Australian College of Neonatal Nurses Inc.
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# Newsletter

December 2017

## About the newsletter

This newsletter is the official communication of the Australian College of Neonatal Nurses to its members, produced quarterly in March, June, September and December. It presents information on a range of professional issues and clinical topics of interest to neonatal nurses. Any member of ACNN may contribute.

Articles should be submitted by email as Word documents. Any images should be in jpg format. Referencing style should follow the Vancouver style. All content will be edited to newsletter standard.

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Please send correspondence to the newsletter team at newsletter@acnn.org.au

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### Next deadline: 1 February 2018

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| | |
|---|---|
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## President's Report

I am delighted to provide my last report for 2017, a year that has been very good for our organisation which has continued to grow and strengthen. At the time of writing this, we have 883 financial members with another six new applicants – what an achievement, nearly 100 per cent increase in a few years. How good would it be to have 1,000 members by our next conference? So let's all keep encouraging our colleagues to join.

Our branches and special interest groups also grow, and we now have five branches and six special interest groups. Please look on the website for their activities. Excitingly, in the last two years we welcomed the new ACT Branch and most recently the Neurodevelopmental Care SIG. We also have some interest in establishing a branch in Western Australia, which would be fabulous.

Our conference on Fraser Island was a great success, with glowing reports from our invited speakers and delegates. Work is now underway organising the 2018 conference which will be held in Launceston, 29 – 31 August 2018. I think Tasmania will be a great venue for our next conference.

I am also pleased to say that the scholarship with the University of Tasmania will be available again in 2018. This is a great benefit for our members.

It has been a privilege to work with the members of the national committee, the operating committees of the branches and SIGs and our representatives on many committees. I thank you all for your dedication and look forward to 2018.

I wish everyone a safe, healthy and Happy Christmas and New Year,

With best wishes,

***Karen Walker***

ACNN President

# A guide to writing abstracts for conferences

**Dr Jennifer Dawson and A/Prof Karen Walker**

It is an important and sometimes challenging task to write a concise, but eye-catching abstract to submit to conference organisers. Abstracts are the first impression of your work and describe what you plan to present. They are also the primary basis upon which the program committee selects papers for inclusion in the program, thus a poorly written abstract submitted to a conference organiser is very unlikely to be accepted. Conference organisers generally receive many more abstracts than can be presented, thus the importance of creating a well-written abstract is a skill, which can be learned. Mastering this skill will increase the probability that your work will be selected for presentation. This paper provides some advice for writing a well-structured abstract.

*Know the rules*

The first rule of writing abstracts is to know the rules. Organisers of scientific meetings set explicit limits on the length of abstracts. Authors must pay close attention to the published details of the meeting including deadlines and suggested format. The 'house style' of the conference can include directions on type and size of font, line spacing, margins and word counts. Additionally, ACNN conference abstracts must fit into a formatted box. Since reviewers have many abstracts to read and rank, those that don't conform to the stated rules may not be scored highly and for some conferences may not even be considered.

*The abstract must be of publishable quality*

The abstract of a conference presentation is generally the only part of the presentation that is published in conference proceedings. Therefore, it must be of publishable quality and should represent what is in your presentation.

Grammar and spelling are important. Things to avoid when constructing your abstract:

- Writing long sentences (recommended maximum approx. 25 words)
- Writing incomplete sentences
- Grammatical mistakes, for example, using inappropriate tense of verbs or improper subject-verb agreement
- Using exaggerated, overblown and grandiose words
- Using non-required synonyms and repetitive words

*Ensure you have sufficient time to write your abstract*

Although short in length, a good abstract typically takes several days to write. Take this into account when budgeting your time. Seek the help of an experienced mentor. Share the abstract with your mentor and make revisions based upon the feedback. Allow others to read your draft for clarity and to check for spelling and grammatical mistakes. Reading the abstract orally is an excellent way to catch grammatical errors and word omissions.

Avoid the use of medical jargon and excessive reliance on abbreviations.

Limit abbreviations to no more than three and favour commonly used abbreviations. Always spell out the abbreviations the first time they are mentioned unless they are commonly recognised (e.g. NHMRC).

