and inadequate preparation for 'all things remote', including culture shock.

"Now, more than ever, agencies and health services are so desperate, they are sending out people who are, at times, totally outside their comfort zone.

"[That] can set staff up to fail, and so the staff don't hang around. High turnover is not good for the Health Service, communities; not good for the nurses who can't stay, not good for those who do stay, and not good for the agencies," says Kellie.

Kellie, a nurse for 26 years, has seen this pattern repeat itself. She came full circle over an eight-year period by moving from metro to regional to rural quite quickly, and then onto remote. In the same speedy fashion, she then reversed those steps to move to Brisbane to undertake further study.

Kellie and her big sister (Yapa) Djandi Ganambarr, a community leader and Elder in the Dartiwuy Clan from Galiwin'ku who adopted Kellie into her family in October 2020.

"I was young, enthusiastic and full of adventure, seeking that buzz [of] adrenaline when I started preparing to go remote in 1997," she says.

"The day before I left for my R&R experience, my Mum discovered the family she never knew of and I discovered my own Indigenous heritage.

"I hadn't been raised in the culture, and in those first five years working remote, I learned how misinformed, uneducated and naive I was. I wasn't aware just how much until I embraced my own identity."

Kellie went on to gain a Diploma in Health Science (Holistic Counselling) to improve her communication skills, worked through her own lived experience of PTSD, became a Facilitator in the Applied Suicide Intervention Skills Training (ASIST) and obtained a Certificate IV in Training and Assessment. She worked in mental health for eight years, in areas including suicide prevention, clinical supervision, patient safety and the prison system.

Kellie's current job with the Aboriginal Medical Service Alliance NT is in the role of clinical COVID-19 advisor, and it covers the Top End including the Big Rivers and East Arnhem regions.

"I put my hand up to invest time on the CRANAplus Roundtable because of my passion to share my knowledge on psycho-social aspects, emotional wellbeing and the trauma people are exposed to – whether it's vicarious or primary – when they go into remote locations," she says.

"My passion is to raise awareness, to highlight that going remote is going to be a life-changing decision," says Kellie. "There are going to be extreme highs and extreme lows.

"A lot of conversation around safety issues and the fact that remote health services are grossly under-resourced continually falls on deaf ears," says Kellie. "It's time it was made a priority.

"There is a high burnout rate, a high attrition rate, for many well-known factors, historical and on-going.

"The trouble is remote health tends to be reactive. There are so many complex and overlapping demands. But aiming to keep staff happy, healthy and content, that should be a priority."

The Roundtable in February explored reasons and possible actions to address safety issues, including direct advocacy in the political arena in the lead-up to expected elections this year.

An outdoor class run by Shepherdson College (a school on Galiwin'ku) with a focus on healthy eating options and cooking up local traditional foods.

"We need to prepare people better, be frank and upfront about what they will be dealing with," Kellie says. "It's about being aware of the skills that will be needed, and the day-to-day situations that arise.

"A lot of people don't realise... how comprehensive the primary health care model is in remote, the advanced clinical skills required, the extra qualifications and experience you need. You can have the best intensive care or emergency nurse, but when you're out there, you face less equipment, less resources, maybe two people to assist if you're lucky – not 10 people who respond at the push of a button on the ward wall."

The situation forces some people to leave because they feel unsupported, as does the living standards and substandard accommodation for which they may not have been prepared.

The solution requires preparedness for culture shock and Kellie wants to see a New to Remote program focus on resources and assistance for nurses and midwives, with 'new' applying regardless of age or experience elsewhere.

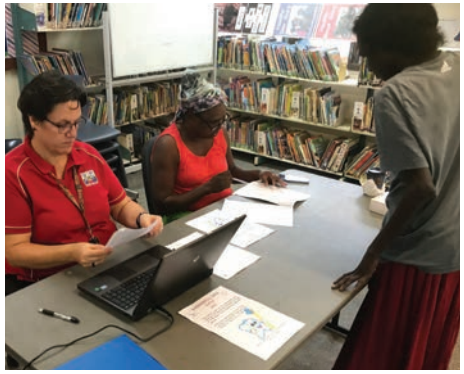
"Health workers go out there because they want to work in culture and with the mob and that's great, but they need to be given as much cultural information as possible," she says.

"When they put their feet on Country, they are in another world... Each community, each language group, and sub groups have their own culture. It's much more than the difference between tropical country in the North and the desert country in the Centre.

"They hit the ground running. If they're lucky, they might get the keys to their accommodation before they get thrown into a clinical situation.

"Every health service should have a location-specific cultural manual provided immediately to new staff, information that is constantly updated. There is not one size fits all."

Kellie suggests one of the best ways to prepare people for remote work is through storytelling and photos where appropriate, using real-life experiences to show "this is reality and this is what happens."



Top: Kellie and an AHP in the school library cross-checking new enrolments onto the clinical database. Above: Working for Miwatj Health Aboriginal Corporation.

She highlights that support needs to continue even after nurses and midwives return home.

"When nurses return home, the tendency is to share the wonderment, the uniqueness, the fresh stories full of adventure which are gripping to listen to," she says.

"People may not be fully aware they have been traumatised. They have integrated into the setting. It has become the norm. They forget basic boundaries and decide 'we just have to get on with it.' They might say, 'I would not normally do this, but I am on call, I better do it.' They make maladaptive decisions, psychologically sacrificing themselves, moving into the local groove.

