AUSTRALIAN NURSE TEACHERS SOCIETY

E-BULLETIN

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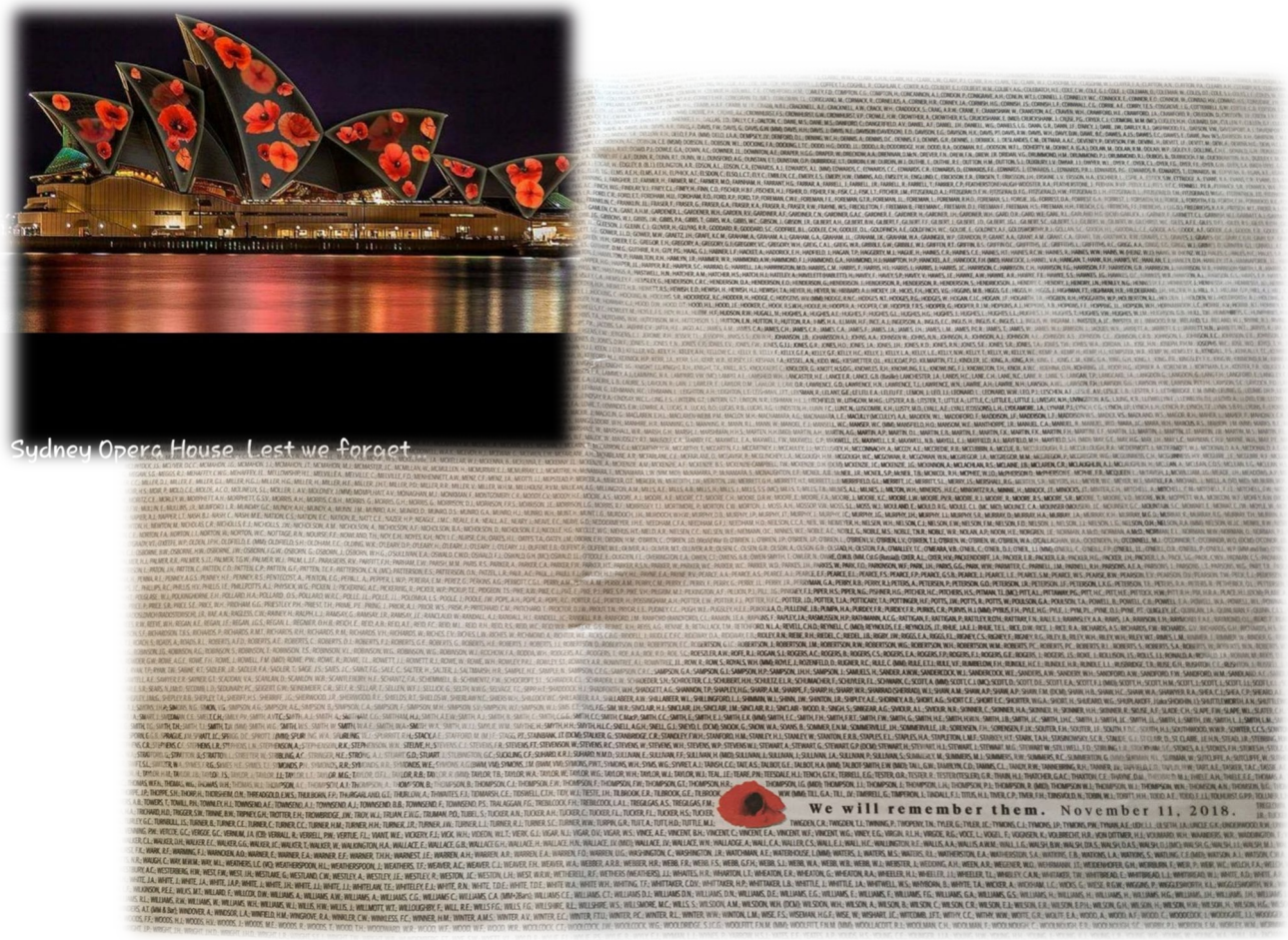

COVER DESIGN: Centenary of Armistice Day 1918 - 2018

Sydney Opera House (Facebook) and Names of the fallen from SA (Front page Sunday Mail/Advertiser 11/11/2019)

ANTS W

WORKING TOGETHER FOR THE FUTURE OF NURSING, MIDWIFERY AND HEALTHCARE

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INSIDE THIS ISSUE

FROM THE EDITOR'S DESK

Welcome to the Summer Edition for 2018

Can you believe this is the final e-Bulletin for 2018?

MEMBER (and non-member) SUBMSISSIONS are encouraged and welcomed at any-time

Email Karen.simunov@sa.gov.au OR newsletter@iinet.net.au

I have recently been fortunate to be invited to Brisbane and Gold Coast with a PCO Group to review venues for conferences, meetings and other activities. Included in the visits were smaller places of interest for partner programs, family activities, accommodation, catering and the like. A very big THNAKYOU to the Brisbane Marketing and Destination Gold Coast for their hospitality and invitation. From the ANTS Perspective this gave an insight into options and planning for NNEC 2020.

The theme for this e-Bulletin is Remembrance Day

Karen Simunov
E-BULLETIN EDITOR

Reference: https://www.awm.gov.au/commemoration/armistice

In Flanders Fields

In Flanders fields the poppies blow
Between the crosses, row on row,
That mark our place: and in the sky
The larks, still bravely singing, fly
Scarce heard amid the guns below.

We are the Dead. Short days ago
We lived, felt dawn, saw sunset glow,
Loved and were loved, and now we lie
In Flanders fields.

Take up our quarrel with the foe:
To you from failing hands we throw
The torch; be yours to hold it high.
If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders fields.