*Use headings*

The scientific abstract is usually divided into five unique sections: Title and author information, Introduction, Methods, Results, and Conclusion. When the abstract is not describing research findings alternative headings may be required.

**Title and author information**: The title should summarise the abstract and convince the reviewers that the topic is important, relevant, and innovative. To create a winning title, write out 6 to 10 key words found in the abstract and string them into various sentences. Once you have a sentence that adequately conveys the meaning of the work, try to condense the title while still conveying the essential message. You should limit the length of the title to no more than 12 words. Some organisations require a special format for the title, such as all uppercase letters, all bolded, or in italics. Be sure to check the instructions.

Following the title, the names of all authors and their institutional affiliations are listed. It is assumed the first author listed will make the oral/poster presentation. Determine if the first author needs to meet any eligibility requirements to make the presentation. For example, the first author may need to be a member of the professional society sponsoring the research meeting. This information is always included with the abstract instructions.

**Introduction**: This usually consists of one or two sentences outlining the question addressed by the research, clinical or other issue. Make the first sentence of the introduction as interesting and dramatic as possible. For example, "100,000 people each year die of…" is more interesting than "An important cause of mortality is..." The final sentence of the introduction describes the aim/purpose of the study or the study's hypothesis.

**Methods**: This is the most difficult section of the abstract to write. It must be scaled down sufficiently to allow the entire abstract to fit into the box, but at the same time it must be detailed enough to judge the validity of the work. For most clinical research abstracts, the following areas are specifically mentioned: research design; research setting; number of patients enrolled in the study and how they were selected; a description of the intervention (if appropriate); and a listing of the outcome variables and how they were measured. Finally, the statistical methods used to analyse the data are described.

**Results**: This section begins with a description of the subjects that were included or excluded from the study. For those excluded, provide the reason for their exclusion. Next, list the frequencies of the most important outcome variables. If possible, present comparisons of the outcome variables between various subgroups within the study (treated vs. untreated, young vs. old, male vs. female, and so forth). This type of data can be efficiently presented in a table or figure, which is an excellent use of space. Before using tables/figures, check the rules to see if they are allowed in the abstract. Numerical results should include standard deviations or 95% confidence limits and the level of statistical significance.

**Conclusion**: State concisely what can be concluded and its implications. The conclusions must be supported by the data presented in the abstract; never present unsubstantiated personal opinion. If there is room, address the generalizability of the results to populations other than that studied and the weaknesses of the study.

## Joint European Neonatal Societies (jENS) 2017 conference

**Amy Forbes-Coe**

The beauty of Venice, surrounded by water which reflects the amazing architecture discovered via secret passageways hiding beautiful churches lined with Veronese and priceless marble. From the narrow back streets to the Grand Canal it is a city to be discovered on foot, comprising 177 waterways splitting the city into 118 different islands and 400 bridges of which only four cross the Grand Canal. There are always top ten lists of attractions suggested by any travel guide and then there are exhibitions and museums you discover on the way that might take your fancy but a must in Venice is to attend an opera at Teatro La Fenice and a Sunday morning mass at Basilica di san Marco. I think you could probably cover the city in four to five days.

On a more serious note, the conference: joint European Neonatal Societies 2017 (jENS), an international conference that is supported by European Foundation for the Care of Newborn Infants / European Society Paediatric Research / Union of European Neonatal and Perinatal Society / Council of International Neonatal Nurses / Vivere and Societa Italiana Neontologia, discussed many important subjects with a few take home messages. To name but a few: resuscitation, physiological cord clamping, oxygenation and retinopathy of prematurity (ROP).

Have we really considered the long-term effect of our initial resuscitation and how important it is to support fetal to neonatal transition with lung inflation and aeration, a key to cardiac transition and therefore, an increased pulmonary blood flow and increasing oxygenation? Further discussion considered sustained versus standard ventilation and even though early results showed reduce mechanical ventilation by five days and no effect on death before discharge, no other relevant respiratory outcome was identified. However, the findings will be published in a Cochrane review update in 2018.