"Often, the real trauma is pushed aside. It's still processing and the full impact is yet to come."

2022 CRANAplus Awards

Professional recognition of the excellent work of remote area health practitioners has never been as important to the CRANAplus community of members and stakeholders as it is now.

Now is the time to look around at your peers, colleagues and team members and consider nominating them for a 2022 CRANAplus Award.

This year's awards program features the Aurora Award for the Remote and Isolated Health Professional of the Year.

The Excellence in Remote Health Practice Award and the Collaborative Team Award are also returning for 2022.

We have also launched The Ray Wyeth Early to Remote Practice Award, in honour of the late Ray Wyeth (pictured right).

In 2012, Ray transitioned to remote area nursing, fulfilling a lifelong goal. In the years that followed, he emerged as an inspirational mentor to nurses considering their own remote transition.

This new award follows Ray's lead in encouraging and recognising an emerging remote health professional.

Those currently working in a remote area with less than three years' experience in remote area practice (at time of award closing) are eligible for nomination.

They must demonstrate:

- A high level of commitment to their development.
- An ability to work with individuals and communities through culturally appropriate partnerships.
- Strong commitment to the principles of comprehensive primary health care.
- Development of culturally safe capabilities and practices.
- Care consistent with the values of CRANAplus.

Award winners will be announced at our annual conference. They will feature in the CRANAplus magazine, website and an industry press release, be recognised in a special email to all our stakeholders, and receive a cash prize along with their trophy.

Applications are open on the CRANAplus website at crana.org.au/awardnominations. Any individual, group or community may nominate a person for an award between now and 30 June 2022.

Professional development grant

CRANAplus is also offering the Country Women's Association Rural and Remote Nursing and Midwifery Professional Development Grant this year. This grant provides funds to support those currently enrolled in a program of study or course to gain new skills and knowledge relevant to their practice and setting. Registered nurses, registered midwives and enrolled nurses can apply if they are currently living in a MMM 4-7 setting and working in a clinical role.

Visit crana.org.au/educationgrants for more information.

Connect

ED to PHC: Leonie's leap of faith

Leonie Higgs made a 'leap of faith' into remote health in late 2021 when she took a primary health care position in Cape York. We caught up with her in January to discuss her new sense of purpose, staying close with family, and her experience as a Māori nurse in remote Australia.

Leonie Higgs has spent the last five months working full-time for Aurukun Health Service, after making a radical change from a career in metropolitan hospitals and major trauma centres.

"I was at that stage of my career when I was thinking, I'm tired of emergency, I'm tired of trauma," Leonie says. "There has to be something else out there in nursing.

"It's not until you actually come out into the remote communities that you realise, yeah, I can make a difference... It quickly becomes clear how much nurses are needed and appreciated.

"I feel more valued out here than in the major hospitals. [There] you stabilise clients and move them onto their speciality, and that's the end of that. Whereas here it's more chronic. It's health literacy, education, and being here all the time.

"In the metro setting, all the junior doctors or NPs that are coming through do all the things like plastering, suturing, stapling, managing people with pain. Whereas here, you get the opportunity to learn all of these skills and our scope opens up."

During her two days off a week, Leonie occasionally heads to Aurukun Landing, listens to music ("Strictly RnB" including SIX60 and L.A.B.), and studies her masters in Gerontology, which she is set to complete by 2023.

When out and about, she's often in the company of camp dog Boo (pictured below left), with whom she's developed a mutual bond.

Above, left to right: Leonie and Joe Tuitupou (Security); Kristy Benjamin, Maxine Hafey, Jeanene Monahan and Leonie (back); Atima Bin-Juda, Leonie, Maddison Blake.

Leonie says that coming from a Māori background, her family is her life force, and so it's been hard to be apart. However, she's found ways to stay close.

"I talk to them every day, I Face Time them," she says. "My family is really, really good. They understand. I discussed it with my family [before leaving] and my husband said to me, 'If that's what you want to do, you go. If you find you enjoy it, I'll stay home with our youngest child and take care of the house'."

Maintaining these connections with family and developing new connections with her team has helped Leonie to manage the work and the on-call hours.

"You know that if anything goes pear-shaped while you're at work, they're there," Leonie says, speaking of her team. "They've got your back. These people were all strangers to me before I came here, but you learn to rely on your colleagues. You treasure their skills and what they have to offer."

The connections she has formed with community have also helped Leonie to feel at home: "[People in the community] get to know you and they ask for you specifically.

"It's like you get to be part of their families.

"I've got one lady here who wanted to adopt me. I said to her 'Thank you so much, I appreciate it, but I have a family'.

"She's got diabetes, and she knows I'm going on leave tomorrow, and she says to me, 'Girl, I'll come see you at the airport.' I said, 'Oh no, Auntie, don't come and see me off because I know it's difficult for you to get there and I'll be back in three weeks.' You build those relationships with the locals that you treasure."

Leonie has a Māori moko kauae, a traditional facial tattoo that represents who she is, where she is from, and the story of her people, the Ngāti Porou, who are custodians of the Gisborne region on the east coast of New Zealand's North Island.

Her heritage increases her awareness of the struggles faced by Australia's First Peoples, but she emphasises that no one can understand these better than Indigenous Australians themselves.