The poem was written by a Canadian Medical Corps doctor, Major John McCrae, who was serving with a Field Artillery Brigade in Ypres.

The death of one of his friends in May 1915, buried in the cemetery outside his dressing station, affected him severely and he wrote his poem as a way of expressing his anguish at the loss.

He was dissatisfied with the poem when he finished it and threw it away, but one of his fellow officers retrieved it and was so moved that he sent it to the media in London, where it was published by Punch on 8 December 1915.

Its simple but evocative encapsulation of the horror of the trenches has made it the most famous of the war poems.

Reference: https://www.army.gov.au/our-history/traditions/in-flanders-fields

ANTS PRESIDENT'S REPORT

DECEMBER 2018

Hello members Wow... that went went fast … it seems like only a few days ago I was writing the first president report for 2018, now I'm writing one for the final bulletin of 2018. Time certainly has moved this year.

ANTS has had a solid year this year with a slight increase in memberships, welcome back past members, some may have re-joined for reduced conference rates, or reduced ACN rates or simply for the networking opportunities. What ever your reason, it's great to have you back, stay on board for some ANTS announcements over the next few months. Unfortunately I needed to close-off our Facebook page due to ongoing security issues. Hopefully I will be able to revive our Facebook presence in the near future

2018 saw NNEC held in May, Melbourne. I would like to thank all who attended, and to those who took the time to submit an abstract and present an oral or poster - without your presentations and sharing your work our bi-annual conference would not be as good. NNEC 2018 was fortunate enough to attract some fantastic exhibitors, many of whom provided feedback that for them the attendees were engaging and they enjoyed being part of conference - hope fully we can convince them to return in 2020

This year again we have maintained bronze affiliation with the ACN, through this affiliation, members can access a discounted ACN membership with the benefits that all ACN members can access. The affiliation has provided other benefits for members. One member received a free registration to the 2018 conference and another a years' free membership. Thank you to members who participated in the competitions ran during the year.

Ausmed conference and publishing company have again supported us this year, through being willing to allow us to have some advertising at a number of their conference days. Thanks to the Ausmed crew - your support is much valued to our organisation

2019 - what are we doing ... *Victoria* - you now have a National Exec rep - thanks Zoe it's great to have you on the team Zoe is planning a couple of education and meet and greet events in Melbourne. Keep your eyes open for emails , notices etc. Members events haven't been very regular in the last few years, hopefully Zoe can set the pace for us all again. *SA* - the Exec team based in SA are also planning a couple of events, meet-n-greet , networking and education. Watch for upcoming information. *Other States* - if there is any members out there willing to host/run short events let us know we can help you set them up.

Planning for 2020 NNEC … yes it's not that far away. Please note we are moving the conference from May to November - dates will be published early in the new year. In 2020 we will head to Queensland, and the lucky city that gets to host us will also be announced soon. For 2020 we planning to do something a little different, change it up and hopefully pack the event ! But more of that later...

Thank you all for your ongoing support in 2018and don't forget to come back in 2019.
Have a safe and happy holiday season take care of yourselves and your families

Michelle, ANTS President

ARMISTICE DAY 1918 – 2018

References: https://www.awm.gov.au/

One hundred years ago on 11 November 1918, four bloody years of brutal conflict came to an end. Almost 62,000 Australians died fighting for our freedom and in service of our nation

Australian War Memorial, Canberra displayed 62,000 hand-crafted poppies as the centrepiece of commemorations, symbolically representing Australian lives lost in the First World War.

1918: After several months of fighting on the Western Front, the Allies finally broke through the Hindenburg Line and the German army was beaten.

The Armistice came into effect at **11am on 11 November 1918.**

The guns fell silent on the Western Front and after more than four years of unimaginable bloodshed and destruction, the war was finally over. .

1919: Armistice paved the way for the signing of a formal peace treaty, 'Treaty of Versailles', and the end of the war six months later. On 28 June, the treaty was signed with Australian Prime Minister William Morris (Billy) Hughes and Deputy Prime Minister Joseph Cook adding their signatures on Australia's behalf.

After the Second World War, Armistice Day became Remembrance Day, a time to commemorate war dead from all conflicts

Australian Nurses in WW1: More than 3000 Australian Nurses were deployed overseas in WW1 with their service, bravery and dedication remembered and not forgotten.

Among these was Staff Nurse Rachael Pratt (1874–1954), Australian Imperial Force, Australian Army Medical Corps, Third Australian General Hospital aged 41 years. Posted aboard the RMS Moolton, Greek island of Lemnos, Egypt and France.

It was in July 1917 at a casualty clearing station in Ball Bailleul, France, a bomb exploded nearby. Shrapnel injured her back, shoulders and punctured her lung. She continued to care for her patients after the attack ended right up until she collapsed. Later being evacuated to Britain for treatment and convalescence, the posted to various Australian auxiliary hospitals before returning to Australia at the end of the war.

Awarded the Military Medal for "bravery under fire" … first and only Australian nurse to be wounded and one of eight only eight Australian nurses to receive it during the First World War.

Available on the Australian War Memorial's website at http://www.awm.gov.au/education/resources/nurses

Australian War Memorial Honour Roll: A series of bronze panels record the names of 102,000+ members of the Australian armed forces who have died during or as a result of warlike service, non-warlike service and certain peacetime operations.

In the Commemorative Area is the leatherbound Commemorative Roll, which commemorates Australians who died during or as a result of their service in same conflicts or operations in service of Allied nations, the Merchant Navy, and with civilian organisations.

Red Poppies: The Flanders poppy marks the Armistice of 11 November 1918, and also used in Anzac Day observances. The red poppies were amongst the first plants to appear on the battlefields of northern France and Belgium. In soldiers' folklore, the vivid red came from their comrades' blood soaking the ground.