What about delayed cord clamping thought to be rephrased as physiological cord clamping: does it depend on the condition of the baby? What evidence is available in the compromised infant? Is it still a topic for further research or are the benefits for preterm babies evident? Little evidence is available but currently the results from the APTS Trial are under review for publication.

Further research also discussed oxygen in the delivery room and whether it is best to use 21%, 30%, 60% or 100% and noting two significant results – whatever resuscitation is conducted, to be successful the heart rate should be above 100bpm by 5 minutes of age and oxygen saturations above 85%. If not the chances of morbidity and mortality increase, with death (related to heart rate) and intraventricular haemorrhage (related to oxygenation) becoming paramount.

Another area with an interesting discussion was retinopathy of prematurity, not only reviewing our resuscitation techniques but also strongly associating an infant's nutrition with the first month of life and how the introduction of Smoflipid® into many units improves neurodevelopmental outcome. Researchers also noted that low arachidonic acid levels in preterm babies within the first month of life were a strong predictor of severe ROP as well as the variability in saturations. The recommended target saturations were to be between 87% – 95% and if an infant is receiving supplement oxygen

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then saturations and your target parameters should never be 95% – 100%. This study also identified a low haemoglobin within the first week of life as a strong indicator for ROP along with thrombocytopenia with sepsis and had three recommendations for clinical practice:

1. Optimise oxygen delivery – target saturations
2. Optimise nutrition – encourage breastfeeding
3. Think twice before taking a blood sample especially within the first week of life.

A new Neonatal Nurse Practitioner methods group was set up in association with COINN and will generate a global network of NNPs to discuss recruitment, roles and sustainability of this position. As members of the ACNN you are more than welcome to generate your interest in this sub-group of COINN to receive updates from the group. Unfortunately, only six per cent of delegates registered for this conference were nurses and, so I think we should all save the date and some pennies for 17 – 21 September 2019 in Maastricht, especially as there will be no annual ACNN conference held that year*.

*All photos by permission*

*Editor's note: the annual ACNN conference is suspended in 2019 due to the COINN conference being held in Auckland, New Zealand. The ACNN Executive will be assisting NNCA in organising that event.

## NSW Jessie Everson-Checkley Scholarship Reports

### *Australian College of Nurse Practitioners Conference*

***Amy Barker and Kristen James Nunez***

We would like to firstly start by thanking the ACNN NSW branch committee for their generosity in awarding us the Jessie Everson-Checkley Scholarship which supported us to attend the annual Australian College of Nurse Practitioner Conference in September 2017.

The Australian College of Nurse Practitioners Conference was held in sunny Brisbane and ran from Monday 4 September to Thursday 7 September 2017. The conference attracts Nurse Practitioners (NPs) and Advanced Practice Nurses from throughout Australia and from a variety of specialist areas, and showcases the work that Nurse Practitioners are doing nationally. It provided us a great opportunity to network with other Nurse Practitioners and we were in awe of what is being done by the Nurse Practitioner group in this country. Nurse Practitioners are leading the way in providing holistic, best practice care in some of the most remote and rural areas with little medical or interdisciplinary support. Our hats came off to these NPs. But also within the metropolitan area, Nurse Practitioners are improving the health trajectories of so many patients, improving outcomes and engaging patients to be key players in their own health. From a paediatric perspective, there is some great work happening in paediatric palliative care with Nurse Practitioners leading their care and providing palliative kids and their families more opportunities to advocate their wishes.

We were fortunate enough to also present some of our own work at the conference. We discussed the Nurse Practitioner-led Acute Review Clinic which is run out of Grace Centre for Intensive Care at The Children's Hospital at Westmead. The clinic was an initiative commenced by the Nurse Practitioner when the role was first established in 2014, and was established as we had noted the increasing complexity of the babies cared for in Grace. This then had an inverse effect with babies requiring ongoing complex health needs care that would continue at discharge. We were discharging far more babies into the community with significant medical care requirements, including respiratory support such as home CPAP, complex feeding issues, multiple medications including narcotic weaning, stoma care, wound management and specialist procedures.