"My people have come such a long way with health literacy," she says. "We have doctors, we have Māori nurses. And you come to this big country called Australia and into these remote communities and see how some First Nations people are living in challenging conditions and having to travel long distances to access basic health services.

"You have to get Indigenous workers for Indigenous people. They understand, they know what they're going through, and they can relate.

"Even though I'm black, they class me as white because I've dropped into this community. Some of them have never seen a Māori person before. They're like, 'What you got that tattoo on your chin for?' When you sit down and explain it to them, they're like, 'Oh, that's beautiful.'

"We need to support our First Nations people to help improve health outcomes, so that elders can pass on their valuable knowledge and skills to the next generations to follow."

When CRANAplus spoke with Leonie in January, she had recently applied for her contract to be extended for six months.

While she isn't sure what the next five years hold, she says "One thing I know for sure is that I absolutely enjoy being a remote nurse and being a part of a team that really cares. It's liberating to feel that you're contributing to the community and making a difference.

"If I could have done this long ago, I would have. Hindsight's a beautiful thing.

"I think [metropolitan nurses] should just do it, if they have even the tiniest inkling to come remote. Otherwise, they don't know whether they'll like it or not. You miss out on so many things if you aren't open to new experiences. You've got to take the plunge."

You can take the first step towards a career in remote nursing by emailing TCHHS-NursingMidwifery-Recruitment@health.qld.gov.au

Improving safety in remote clinics

RN and research student Laura Wright discusses the findings of The Remote Area Safety Project, her mixed methods study involving a literature review, survey, interviews, and policy analysis. What are we doing well, how can we keep nurses safer, and is safety legislation fit for purpose?

What inspired you to investigate remote safety?

The murder of Gayle Woodford back in 2016 and the recommendations that were released from that via the CRANAplus Report, NT Health, and Gayle's Law. We wanted to know: what's actually been put in place years later?

What is one recommendation that clinics have followed quite well?

Many clinics now have never alone policies, even though it isn't widely legislated yet. It's a relatively new recommendation, so I thought that was pretty good. I think it strengthens the safety net provided by actions like checking up on each other and preventing patients from seeking help at RANs' houses.

What is a safety recommendation the sector is failing to follow?

One gap is around safe accommodation. One in four participants didn't even have working fire alarms or working locks on their accommodation.

This point relates to basic requirements required by law through the National Uniform Legislation for Work Health Safety... The WHS legislation requires that in remote or isolated areas where the employer provides the accommodation, they have to maintain it to a standard that doesn't place the worker at health and safety risks.

But even when [a safety requirement] was specifically legislated it wasn't necessarily in place.

Do you think some of these facilities were made before safety was a talking point, and now that safety is increasingly discussed, their inadequacies are becoming obvious?

That's what I've heard, especially for the clinic buildings. Quite a few RANs have commented that as the old buildings are being rebuilt or renovated, safety considerations are coming more into it.

But accommodation... A few RANs have said their employers are really on the ball with getting issues fixed, but many more spoke of a lack of response to maintenance requests.

Do the RANs you talked with feel safety education is good enough?

The access to orientation and training needs improvement, but those who did access the training found it helpful. One of my participants did a transition to remote program, and said it was really good within that program. Another participant didn't even get an orientation and was on call on their first night.

What states and territories are safest?

Some regions are better than others, but it really differed community by community as to how well [safety recommendations] had been implemented. Interestingly, how safe people felt didn't necessarily relate to how safe their clinic or accommodation was. The vibe of the community also had a big part of it, whether it was seen to be a peaceful community or not.

There were some health services where their policies looked good, but where staff said it's more of a 'she'll be right' approach. Whereas in other health services, the staff said [management] are completely onto it.

It was also about resourcing; putting their money where their mouth is.

Due to under-resourcing, is there sometimes a conflict in a nurse's mind between maintaining safety and getting the job done? Does that put nurses in an awkward spot?

Definitely. For example, there were the downsides of trying to run around finding your second responder, if they're not picking up the phone and you've got a sick patient you've got to see.

The positive was that when the second responder was provided, when the proper resourcing was there, people were enabled to provide really good care.

How did the nurses you talked with feel about a never alone policy being implemented nationally?

Most feel that the basic recommendations, like never alone [policies], should be across the board, but that there needed to be some variability based on individual clinics and communities. Most seemed amenable to the idea there could be a basic set of expectations. For example, everyone should be able to expect to not go on call outs alone, a safe clinic and accommodation, and safe communications equipment. Most of which is already in legislation anyway.

How can the existing legislation become more effective at improving safety?

It would be reasonable to have a set of safety standards that clinics or health services can be held to and assessed against.

Clinics that were doing well at meeting the safety needs of their staff would be able to attract more staff because they'd have a good safety score. Then RANs would be able to make an informed decision when going to work in an unsafe community or clinic.

It would almost improve that pathway so we're not turning off new staff who are just starting remote and then end up accidentally in an unsafe clinic, going "I cannot deal with this".

More experienced staff felt better prepared to work in unsafe settings because they've built up the strategies to address that and stay safe. ▸▸

Devil's Marbles.

Mt Isa.

Would a 'safety score' exacerbate staffing shortages in some areas?

That's the problem, it probably would. I guess that could be a strong driver to improve though, because most of these are legislated anyway, so it's something that does need fixing... It's such a complex topic. These nuanced discussions are hard to get down into a short article!

