Your nursing future is here

Primary health care nurses working to the breadth of their scope of practice

Why it pays to employ a nurse

Thunderstorm asthma – how do we prepare for this spring?
Finding continued support for your ageing patients is challenging.

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– Heidi, Registered Nurse.
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Primary Times

Primary Times is the official publication of the Australian Primary Health Care Nurses Association (APNA) and is published four times a year in Autumn, Winter, Spring and Summer.

APNA is the peak national body for nurses working in primary health care, providing representation, professional development and support at a local, state and national level.

AUSTRALIAN PRIMARY HEALTH CARE NURSES ASSOCIATION INC.
Level 2, 159 Dorcas Street
South Melbourne VIC 3205
ABN 30 390 041 210
ARBN 111 194 293
T: 1300 303 184 F: (03) 9669 7499
www.apna.asn.au

EDITOR
Stephanie Hille
editor@apna.asn.au

ADVERTISING
Jonathon Tremain – Tremain Media
T: 02 9988 4889 E: jonathon@tremedia.com.au
www.tremedia.com.au

EDITORIAL ADVISORY COMMITTEE
Kathy Godwin (Chair)
Professor Liz Halcomb
Anne Matyear
Dr Jacqui Young

DESIGN
Perry Watson Design

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PLATINUM PARTNER

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By nurses, for nurses

As many of our members will attest, we have had a torrid flu season nationally. As we move towards warmer weather, I hope you receive some respite from the high influx of people with winter illnesses. I also hope you get some time to collect your thoughts and reflect on the direction of primary health care and the cutting-edge activity that is happening at our professional association.

My Nursing Future launched
After 18 months of very hard work, APNA is very excited and proud to announce the release of the career planning website and tool for nurses working in primary health care. As your President, I had the great pleasure to launch MyNursingFuture.com.au at the plenary of the Primary Health Care Research (PHCRIS) conference in Brisbane.

Planning and testing of the career planning site has been rigorous. The team conducted a comprehensive review of national and international literature. We then conducted extensive consultations with primary health care nurses and other stakeholders including employers, universities, health bureaucrats and policy makers who were keen to support APNA working towards a clearer career direction and reinforce professional satisfaction for nurses working in primary health care. There is strong recognition of the need to build the capacity and prospects for primary health care nurses if we want to build a dynamic and vibrant workforce, especially as the emphasis for healthcare is shifting to prevention, early intervention and harm minimisation models.

Thankyou to all those who contributed to the building of My Nursing Future. Thanks to the hundreds of nurses who attended our consultation workshops. You helped us collect valuable information to build an accurate profile of the workforce, and helped us to form a ‘big picture’ view of what nurses want and need to support them. I attended the consultation workshop in Canberra, and was heartened not only by the enthusiasm of the nurse participants, but also the high level of interest from employers, PHNs, state and federal health departments, all wanting to know how they could attract and support nurses. I met nurses who had flown from interstate to attend the Canberra meeting because they had not been able to attend a local meeting. There was one nurse in her seventies who had driven an hour and a half along the country roads to attend the evening meeting because she wanted to have her say before she drove that same trip home that night. The wealth of knowledge and commitment from nurses such as this has helped shape this important piece of work that has been developed by nurses, for nurses!

APNA also extends a big thank-you to our expert advisory group. We thank them for sharing their expertise, helping us draw together and highlight the similarities we share across primary health care settings, and for being tough, critiquing the framework and helping navigate complexities to ensure we developed a resource that would resonate with our target audience, primary health care nurses.

The person-centred design approach that was used by the APNA team to undertake the research and develop a framework that met the needs of users, generated much interest at the PHCRIS conference and kept the APNA booth busy for the three days of the conference. Potential benefits that can flow from My Nursing Future will be to link nurses and prospective employers, and, by describing the breadth of nursing roles, have a positive impact on strengthening undergraduate nursing curriculums and clinical placements, as well as assist nurses to identify opportunities for career progression and as a promotional tool. You can do all of this on your mobile device at a time and place that suits you.

A position on scope
In other exciting news, APNA has been developing a number of resources relating to scope of practice. Whilst this term is often bandied about to describe how much or how little a nurse might be able to do in their role, it is often poorly understood or not used in correct context. I recommend you go to the APNA website and put ‘scope of practice’ into
the search box to reveal a full page of resources including links to our online learning module and links to regulatory bodies to view legislation and frameworks. APNA has recently released a position statement on Scope of Practice that is featured on page 6 and is available on the APNA website on the Position Statement page under Your Profession.

Health Care Homes begin
The much anticipated Health Care Home pilots will commence in October. APNA has representatives Jane Bollen and Melissa Cromarty advising the AGPAL team developing the education resources for the Health Care Homes and I sit on the education advisory group with the Department of Health. Congratulations to all the successful Health Care Home practices. Change can be challenging, but your efforts will help shape the future. We wish you well on your journey developing and applying new models of chronic disease care to the Australian context.

APNA has been advising on several projects that will release papers for public consultation in the next few months. These include the Australian Commission on Safety and Quality in Health Care Primary Care Safety and Quality Framework and the RACGP Green Book: Putting prevention into practice. APNA will advise you when the public consultations are open for comment.

There is strong recognition of the need to build the capacity and prospects for primary health care nurses if we want to build a dynamic and vibrant workforce, especially as the emphasis for healthcare is shifting to prevention, early intervention and harm minimisation models.

Finally, many years ago I did several working trips as a nurse on the Fair Star cruise ship. Every emergency that you see in general practice you saw on the ship and then some. See page 24 to read a profile on cruise ship nurse Emma to get an idea what it’s like.

Enjoy your spring!
Primary health care nurses working to the breadth of their scope of practice

Nurses working to their full scope of practice as part of an interdisciplinary team can enable more integrated, efficient and accessible healthcare. APNA has developed a position on primary health care nurse scope of practice.

This position outlines the advantages of nurses working to their full scope of practice which includes benefits to the health and wellbeing of the Australian community and the healthcare system more broadly. At a time of rising healthcare costs, increasing rates of chronic disease and an ageing population, it is essential that nurses are working to their full scope to combat emerging healthcare challenges.

This position has been developed for a range of stakeholders including primary health care nurses, employers, other health professionals, government and policy makers, nursing associations, regulatory bodies and education providers. It is recognised that all stakeholders have a role to play in supporting primary health care nurses to work to their full scope. As such, APNA has identified a number of key recommendations that all stakeholders can support and implement.

APNA encourages nurses to:
- better understand your scope of practice
- have a conversation with your colleagues and or employer about your scope of practice
- where possible, promote and advocate for nurses to be equal partners in primary health care

The following is an extract from the position.

Nurses are skilled, regulated and trusted health professionals with extensive distribution across Australia. Primary health care nurses working to the breadth of their scope of practice facilitate better outcomes for patients, enhanced productivity and value for money for health services.

Scope of practice

Scope of practice for nurses is determined by professional registration (i.e. registered nurse or enrolled nurse), endorsement (i.e. prescribing scheduled medicines by nurse practitioners), educational background, nursing experience and clinical specialisation.

A nurse can build their clinical and professional capabilities to expand their scope of practice through education and training to develop a broader skill set that remains within the legislated professional practice standards and competencies.

An individual nurse’s scope of practice may vary considerably from that of another nurse. Tools such as the Nursing practice decision flowchart developed by the Nursing and Midwifery Board of Australia can assist nurses to determine their scope of practice. Nurses are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice.

Benefits of primary health care nurses working to their full scope of practice

Primary health care nurses working to the breadth of their scope facilitates better outcomes for patients, enhanced productivity and value for money for health services.

Primary health care nurses can facilitate increased access to healthcare. This may be via increased services, reduction in waiting times, more timely assessments and referrals. This is particularly important given the increasing burden of chronic disease and the challenges associated with workforce shortages in Australia’s primary health care system.

Encouraging and enabling primary health care nurses to work at full capacity within their scope of practice will provide benefits at all levels, from individual and team, to the healthcare system nationally and most importantly to the health and wellbeing of the Australian community.

There are two main elements to scope of practice:

<table>
<thead>
<tr>
<th>Professional practice</th>
<th>Individual practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scope of professional practice is set by legislation. This includes professional standards such as standards for practice, codes of ethics and codes of professional conduct.</td>
<td>The scope of practice of an individual nurse includes that which the individual is:</td>
</tr>
<tr>
<td>• educated</td>
<td>• educated</td>
</tr>
<tr>
<td>• authorised</td>
<td>• authorised</td>
</tr>
<tr>
<td>• competent, and</td>
<td>• competent, and</td>
</tr>
<tr>
<td>• confident to perform.</td>
<td>• confident to perform.</td>
</tr>
</tbody>
</table>
Barriers to optimal scope of practice

A number of barriers are currently preventing nurses from working to their full scope of practice.

Primary health care nurse financing

Primary health care nursing is funded from both public and private sources. The way that healthcare is funded can influence the structure and viability of clinical service models and the roles and tasks of primary health care nurses who work within them.

Intra-disciplinary and inter-disciplinary support and awareness of full scope of practice

Perceptions and attitudes by other health professionals or employers about the role of primary health care nurses may limit a nurses’ ability to work to their full scope of practice. The scope and functions of primary health care nursing have evolved and expanded into some areas of practice that have traditionally or historically been assumed the responsibility of other medical professionals. This has the potential to create professional tensions between primary health care nurses and medical professionals such as general practitioners. Therefore a greater understanding and support for the full breadth of the primary health care nurse role by all members of the healthcare team is essential to enhancing intra-disciplinary collaboration and effective patient care.