Having been monitored so closely in Grace, who was going to continue this supervision of care in the interim period between discharge and paediatrician follow-up? Also could we be discharging babies home earlier when they could be reviewed in the clinic to ensure weight gain and growth were continuing?

The Nurse Practitioner-led Acute Review Clinic was therefore designed to:

- Support earlier discharge
- Support continuity of care following discharge
- Ensure that adequate medical supervision was maintained during the period of discharge to community services
- Support community services to relieve the demand on

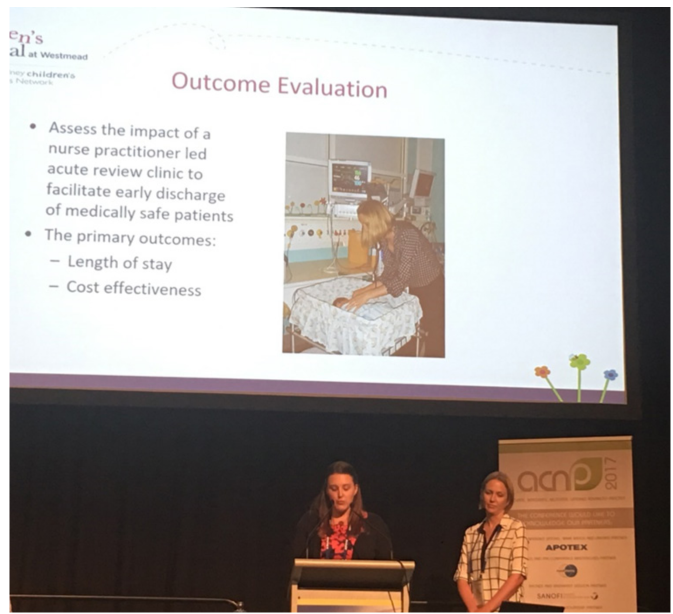
their services

- Shorten length of hospital admission and ultimately save money

We presented some data from an 18-month period between June 2015 to December 2016, focusing on two objectives: saved bed stay days and financial benefit. During this period the Nurse Practitioners reviewed 57 patients with 79 patient encounters. The mean time to their first review was 3.9days. With the cost of a high dependency bed of $1,500 per day this totaled a saving of $309,000!

Our presentation was well received and we were congratulated by many at the conference on our work.

The conference is run annually, with the 2018 conference to be held in Canberra in September. We will certainly be attending again and look forward to showcasing some more of the work the Nurse Practitioner group is leading in Grace, as well as hearing about the fantastic work of fellow Nurse Practitioners nationally.




*Amy (L) and Kristen presenting*

## *ESPNIC 2017*

### ***Robyn Richards***

CNC Neonatology RNSH

This report is a summary of the conference, the European Society of Paediatrics and Neonatal Intensive Care (ESPNIC) I attended in June in Lisbon, Portugal, supported by a Jessie Everson Checkley Education Grant, which I was pleased to receive from ACNN NSW. I had joined ESPNIC when I attended the International Neonatal Conference in Belfast in 2013, but this was the first ESPNIC conference I was lucky enough to attend.

I received the grant as I had submitted two posters, one regarding the work undertaken in continuous practice improvement (CPI) by the NSW NICUS Neonatal CPI Group, and the other, a case review on the management of a complex baby with hypoxic ischaemic encephalopathy (HIE).

After spending time in beautiful Wales with my husband's family, we travelled to Lisbon and stayed at a hotel close to the conference venue. This enabled me to walk to the venue each morning while my husband explored Lisbon via the tram system.

There was a preconference workshop targeted particularly at nursing staff that I had registered for, but it was cancelled due to lack of registrants, which was very disappointing. I received notification via email (the wonders of travelling with email access) and registered for a ventilation workshop instead which mainly concentrated on paediatric ventilation. Talking to some of the other nursing attendees from the United Kingdom, they had not been granted an extra day's leave to attend this nursing workshop.

The next day, at the official opening of the conference the attendees were entertained by a lively troupe of young instrumentalist's /singers/ comedians, which was a fantastic way to get the conference underway.