You said before that some participants felt never alone policies needed to be flexible. Could you share an example of this?

Not all communities could obtain local drivers as second responders, so in some if they wanted a second person it had to be a nurse.

There was discussion about how to have another person there to improve safety, without creating more safety problems by increasing fatigue.

How important is the inclusion of local drivers as second responders?

You've got the safety from the local knowledge they provide.

They can also help nurses to show respect and cultural safety, for example by respecting the boundaries of a men's business area.

For ages RANs had been saying going out alone on callouts isn't great, but the response was "we can't afford to have more nurses" – until Gayle's murder, when there was a realisation that it doesn't necessarily have to be another nurse (unless it's a clinical emergency).

That's such a good idea – yet this answer never really came up until the crisis. It was a bit like, yes, we've finally found a solution. Which gives me hope that for all these other safety issues – which seem so huge – that there is an answer out there. We've just got to find it.

How can our readers access your research?

My thesis lays out the findings of all four stages of the project, and they'll also be published as academic journal articles. I'm sure CRANAplus will be happy to share the link with everyone, and I'll post them to my LinkedIn account as they become available: **https://www.linkedin.com/in/laura-wright-654277124**

Making a difference to the rural health workforce

After studying nursing and paramedicine with Charles Sturt University, Elyce worked as a nurse in Young, Bathurst and Broken Hill. She built her skills as a critical care nurse before heading back to Wagga Wagga to tackle her PhD and begin a new phase of her career as a lecturer at Charles Sturt.

It's a role that sees her empower the rural health workforce through education, mentorship and research. And it's a role that has enabled her to get a clear snapshot of the state of rural health in Australia.

"Most of us would be aware that the health outcomes of people in rural communities aren't as good as those of our metro counterparts. But we deserve the opportunity to have those positive outcomes!

"Without equitable access, the strength of our communities – whole towns and villages – are impacted. That's often because what happens in a small community affects everyone. It's not contained to just one person – there's the network effect.

"A lot of rural families, like mine, are farmers. They've had years of drought, bushfires and now a pandemic. That has had such an impact on mental health. People in these communities are saying that they need help. But they often have limited options to get that help.

"Though technology has enabled telehealth services to play an important role, country people often want to sit down and talk with people, face-to-face. Technological initiatives are one part of the solution. However, they're not the whole solution. Rural and remote communities should be able to choose. To have the option between telehealth and face-to-face services."

Elyce explains that there are some things that can be done immediately to ensure country people enjoy good health and wellbeing.

"Firstly, we need the health workforce to live and work in our rural communities. We must try and attract a range of health professionals to rural, regional and remote communities. Then we need to help them become part of those communities. Foster their connection with the community so they'll want to stay.

"Secondly, we need to give equal professional development opportunities to those health workers who already live in country areas. It's about supporting our current health workforce; particularly in research and education."

Charles Sturt's Master of Nursing (with specialisations) includes a new rural and remote nursing specialisation. Developed in consultation with industry, this specialisation is the only one of its kind in NSW, and one of only two in Australia. If you want to advance your career and extend the real and lasting difference you make in your community, consider the Master of Nursing at Charles Sturt University. Or ease back into study with Charles Sturt's new graduate certificates in nursing, complete your course part-time in just eight to 10 months, and receive credit when applying for the Master's. Choose from:

- Graduate Certificate in Nursing (Aged Care)
- Graduate Certificate in Nursing (Clinical Education)
- Graduate Certificate in Nursing (Leadership and Management)
- Graduate Certificate in Nursing (Rural and Remote Nursing).

For more information, visit study.csu.edu.au/master-nursing

New resources to improve QUM

Photo: Dragana Gordic – stock.adobe.com

NPS MedicineWise has just released three new resources to make it easier to follow a quality use of medicines (QUM) approach and reduce pressure on nurses moving between communities.

Not-for-profit NPS MedicineWise has developed three new resources to promote quality use of medicine (QUM) in the provision of medicines to residents of remote Aboriginal and Torres Strait Islander communities.

The resources are part of the S100 Remote Area Aboriginal Health Services (RAAHS) Program and were developed in consultation with a range of stakeholders. Their release coincides with the publication of this magazine.

What new resources are available?

NPS MedicineWise's new Online Resource Hub is designed to help health professionals, including nurses and Aboriginal health workers, to navigate state, territory, and local variations, by providing curated information and links to tools and resources related to:

- Policies, state legislation and scope of practice
- Medication management, including ordering transport and stock management
- Clinical tools and resources including health professional and consumer resources
- Templates/information focused on medicine supply and administration.

Eleanor McKean, Educational Visitor with NPS MedicineWise and former Thursday Island-based Pharmacist, knows how challenging it can be to find the correct information.

"There is a lot of information out there, but it's across so many different websites that unless you know what you're looking for exactly... and even then, it can sometimes be extremely difficult to find," she says. ▸▸

"Our curated hub is designed to be a one-stop-shop... [so] you don't have to do a Google search and go through 50 different things to see if it's what you wanted."

In collaboration with NT Health, NPS MedicineWise has also developed a Drug Room Audit, modelled on the NT Health PHC Drug Storage Room Audit, that could be utilised across all primary health care sites.

This resource provides a standardised approach for centres to ensure appropriate storage conditions and stock control, while promoting overall quality use of medicines.