The sight of the battlefield poppies inspired Lieutenant Colonel John McCrae to write 'In Flanders Fields'. Moina Michael (American YMCA) read this poem and decided to wear a red poppy always as a way of keeping faith. At the November 1918, YMCA international secretary meeting she inspired Anna Guerin (French YMCA) who extended the idea by selling poppies to raise money for widows, orphans, and needy veterans and their families.

The poppy became widely accepted as the flower of remembrance. The Australian Returned Soldiers and Sailors Imperial League (forerunner to the RSL) first sold poppies for Armistice Day, 1921. Importing one million silk poppies, made in French orphanages. The proceeds divided between a charity for French children, League's own welfare work, and League's national coffers.

Also becoming popular Anzac Day wreaths. At the 1940 Dawn Service in Palestine, each soldier dropped a poppy as they filed past the Stone of Remembrance. In 1993, this practice began at the Internment of the Unknown Soldier. As people queued beside the Roll of Honour to lay a single flower by his tomb, they pushed RSL poppies into the panel cracks panels bearing the names of the fallen. This practice continues today.


The Canberra Times

ENTOMBMENT OF THE UNKNOWN SOLDIER

Homecoming of a hero

'In their sacrifice, there is faith enough for all'

The Tomb of the Unknown Soldier: The original unknown soldier was entombed in Westminster Abbey, London 11 November 1920. His body intended to represent all the young men killed during the Great War. On the same date, an unknown French soldier was buried under the Arc de Triomphe. Several other allied nations soon entombed unknown soldiers of their own.

In 1993 the last unknown Australian soldier was brought home to mark the 75th anniversary of the end of the First World War, recovered from Adelaide Cemetery near Villers-Bretonneux, France and transported to Australia. Interred in the Hall of Memory at the Memorial on 11 November 1993. Buried with a bayonet and sprig of wattle in a Tasmanian blackwood coffin, and soil from the Pozières battlefield scattered in his tomb.

The Unknown Australian Soldier represents all Australians who have been killed in war.

COMING SOON ... NNEC 2020

THEME |	INSPIRE, MOTIVATE AND EDUCATE
VENUE |	TO BE ANNOUNCED IN EARLY 2019
DATE |	NOVEMBER
WHERE |	QUEENSLAND
SUBMISSIONS |	FOR FREE PAPERS, POSTERS , SHORT PAPERS AND MINI POSTERS AND SOME WORKSHOP SESSIONS CALLED FOR LATE 2019
REGISTRATIONS |	WITH MORE PACKAGE OPTIONS THAN EVER BEFORE WILL OPEN IN APPROX MARCH 2020

STAY TUNED FOR MORE INFORMATION .....

REPORTS

Wounds Australia Conference | Advancing Healing Horizons: Towards the Cutting Edge in Wound Care | October 24-26 2018

An opportunity to network and catch-up on contemporary wound management practices after being out on secondment for the past (2) years and held in my home-town of Adelaide.

Held over (3) days with workshops (optional) and breakfast sessions (optional) there was something for everyone. Attending with my colleagues we planned and nominated for which sessions to attend for what we have a responsibility to teach and this worked well.

I applied to be a judge from an EOI and was accepted as one of three for the new "Speed Talk" sessions … thank goodness I had reviewed and memorised the marking criteria as when the session was about to start I realised I had lost my reading glasses and had to write in my notebook and transcribe post session (LOL).

Overall an excellent conference and look forward to the next one to be held in November 2020, Brisbane, Queensland … my aim is to attend both the Wound and NNEC Conferences (both planned for about same time in Queensland) with a holiday in the Sunshine state.

Karen Simunov, ANTS Member, SA

CoNNMo Meeting - October

ANTs has continued to participate in the CoNNMO meetings - the most recent held in Sydney in October 2018. As ANTS rep I was fortunate enough to be re-elected to the CoNNMO council for a further 2-year term.

Being a rep. on this council and working other professional nursing bodies is certainly an amazing networking opportunity as well as a great way to keep promoting ANTS as an organisation, who we are and what we do.

If you don't visit the CoNNMO website, (http://connmo.org.au/index.php/meetings)make it a part of your own personal professional development activity.The website provides updates of relevant issues to nursing practice, legal and social through out the year, as well as access to CoNNMO meeting minutes and a links to other relevant health websites and information both federal and state.

As a council member we meet 6 times per year, 2 x face to face for planning purposes, venue is determined by the number of state reps on council at the time, where the highest population is from is the state the meeting is held in. 4x teleconferences to discuss relevant business and potential mail outs and releases of information to member organisation. Twice per year at the CONNMO member organisation meeting. My current term now has 18 months to go and I plan to continue to actively participate with my council colleagues.

Michelle Girdler, ANTS CoNNMO Representative

MEMBER AREA

MEET THE EXECUTIVE COMMITTEE

Dr. Christine TAYLOR, is a Senior Lecturer at the Parramatta campus of the School of Nursing and Midwifery, Westerns Sydney University. Christine is a Registered Nurse who is an experienced Clinician, Educator and Researcher.

The main areas of practice, education and research are Child and Family Health, Paediatrics and Neonates.

Christine has over 20 years' experience in tertiary education in a variety of undergraduate and post-graduate areas and holds a governance position within the School of Nursing and Midwifery.

Email Contact: ch.taylor@uws.edu.au

ANTS RESEARCH GRANT / SCHOLARSHIP

ANTS WEB LINK: https://www.ants.org.au/ants/mod/page/view.php?id=7

Research Grants:

Individual grants not to exceed $2000.00. Encouraging research with the primary focus on Nurse and/or Midwifery Education within all fields of nursing/midwifery educational practice a seeding grant to members (membership criteria).