The conference ran over 4 days (5 if you include the pre-conference workshop) with over 1,100 participants mainly from Europe, but with a reasonable contingent from Australia, New Zealand, America and Canada. EPSNIC[1] has a nursing president and medical president, and also has chapters you can nominate to join. These are respiratory, ethics, cardiovascular, infection, neuro critical care, metabolism, pharmacology, resuscitation and quality improvement, patient

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*Cont. from page 5*

safety and long term outcomes. The ESPNIC website also has webcasts and other educational material you can access, if a member.

The conference was opened by the Minister of Health for Portugal, who welcomed us and spoke about the improving health of the Portuguese population, especially improvements in maternal, infant and paediatric health status. A lot like PSANZ, the conference then had breakout sessions to choose from. There were a number of presentations on quality improvement in the PICU/NICU, including the nurse's role. An afternoon session was on the use of antibiotics in sepsis; the right drug at the right time at the right dose, which antibiotic should we use in sepsis; the use and misuse of antibiotics, antibiotic dosing; how much and when should we give our antibiotics and finally a presentation from Agnes van den Hoogen on the prevention of nosocomial infections in the NICU and PICU which was inspiring. I was lucky later to catch up with Agnes van den Hoogen, a nurse scientist at the University Medical Centre of Utrecht (UMCU) Wilhelmina Children's Hospital (WKZ) Utrecht Netherlands, whom I had met at PSANZ earlier in the year. At the beginning of the conference she had been awarded lifetime membership of ESPNIC, for being the first nursing president of ESPNIC, and for her ongoing involvement and contribution today. There was also a presentation about a study that had evaluated paediatric and neonatal research priorities for the future. Incidentally, Agnes had presented about this very topic at PSANZ.[2] Agnes also presented on hand hygiene (HH) rates in Europe, which sadly aren't as high as in Australia. Throughout the conference there were a number of other presentations on how different European countries are trying to achieve improvements in hand hygiene compliance rates and a reduction in associated infection rates. I was shocked by the low rates of HH compliance in Europe that were reported at the conference. One thing we have is *Hand Hygiene Australia* which dictates a minimum standard of HH across all ward areas.

There were also a number of ethics presentations including a discussion on end of life and resuscitation decisions in NICU and PICU, why are they different and is this justified? Another presentation was about how decisions are shared between the multidisciplinary team in NICU. This was a presentation of a European survey undertaken regarding perceptions of the team including nursing expectations and parental involvement in the decision to withdraw intensive care support. This presentation was particularly thought-provoking as the presenter included photos of mothers with their infants, and discussing their thoughts and experiences of their time in NICU. Another topical presentation was doing things *to* the patient vs. *for* the patient, which was from the perspective of a paediatric intensivist, but still has connotations for neonatal care. A number of presentations were regarding supporting either paediatric or neonatal families experiencing loss and helping the grieving process, either by support in the individual unit or with a home palliative care team. To supplement the ethics of care in NICU and PICU there were a number of presentations by parents of infants and children. One mother presented on her journey with a baby, now nine years of age, with multiple congenital abnormalities including a congenital heart defect requiring multiple surgeries. Her presentation was called *Hard truths versus beautiful lies*, and subtitled *I still prefer the hardest truth*. Some of her statements were beautiful lies; "don't worry I promise you after the heart surgery he will be able to eat with his mouth", hard truth (on Christmas Eve) "I'm sorry but he has to be admitted to hospital again, he is not well". This mum is now on the board of governors for the Centre for Children with Heart Disease (APACDC) and is heavily committed to improving education and communication for parents and staff. Her closing statement was "you may start looking after a fragile baby, but you will end up caring for a loved son".

One of the most topical presentations that can be applied to neonatal nutrition was routine gastric residual volume measurement and energy target achievement in the PICU. This was a matched comparison study carried out between paediatric units in Liverpool (UK) and Lyon in France. This has motivated me to evaluate our current feeding practices in NICU.