"By having procedures in place such as an audit to check that, for example, your fridge temperature is being monitored correctly, that means that we might see less wastage," Eleanor says.

The final resource is a QUM checklist for handover documents to upskill new staff commencing work in RAAHS. It includes information on contact details for pharmacy services and the processes of medication transport, including in case of a cold chain breach.

"There's often a lot of staff movement," Eleanor says. "If there's [an onboarding checklist] that's there in the primary health centre (PHC) ready to go it can help reduce some of that transition when a new person comes through."

Managing transitions of care

With relevant information often being hard to locate, the risk as a health provider is that you do something that's not approved in your current site.

"That might get brought up as a complaint to a health service, and it could also cause delays in patients receiving appropriate medications," Eleanor says.

These delays can arise due to a lack of coordination between health services during transitions of care, which is an issue these resources are intended to remedy.

"Patients may come out of a hospital in a large centre, where maybe they were prescribed something that's not available to them in their local community," Eleanor says.

"They get back to the community and may not have access to that for an extended period; for example, if it has to come by a barge and it takes a week. There may also be seasonal issues with flooding and access.

"Also, non-PBS (Pharmaceutical Benefits Scheme) medicines aren't covered under the Section 100 Indigenous Supply Scheme, which is how most people get their medications in these remote communities.

"That means that if you are treating something with a medication that's not on the PBS it may require a payment... are patients able to pay? And, if they're getting it from a state-run primary health centre, who do they pay? Is there a facility to take payment?

"Some sites reduce this by having non-PBS items on their local formulary."

Reducing pressure on nurses

Long-term nurses often have the deepest understanding of local medication usage and supply.

However, unless they are nurse practitioners, they cannot supply unless a medication is written on a drug chart by a prescriber – a situation that can highlight grey areas around scope of practice.

"A lot of remote area health centres don't have doctors, so they have nurses and Aboriginal health professionals having to do jobs they're not traditionally trained for," Eleanor says. "Given the extended scope of practice in remote settings, [health professionals may be] doing prescribing and supply of medications, counselling on medications, acute care in a way that wouldn't necessarily occur in a larger centre. All these things are creating pressure.

"The sheer number of visiting practitioners who often don't understand local context can add pressure. That local knowledge is important to ensure the prescribers aren't prescribing medications that are difficult to get."

NPS MedicineWise's resources are designed to provide clarity; to give access to CARPA or PCCM depending on the site's preference, or to clarify what authorities are required to prescribe medications. This will hopefully reduce stress and improve health outcomes, by ensuring timely provision of the correct medicines in the correct dosages.

"[These resources may] also potentially lead to improved communication – if people follow the links to cultural competence courses we provide as part of the web hub" Eleanor said. "This may mean people who are receiving medications better understand what they're for, how to use them, how to dispose of them safety."

Images, left to right: Island health care underlines the challenges of stock management; Friday Island; Thursday Island scenery; A decorated tree on Thursday Island.

Navigating the medical labyrinth with confidence

"Nurses and AHPs are the backbone of most primary health centres," Eleanor concludes. "They're the ones on the ground, treating everything from birth through to death. Having all these resources means they have places to go when they're facing something unfamiliar – which they probably will."

To view and utilise these new resources, head to www.nps.org.au/RAAHS

FASD Myth Busting

CRANAplus catches up with Robyn Smith, the Helpline Manager for the National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD), to tackle four common Fetal Alcohol Spectrum Disorder myths.

Myth #1: "You shouldn't put a label on it"

"Sometimes paediatricians, doctors, GPs or others may say 'you don't want to put a label on that child', but I think it's detrimental not to seek support for that child as they're growing up," Robyn Smith says.

"I've spoken to a lot of adults who have FASD and they've had a huge amount of relief out of getting a diagnosis... They tell us that as a child growing up they felt like they were 'dumb' and 'stupid' and they gave this label to themselves. Therefore, it is so important for them to realise their brains think differently to other people, and they need support with tasks.

"As a matter of fact, individuals with FASD, some of them have a normal range IQ," Ms Smith adds.

Myth #2: That FASD is necessarily a visible disability

"Alcohol is the only substance that causes three particular facial features, called sentinel facial features" Ms Smith says. "The three features are small eyes (specifically, short palpebral fissure length), a smooth philtrum, and a very thin top upper lip.

Robyn, right, presenting on FASD.

"The facial features are only formed on four days of the pregnancy, which is day 17 to day 20. If there's no alcohol consumed in these four days, then there's no facial features, which means that less than 20 per cent of individuals with FASD have facial features. It is often referred to as an invisible disability for this reason."

Ms Smith says the confusion is partly caused by changes to diagnosis in 2016. The three or four different diagnoses that used to exist have now been simplified to FASD with three sentinel facial features and FASD with less than three sentinel facial features – but she stresses that despite the reduction, there is increased recognition of the disorder's diversity.

"The operative word is spectrum," she says, "because there's no two the same; because people living with FASD can be polar opposites, actually."

Myth #3: That limited drinking during pregnancy is safe

"We have had people say, 'my mother drank when she was pregnant with me and I'm fine'," Ms Smith says.

"That could be a debatable fact. You might be. But you never know what your full potential was. Maybe if your mother hadn't consumed a few of those alcoholic beverages... we don't know. There is no known safe limit for consumption.