Formal education, training and career frameworks

There is currently a lack of formal education and training pathways into primary health care nursing and no framework for skills development and career progression.

Our recommendations

Patient care could be improved through nurses working to their full scope of practice and therefore APNA recommends the following.

<table>
<thead>
<tr>
<th>Employers and other health professionals:</th>
<th>Governments/Policy makers:</th>
<th>Nursing associations/Regulatory bodies:</th>
<th>Education providers:</th>
<th>Primary health care nurses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support team-based care and empower and enable primary health care nurses to work at full capacity within their scope of practice.</td>
<td>Continue to support the development, implementation and evaluation of career and education pathways, transition to practice initiatives and nurse clinics in primary health care.</td>
<td>Continue to support primary health care nurses to understand and enhance their scope of practice.</td>
<td>Ensure that nursing curriculum and training is inclusive of primary health care nursing.</td>
<td>Use the appropriate standards for practice, codes of ethics and codes of professional conduct to determine your professional scope of practice.</td>
</tr>
<tr>
<td>Invest in the future of primary health care nurses by offering primary health care nursing student placements.</td>
<td>Continue to support continuing professional development for primary health care nurses including access to scholarships, grants and bursaries for education and training.</td>
<td>Continue to address the barriers to optimising the primary health care nursing workforce. For example, increase nursing skills and confidence via further initiatives like the Nursing in Primary Health Care (NiPHC) Program.</td>
<td></td>
<td>Use professional judgement, by considering your educational attainment and professional experience, to determine your individual scope of practice.</td>
</tr>
<tr>
<td></td>
<td>Develop and implement a primary health care nursing financial model that is flexible, accessible, sustainable, uncomplicated and nurse led.</td>
<td></td>
<td></td>
<td>Strengthen and extend your scope of practice by updating or enhancing your knowledge, skills, confidence and competence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strengthen your scope of practice by engaging in continuous quality improvement activities to enhance nursing care and therefore patient outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Form strategic alliances within the nursing profession and with other disciplines to promote and advocate for nurses to be equal partners in primary health care.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Understand the opportunities and challenges that different funding mechanisms present to ensure patients can access the care they need.</td>
</tr>
</tbody>
</table>

Where possible, APNA will be advocating on behalf of our members to facilitate the implementation of these recommendations.

What do you think? Talk to your colleagues, talk to your employer – do their views on nurse scope of practice need to be challenged?

APNA’s position statement Improving patient outcomes: Primary health care nurses working to the breadth of their scope of practice is now available on the APNA website. The complete version is fully referenced. Look under APNA Position Statements at www.apna.asn.au/profession.
Your nursing future is here

APNA members have been talking about the lack of a career structure for nurses in primary health care for years. With investment from the Government, extensive consultation spanning time and distance, input and examination from nurses and nursing experts from all fields, a career and education framework for nurses in primary health care is ready.

How did we capture what nurses need?

The framework was developed using an evidence-based and rigorous approach, starting with a literature review. This was used to identify what career and education pathways were available for nurses and health professionals (both national and international), and how the Australian nursing workforce could benefit from a similar framework for nurses working in primary health care.

An environmental scan was conducted to understand the areas of primary health care in which nurses had a predominant role. This identified settings such as refugee health, community health, Aboriginal Health Services, general practice, correctional health, residential care and more.

So now the team had an idea of what other frameworks looked like and the areas of primary health care nursing that should be further investigated, but we still needed to know what the framework needed to address and how current and future nurses would access this information.

A consultation was conducted from early 2016 through to July 2017; face-to-face workshops, interviews, prototype testing, online consultation, focus groups and conference presentations. Key participants included those with expertise across a range of primary health care settings and with a variety of focus areas, including clinical, policy, management, research and education.

The need for a framework and supporting resources was clearly articulated by all participants and demonstrated a current gap, while outlining the many and varied potential impacts the framework would have on recruitment and retention of nurses in primary health care settings.

What we found by talking to many, many nurses, is that they find it difficult to describe their professional value to their employer, to describe the breadth of their role and identify professional strengths, and actively plan their CPD.

Stakeholders saw value in the framework to improve the perceived value and professionalism of the nursing role in primary health care. Other major themes consistent across the range of consultations included:

- the positive impact the framework would have on strengthening undergraduate nursing curriculums and clinical placements,
- the development of transition support programs,
- supporting recruitment and retention,
- identifying relevant formal and informal education pathways and options,
- describing the breadth of nursing roles,
- the opportunities for career progression,
- and as a promotional tool.

Current and future nurses told us the way they access career and education information is predominantly via mobile phone. So we invited nurses to work with APNA to develop a mobile-responsive website which would...
contain resources, information, contacts and visual career pathways, for nurses to explore and navigate the potential of working in primary health care.

Everything down to the My Nursing Future logo, the colours in the self-assessment report, the wording in the self-assessment, videos of nurses working in primary health care, career advice articles, and the words of wisdom, were all developed by current and future nurses.

Not another pdf

Nope. Instead of producing yet another document/handbook, the framework and all of the supporting resources are housed in a very nifty website which you can use on your mobile, tablet, laptop, desktop…

MyNursingFuture.com.au has been designed to provide current and future nurses with insight into the roles of nurses working in primary health care. The self-assessment that nurses complete on the MyNursingFuture.com.au website acts as an interactive version of the framework.

The self-assessment enables nurses working in primary health care to professionally reflect on their level of practice across the five domains of primary health care nursing; Clinical Care, Education, Research, Optimising Health Systems and Leadership – adapted from the Strong Model and Ackerman et al. Responses are weighted according to whether a nurse indicates they are learning, confident in or lead/guide others in relation to their nursing practice.

The self-assessment takes up to 60 minutes and is a professional reflection activity that enables nurses currently working in primary health care to understand what level they practice at, and identify strengths and areas to grow according to each domain.

Upon completion, nurses will receive a personalised report which will:

- Identify your level of practice
- Identify areas you would like to progress, set career goals, and extend your scope of practice
- Assist you to actively plan your CPD
- Showcase your skills, knowledge and experience, and demonstrate to managers/employers how your skills can be better utilised
- Assist your search for different career opportunities in primary health care
- Results can be built into your nursing role and key performance indicators with your employer/manager
- It is important that primary health care nurses understand and can articulate their professional value, and have the means to continually evolve in their careers – MyNursingFuture.com.au provides nurses with the tools and support to do so.

The self-assessment currently available on My Nursing Future has been built for registered nurses. We are building a framework specific to enrolled nurses which will be available later this year.

See where your career can take you, visit MyNursingFuture.com.au.

References

Chronically underfunded: How can we effectively manage chronic disease on a primary care budget?

A new report released in July examined Australia’s commitment to preventative healthcare, and the results are alarming. Treating chronic disease costs the Australian community an estimated $27 billion annually, and yet Australia currently spends just over $2 billion on preventive health each year. The report – a collaboration between the Heart Foundation, Kidney Australia, Alzheimer’s Australia, the Australia Health Promotion Association and the Foundation for Alcohol Research and Education – claims that at just 1.34% of Australian healthcare expenditure, the amount is considerably less than OECD countries New Zealand, Canada and the United Kingdom, with Australia ranked 16th out of 31 OECD countries by per capita expenditure. 1

So what’s the solution?

Nurses are invaluable in managing chronic conditions, and addressing biomedical- and lifestyle-related factors that can dramatically reduce the impact of chronic conditions on our patient’s lives.

APNA’s Contemporary Chronic Disease Management workshop series is specifically designed to draw on nursing practice, while acknowledging the limits of primary care resources, in managing chronic disease. The workshop covers:

- Care coordination: Why now is the time to get it right
- Facilitating health behaviour change
- Spirometry: Understanding, interpreting and recognising abnormalities
- Chronic pain and addiction
- Wound care: Skin tears, burns and venous leg ulcers

See our website for upcoming workshop dates and locations – www.apna.asn.au/education/cdmha

Reference
Enhanced nurse skill in wound care

Cheryl ‘Frankie’ Frank is one of APNA’s lead nurse educators, upskilling nurses of varying backgrounds and experience in how to manage wounds in primary health care settings.

A Clinical Nurse Consultant specialising in wound management in the Gold Coast health district since 1996, Cheryl brings a wealth of experience to APNA’s Foundations of General Practice Nursing workshops and the Contemporary CDM series running year-round across the country.

Committed to the management of wounds in primary health care, the Wound Busters Clinic came runner up in the 2014 National Lead Clinicians Forum for education tailored for doctors and nurses in general practice.

Reflecting on the progressive role of nurses, Cheryl says, ‘historically the management of wounds focused far more on the products than diagnosis and enhanced nursing skill.’

As a senior clinician and peer educator, Cheryl has influenced this shift.

In line with APNA's message, Cheryl upholds that in collaboration with the practice team, nurses play a key role in preventable hospitalisation through early detection, diagnosis and referral.

‘To participate in robust discussions regarding the implementation of enhanced nursing skills and observations in their primary health workplace is extraordinarily stimulating. It is extremely fulfilling to be a small part of motivating innovation in general practice nursing praxis.’

The Nurse Foundations workshop provides an orientation to the principles of wound management, covering acute versus chronic wounds and recommended dressings; while the Contemporary CDM sessions offer a more in depth half-day training.

It is clear that Cheryl’s love for educating nurses in primary health care is very much reciprocated…

‘What a fountain of knowledge Cheryl is, loved listening and learnt a lot from her talk. I could have listened to her for a lot longer.’

‘Excellent delivery. Great examples. Useful advice to take back to practice.’

‘Being new to practice nursing, I now have much better understanding of wound care!’