Another presentation that I thoroughly enjoyed was *Are quality improvement projects the next RCTs for nurses, and is multi-professional research the way of future*? We all know that nurses do not work in isolation, they work in a team. Different professional team members bring different skills and expertise that can be utilised to improve practice and care. Nurses need to ask the questions that matter clinically to their practice in NICU and SCN. We need a strong evidence base to support our clinical nursing practice. We need to change the balance from nurses being the ones who deliver fundamental care to also researching the care to ensure it is effective and safe. Did you know that approximately 85 per cent of care in intensive care units is delivered by nurses, yet almost all research in this field is undertaken by doctors ... we need to ask ourselves, why?

Although I initially felt that the paediatric content outweighed the neonatal content markedly, on reflection there were many presentations that I could learn from and adapt for use in my daily practice as a Neonatal CNC.

After the conclusion of the conference, we spent another 10 days in Portugal, soaking up the history and culture of this beautiful area of Europe, drank some fantastic Portuguese wine, visited some amazingly old historic sites and had a relaxing few days on the Island of Madeira. The next ESPNIC Conference is in Salzburg Austria 18 – 21 June 2019 if you are

looking for a conference to attend while travelling in Europe or the UK.[3]

So again, thanks to the ACNN NSW branch committee for awarding me the educational grant to put towards my attendance at this worthwhile conference.

*View from our hotel on Madeira*

### References


1. http://espnic-online.org/
2. Tume LN, van den Hoogen A, Wielenga JM, Latour J M (2014). An electronic Delphi study to establish pediatric intensive care nursing research priorities in twenty European countries. *Pediatr Crit Care Med*. 15:5, :e206-13.
3. www2.kenes.com/espnic-2019-lp-kmu/


## QLD Branch Newsletter

What a great time at Fraser Island, not only was there an abundance of delegates the program was fantastic. Although the week started with rain, it fined up and did not seem to dampen anyone's spirits. Well done to the organising committee.

*All photos by permission*

The Queensland delegates had great representation in the poster and oral presentations throughout the conference. The QLD research awards were awarded to Kobi Best for *Best Presenter* and Anne Dawbney for *Best New Presenter*.

The lucky winner of the ACNN Raffle of $1,000 towards ACNN next year in Tasmania or COINN 2019 was Michelle Prentice.

Michelle Curtis was granted some well-deserved accolades by receiving the Mark New Quiet Achiever Award and honorary life membership to ACNN.

The organising committee for QLD has been busy and we have scheduled a Respiratory Workshop on 10 March 2018 at Logan Hospital. This will then be followed by an evening seminar, details to be circulated to members before Christmas. The second evening seminar will be held at Sunshine Coast in October (date TBA).

# Wanted

Items of interest to ACNN members everywhere

Please consider contributing to this newsletter

Send contributions to newsletter@acnn.org.au

# Low Resource Countries Special Interest Group

## *Reflections on the Papua New Guinea experience*

In May this year I was lucky enough to join a team of enthusiastic and talented neonatal nurses, members of the ACNN Low Resource Countries Special Interest Group, on a trip to Papua New Guinea (PNG) to teach in the Helping Babies Breathe (HBB) program. I squeezed my 1kg of clothes into my bag around the 29kg of ultrasound gel and met Neonatal Nurse Practitioner Gill Mibus at the airport. "Could I fit anything else into my bag?" she asked. Well … I did have carry-on luggage that wasn't yet at capacity, so Gill loaded me up with even more paraphernalia. We left Adelaide at 6am and flew to Brisbane and then on to Port Moresby, landing in Goroka in the Eastern Highlands in the late afternoon. Goroka is the capital of the Eastern Highlands Province, a town of approximately 20,000 people, and 1600m above sea level. The Goroka General Hospital has 265 beds and a very busy labour ward and neonatal unit.

PNG is a land of great beauty. Coming from the driest state in Australia to the greenery and lushness of PNG was wondrous! We were lucky enough to spend a night at a tourism and development centre out of Goroka (Appropriate Technology Projects, or ATprojects) and took a very early morning walk climbing into the hills to see the Birds of Paradise. I'm sure there are not many people on the planet who've seen a Bird of Paradise in its natural setting – what a treat! Amongst the inspirational projects undertaken by ATP is building and distributing toilets to remote schools in PNG, with the help of locals and supported by Oxfam.