"Not every alcohol-exposed pregnancy results in FASD. It is one out of 13 that results in FASD... Do you want that one to be your baby? Do you want to take that risk? It's like playing Russian Roulette.

"A recent study found that a woman had one alcoholic drink each night over her pregnancy and she had twins. When they were born, one twin had FASD, the other didn't. It's the epigenetics of the child and the susceptibility.

"This is why NOFASD supports the Australian National Health and Medical Research Council (NHMRC) guidelines which advise that no alcohol should be consumed during any stage of a pregnancy.

"This includes the time before a pregnancy is identified and until breast-feeding is discontinued."

Myth #4: That FASD is specific to certain groups of people

"It is not a low socio-economic issue or an Indigenous problem," Ms Smith says. "Alcohol is part of the Australian culture. It's nothing to come home from work and to have a glass of wine while you're cooking tea, and another glass after when you're eating. We use it to celebrate, to commiserate, to have a good time. It is so commonly used in every walk of life."

On the topic of whether it is more prevalent in rural or remote settings, Ms Smith says "It's very much a possibility, but there hasn't been any study on that."

She points out that only two studies have been done on prevalence in Australia, one in Banksia Hill Detention Centre, one in Fitzroy Crossing.

"There was a Senate Inquiry into FASD [in 2020]," she adds. "One of the outcomes of that is that hopefully we will have a mainstream prevalence study here, rather than a study of a special population group like young people in detention".

Even now, though, studies in comparable jurisdictions like Canada and alcohol consumption statistics in Australia suggest the national rate is high.

"There was a prevalence study done in Canada, in 2018, which found that four per cent of the population there had FASD," she says. "When you compare the statistics for that same year of how much alcohol was consumed, Australia's consumption was much higher.

"With those results, you can estimate that at least 2 to 5 per cent of the Australian population would be living with FASD. This means that there's more people affected by FASD than by autism, spina bifida, cerebral palsy, Down syndrome and SIDS combined."

For more information on FASD, free FASD resources, and FASD advocacy, head to crana.org.au/FASDmythbusting or nofasd.org.au. Alternatively, contact the NOFASD Australia Telephone Helpline on 1800 860 613 for more information on the best way to work with and support individuals living with FASD.

Stroke retrieval changes ahead

"For the first time in Australia's history, the Stroke Alliance aims to close the health care gap in providing stroke care across our vast continent," says Skye Coote (NP, CCRN, MN, NVRN-BC, ANVP-BC), the Alliance's Senior Project Manager for Clinical Education. "The work of the Alliance will result in more patients with stroke receiving life-saving treatments and accessing world class stroke care."

Flight nurses' ability to improve stroke outcomes for rural and remote patients will soon improve, thanks to the Australian Stroke Alliance's transformational prehospital retrieval program.

The Stroke Alliance aims to shrink a typically 3-tonne hospital-based CT scanner into a smaller device so an airborne emergency department can travel to the patient. The team is overseeing the design, build and integration of world-first, lightweight and portable brain scanners that will be placed into air ambulances, allowing faster diagnosis of stroke in any setting.

As well, a truly national telehealth network will connect nurses, paramedics and country doctors to city-based neurologists to speed up pre-hospital stroke diagnosis and treatment.

The $40 million, federally-funded Stroke Alliance, incorporating 37 national health and tech partners, is determined to reach the eight million people living in rural and remote Australia who, through the tyranny of distance, do not have access to fast stroke diagnosis.

Drivers of change

Treatments for acute ischaemic stroke and haemorrhagic stroke are completely different and accurate diagnosis relies on an urgent brain scan. Access to a scan directly influences a patient's time to treatment and their likely chance of survival.

Skye Coote at MSU in 2021.

Not only do rural and remote people have 20 per cent more strokes than those in urban settings, most have to travel more than 200km for help, doubling the likelihood of significant, lifelong disability. Only three per cent receive care in a specialist stroke unit compared to 77 per cent of people in metro settings.

The Alliance is also addressing the disproportionate impact of stroke on First Peoples. Although they make up three per cent of the population, they represent 16.5 per cent of Royal Flying Doctor air retrievals for stroke.

What happens next?

From 2023, the scanners and telehealth platform will be tested and validated in the clinical setting, providing an unprecedented level of support to first responders.

The Stroke Alliance is working in close partnership with the nation's ambulance authorities and the Royal Flying Doctor Service in preparation for a pilot study of the brain scanners. A comprehensive education program will precede the launch of the devices to ensure first responders are fully informed and that their unique requirements have been met.

The telehealth platform, known as Zeus, really is the backbone of the program. It has been designed by perfusion imaging specialist, Associate Professor Andrew Bivard and neurologist, Professor Mark Parsons.

The Zeus app is already being tested in the field and is performing exactly as anticipated on Melbourne's mobile stroke ambulance.

Early in 2022, it will be installed in selected road ambulances in NSW and Victoria. Paramedics who have seen and tested the Zeus app have been impressed and are keen to see it as a standard tool in the diagnosis of stroke.

How the technology works

Zeus allows essential clinical data to be shared with the receiving hospital, influencing treatment decisions and increasing the safe and timely delivery of medications. Sometimes, that will mean the stroke ambulance needs to go past the nearest hospital to reach a specialist stroke centre where an endovascular team is prepped, ready to remove a clot from a blocked blood vessel. According to Professor Parsons: "Getting the right patient to the right hospital as quickly as possible is critical".