Applications be considered as demand dictates.

Scholarships:

To a maximum of $1000 are available (membership criteria) to attend conferences/seminars.

Priority will be given to conferences with a strong nursing education focus.

Applications are available quarterly and close:

31st January	30th April
31st July	31st October

SCHOLARSHIP FINAL REPORT – BEV COPNELL

PAEDIATRIC NURSING CONTENT IN UNDERGRADUATE CURRICULA

LA TROBE UNIVERSITY, AUGUST 2018

Background

It is well recognised that children are a vulnerable group with specific risk factors influencing their health; they also have unique physical, psychosocial and developmental needs and nurses require specific knowledge and skill to meet these needs (1, 2). There is less consensus on the extent of this knowledge and skill and how they should be gained. In common with most developed countries, but unlike the United Kingdom, Australia has no separate registration for children's nursing, and while there are recommendations surrounding specialist paediatric qualifications for those who nurse children (3), these are not enshrined in legislation.

Children may be cared for in a variety of healthcare settings in addition to stand- alone acute care facilities. Recognising this, several Australian organisations have published position statements and standards for the care of children across all healthcare settings, which include the need for healthcare professionals to have appropriate education in the special and unique needs of children and their families, in health, illness, and disability (3-5). The Australian College of Children and Young People's Nurses (ACCYPN) considers that, for nurses, education is required at both undergraduate and postgraduate level (6). While competencies have been developed for the specialist (usually with postgraduate qualifications) paediatric nurse (7), ACCYPN contends that all nurses caring for children should meet a minimum standard. These standards include but are not limited to: the assessment of children's health, development and well-being, and recognising and acting upon deviations from the norm; understanding of common health issues affecting children and young people, with management and practice based on the best available evidence; and the provision of family centred care (5). It also stipulates that undergraduate programs should enable graduates to practise at this minimum standard, and that relevant clinical experience is an essential component of generalist education, as well as specialist (6). It is of note, however, that national accreditation standards for undergraduate courses do not stipulate any specific content (8), and that neither registered nurse competencies, nor the standards that have replaced them, make any mention of specific population groups (9, 10).

The ability of generalist programs to meet this standard has been contested. Commentators in the UK, where the debate has raged for more than a decade, argue that generalist programs cannot provide sufficient paediatric-specific content; that the curriculum is too broad and, hence, some important areas neglected; and that this will have a significant negative impact on recruitment and retention of nursing students (11-15).

There is little research to support or refute these concerns. Only three studies were found that directly investigated the paediatric-specific content in undergraduate curricula. Surveys in Ireland (16) and the US (17, 18) found great variation in the amount, type (integrated or discrete) and focus of this content. All colleges participating in the Irish study (16) reported that clinical placements in paediatrics were provided, but it was not clear whether this was compulsory for all students. Some courses in the US did not offer a clinical component other

than simulation, while the clinical hours that were undertaken varied considerably (17, 18). McCarthy et al. (18) identified competition for clinical sites, lack of quality clinical sites and inadequate numbers of preceptors as the main barriers in providing clinical experience. Difficulties in hiring suitably qualified and experienced academic staff were reported as a barrier to development and delivery of paediatric nursing content by almost 75% of their respondents (18). No further examination was made of the reasons for the identified variations, while the other two studies (16, 17) did not address this at all. No studies have examined the effect of this variation on student outcomes. However, Curry and Samawi (17) surveyed staff nurses and nurse managers in paediatric healthcare facilities and found that 36% believed new graduates were weakly prepared to work there; 58% believed students required better academic preparation and 89% that they needed more clinical preparation. No similar studies have been undertaken in Australia. Hence, the paediatric-specific content of Australian undergraduate programs, and whether graduates are adequately prepared to nurse children, are largely unknown.

Aims

The aim of this study was to examine how, and to what extent, curricula of Australian undergraduate nursing courses prepare students to care for children.

The study addressed the following questions:

- What content specific to children, both theoretical and clinical, is included in the course curriculum and how is it delivered?
- What is the expected outcome of the course with respect to graduates' ability to nurse children?
- What factors contribute to the curriculum taking the form that it does?

Methodology

A descriptive exploratory approach was used in this study. All undergraduate (Bachelor) degree programs accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) as leading to initial registration as a nurse, were eligible for inclusion. Double degrees, graduate entry programs and RN to BN conversion programs were excluded.

Eligible programs were identified from the Nursing and Midwifery Board of Australia (NMBA) website. Basic information about the structure of each program was obtained from the institutions' websites. Heads of schools or departments through which the programs were offered were then contacted for permission for their program to be included in the study. They were asked to forward the information about the study to the course coordinator, or other academic staff members as they considered appropriate.

Data were collected by individual, semi-structured interview with the nominated staff members. An interview schedule was developed based on the research questions. Questions relating to program content focused specifically on the minimum standards developed by ACCYPN (5). All interviews were conducted by the same investigator. The majority of interviews were held by telephone, with one undertaken by videoconferencing and one face to face. Interviews were recorded and then transcribed. Quantitative and qualitative content analysis were used

to analyse the data. Curriculum details were quantified and presented in aggregate form, as frequencies and means/medians. Qualitative data were coded and categorised.

The study was approved by the Monash University Human Research Ethics Committee (Project ID 294) and (following the relocation of the Chief Investigator) by La Trobe University Human Ethics Committee (HEC17-087). Participation on the part of the departmental head and the course coordinator was voluntary; participants were informed that they could withdraw their consent at any point prior to data analysis. Participants provided written consent prior to interview. Information that could identify either institutions or individuals will not be made public. Electronic data are stored on a password protected computer. Data will be stored for seven years, after which time electronic files will be deleted and hard copies shredded.