‘Cheryl was fantastic, her knowledge of wound care and presentation was superb.’

‘One of the best ever presentations on wound management applicable for general practice. Thank you!’

Access to education online

Pertussis

Pertussis, also known as whooping cough, is an extremely contagious respiratory infection. In a household where someone has whooping cough, an estimated 80–90% of the unimmunised contacts of that person will acquire the disease.

Reviewed and updated for 2017, APNA’s Pertussis online learning course provides nurses with information on immunisation rates, symptoms, preventing pertussis using various strategies, incentives and delivering immunisation services. Free for APNA members, this course will take approximately one hour to complete.

Palliative Care

Approximately 50% of Australia’s 144,000 annual deaths are expected or anticipated, suggesting that there are some 72,000 Australians with potential palliative care needs. As our population continues to age, the incidence of serious chronic and life-limiting conditions will increase. This reality makes palliative care the responsibility of all health professionals.

Reviewed and updated in 2017, APNA’s Palliative Care online learning course provides nurses with information on understanding and implementing a palliative approach, and identifying where a palliative approach fits within the nurse role. Free for APNA members, this course will take approximately two hours to complete.

General Practice Financing

Understanding how general practice operates as a small business and knowing what funding is available can be confusing at the best of times. APNA’s General Practice Financing online learning course has been updated for 2017.

Free for APNA members, this 1.5 hour course will look at Australian general practice funding as well as provide an introduction to the financing of healthcare, funding mechanisms, changes to financing in Australia and funding for nurses.

Visit APNA Online Learning at https://apna.e3learning.com.au for these courses and more.
Valuing Nurses

Why it pays to employ a nurse

One of the biggest barriers nurses face in being valued is one of perception. When employers, managers, or even nurses themselves, can’t articulate their contribution and impact, it’s up to all of us to know how to describe the benefits a nurse can bring to their employer.

The case for employing a nurse

There are significant opportunities to develop the role of nurses in primary health care and enhance their function in a range of primary health settings as part of the primary health care team and to improve the health outcomes of individuals and communities.

Nurses working in primary care undertake a breadth of work and can make a significant difference to the level of care provided within an organisation.

‘Primary care nursing is not a set-and-forget position, according to nurse Faye Clarke. ‘It’s a constantly changing role, as it must be. My responsibilities need to grow and align with the evolving requirements of the community that we serve. This ensures that we service our patients effectively while the organisation, although non-profit, can maximise its income.’

This work can include health promotion, disease prevention, palliative care, advocacy, research, policy planning and development, and education for health professionals and patients. Significant research has been undertaken regarding the evolving role of nurses in primary health care in Australia and how they can improve individual and community health outcomes.

Financing nurses – issues and impacts

In recognition of the importance of nurses in general practice and the challenges of ensuring a viable workforce into the future, the Australian Government offers financial incentives to encourage uptake of nurses in general practice, particularly through the Practice Nurse Incentive Program (PNIP). There is evidence of a spectrum of financing models within general practices, and that current financing models have benefits and challenges.

‘With the nurses on board, we’ve been able to deliver more services to our patients while also realising a financial benefit’

– Practice Manager, Irwin Cozens

Read more…

• Key research and evidence: The case for employing nurses in general practice
• Funding sources providing financial benefits to your practice
• Indirect funding for nursing in general practice

The impact of nurses on quality and safety

There is emerging evidence that as part of a primary health care team, nurses can improve quality and safety. The nurse role is well suited to implementing quality and safety systems embedded in accreditation processes. The Australian Primary Care Collaboratives Program is delivering an evidence base regarding the positive impacts that a quality and safety approach can have to managing chronic conditions in primary health care settings.

‘Patients win because our ability to deliver more comprehensive care is a significant driver in improving outcomes’

– Dr Andrew Kirwan

The importance of teamwork

A key issue for primary health care services is determining the roles of a nurse, and how this can complement the roles of other professionals within the organisation. Given the potential scope of practice of a nurse, when determining appropriate activities a range of considerations should be taken into account including the skillset and capacity of the nurse themselves (including generalist and specialist expertise) and the types of roles that will be relevant for the local serviced communities.

‘Importantly, our nurses are well aware of their own limitations – they are experienced, qualified professionals. We are happy to allow them a measure of autonomy commensurate with their level of skill, training and expertise’

– Dr Gary Kilov

Other factors to consider include how potential activities will complement the skillsets and interests of doctors and other health practitioners, and what activities are financially viable. In order to bring these considerations together, teamwork and leadership is vital.

Workforce development

Primary health care nursing is evolving. There is evidence to suggest that given the generalist nature of nursing competencies, there are limitations regarding the exposure to primary health care issues provided to nursing undergraduate students. This has implications regarding the level of support of nurses when they enter primary health care settings.

More emphasis needs to be placed on community healthcare as part of the syllabus delivered to nursing students, says nurse Alison Logan. ‘This is going to be the focus for the foreseeable future so it’s important to understand that nursing in the primary care setting will open the door to a multitude of career options – all you need to do is have an open mind.’

Read more…

• Key research and evidence: The case for employing nurses in general practice

Primary Times | Volume 17 Issue 3
Nurses bring it all together

The nurse role goes beyond the clinical and administrative, to function in a way that is oriented towards patients, their organisation and the community.

Phillips et al determined that nurses have six key operating roles: patient carer, organiser, problem solver, quality controller, educator, agent of connectivity.

This study found, for better or worse, that nurses cycle between these roles because of the way they work:

- Nurses are highly mobile, in contrast to doctors and administrative staff.
- Nurse offices are often located in central places like treatment rooms or in thoroughfares.
- Nursing time is often regarded as a fluid commodity, which is constantly accessed and utilised by different people.
- Nurses are highly focused on ‘doing’, with their activities being varied and often reactive to patient or medical need.
- Nurses are relatively spontaneous and unstructured, especially in their contact with patients.

‘Nurses bring an intangible ‘added benefit’ and their capacity to deliver comprehensive and holistic care, creating a whole that is greater than the sum of its parts. The role of nurses as agents of connectivity has not been previously articulated, and is central to this capacity. This role helps bond the practice and make it resilient and responsive to change.’

Employing a nurse

APNA has produced a suite of resources to help primary health care organisations employ nurses and optimise their role.

Risk assessment tool

The risk assessment tool can support health services identify and assess the risks to be managed when employing a nurse. Working with nurses in primary health care settings can bring many benefits, including shared clinical workload, improved organisation of organisation systems, improved quality management (including accreditation), increased income and improved patient care through a teamwork approach.

Case study

Efficient practices make for optimal healthcare

According to Dr Gary Kilov of the Seaport Practice in Launceston, primary care nurses improve the efficiency and functioning of his practice. ‘It’s about addressing the needs of patients,’ he says. ‘The nurses bring a skill set to general practice that complements the expertise of doctors. There’s no better example of this than chronic disease – primary health care in today’s society is geared towards the management and prevention of long term conditions. Undertaking such a significant proportion of my workload without the support of primary care nurses would be unquestionably difficult.

‘The multidisciplinary model of care is gaining momentum and understandably so. It’s the way forward for general practice. GPs may not have the luxury of spending significant amounts of time with patients, but we still aim to deliver excellence in care – that’s where our nursing colleagues come in. Not only do patients appreciate the access to a wider range of services within the one practice, they take comfort from the continuity of care.’

Nurse Suzanne Marshall says that tag-team consulting enables the practice to better accommodate patient needs. ‘Patients with a chronic illness see the GP but also have one-on-one time with a nurse to talk through any concerns, receive education about their condition and set treatment goals. We’re also responsible for preparing the care plans for the doctors to review. It would be a big ask if the doctors had to do all this, as well, in the little time that they have with patients.’ The nurses also perform diagnostic tests such as urinalysis, blood sugar levels, blood pressure measurements and weight checks prior to the patient’s appointment with the doctor – it’s much more efficient to have the results available for discussion there and then. The end result is that patients receive comprehensive care without feeling rushed out the door. Everyone’s happy.’
Why it pays to employ a nurse

The examples provided in the following table are based on real challenges that organisations sometimes experience. You must take into account your own situation and describe risks specific to your organisation. The ‘likelihood’ and the ‘impact’ of risk vary between organisations and should be adjusted to suit your circumstance.

This risk assessment should be conducted in conjunction with the Benefit assessment tool, which helps you identify the potential benefits of employing a nurse. By completing this risk assessment, you will be encouraged to critically think about risks your organisation may face and how these are best managed.