Based on the urban mobile stroke ambulance model, researchers know Zeus and the use of a brain scanner in the vehicle may lead to earlier treatment by up to two hours. Of course, the impact in rural and remote settings is yet to be measured but it is anticipated that a brain scan at the site of the stroke will allow thrombolysis or other treatment decisions to be made within minutes.

The impact of treating even one hour earlier provides a stroke survivor with more than one extra year of disability-free life.

As a result, instead of only being able to provide supportive in-flight care, staff will administer targeted, specialised stroke treatments to their patients. They will be able to treat patients with thrombolysis, antihypertensives, anticoagulation reversal agents, identify those patients needing specialist stroke care and accurately and confidentially triage stroke care in the pre-hospital setting.

Customised features are accessed from a phone or web-browser with audio-visual assessment of a patient, phone camera and image sharing, region-specific patient assessment forms, pre-notification for clinicians, individual patient record export, administrator automatic reporting, and data collection for analysis.

The Alliance invites pre-hospital retrieval services to co-design the path ahead to ensure this ambitious initiative takes off in 2023.

At the end of the day, the team wants to reduce disability and deaths from stroke. Independent analysis has calculated that some 45,000 disability-adjusted life years (DALYs) will be saved over 30 years through the Australian Stroke Alliance's interventions.

This project is an initiative of the Australian Stroke Alliance, bringing together 37 organisations committed to improving urgent pre-hospital stroke care across the nation. To find out more or to contact us, visit www.austrokealliance.org.au

The Australian Stroke Alliance is an initiative of the Australian Government. ●


The RFDS in Tanami Downs.

MSU Paramedics.

Equal opportunities needed for all health students

Two thirds of nursing students never had the opportunity to complete a rural or remote placement, recent National Rural Health Student Network (NRHSN) research has shown. NRHSN Chair Jean-Baptiste Philibert MD IV WSU explores how our institutions can empower a greater number of students to go remote, for longer.

The Australian health care system exposes its students to various settings and locations to best prepare them for the diversity of their future practice. This includes crucial exposure to rural and remote practice. Unfortunately, despite the best efforts of all involved, the COVID-19 pandemic has and continues to disproportionately affect the more remote placements of health students due to a variety of factors such as protecting vulnerable communities and border closures. The Northern Territory had some of the most disrupted placements over that period, yet provides life-changing experiences, as I was lucky enough to experience in Tennant Creek in 2019 and Yuendumu in 2020.

These placements are crucial for the future workforce of the Territory and all remote locations in Australia. The literature has shown that the longer the placement, to a duration of up to three months in rural and remote Australia, the greater the likelihood the student will practice rurally.

Medical students, such as myself, are well supported to experience long term placements in rural and remote areas via funding provided to the Rural Clinical Schools (RCS) by the Rural Health Multidisciplinary Training (RHMT) program.

These opportunities are, however, sparser to students studying non-medical courses, yet these professions are crucial to the future of rural and remote Australia and constantly facing shortages. Disciplines such as Nursing, Pharmacy and Audiology only have placements in rural and remote settings of less than four weeks and none of the non-medical degrees have the opportunity for a long-term placement in rural and remote Australia (greater than six months). Furthermore, the literature demonstrates that often these students had to source and fund the placements themselves.

This is reflected in a 2021 survey from the NRHSN to its members on short-term rural placement opportunities. The NRHSN received over 500 responses, of which over 50% were by non-medical students. 87% of the survey respondents were interested in short-term placements in rural and remote settings. 33% of the survey respondents had not had any exposure to rural health through their degree, increasing to 53% for nursing students. Two-thirds of nursing students never had the opportunity to complete a rural and remote placement.

The 2022 NRHSN Executive Group.

Similar figures were seen in Allied Health students. Of the students who had been on a short-term placement program, 85% intended to work or train rurally, and the main factor in influencing them was their past placement in such settings.

These figures demonstrate that rural intent is not necessarily followed through in non-medical students due to the lack of opportunities provided to them. This was confirmed by the two main barriers identified by these students which were contacts to facilitate placements (31%) and financial barriers (22%).

These are essentially removed for medical students who take part in the extended placements in rural and remote Australia through their RCS.

The survey respondents saw an ideal placement being between two to five weeks in length and regarded accommodation and financial support as a key component of a successful placement. There is therefore significant scope to remove the existing barriers that Nursing, Midwifery and Allied Health students face for them experience all that rural and remote Australia has to offer.

The existing opportunities such as the CRANAplus undergraduate scholarship are fantastic support for these students but more can be done to remove the issues with sourcing placements, particularly in the uncertain times we live in.

Therefore, the NRHSN is advocating for the establishment of a multidisciplinary program with repeated longitudinal exposure for Nursing, Midwifery and Allied Health students to experience life in rural and remote Australia beyond the constraints of their degrees.

Why students applied or would apply for a program outside of their university:

"The greatest barrier as a first-generation working-class student was financial, as not only are students supporting themselves in the rural community, but they are sacrificing time at work while away. The ideal program would support students financially."

"I applied as I craved rural experience, due to COVID-19 preventing all pre-planned rural activities through my university... [I] wanted an individual experience that would enable me to replicate the environment in which I could work in the future... separate from the safety of my university friends, where it was just myself, the mentor and the community."