Results

At the study commencement, eligible programs were offered by 34 institutions: 32 universities and two colleges of education. Examination of program structure, as published on the institutional websites, indicated that 12 of these (35.3%) included a compulsory subject relating to children, while 14 (41.2%) had no discrete subject. A further eight (23.5%) offered an elective subject relating to paediatric or child health nursing. Three institutions that had discrete, compulsory subjects offered an elective paediatric subject as well, either named as such or contained as a module in an umbrella subject. Three elective subjects combined maternal health and paediatrics. All subjects, compulsory and elective, had identical weights, as 0.25 of a semester's full time load, or 1/24 of a three-year program.

Of the 34 institutions, 19 (56%) participated in the study, representing four states. In terms of structure, they were representative of the national picture: eight (42.1%) had no discrete subject, seven (36.8%) had a compulsory discrete subject (including three with an additional elective) and four (21.1%) had only an elective subject. It should be noted that several institutions were in the process of either developing or rolling out a new curriculum; participants from these institutions generally discussed the version of the curriculum that was relevant to the topic or question, with issues relating to both old and new versions identified.

Amount and type of content

The amount of paediatric-specific content in the programs was difficult to quantify in terms of number of hours. Programs that did not have a discrete paediatric subject adopted a lifespan approach, with content relevant to children included (to a greater or lesser extent) in the majority of subjects. Most programs that did have a discrete subject also included child-specific content in other subjects. One program with a discrete theory subject also devoted 50% of a clinical (laboratory-based) subject to paediatrics, as well as adopting a lifespan approach across the curriculum. While there was certainly the potential for programs without a discrete subject to have less content than those that did, this did not always eventuate. For example, in one program the discrete subject included one week of paediatrics and one week of child and family health, with only a small amount of child-specific content in other subjects.

Participants were asked about specific topics that were included in the curriculum, using a checklist generated from the ACCYPN minimum standards (Table 4.1). Only paediatric

medication administration had substantial inclusion in all curricula. The depth to which the topic was taught was unclear. While child assessment and physical development were covered by all programs, in four this was to a limited extent. Five institutions did not include basic paediatric life support as part of the program, but in two of these students undertook a program from an external provider. Common childhood illnesses was the topic least likely to be substantially included in compulsory subjects, although it was included in elective subjects (Table 4.1). One participant suggested that it was preferable to focus on the key concepts of body system dysfunction and the differences between age groups, rather than teach students about specific illnesses:

> *'I think that we have to move into more of a concept delivery rather than a disease process, and I think some people still struggle with that. So until we can move towards that, then I think that we're still going to be caught up in teaching some diseases that are not necessarily relevant to be taught in the undergrad. They'll be exposed to them, and they can learn those when they're in their clinical placements, but what they need to know is how to problem solve, how to be safe, how to assess. So they need to be given the frameworks for management so that they can do the appropriate things. (Coordinator, University #3)*

TOPIC	INCLUSION		
	Substantial	*Some*	*Not or unsure*
Child assessment	15 (79%)	4 (21%)	0
Physical development (differences between child & adult)	15 (79%)	4 (21%)	0
Psychological development/communication	14 (74%)	2 (11%)	3 (16%)
Common childhood illnesses	12 (63%)	4 (21%)	3 (16%)
Paediatric medication administration	19 (100%)	0	0
Basic paediatric life support	13 (68%)	1 (5%)	5 (26%)
Family centred care	15 (79%)	3 (16%)	1 (5%)
Legal/ethical issues (eg child protection)	17 (89%)	0	2 (11%)

Table 4.1 Child-specific topics included in the core curriculum

The amount of clinical experience that students received varied considerably (Table 4.2). Only three institutions were able to source placements for all their students; all of these had a compulsory discrete paediatric subject. The majority offered places to less than 10% of students. All placements were in acute care paediatric settings. The commonest reason given for low numbers of places being sourced was competition with other universities. One coordinator suggested that more places could be sourced if the curriculum was more flexible in terms of timing and length of placements. The three institutions that were able to place all of their students appeared to have strong relationships with clinical facilitities (large paediatric hospitals). All three participants said it was not easy to find these placements, despite the relationships. In addition, students might encounter children in other placements, such as community health, mental health, general clinics and Emergency Department, but this was serendipitous rather than planned. Students in rural and regional areas were more likely than those in metropolitan areas to see children in other placements.

Non-acute care placements specifically aimed at exposing students to children were relatively rare and even harder to source. Some institutions were able to place small numbers of students in paediatric community/primary health areas, or were seeking to do so, or in

Maternal Child Health/well baby clinics. Other participants, however, reported they had had to abandon clinic placements in these areas as they were not meeting students' learning requirements. Two participants mentioned international exchange programs, where students were likely to be exposed to children. One participant described an innovative program in which students attended a camp for children with renal disease. Another reported that some students had a placement in special needs schools, and another was able to source a few places with school nurses, but these were the only examples of school-based placements. Several other participants indicated that they had explored the possibility of placements with school nurses but had either been unsuccessful in obtaining offers, or the programs were deemed unsuitable for students' learning needs.

STUDENT COHORT % UNDERTAKING CLINICAL PLACEMENT	NO. OF INSTITUTIONS (%)
<10	10 (53%)
13-15	2 (11%)
20-30	4 (21%)
100	3 (16%)

Table 4.2 Percentage of students receiving clinical placement in paediatrics

The amount of laboratory-based learning varied considerably. Of the eight programs with no paediatric subject, three included simulation directly focused on children. Four of the seven discrete compulsory paediatric subjects and three of the seven elective subjects included simulation. Three programs (two with an integrated curriculum and one with a discrete subject) involved actual children rather than mannequins in simulation sessions, although in one program these sessions were available only to a small number of students. Only one participant spoke of using simulation to compensate for a lack of clinical experience, although another (*Academic, University #15*) acknowledged the possibility: *"With so many students we can't offer [placements to all]. Simulation would really narrow that gap – one thing we're not doing well in paeds curriculum. Never going to have the placements but simulation in lab settings can really start to bridge that gap."* In most programs it appeared to be used as preparation for practice, with those in which students were guaranteed a paediatric placement containing the most laboratory-based education.