Related content

- Selection Criteria Checklist
- Indirect funding for nursing in general practice
- Case in Point – a series of case studies demonstrating real examples of the benefit of nurses

Table 2: Benefit Assessment Tool

This table provides examples of benefits that may be applicable to your practice:

<table>
<thead>
<tr>
<th>Examples of benefits</th>
<th>Analysis</th>
<th>Explanation of benefits</th>
<th>Your practice strategies</th>
</tr>
</thead>
</table>
| Capacity to extend service delivery to patients                                     | Likelihood: Very Likely*  Impact: Major*  Benefit Rating: 5 | - Shared clinical workload  
- Patient assessment and preparation of draft MBS care plans (GP Management Plans and Team Care Arrangements)  
- Patient assessment and preparation of draft patient MBS health checks and health assessments  
- Increased opportunity for patient education and improved lifestyle risk management  
- Opportunity to develop nurse clinics for areas such as (but not restricted to) healthy lifestyles, immunisation, chronic disease management, men’s health and women’s health  
- Improved triage processes in the practice | ☐ Yes ☐ No (Include your own responses and actions to maximise the benefit) |
| Improve range of clinical skills within the practice                               | Likelihood: Likely*  Impact: Moderate*  Benefit Rating: 3 | - Specialist nursing skills can provide valuable benefits, e.g. a nurse with expertise in asthma/spirometry management, a nurse immuniser, a diabetes nurse educator, a nurse wound care specialist | ☐ Yes ☐ No |
| Management of recall and reminder systems for patient follow up                    | Likelihood: Very Likely*  Impact: Moderate*  Benefit Rating: 3 | - Improved follow-up of patients and more opportunities to provide outstanding continuity of care  
- Increased active management of patients requiring regular follow-up  
- Potential reduction in medico-legal risk | ☐ Yes ☐ No |
| Ability to attract more general practitioners to the practice                      | Likelihood: Likely*  Impact: Moderate*  Benefit Rating: 3 | - General practitioners may feel more supported and professionally satisfied working in practices that employ or engage nurses  
- Improved work-life balance for general practitioners | ☐ Yes ☐ No |

Reference


Nutritionally supports the development of the immune system through Nutricia’s patented blend of prebiotic oligosaccharides (0.8g/100mL).1,2,4

An extensively hydrolysed formula of first choice available without a script5,6

FOR FORMULA FED INFANTS

For more information visit
ONLINE STORE for parents and caregivers
mumstore.com.au

Breast milk is best for babies: Professional advice should be followed before using an infant formula. Introducing partial bottle feeding could negatively affect breast feeding. Good maternal nutrition is important for breast feeding and reversing a decision not to breast feed may be difficult. Infant formula should be used as directed. Proper use of an infant formula is important to the health of the infant. Social and financial implications should be considered when selecting a method of feeding.

Available OTC in pharmacy only

References:


Immune Support

Nutritionally supports the development of the immune system through Nutricia’s patented blend of prebiotic oligosaccharides (0.8g/100mL).1,2,4

Allergy Management

Proven efficacy. Aptamil® AllerPro™ is tolerated by 97% of infants with mild to moderate cows’ milk protein allergy.3

For infants with mild-moderate cows’ milk protein allergy

Available OTC in pharmacy only

References:


FOR HEALTHCARE PROFESSIONALS ONLY

Nutricia Australia Pty Limited, Level 4, Building D, 12–24 Talavera Road, Macquarie Park, NSW 2113. July 2017. ANZ/AAP1/16/0005a. 14394-PT.
Nurses play a key role in implementing effective preventative health services in primary health care, and often lead the team in the management of recalls and reminders. A systematic approach to how preventative care is implemented in individual workplaces is essential, as we know higher levels of preventive services are likely to reduce morbidity and mortality from preventable diseases.

So, where to start? To quote Maria from The Sound of Music, the beginning is a very good place to start. When establishing or reviewing your recall and reminder system, it is imperative that everyone (including administration staff) is aware of and understands at a minimum, the difference between recalls and reminders, and for nurses and practitioners, what constitutes clinical significance.

In the establishment or review of the recalls and reminder system, ensure your workplace is following the relevant recommended guidelines or accreditation standards around the management of recall and reminder systems, such as:

- Aged care – Quality of Care Principles
- Correctional health – National Commission on Correctional Health Care Standards
- General practice – Standards for general practices (4th edition) including Interpretive guide for Aboriginal and Torres Strait Islander health services

Ensuring that risk is mitigated while managing the daily requirements of the workplace and workload are taken into consideration can be a fine balancing act. If each member of the team is aware of differences between a recall and a reminder,

**Key terms**

**Reminders**
Reminders are used to initiate prevention with patients who may benefit from participating in appropriate health promotion and preventive care activities or who may require appropriate and timely review of their treatment and/or their medical devices. Reminders can be either opportunistic or proactive.

**Recalls**
Recalls are a proactive follow up to a preventive or clinical activity and are designed to facilitate patients receiving further medical advice in relation to matters of clinical significance.

**Clinical significance**
This depends on the probability that the patient will be harmed if further medical advice is not obtained as well as the likely seriousness of the harm. While not every test or referral needs to be confirmed, if there is a reasonable suspicion of a clinically significant outcome, then the doctor has a duty to attempt to follow up and recall the patient. Inadequate follow-up and recall may jeopardise the patient’s healthcare and place the responsible doctor(s) at medico-legal risk.
**Key points for general practice**

1. The practice needs a documented system for the follow up of tests and results, with a strong focus on risk management. The system should delineate mechanisms for dealing with normal results, abnormal results (urgent and non-urgent), and important tests/referrals.

2. The system should delineate mechanisms for the follow up of results and the follow up of clinically significant tests.

3. The system should cover how tests and results are communicated to patients.

4. Effectively uses registers and reminder systems to prompt intervention and promote best practice care.

In the process of establishing or reviewing recall and reminder systems, APNA recommends that practitioners contact their medico-legal insurer for advice or precedent to inform their protocols. This may help the workplace and practitioners feel more assured about the implementation of recall and reminder protocols. The importance of having effective, systematic protocols and procedures around recalls and reminders cannot be underestimated. This is especially true in light of the increasing burden of chronic disease and the ever-increasing workload of nurses and medical staff in primary health care. Making time for recall to reduce the risk of harm, and being proactive about reminders for preventative health, may be a small short-term sacrifice for a long-term healthier future to increase the overall health and wellbeing of your population.

APNA’s Nurse Support Line is a member benefit available exclusively to APNA members, and is available during work hours Monday to Friday on 1300 303 184.

**References**

Thunderstorm asthma – how do we

People who are allergic to ryegrass pollen can experience asthma symptoms during springtime thunderstorms in regions with high ryegrass pollen concentrations – even if they have never had asthma before.

Primary health care nurses can help reduce the risk of thunderstorm asthma in two main ways:
- By ensuring that patients with ryegrass pollen allergies are taking preventive medication from October to December – this means intranasal corticosteroids for people with allergic rhinitis and inhaled corticosteroids for people with asthma.
- By advising people at risk to avoid being outdoors in wind gusts during springtime thunderstorms.

What happened in the 2016 Victorian thunderstorm asthma epidemic?
On the Monday evening of 21 November 2016 the world’s largest recorded epidemic thunderstorm asthma event occurred in and around Melbourne and Geelong.1 Hospitals, ambulance services, general practices and community pharmacies were overwhelmed by an influx of people with breathing problems. Over several hours, hospital emergency departments were overloaded by high numbers of people presenting with asthma. Victorian authorities believe that at least nine people died in November as a result of thunderstorm asthma,1 pending the official findings of an inquiry by the Victorian State Coroner.

Thunderstorm asthma epidemics have previously occurred in Australia, predominantly in New South Wales, Victoria and the Australian Capital Territory.1–3 All occurred in October or November.

What, when and who?
What is it and what causes it?
Thunderstorm asthma is an unusual cluster of allergic asthma flare-ups (including severe acute asthma) associated with springtime thunderstorms. It is not necessarily a special kind of asthma. However a certain type of thunderstorm appears to be needed, together with a high pollen count, to trigger this event.

People who are allergic to grass pollen can develop asthma when they inhale outdoor air that contains a high concentration of pollen grains.4 Thunderstorms may increase the risk by breaking up pollen grains into very small particles that penetrate lungs more easily (see Figure 1), but this is not proven.2 Fungal spores may also contribute to thunderstorm asthma in some people.2

All thunderstorm asthma epidemics in Australia are thought to have been caused by the pollen of perennial ryegrass, a common pasture crop.2 High rainfall might contribute to thunderstorm asthma conditions by promoting ryegrass growth and pollination – the Victorian epidemic occurred following a period of unusually high rainfall (see Figure 2).

When does it occur?
The risk is greatest during the first 30 minutes of a thunderstorm, when there are usually gusty winds (see Figure 3). Symptoms can continue or worsen into the next day.

Figure 1: One hypothesised mechanism of thunderstorm asthma. Storms might increase allergic reactions by breaking pollen grains into smaller particles that are more easily breathed in. Source: Marks et al (2001).7 Illustration courtesy of Alex Gonzales.
prepare for this spring?

Risk factors for thunderstorm asthma
Both of:
- hypersensitivity to ryegrass pollen
- exposed to open air during a thunderstorm in pollen season (i.e. outdoors, or indoors with windows/doors open)

Plus either or both of:
- allergic rhinitis (with or without known asthma)
- asthma (especially if poorly controlled or not taking an inhaled corticosteroid asthma preventer).

How can we stop it happening again?
Thunderstorm asthma could be reduced by:

Identifying people at risk
Identifying people at risk because they are allergic to ryegrass allergy – this includes people with positive allergy tests and people who are very likely allergic because they have seasonal allergic rhinitis.

Good hay fever control
Taking regular intranasal corticosteroid starting by 1 October and continuing through December.

Good asthma control
Taking regular preventer treatment containing inhaled corticosteroids, if prescribed (especially important 1 October–end December) and having an up-to-date individualised written asthma action plan.

Education
Warning about the risk of springtime thunderstorms, avoidance advice, and asthma first aid. People at risk should avoid breathing outdoor air during a springtime thunderstorm, especially during wind gusts just before the storm breaks. (See Table 1 on next page)

Who is at risk?
People with seasonal allergic rhinitis (hay fever) who are sensitised to ryegrass pollen (with or without known asthma) are at risk of thunderstorm asthma. In Australia and internationally, at least 90% of recorded cases of thunderstorm asthma have occurred in people with a history of allergic rhinitis. During thunderstorm asthma epidemics, people with a previous diagnosis of asthma have the worst outcomes (e.g. life-threatening asthma or death).