"To get experience rurally, as I haven't been offered rural experience through my rural clinical school despite multiple applications."

"As I live in an outer metropolitan suburb of Adelaide it was the only way to get an experience of more remote health."

The National Rural Health Student Network (NRHSN) is the peak representative body for medical, nursing and allied health students who are passionate about pursuing careers in rural health. With over 11,000 members from 29 Rural Health Clubs (RHCs) across the country, the NRHSN is one of Australia's largest student organisations in the health sector. The NRHSN is an initiative of the Australian Government Department of Health, administered by the Consortium of Rural Workforce Agencies (RWAs). The NSW Rural Doctors Network is the RWA managing the NRHSN on behalf of the consortium. ●

Sexual health in later life

Pauline Cassar RN/ RM Clinical Workforce Educator, SHINE SA, **invites us to start conversations about sexual health that could change lives.**

As we move into the later decades of our lives, it is common for people to have sex less frequently, however studies have found that stopping having sex altogether is more often due to the lack of an available partner or health issue rather than due to aging itself (Bourchier et al, 2020). This challenges the stereotype that as we age, we at some point become asexual.

Studies in both Australia and overseas have shown that older people commonly continue to be sexually active in their later decades, viewing sex and intimacy as an important part of their lives and contributing to their overall wellbeing (Bourchier et al 2020). The World Health Organization views sexuality as 'a central aspect of being human throughout life' and is regarded as an essential component of wellbeing, happiness and quality of life (WHO 2002).

A healthy sexual life is important across all adult age groups and is an important aspect of active ageing.

So how is this relevant to me as a health professional I hear you ask? You may be aware that rates of common STIs are on the rise, but did you know rates of STIs in people over 40 are increasing at a faster rate than in younger people? Take chlamydia for example, by far the most commonly reported STI in Australia. Between 2009 and 2018, the rates of infection in people over 40 has almost tripled (Kirby Institute, 2020) The highest rates are in the 20–24 year old age group which comes as no surprise and STI prevention and education programs are rightly targeted at young people. However, there is an emerging group of older people who are at risk of STIs which health promotion messages may not be reaching.

There are many factors at play which may explain this trend. Sexual health knowledge varies among older Australians, but it is generally lower than among younger people. They may have had little if any sexual health education in their youth and the knowledge they do have may be out of date. (Bourchier et al, 2021). Older people who are divorced or widowed and are re-entering the dating scene may not perceive themselves as being at risk of STIs and condom use in older adults is lower than in younger people. In a survey conducted by Family Planning NSW in 2014, 80% of heterosexual men over 60 using online dating reported not always using a condom (FPNSW, 2018). Equally concerning, older women were less likely to insist on condom use particularly after menopause when the risk of pregnancy is no longer a concern (Bourchier et al, 2020).

Fortunately, STI testing in older adults has increased in recent years, however, there are still several barriers preventing many older people having conversations with their GP or health provider around sexual health. They may feel embarrassed to bring the subject up or fear they won't be taken seriously. They may be unaware of the signs and symptoms of STIs or that many sexual issues such as erectile dysfunction can be treated. Another example is vaginal dryness which is a very common experience after menopause. Many people may not be aware that there are simple treatments that can help such as the use of vaginal oestrogen creams. Unless the conversation is started, people may experience sexual problems for many years, unaware that help is available.

Some of the barriers cited by GPs are a lack of time, fear of causing offense, respect for privacy, or simply assuming sexual health isn't relevant or important to their older patients, assuming that they are 'passed all that' (Bourchier, 2021). Unfortunately, the result can be that each party is waiting for the other to make the first move. The health professional leaves the ball in the client's court and the older person waits to be asked resulting in missed opportunities for STI screening and sexual health information (Bourchier et al 2021).

With the rates of STIs on the rise among older Australians, its time to talk to our older clients about their sexual health. By asking in a sensitive, respectful way and normalising sexual health at all stages of adulthood, perhaps we can be the ones to make the first move and get the conservation started.

References

Bourchier, L. Malta, S. Temple-Smith, M. Hocking, J. (2020). Do we need to worry about sexually transmissible infections (STIs) in older women in Australia? An investigation of STI trends between 2000 and 2018, *Sexual Health 17(6)* 517-524 https://doi.org/10.1071/SH20130

Bourchier, L. Temple-Smith, M. Malta, S. Hocking, J. (2021) *Yes, Older people are having sex and we need to talk about it.* Retrieved from: https://pursuit.unimelb.edu.au/articles/yes-older-people-are-having-sex-we-need-to-talk-about-it

Family Planning NSW. (2018). *Older men who use online dating at risk of STIs.* Retrieved from: https://www.fpnsw.org.au/media-news/media-releases/older-men-who-use-online-dating-risk-stis

Kirby Institute (2020) *National update on HIV, viral hepatitis and sexually transmissible infections in Australia 2009-2018*. Retrieved from: https://kirby.unsw.edu.au/sites/default/files/kirby/report/National-update-on-HIV-viral-hepatitis-and-STIs-2009-2018.pdf#page=16

World Health Organisation (2002) *Defining sexual health Report of a technical consultation on sexual health.* Retrieved from: https://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

SHINE SA

CRANA plus
improving remote health

Passion
Purpose
Influence
Impact

39th CRANAplus Conference

SAVE THE DATE

4-6 October 2022
Adelaide

www.cranaconference.com