Perceptions of curriculum structure

All participants defended their own curriculum structure, explaining the rationale underpinning it. Advantages and disadvantages of both an integrated structure and discrete content were apparent.

Participants who taught in an integrated curriculum argued that this approach resulted in better student learning. This structure enabled scaffolding of content throughout the three-year program, and enhanced application of topics to the clinical context. However, this approach depended on the curriculum being implemented, which did not always occur. One participant suggested that the curriculum could be *"lost in translation" (Coordinator, University #14)* by the time it was actually being taught. This process was not always apparent to the program coordinator or other senior academics.

The main advantage of teaching child-focused content in a discrete subject was that it ensured the content was taught. It also enabled specific assessment of the content, which did not always occur when content was integrated. The disadvantage was that it was seen as

promoting a silo effect: students saw subjects as separate entitities and did not transfer knowledge to other parts of the program. They were more likely to perceive content as unimportant and to express resistance to learning. The silo effect could be seen amongst academic staff also, with individual subject coordinators being unaware of what was being taught in other subjects, and even program coordinators not having a detailed understanding of program content.

Expectations of outcomes

All participants expected graduates of their program to have some knowledge about caring for children, with all but one identifying skills they expected them to have acquired. Understanding differences between adults and children, and being able to communicate with children, were frequent responses. Being able to practise safely, including administering medications and recognising and reporting abnormalities, were also identified by several participants. Some acknowledged that they would not expect graduates to have the same level of competence as in caring for adults.

Some participants expected knowledge and/or skills that had not been taught in the program, such as presentation and management of common illnesses. Even if content had been taught, particularly in integrated curricula, it was not necessarily assessed. Only one participant described extensive assessment, including clinical compentencies in paediatrics that students had to achieve. Thus, it seems likely that at least some educators had misplaced confidence in, or at least were overly optimistic about, their graduates' knowledge and skills.

Factors influencing content and teaching

Almost all participants spoke of the difficult decisions that had to be made when writing a curriculum. *"It's hard to fit everything in",* or similar, was a common complaint. Paediatrics was seen as being in competition with other topics or areas. As one participant (*University #11*) *said: "It's actually pretty easy to teach a Bachelor of Nursing program. What isn't easy is to get everybody to agree to what should be taught."* A number of factors could contribute to decisions about what, and how much, to include.

Child-specific content was more likely to be included and emphasised in the curriculum if there was an active champion promoting it. In many institutions this meant a senior academic with paediatric experience. Junior academics, at lecturer level for instance, generally found it harder to have their views heard, particularly if it was not taught as a discrete topic. In other institutions the push had come from industry; this was particularly the case in areas where children's healthcare services were expanding. Other participants spoke of the need for commitment to a balanced curriculum; in these cases the champion did not promote paediatrics specifically but ensured all relevant content was included. This was contrasted with situations in which "those with the loudest voices, who thought that their stuff was more important, got space in the curriculum" (subject coordinator, University #12).

In many participants' narratives, a tension was apparent between the view that paediatric nursing is a speciality, and the view that it is part of generalist practice. This tension appeared to influence the degree of prominence of child-specific content in the curriculum. Only one participant clearly articulated an approach to resolving this tension, contrasting the

knowledge needed by all gradauating nurses with that of nurses planning to specialise in paediatrics: “If this [the compulsory subject] is a subject that every student has to take, what is the absolute bottom level of knowledge and skills that we want them to graduate with?” (subject coordinator, University #12), with more specific content included in the elective subject.

As indicated above, inclusion of child-specific content in the curriculum was not sufficient to ensure it was taught. Strategies to prevent intended content being eroded were difficult to identify. All participants acknowledged that it was essential to have teaching staff with paediatric experience and knowledge to deliver the content. For some this was a major obstacle.

Implications and conclusions

This study identified considerable variation in the amount and type of content specific to children in Australian undergraduate programs. Relatively small numbers of students receive clinical education, in the form of either clinical placements or simulation. While there was widespread agreement that all nursing graduates should have some knowledge and skills in caring for children, it is doubtful that many would meet the minimum standards advocated by ACCYPN (5).

The question of where and when nurses caring for children should acquire these knowledge and skills was not directly addressed by this study. While the participants indicated that universities should assume some responsibility, there were also suggestions that industry had a role to play. Further research on this topic, from the perspectives of industry and from practising nurses themselves, is recommended.

Curriculum structure per se – that is, integration of content versus discrete subjects - did not emerge as the main influence on child-specific content and its teaching. There is little empirical evidence to support one structure over another. The effectiveness of the structural approaches, in terms of facilitating desired student outcomes, requires investigation.

The main influence on curriculum content was the views and attitudes of senior academics. The degree of variability in content is enabled by lack of mandatory requirements by the accrediting body. This study contributes to the current debate on whether a national curriculum is warranted, or at least tighter regulation of program content.

This study has implications beyond paediatric nursing. Curriculum content on topics such as aged care and mental health is likely to be influenced in similar ways. Finally, there are implications for the teaching of other health care disciplines.

Outputs

Two conference presentations have arisen from this study:

- Paediatric nursing content in undergraduate curricula. Oral presentation at 7th International Clinical Skills Conference, Prato, Italy, May 2017.
- Child-specific content in undergraduate nursing curricula. Oral presentation at 7th International Nurse Education Conference, Banff, Canada, May 2018.
- A manuscript for publication is currently in preparation.