People with asthma are at higher risk of having an asthma flare-up triggered by a thunderstorm if their asthma is poorly controlled or they are not taking regular preventer treatment with an inhaled corticosteroid. People who do not have allergic rhinitis or asthma are at very low risk of thunderstorm asthma.
Thunderstorm asthma – how do we prepare for this spring?

Asthma and allergic rhinitis resources

- Written asthma action plan templates – www.nationalasthma.org.au/health-professionals/asthma-action-plans

Source: National Asthma Council Australia 2017

*Judi Wicking would like to acknowledge Jenni Harman for editorial assistance in the writing of this article.

References


Primary health care nurse’s guide to preventing thunderstorm asthma

<table>
<thead>
<tr>
<th>People with allergy to ryegrass pollen (probable* or definite)</th>
<th>Current asthma (any asthma symptoms during the previous 2 years or currently taking asthma treatment)</th>
<th>Any asthma history (no asthma symptoms for &gt;2 years without treatment)</th>
<th>Allergic rhinitis but never asthma (never wheeze with hay fever symptoms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure taking preventer containing inhaled cortico-steroid, if prescribed. Check adherence October–December.</td>
<td>Ensure recent thorough review of asthma status to rule out or identify need for preventer treatment</td>
<td>Ensure taking intranasal corticosteroids October–December. Provide treatment plan.</td>
<td></td>
</tr>
<tr>
<td>Check inhaler technique for preventer and reliever</td>
<td>Check inhaler technique for reliever</td>
<td>Check nasal spray technique</td>
<td></td>
</tr>
<tr>
<td>Check has up-to-date written asthma action plan that includes thunderstorm advice</td>
<td>Remind how to recognise asthma symptoms and what to do. Provide asthma first aid plan and explain when to call ambulance.</td>
<td>Explain how to recognise asthma symptoms and what to do</td>
<td></td>
</tr>
<tr>
<td>Advise carry reliever at all times (check expiry date)</td>
<td>Advise have access to reliever (e.g. in home, school or work first-aid kit)</td>
<td>Provide asthma first aid plan and explain when to call ambulance.</td>
<td></td>
</tr>
</tbody>
</table>

*It is reasonable to assume that people with seasonal springtime flare up of allergic rhinitis symptoms are sensitised to ryegrass pollen. People with allergic rhinitis symptoms all year round may need allergy testing to identify any ryegrass pollen allergy.

Table 1

Messages for patients

- If you are allergic to ryegrass (e.g. if you get hay fever in spring), you could be at risk of thunderstorm asthma.
- Be proactive leading up to spring – don’t wait for something to happen. By football grand final weekend, you should be taking your hay fever nasal spray, asthma preventer, or both – unless you already take them all year round.
- If you have asthma, follow your written asthma action plan.
- During storms with wind gusts, get inside a building or car with the windows shut and the air conditioner switched to recirculate/recycled.
- Put an asthma first aid poster on your fridge.

Nurses will be hugely influential in the preparation, prevention and promotion of asthma and allergic rhinitis management for patients this pollen season. APNA has been involved in the public and health practitioner campaign preparation and will provide members with resources and information during the season.
Help numb the pain
Help numb the fear

• Vaccinations • Insertion of catheters • Blood sampling • Superficial surgical procedures • Mechanical cleansing of leg ulcers • Minor cosmetic procedures

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numit 5% cream

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Correct diagnosis of chronic obstructive pulmonary disease (COPD) is the first step to properly managing patients with suspected or confirmed lung disease. This is the topic of the latest NPS MedicineWise educational program for consumers and health professionals.

Spirometry is the best standardised, most reproducible and most objective measurement of airflow limitation required for diagnosing COPD, is the gold standard for diagnosing fixed airway obstruction and plays a role in distinguishing between COPD and asthma. Yet local and international primary care studies show that spirometry is vastly underutilised as a tool for accurately diagnosing COPD. In a large Australian population survey (45 and Up Study 2001–2014), most study participants (82%) started on medicines for chronic airways disease had not had lung function testing performed within 12 months, either before or after their initial prescription.

What’s more, misdiagnosis is common; between 20% and almost 40% of patients aged over 40 who are diagnosed by history and physical examination as having asthma actually have COPD. Conversely, some patients are diagnosed as having COPD when they in fact have asthma.

COPD is preventable and treatable

Patients with chronic respiratory diseases are among the ‘frequent flyers’ of primary care. According to the Bettering the Evaluation and Care of Health (BEACH) survey, in the period 2005–06 to 2014–15 the estimated rate of COPD management in general practice increased from 0.7 to 0.9 per 100 encounters.

The main aims of pharmacological treatment are to control symptoms and to reduce the risk of severe exacerbations or deterioration. As long-term exposure to lung irritants that damage the lungs and the airways is the most common cause of COPD, primarily smoking but also industrial dust, chemical fumes and air pollution, many cases of COPD are preventable by avoidance or early cessation of smoking. Stopping smoking is also the simplest way to help improve symptoms and slow the rate of COPD progression. Early diagnosis of COPD is important because smokers with demonstrated airway obstruction are more likely to quit smoking.

So how can nurses cause an effect?

Early detection of airflow limitation and early intervention with medicines, pulmonary rehabilitation programs and programs to assist with stopping smoking can delay lung function decline, reduce the burden of COPD symptoms, reduce the risk of exacerbations and improve patients’ quality of life. Spirometry is a painless and non-invasive test for detecting and evaluating lung disease that can be done in general practice and primary health care.

Although spirometry is not difficult, it requires some effort from patients. Nurses can, with training and experience, ensure this test is used appropriately and effectively so that patients get the care they need.

Spirometry in practice

There are several reasons for the underuse of spirometry, including time constraints, staffing issues, inadequate training and expertise, and lack of confidence in interpreting data.

Spirometers are easier to use

Spirometers used to be large and cumbersome instruments. Now, thanks to technological advances, spirometry can be done much more easily in a primary care setting with smaller, plug-and-play devices that can be integrated with practice management software. Standardised predicted reference values for spirometry are available and are pre-programmed into spirometers.
Spirometry for COPD – Putting it to good use

A wide range of resources on spirometry is available in the Spirometry Users and Buyers Guide, which can be downloaded free from the National Asthma Council Australia website.

Training to properly administer and interpret the procedure

Because spirometry is based on maximal forced exhalation, the accuracy of its results is highly dependent on the patient’s understanding of what is expected, cooperation and best efforts. Accordingly, proper technique is essential and there are guidelines as to how to best prepare patients for spirometry.21

Having dedicated trained staff performing spirometry is a good option in a busy practice.22 This can address time barriers for busy GPs, improve the quality of testing and enhance teamwork to improve efficiency and delivery of care.

Spirometry training courses* are offered by:

- National Asthma Council Australia
- Asthma Australia
- Asthma Foundation South Australia
- Lung Health Promotion Centre at The Alfred
- Queensland Health
- Indigenous Respiratory Outreach Care (IROC) Program
- Spirometry training professionals

*Courses may be face-to-face or online, and vary in duration, cost and accreditation status.

Spriometry resources

A wide range of resources on spirometry is available from the National Asthma Council Australia.

- Spirometer Users’ and Buyers’ Guide – a guide to selecting a spirometer, including a summary of the specifications, features and suppliers of the main spirometers on the Australian market, plus general information about the measurement and application of spirometry in the primary care clinical setting
- Spirometry: The Measurement and Interpretation of Ventilatory Function in Clinical Practice – an introductory handbook for people involved in performing and interpreting spirometry in primary care
- Pocket Guide to Spirometry, 3rd edition – a detailed guide to spirometry, including what a spirometer is, how to use one, how to interpret the test results and the different types of spirometers
- Performing Spirometry in Primary Care – a video demonstrating correct technique for spirometry on patients in primary care

More information and helpful resources

A new health professional program on COPD medicines and inhalers – developed by NPS MedicineWise – provides health professionals with an update on the latest COPD products that have been PBS listed over the last couple of years including fixed-dose combination inhalers. Resources available at nps.org.au/copd include:

- NPS MedicineWise case study
- NPS MedicineWise News
- NPS MedicineWise patient resources on getting ready for spirometry and inhaler technique

References


Practice points for primary healthcare nurses

- Increase your knowledge and awareness of the role of spirometry in primary care, particularly for chronic obstructive pulmonary disease (COPD)
- Develop your skills to perform high quality spirometry
- Maintain your competence to perform spirometry via educational programs
- Learn strategies to incorporate spirometry testing into routine clinical practice

Managing COPD using a stepwise approach

Navigating the plethora of COPD medicines

Multiple single and fixed-dose combination (FDC) inhalers and medicine classes are approved to treat COPD. There are short- and long-acting beta-2 agonists (SABAs and LABAs), short- and long-acting muscarinic antagonists (SAMAs and LAMAs), and inhaled corticosteroids (ICS)*.1,2

But this range of choice comes with challenges, with health professionals having to decide which of the many medicine or inhaler options is most appropriate for each individual patient with COPD.

Fortunately, Australian COPD guidelines, including those developed by Lung Foundation Australia and the Thoracic Society of Australia and New Zealand, can help nurses navigate the options available and determine when and how to treat.1,2

*ICS monotherapy is not indicated for COPD.