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PROFESSIONAL ASSOCIATION | ACMHN

AUSTRALIAN COLLEGE OF MENTAL HEALTH NURSES

The Australian College of Mental Health Nurses (ACMHN) is the peak professional mental health nursing organisation and the recognised credentialing body for mental health nurses in Australia.

It seeks to represent the profession at all levels of government and across all health service sectors. In addition, the ACMHN sets standards for practice, supports mental health nursing research and provides a forum for collegial support, networking and ongoing professional development for its members. Importantly, the ACMHN also works to promote public confidence in and professional recognition of mental health nursing.

PHILOSOPHY

The Australian College of Mental Health Nurses Inc. believes that mental health nursing is a unique interpersonal process, which promotes and maintains behaviours that contribute to integrated functioning for individuals and communities.

Mental health nursing is therapeutic in itself in the caring, honest and trusting relationship it conveys. Mental health nursing embodies the concept of caring by supporting clients who are unable to maintain mental, social or physical health functions for themselves and empowers the client to take an active role in self-advocacy and self-care.

Caring extends to self and peers, as an active factor in promoting mental health

OBJECTIVES (ABBREVIATED)

The Objectives of the Australian College of Mental Health Nurses are to:

- Enhance the mental health of the community .. improve service and care delivery .. promote the prevention of mental illness and disorder …
- Provide professional leadership and authority …
- Provide continuing professional education and practice development …
- Ensure mental health nursing issues and matters remain a focal point on all agendas …
- Set national standards of practice and promote best practice …
- Provide strategic leadership to influence legislative, statutory and funding bodies and key stakeholders …
- Build and maintain membership, professional capacity and infrastructure
- Maintain position as a non-industrial and non-sectarian organisation …
- Promote public confidence and professional recognition of the services …
- Encourage professional accountability, autonomy and partnership …

- Provide a forum for collegial support, networking and collaboration …
- Facilitate and disseminate research and continuing practice development …
- Represent the profession and provide advice to consumer and carer agencies, …
- Participate in policy development concerning the profession of mental health nursing …

MEMBERSHIP

- Ordinary Member - Registered Nurses and Enrolled Nurses with an interest in the field of mental health.
- Associate Member - For people who have a special interests in the mental health field and who are not otherwise eligible for the Ordinary Member category.
- Maternity Leave - renewal.
- Retiree
- Full-Time Student - undergraduate nursing students or RNs enrolled in a full-time postgraduate course with relevance to mental health nursing.

SPECIAL INTEREST GROUPS (SIGS)

Special Interest Groups (SIGs) are groups established by members of ACMHN who have an interest in facilitating, advancing and promoting a particular area of interest in mental health on behalf of the ACMHN.

As part of the ACMHN membership package, members are offered the opportunity to join a SIG.

SIGs provide a network for members with shared interests and expertise to participate in the development of the specialist interest, exchange views, disseminate information, provide support, promote research, and organise activities such as conferences.

- Consultation-Liaison SIG
- Clinical Supervision SIG
- Perinatal and Infant SIG
- Primary Mental Health Care Care SIG
- Aboriginal & Torres Strait Islander SIG
- Older Adults' Mental Health SIG
- Forensic Mental Health SIG
- Mental Health Nurse Practitioner SIG

FURTHER INFORMATION

Website	http://www.acmhn.org/
Email	membership@acmhn.org
Phone	1300 667 079

PERSONAL DEVELOPMENT/EMPOWERMENT

Mind Matters: Why we need to talk more about mental health at work

https://psnews.com.au/2018/11/12/mind-matters-why-we-need-to-talk-more-about-mental-health-at-work/

Alyssa Mastromonaco is no stranger to tough conversations: among other leadership roles, she served as White House Deputy Chief of Staff for Operations under former US President Barack Obama. So, when she switched to a new antidepressant, she decided to tell her boss.

> "I told the CEO that I was on Zoloft and was transitioning to Wellbutrin," Mastromonaco said.
>
> "I can react strongly to meds, so I was worried switching would shift my mood and wanted her to know why."
>
> "I talked about it like it was the most normal thing in the world — it is!"
>
> Her boss was supportive.
>
> "You got it," she said.
>
> When Mastromonaco goes to work, she and her mental health struggles do not part ways at the door.
>
> "You want me," she said, "you get all of me."
>
> Mastromonaco brings tremendous talent to her workplace — but she also brings her anxiety.

The same is true for high-performing employees everywhere: one in four adults experiences mental illness each year. And yet we're loath to talk about mental health at work.

If we're feeling emotional at work, our impulse is to conceal it. We're hesitant to ask for what we need — flex time, or a day working from home.

Mental illness is a challenge, but it is not a weakness.

When we acknowledge our mental health, we get to know ourselves better, and are more authentic people, employees, and leaders.

Research has found that feeling authentic and open at work leads to better performance, engagement, employee retention, and overall wellbeing. Failure to acknowledge an employee's mental health can hurt productivity, professional relationships, and the bottom line.

So what needs to change?

Human capital is the most valuable resource in our economy. Diversity is promoted however, there's a giant hole when it comes to understanding how temperament and sentiment play into the trajectory of success.

Recognition of neurological and emotional diversity in all of its forms, workplace cultures need to make room for the wide range of emotions we experience.

We need to have the option to ask for help, and feel safe doing so.

We need flexibility, sensitivity, and open-mindedness from employers — of the sort they'd give to a broken bone or maternity leave. We're not there yet .. programs to educate employees about mental health issues, encouragement to seek help and support colleagues.

"Learn how to listen to their concerns, and then act."

Offer free onsite counselling sessions to employees and their families, and courses on mental health first aid that teach them how to recognise signs of mental illness in others.

The goal is to empower people to achieve their optimal state of wellbeing.

Organisations that realise, given the right support, employees who struggle with their mental health can do great work.

Most people who suffer from chronic anxiety or depression are excellent at faking wellness. But we never know when an attack might be around the corner.

This is why a work environment that is open and understanding is so important.

Anxiety is a lingering expectation that something bad is going to happen, and if we don't talk about it, it's harder to recognise our triggers and learn healthy ways to cope.

But when we do talk about it, we can actually teach ourselves to harness it in ways that play to our strengths.

Times are changing, and people struggling with mental illness, are more likely to get the help they need at work than ever before.

Along with employee assistance programs, conversation and education are fundamental if our goal is to increase understanding and reduce the stigma around mental health.

Think of what the cost is — for the people and the employer — when a whole slice of the population struggles to express their most basic needs.

The burden of depression and anxiety is shared by all members of a workplace, and it's a vicious cycle.

Change starts with you, managers and HR professionals recognising the problem and doing something about it.

Because when people get the space and the support they need, it can change their careers, and their lives.

* Morra Aarons-Mele is the founder of Women Online and The Mission List. She tweets at @morraam.

DIARY | CONFERENCE AND HEALTH PROMOTION

| 2019 Dates

19th International Prader-Willi Syndrome Organisation (IPWSO) Conference 2019 | Cuba | www.ipwso.org/conference

18 – 19 March | 8th World Congress on Midwifery and Women's Health | Sydney | http://midwifery.nursingconference.com

17-19 March | 42nd Australian Association of Stomal Therapy Nurses Conference | Power of connections – coming together | Sydney | http://www.stomaltherapyconference.com/

24-27 March | 15th National Rural Health Conference | Hobart | www.ruralhealth.org.au/15nrhc/

12-15 April | International Society of Nephrology's Biennial World Congress of Nephrology | Melbourne | www.isnwcn2019.org/

5-8 May | Council of International Neonatal Nurses Conference | Enriched family - enhanced care | Auckland | http://www.coinn2019.com/

13-14 May | 29th Surgical Nursing & Nurse Education Conference | Encompassing Nursing Education in the field of Surgical Nursing | Perth | https://surgical.nursingconference.com/

10-15 June | 24th World Congress of Dermatology | A new era for global dermatology | Italy | https://www.wcd2019milan.org/

17-20 June | Lowitja Institute Indigenous Health & Wellbeing Conference | Darwin | http://www.nirakn.edu.au/event/2019-lowitja-institute-international-indigenous-health-and-wellbeing-conference/

21-22 June | 53rd World Congress - Nursing & Health Care | Exploring Innovations and Latest Advancements in Nursing & Health Care | https://nursingcongress.nursingconference.com

20-22 June | CNSA Annual Congress | The Complexity of Cancer Care: What will the future of cancer nursing look like? | Melbourne | http://www.cnsacongress.com.au/

29 – 30 July | 34th International Conference on Oncology Nursing and Cancer Care | Melbourne | htpp://cancer.nursingconference.com

15-17 August | MCFHNA Conference | Navigating the future: New directions in Maternal, Child and Family Health | Sydney | www.mcafha.org.au

25-26 September | International Council of Nurses (ICN) 21st International Conference on Nursing 2019 | London | www.icn.ch/

| 2020 Dates

NOVEMBER | Motivate, Inspire, Educate – NNEC 2020 | Queensland

CHRISTMAS APP! CHRISTMAS APPS! CHRISTMAS APPS ALL DAAAAAY!

Someecards.com |
https://www.someecards.com/memes/christmas/

Where cards poke fun at the season's traditions.

You can create your own or download an existing one to share.

Wordeo |
https://wordeo.com

Something a bit different, you can create a video e-card. Type a message and a video clips are matched from your phone. Add music and change fonts.

Christmas Pics Quiz Game |
https://itunes.apple.com/us/app/christmas-pics-quiz-game/id755281885?mt=8

A photo and a jumble of letters, to spell out what the picture is to advance. Here's the fun twist: the photo is covered by four squares. Tap the squares to reveal

Christmas Wallpapers and Backgrounds |
https://itunes.apple.com/ca/app/christmas-wallpapers-backgrounds/id1176376638?mt=8

Wallpapers for your iPhone or iPad that bring a little Christmas cheer to your device.

A Call from Santa |
https://itunes.apple.com/ca/app/call-from-santa!-voicemail/id933921849?mt=8

For true believers. In this technological age, text my list to Santa or get a phone call from the Big Man himself, telling if your on the naughty or nice list. Enter information as well as the reason for the call, and then schedule the phone call … when it rings, Santa calls.

Christmas Sweeper 3 |
https://itunes.apple.com/us/app/christmas-sweeper-3/id1057340661?mt=8

Got Candy Crush fever but want something a little more Yuletide? Matching Christmas-related objects with "hard" modes for each level, though they're not too difficult.

Elf Yourself by Office Depot |
https://itunes.apple.com/us/app/elfyourself-by-office-depot/id582486077?mt=8

Take pictures of people and put their heads on elf bodies and then they dance. iMessage app included, so you can keep the fun going in your conversations

REFERENCE: http://appcrawlr.com/ios-apps/best-apps-christmas-card-list and https://www.imore.com/best-christmas-apps.

AUSTRALIAN NURSE TEACHERS SOCIETY

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SUBMISSION / ADVERTISING DEADLINES (EXCEPTIONS BY ARRANGEMENT)

Autumn Edition | 15th March
Winter Edition | 15th June
Spring Edition | 15th September
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