Optimising medicines using a stepwise approach

Medicines for COPD should be started and stepped-up gradually until adequate control of breathlessness, functional capacity and exacerbation frequency is achieved.1 In symptomatic patients with COPD, Australian guidelines recommend:1,2

- for patients with mild COPD, initially prescribe a short-acting bronchodilator to be used when required for the short-term relief of breathlessness
- add a LABA or LAMA if symptoms are persistent despite optimal use of short-acting bronchodilators. A LABA and LAMA can be used in combination if monotherapy with a long-acting bronchodilator is inadequate
- consider an ICS + LABA FDC for patients with FEV1 < 50% predicted and two or more exacerbations in 12 months

- If starting a LABA + LAMA FDC, discontinue any existing inhaler containing a LABA or a LAMA
- If starting an ICS + LABA FDC, discontinue any existing inhaler containing a LABA.

You can find the complete stepwise recommendations, as well as a single page summary, on Lung Foundation Australia’s COPD-X website at www.copdx.org.au.

Terminology

LABA  long-acting beta-2 agonists
SABA  short-acting beta-2 agonists
LAMA  long-acting muscarinic antagonists
SAMa  short-acting muscarinic antagonists
ICS   inhaled corticosteroids
FDC   fixed-dose combination
FEV1  forced expiratory volume in one second
FVC   forced vital capacity

Hitting a moving target

Chronic obstructive pulmonary disease is usually a progressive disease characterised by gradual decline in lung function.3 Additionally, people will also present with different stages, or severity levels, of COPD (see Table 1).1

Practice points for primary health care nurses

- Recall that each patient’s medicines should be tailored using a stepwise approach based on the level and progression of their COPD symptoms
- Check patients’ adherence and inhaler technique regularly, before treatment is stepped up, after an exacerbation or at transitions in care
- Develop strategies to obtain quality spirometry results
- Encourage patients to have their medicines reviewed when changing therapy, after an exacerbation or at transitions in care, to avoid harmful duplication of medicine classes


Lung Foundation Australia Stepwise Management of Stable COPD
If we consider COPD a moving target, spirometry can tell us where the target is so that we can select the most appropriate medicine. Spirometry is the most reproducible and objective measurement of airflow limitation available. It can be used alongside symptoms, signs and history of exacerbations to confirm a COPD diagnosis and enable tailoring of treatment according to the severity of COPD being experienced.1–3

Help your patients get the most out of their inhalers

Successful management of COPD relies on use of inhaled medicines. However, it has been reported that up to 90% of patients don’t use their devices correctly and, therefore, may not be receiving the dose they should. Incorrect inhaler use can reduce the effectiveness of prescribed COPD medicines, resulting in poor symptom control.1,4,5

Nurses delivering primary health care can play a central role in training patients in inhaler use and also checking inhaler technique. Patient technique, compliance and confidence levels have all been shown to improve with nurse-led education.6,7 The NPS MedicineWise inhaler technique checklist can be used to teach, check and/or confirm the way your patients use their inhalers.8

The National Asthma Council Australia recommends checking inhaler technique at each patient encounter using the following steps:8,9

- Have the patient demonstrate their inhaler technique, while checking against a checklist of steps for the specific device.
- Demonstrate correct technique using a placebo device and correct any specific errors identified.
- Have the patient repeat the demonstration to check they can now use the device correctly. If necessary, repeat instruction until the patient has all the steps correct.
- Remind patients to bring inhalers to their appointments, so they can demonstrate their technique. This includes the once- or twice-daily inhalers that patients might not usually carry with them. Watch the person use their inhaler — don’t just ask whether they think they know how to use it properly.
- When prescribing a particular inhaler, health professionals need to consider a number of clinical and patient-specific factors, including cognition and dexterity, as well as which inhaler a patient might accept and prefer.1,10–12

Overall, the choice of COPD medicine should take into account potential benefits, side effects and cost of treatment — and patient preference.7

More information and helpful resources

The NPS MedicineWise educational program on COPD medicines and inhalers provides health professionals with an update on the latest COPD products that have been PBS listed over the last couple of years including fixed-dose combination inhalers. Resources available at www.nps.org.au/copd include:

- Patient resources on getting ready for spirometry and inhaler technique
- MedicineWise News: The value of spirometry in clinical practice
- Online case study: Navigating inhaled medicines management

References


<table>
<thead>
<tr>
<th>Lung function</th>
<th>Mild COPD</th>
<th>Moderate COPD</th>
<th>Severe COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The presence of a post-bronchodilator FEV1/FVC ratio of &lt; 0.7 confirms the presence of persistent airflow limitation, and thus of COPD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEV1 60% to 80%</td>
<td>FEV1 40% to 59%</td>
<td>FEV1 &lt;40%</td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>Few symptoms</td>
<td>Increasing dyspnoea</td>
<td>Dyspnoea on minimal exertion</td>
</tr>
<tr>
<td>Breathless on moderate exertion</td>
<td>Breathless walking on level ground</td>
<td>Daily activities severely curtailed</td>
<td></td>
</tr>
<tr>
<td>Recurrent chest infections</td>
<td>Increasing limitation of daily activities</td>
<td>Experiencing regular sputum production</td>
<td></td>
</tr>
<tr>
<td>Little or no effect on daily activities</td>
<td>Cough and sputum production</td>
<td>Chronic cough</td>
<td></td>
</tr>
<tr>
<td>Exacerbations requiring oral corticosteroids and/or antibiotics</td>
<td>Exacerbations of increasing frequency and severity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1. Level of lung function and typical symptoms, according to COPD severity level6–5

NPS MedicineWise

NPS MedicineWise is an independent, not-for-profit and evidence-based organisation working across Australia and throughout the Asia-Pacific region to positively change the attitudes and behaviours which exist around the use of medicines and medical tests, so that consumers and health professionals are equipped to make the best decisions when it counts.
After a 30 year career covering acute and primary care nursing, enrolled nurse Emma tells us what it’s like to work on a cruise ship.

**Where are you from?**
Johannesburg, South Africa

**What’s your work background?**
A four year Nursing Diploma (General, Midwifery and Trauma). I started my nursing career as a student nurse at Steve Biko Academic Hospital in Pretoria, South Africa in 1984. Since then I have more than 30 years of experience in various fields, like pre- and post-natal care, surgical, medical, ICU, trauma and occupational health. I have also completed extra courses to improve my skills and to satisfy my hunger for knowledge.

**How did you get into cruise nursing?**
I love travelling and decided that it’s time to broaden my horizons. Working at sea provides me with the opportunity to travel.

**What is a typical day in your cruise nursing life?**
Working at sea as a nurse, I rarely experience a typical day. The daily work schedule consists of two clinics during the day for crew and passengers. During this time you will do nursing tasks like taking vitals and triaging patients for the doctor, and dispensing medication. At sea we are also responsible for taking X-rays and performing laboratory tests. Another daily responsibility involves managing the administration aspect of the medical centre. This includes keeping the medical centre stock and equipment up to date. Equipment checks are done daily to make sure that the equipment is in good working condition. The medical stock is counted on a regular basis to ensure essential medication does not run out while at sea. Then there is the ‘Medical Shore Party’, which involves manning a medical station on an island during some port calls, if there is no available medical facility nearby. So some days, our ‘office’ is the beach.

**Where are some of the places you have travelled to?**
Some of the places I have travelled include Alaska, Canada, South America, the Falkland Islands, Costa Rica, the Panama Canal, the Caribbean, Cayman Islands, Mexico, Venice, Greece, France, Turkey, Singapore, Thailand, Brunei, Vietnam, Vanuatu, Papua New Guinea, Indonesia, and from Perth all around Australia to Sydney.

**What people do you treat?**
I have treated all sorts of people – anyone can get ill or injured while at sea, just like on land.

**What are some of the problems you’ve treated?**
Working on board a ship you see the same things you would see in an emergency department as well as a common general practice. From common colds and flus to motion sickness as well as scratches and scrapes. I even saw an abdominal aorta aneurism (AAA) once that is very rare but deadly if missed. Without trained professionals on the ship, serious problems could easily be missed and the patient could end up in trouble. Having us on board just gives guests extra peace of mind that they will be safe if anything happens.

**What are your favourite bits about your job?**
It definitely has to be treating the crew members, they are so thankful for anything you do for them. Sometimes you are a mother and other times a friend.

**Do you ever get seasick?**
No. I have a big love for the sea and even got my own skipper’s license so I am used to the motion.

**How long do you go away for?**
My contract is normally four months at a time but sometimes it can be extended. The longest I have been away from home was five months on a single contract.

**How long do you think you’ll work on a cruise ship for?**
At least the next 10 years.

**What have you learned as a cruise nurse?**
Learning in nursing never stops and I am still learning on a daily basis. Working as a nurse on ships you have to be a ‘jack of all trades’ and skilled in all departments. I did however, on a more personal note, learn to appreciate the small things in life. Such as, when I am back at home, opening a window in my room or just driving my car.

**Do you ever get homesick?**
Definitely – we all get homesick, but you learn to deal with it. It just makes getting home that much more special.

**Do people envy your job?**
Yes, there are a lot of nurses that cruise as passengers and come up to me to talk about nursing. They all usually say they envy my job and would love to work on a cruise ship.
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AVAILABLE FOR 70 YEAR OLDS, WITH A 5-YEAR CATCH UP PROGRAM FOR 71–79 YEAR OLDS¹

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MINIMUM PRODUCT INFORMATION: ZOSTAVAX® Zoster Virus Vaccine Live (Oka/Merck), Refrigerator stable

Indications: Prevention of herpes zoster (shingles) in individuals 50 years of age and older. Prevention of postherpetic neuralgia (PHN) and reduction of acute and chronic zoster-associated pain in individuals 60 years of age and older. *Contraindications: History of hypersensitivity to any component of the vaccine, including gelatin. History of anaphylactic/anaphylactoid reaction to neomycin. Primary and acquired immunodeficiency states due to conditions such as: acute and chronic leukemias; lymphoma; other conditions affecting the bone marrow or lymphatic system; immunosuppression due to HIV/AIDS; cellular immune deficiencies. Immunosuppressive therapy including high-dose corticosteroids, but not topical/inhaled corticosteroids. ZOSTAVAX is a live, attenuated varicella-zoster vaccine and administration may result in disseminated disease in immunosuppressed or immunodeficient patients. Active untreated tuberculosis. Pregnancy (see PRECAUTIONS). Precautions: Adequate treatment provisions, including adrenaline injection (1:1000), should be available for immediate use should an anaphylactic/anaphylactoid reaction occur. Consider deferral of vaccination in the presence of fever >38.5°C. Safety and efficacy not established in adults known to be infected with HIV. Use in Pregnancy (Category B2): Do not administer to pregnant females; pregnancy should be avoided for 3 months after vaccination. Use in Lactation: It is not known whether VZV is secreted in human milk. Use in the elderly: The mean age of subjects enrolled in the largest (N=38,546) clinical study of ZOSTAVAX was 69 years (range 59-99 years). ZOSTAVAX was demonstrated to be generally safe and effective in this population. *Interactions with other medicines: ZOSTAVAX can be administered concurrently with inactivated influenza vaccine. ZOSTAVAX and PNEUMOVAX 23 should not be given concomitantly because concomitant use resulted in reduced immunogenicity of ZOSTAVAX. Consider administration of the two vaccines separated by at least 4 weeks. Adverse Effects: headache, erythema, pain/tenderness, swelling, pruritus, fatigue, haematoma, warmth, induration, pain in extremity. Post-marketing experience: varicella, zoster, nausea, arthralgia, myalgia, injection-site rash, injection-site urticaria, pyrexia, transient injection-site lymphadenopathy, hypersensitivity reactions including anaphylactic reactions, rash, necrotizing retinitis. Dosage and Administration: A single dose (0.65mL) administered subcutaneously. Administer vaccine immediately after reconstitution to minimise loss of potency. ZOSTAVAX is not a treatment for zoster or PHN. Based on Approved Product Information dated 26 April 2016.

*Please see change(s) in Product Information

PBS Information: This product is listed on the National Immunisation Program (NIP). Refer to schedule.

More can be done to cut the burden of fractures from poor bone health

Osteoporosis and osteopenia

More can be done to cut the burden of fractures from poor bone health

WESTERN AUSTRALIA

• 45% increase of older people with low bone mass 2012–2022
• 51% increase in annual fractures (over 10 years) to 20,470 fractures per year in 2022
• Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $307 million (69% of which relates to treatment of fractures).

Osteoporosis is increasingly prevalent in an ageing population and may affect a large proportion of primary health care patients including aged care residents.

Minimal trauma fractures (commonly of vertebrae, wrist and hip) are a major health burden in ageing populations.

They cause pain, severe disability and reduced quality of life and are associated with increased risk of repeat fracture and excess mortality. Fracture of the hip is considered the most serious, requiring hospitalisation and surgery, and is associated with the most complications.

In 2012, Australians experienced more than 140,800 fractures related to osteoporosis or osteopenia (the precursor to osteoporosis).

This number is predicted to increase by 30% over the next decade. In 2006–07, approximately one in nine patients hospitalised for osteoporotic hip fracture were discharged to an aged care facility.

People who sustain a hip, vertebral or non-hip major fracture have reduced survival compared with the general population. This elevated risk of death persists for 10 years after an initial fracture, but is greatest for the first five years. Despite this, fewer than 20% of patients presenting with minimal trauma fracture are investigated or treated for osteoporosis.

NPS MedicineWise

See NPS MedicineWise Osteoporosis in aged care clinical topic www.nps.org.au/medical-info/clinical-topics/news/osteoporosis-in-aged-care for more of this article and full references.

Practice points for primary health care nurses

• Assess older patients* for bone health and fracture risk. Assess residents admitted to aged care facilities for fracture risk to ensure effective fracture prevention measures are implemented.
• Consider falls prevention measures for all elderly patients. Work with aged care facilities to introduce measures to reduce the risks of falls for residents.
• Regularly review medicines for elderly patients to minimise falls risk. Consider common adverse effects and polypharmacy when reviewing risk.
• Refer to the NPS MedicineWise decision pathway for PBS-listed treatment selection for management of confirmed osteoporosis and corticosteroid-induced osteoporosis.

*Patients aged ≥70 years are eligible for MBS-subsidised bone densitometry.

Failure to prevent fractures costs

In June this year Osteoporosis Australia released its Burden of disease reports analysing the costs and burden of poor bone health for each state and territory in Australia.

According to the reports, 4.74 million Australian residents aged 50 and above are currently living with brittle bones. This figure is expected to climb in the next five years, leading to a cascade of fractures, which could be prevented, saving millions of dollars and improving patient lives. The report estimates by 2022, there will be 183,105 fractures in Australia each year.

According to Osteoporosis Australia Medical Director, Professor Peter Ebeling AO, ‘A broken bone is usually a sign that we need to take action to prevent more bone loss, as each fracture significantly raises the risk of a further fracture. What is extremely worrying is that four out of five Australians treated for an osteoporotic fracture are not tested for osteoporosis, and therefore, are not offered treatment for osteoporosis.’

‘There is a significant gap in osteoporosis care, and our hospitals are becoming revolving doors for fracture patients being sent home, and returning with new fractures, rather than being properly assessed and treated for osteoporosis.’

Australians are being unnecessarily left to endure the pain of repeated fractures. More often than not, people are sent home, after their fracture has been ‘fixed’, and miss out on essential investigation and care which in many cases would prevent further fractures.

Direct costs of managing fractures from osteoporosis include ambulance services, hospitalisations, emergency and outpatient departments, rehabilitation and community services. The report says these are preventable costs.
OSTEOPOROSIS AND OSTEOPENIA

More can be done to cut the burden of fractures from poor bone health.

NSW/ACT
- 26% increase of older people with low bone mass 2012–2022
- 29% increase in annual fractures (over 10 years) to 63,685 fractures per year
- Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $1.1 billion

VICTORIA
- 39% increase of older people with low bone mass 2012–2022
- 46% increase in annual fractures (over 10 years) to 38,800 fractures per year in 2022
- Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $611 million

QUEENSLAND
- 39% increase of older people with low bone mass 2012–2022
- 46% increase in annual fractures (over 10 years) to 38,800 fractures per year in 2022
- Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $611 million

TASMANIA
- 25% increase of older people with low bone mass 2012–2022
- 32% increase in annual fractures (over 10 years) to 4,900 fractures per year in 2022
- Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $78 million

SOUTH AUSTRALIA
- 25% increase of older people with low bone mass 2012–2022
- 31% increase in annual fractures (over 10 years) to 15,300 fractures per year in 2022
- Direct cost of osteoporosis and osteopenia in adults aged 50+ in 2017: $255 million

Fracture facts
- In 2013 there was one fracture every 3.6 minutes in Australia, 395 fractures per day or 2,765 fractures per week.
- By 2022 there will be one fracture every 2.9 minutes, 501 fractures per day or 3,521 fractures per week.
- Compared to a fracture every 5–6 minutes in 2007 and a fracture every 8.1 minutes in 2001.
- In 2012 there were 140,822 fractures that occurred as a result of osteoporosis or osteopenia. In 2022 it is expected there will be a 30% increase in the annual number of fractures resulting in 183,105 fractures each year.
- The estimated total number of fractures over the next 10 years is over 1.6 million. This includes new fractures and re-fractures.
- Osteoporosis and osteopenia is not just a ‘women’s disease’. Men account for up to 30% of all fractures related to osteoporosis and osteopenia, and their associated costs.

The cost of fractures
- In 2012 the total cost of osteoporosis and osteopenia in Australians over 50 years of age was $2.75 billion.
- It is predicted that in 2022 the total costs will be $3.84 billion.
- That is a total cost of fractures of $22.7 billion over the next 10 years. These costs include ambulance services, hospitalisations, emergency department and outpatient services, rehabilitation, aged care and community services.
- Total direct and indirect cost of osteoporosis, osteopenia and associated fractures over 10 years is $33.6 billion.

What can be done?
- Fund a re-fracture prevention initiative to follow up and coordinate the care of every Australian who has sustained their first fragility fracture.
- Reimburse bone density testing for menopausal women aged 50 with risk factors for osteoporosis.
- More funding for education and awareness programs about healthy bones as prevention is best, and the high rates of osteopenia are alarming.

Photo: www.fracturepreventionmediakit.org
More can be done to cut the burden of fractures from poor bone health

Yvonne, 70, Perth

Retired nurse, sustained multiple hip fractures from osteoporosis

Retired nurse, small business owner and movie enthusiast, Yvonne, fell after tripping on a curb and fractured three of her ribs. While her ribs were healing, Yvonne was referred for a bone mineral density (BMD) test and was subsequently diagnosed with osteoporosis.

‘I fell just after my son got married in 2001, and broke three ribs. I couldn’t work for several weeks and was in immense pain. I had to be very aware of everything I was doing, because you can’t immobilise your ribs like other parts of your body.’

Yvonne is well aware of the toll osteoporosis can have on a person’s body, after serving as a full-time carer to her mother who battled osteoporosis for three decades. Having witnessed first-hand the impact of poor bone health, Yvonne has long adhered to a strict diet and exercise regime, and regular vitamin D and calcium supplements.

‘I used to think about osteoporosis on a daily basis when my mother was alive. She was almost constantly in pain. She lost a huge amount of height when her spine collapsed and eventually ended up like a really round ball.’

Yvonne likens her mother’s bones to eggshells, explaining that every additional year she lived, the orthopaedic specialist found it increasingly difficult to treat her multiple fractures.

After observing her mother’s deterioration from the disease, Yvonne considers herself fortunate to have avoided any further fractures post-diagnosis. Initially, Yvonne was diagnosed with osteoporosis in her hips and spine. However, following treatment, has witnessed significant improvements in her bone health.

‘I’m on the right course of treatment. I see my doctor and have my BMD tested on a regular basis. I take vitamin D and calcium supplements each fortnight, in addition to eating a lot of cheese and other dairy products. Up until I finished work last November, I would also walk 11 kilometres a day throughout the hospital wards. I try to maintain my walking now because it’s pivotal to maintaining strong bones.’

‘It never fails to amaze me the number of people who have a fracture and don’t know they have weak bones,’ Yvonne says. ‘People should be aware of their bone health.’

Jane, 49, Melbourne

Nurse and mother of three diagnosed with osteoporosis aged 38

Clinical research nurse and mother to three Jane was diagnosed with osteoporosis in 2006, then aged 38. A diagnosis of premature menopause led to a routine bone mineral density test that identified osteoporosis.

Each day Jane juggles the schooling of her three children and their various activities with her job as a clinical research nurse in a Melbourne hospital.

Yet despite her hectic schedule, Jane finds time for step aerobics and Pilates, and following a healthy diet. She has eschewed caffeine, takes calcium and vitamin D tablets daily, and even alights her train a stop early to fit more exercise into her day.

Strict adherence to a healthy lifestyle is necessary for Jane, who has been living with osteoporosis for 11 years. The diagnosis came as a shock to Jane, not only due to her age, but her pristine health record.

‘I suspected I may have had a predisposition to osteoporosis, since my mum and my aunties had osteoporosis. I’ve always consumed foods high in calcium, exercised a lot, and never smoked. I was pretty upset at the time. I thought I could have developed the disease in older age, but I was only 38 at the time with three young children.’

Post-diagnosis, Jane underwent a series of X-rays to determine whether she had sustained any fractures.

‘In order to qualify for government-subsidised medication, I had to undergo X-rays. They found a fracture in the middle of my back, in the thoracic section of my spine. I recall in 2000, at the age of 32, when I lifted my two month old son out of his cot and experienced sudden, severe back pain. The pain continued for weeks on end, without respite. I’m sure that was a fracture. At the time, I had no X-rays. No one suggested it, and no one was looking for osteoporosis, given my age.’

A six monthly injection is part of Jane’s osteoporosis management plan. She also attends a Melbourne osteoporosis support group to keep up to date with osteoporosis-related information and tips from other members.

As a nurse specialising in orthopaedics, Jane is aware of how fractures can affect one’s livelihood. As part of her duties, for one day a week, she ensures inpatients with minimal trauma fractures are screened for osteoporosis.

‘I’m concerned about fracturing another bone, because I see what people go through. A lot of people over the age of 50 break their wrist, and come to hospital, have the appropriate fracture treatment and go home. They don’t seem to receive information and advice about re-fracture prevention. Hospital healthcare workers are too busy to take this on, so we need to get people visiting their general practice for information.’

From her observations, Jane maintains there is insufficient education and awareness among those who sustain fractures. ‘Osteoporosis is seen as an older person’s disease, but there are many younger people also living with the disease. It’s a national health priority.’
Anne, 70, Brisbane

Former nurse and avid traveller who has experienced multiple fractures due to osteopenia

Former nurse Anne has been living with osteopenia for nine years.

At 61 years of age, Anne was leading an active lifestyle, working part-time as a nurse in a Brisbane hospital and pursuing various activities, including bike riding. In January 2008, Anne fell off her bike and sustained her first fracture.

‘It was an undisplaced fracture. I had a cast on my wrist for about six to eight weeks before it was removed. Unfortunately, I had another fall on a wet floor shortly after the cast was removed. This fracture caused much more damage, which led to the insertion of pins and plates in my wrist.’

After Anne’s second fracture, her GP advised her to undergo a BMD scan.

‘The scan revealed I had osteopenia. My GP didn’t think it was especially significant at the time. She felt it was possibly age-related. I underwent blood tests and was prescribed vitamin D tablets.’

Six years later, in 2014, Anne and her husband were staying at their holiday unit in Coolangatta. She was mopping the bathroom floor in preparation for the next tenant.

‘I didn’t think the tiles were still wet, but I slipped over. I fell forward and hit my hand on the brick wall. The force of the fall caused two fractures in the upper arm, a spiral fracture of the shaft of the humerus and also fractured the neck of the humerus.’

In severe pain, Anne was unable to move. So her husband called an ambulance.

‘Once the paramedics arrived, they gave me the green whistle to provide pain relief. They managed to get me up from the floor and supported my arm in an immobiliser. Since we were in an older building, they were unable to bring the gurney up to me. With the pain relief and the arm secured in a sling I was able to walk down the stairs to the ambulance. More pain relief was given on the way to hospital.’

Anne was admitted to the emergency department of a private hospital near Coolangatta.

‘I had several X-rays and was given frequent pain relief. The surgeon who came to see me was advising surgery for the following day. I was very well cared for but didn’t know any of the healthcare professionals in the area, so I opted to return to Brisbane for surgery.’

‘My co-workers recommended a Brisbane-based orthopaedic surgeon who operated at the hospital where we worked. I stayed overnight at the hospital in Coolangatta for pain relief, and left the next day.’

After returning to Brisbane, Anne visited the orthopaedic surgeon, had further X-rays and was scheduled for surgery the following day. A metal plate and 12 screws were inserted to stabilise both fractures.

‘I commenced physiotherapy the day after surgery and continued for months after the operation. Unfortunately I never achieved full range of movement to my shoulder so was unable to return to work. Relatively simple things, like hanging IV lines and bags, would have been difficult. I had used all my sick leave and long service leave so had no option but to retire. It was quite depressing to not be able to return to work. I was due to retire but had wanted to leave on my terms.’

Anne has been fracture-free since 2014. She recently joined a dedicated bone clinic in Brisbane that uses weight-bearing exercises, balancing, and low impact movements to help regenerate bone density. This is closely supervised by exercise physiologists, supported by dietary checks and ongoing research.

The need for heightened public awareness and information about osteopenia and osteoporosis is a focal point for Anne.

‘When sustaining fractures, I felt I should have been doing more bone building exercises and have been more proactive treatment-wise. I think GPs need more information about osteoporosis and osteopenia. It would be helpful to have some referral options as it’s sometimes difficult to find what is available.’

Anne is now a strong advocate for improved patient education, awareness and action involving brittle bones.

‘Preventative measures often help keep people out of trouble and out of hospital,’ says Anne. ‘If you suspect you’re at risk of fracture, you should keep asking questions of the relevant health professionals.’

Osteoporosis Australia

Osteoporosis Australia is a national not-for-profit organisation responsible for providing osteoporosis information and services to the community and health professionals. Find the series of state and territory reports published in June highlighting the extensive costs of fractures from poor bone health at www. osteoporosis.org.au/burdenofdisease. The reports show the cost impact of osteoporosis and fractures in each state for the population 50 years and over.

SOS Fracture Alliance

The independent SOS Fracture Alliance is Australia’s only national alliance focusing on the prevention of osteoporotic fractures. Formed in October 2016, the SOS Fracture Alliance unites 30 medical, nursing, allied health, patient and consumer organisations focusing on the prevention of osteoporotic fractures, in order to make the first break, the last.
You’ve got mail

More than fifteen years ago, isolation drove a handful of nurses working in general practice to form APNA.

Now, the primary health care nurse community is strong and united – with clear direction, drivers and aspirations. However, it is a characteristic of primary health care that nurses can still find themselves professionally isolated at times.

We’ve been dishing out postcards all over the nation – to get nurses talking, to show what you have in common, what you can learn, and to share your love of nursing with each other.

We hope these words breathe wisdom and passion into your nursing life.
FROM MEMBERS

My advice for nurses new to primary health care is...

Mel to
APNA
159 Dorcas Street
South Melbourne VIC 3205

Belong. Connect. Learn. And be inspired at www.apna.asn.au

APNA is part of my nursing story because...

Mel to
APNA
159 Dorcas Street
South Melbourne VIC 3205

Belong. Connect. Learn. And be inspired at www.apna.asn.au

No-one else would listen and support me as an EN working in general practice.

Mel to
APNA
159 Dorcas Street
South Melbourne VIC 3205

Belong. Connect. Learn. And be inspired at www.apna.asn.au

After some experience in hospitals in the public health system, I was assisting to gain new skills and transition current skills to nursing from a different perspective. I have motivation for nursing.

Mel to
APNA
159 Dorcas Street
South Melbourne VIC 3205

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Supporting nurses in primary health care

I have a member who joined APNA after a P.N. Network ever went to the APNA Conference.

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South Melbourne VIC 3205

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Supporting nurses in primary health care

You need to pace yourself and get a good understanding of the key duties of your head area. It won’t happen over night, it won’t happen but work will happen. Support.

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Pioneers in science, experts in allergy protection and management

BREAST MILK IS BEST FOR BABIES: Professional advice should be followed before using an infant formula. Introducing partial bottle feeding could negatively affect breast feeding. Good maternal nutrition is important for breast feeding and reversing a decision not to breast feed may be difficult. Infant formula should be used as directed. Proper use of an infant formula is important to the health of the infant. Social and financial implications should be considered when selecting a method of feeding.

FOR HEALTHCARE PROFESSIONALS ONLY
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