We travelled with our host and drivers/guards to several remote villages to teach the HBB program to traditional birth attendants (TBAs). Not being able to speak each other's language did not seem to be an issue. We used sign language and role play in teaching the HBB program, and the TBAs were very quick to pick up the information and loved to practice on the mannequins. We had lots of fun and laughs with the TBAs as they also role-played greeting a woman in labour, supporting the delivery and resuscitating the baby. They were very grateful for the equipment we gave them such as gloves, suction bulbs and masks. We also provided solar powered headlamps, as they did not have electricity in most places and the lamps were to aid deliveries at night time. The roads were atrocious – I've travelled on roads in Nepal and these were much worse! There was no way a woman in labour could be taken by an ambulance from one of the remote villages to Goroka Hospital hence the need to upskill the TBAs to manage the more complicated deliveries on their own. They do have smaller local health centres where women can obtain antenatal care and they are encouraged to attend these clinics for their deliveries. But often they simply are too advanced in labour, or too unwell to travel even to these clinics and hence the need to train the TBAs.

The conditions in the delivery suite at the Goroka Hospital were quite primitive, and the women laboured in small cubicles separated only by curtains. Several beds had no mattresses as they could not afford to replace them, so the ACNN LRC donated new mattresses. I found the biggest challenge on the trip was observing practice in the neonatal unit. There were some very small babies there, around the 1kg mark, and without reliable gas supplies there was no way the babies with respiratory distress could receive any form of assisted ventilation. I watched one baby die that could easily have been saved with CPAP in one of our units. The staff seemed quite matter of fact about it but I'm sure it was distressing for them to feel powerless. There were quite a few nursing students in the neonatal unit when we were there and they were very hands-on. It was great to see kangaroo care being routine in the unit, and women looking very confident handling their tiny babies. The paediatric ward was depressing as there were many small babies and children with treatable infections and even cardiac conditions who would not receive adequate treatment or medications, due to cost constraints and lack of access to tertiary level services and skilled specialists.

Despite being advised by the Department of Foreign Affairs and Trade to exercise a 'high degree of caution' in the country, especially since the elections were about to be held and there had been violent clashes between tribes in the Highlands, I found the people to be friendly and curious. I never felt unsafe on our trip even strolling around the open markets in Goroka, stopping for photos with the local people and walking to the local shops. As several members of our team had been to Goroka before, they were well known to the hospital staff and were greeted with hugs and smiles in every area. Our team arrived with a couple of hundred kilos of equipment and supplies for many areas of the hospital, and we felt like minor celebrities when we walked around the hospital.

Our accommodation at the hospital was clean and spacious and despite the full days, we had a lot of fun in the evenings. I would recommend this trip to anyone wishing to experience neonatal nursing in a developing country. It really provides perspective on our own environment, and made me feel very grateful to be able to share that wealth and experience. Thanks to the ACNN LRC SIG for the opportunity to tag along!

***Dr Trudi Mannix***

RN, RM, NICC

## Trip to PNG September 2017

I joined the Low Resource Country (LRC) Special Interest Group (SIG) as a member of ACNN during September 2015. I was interested in learning how an individual as part of the ACNN organisation could contribute to the field of Neonatology in a low resource developing country setting.

In September 2017 as a part of this group I participated in a trip to Papua New Guinea (PNG). Six neonatal nurses, one midwife and one neonatal doctor travelled to Goroka in PNG. The 10-day trip aimed to educate students, midwives, nurses, and village birth attendants in basic neonatal resuscitation.

*ACNN LRC Group*

PNG has a population of just over 8 million people and is Australia's nearest neighbour. It is a very poor country that lacks resources, infrastructure and educational support for many people particularly outside of the capital, Port Moresby.

Goroka is a town of about 20,000 people in the Eastern Highlands area of PNG. The town is approximately 420km from Port Moresby and can only be accessed by plane. The area is very mountainous and there are few roads that are in a very poor condition. Many villages that relate to Goroka for medical care are very isolated and are scattered throughout the area.

It is customary for women in PNG to give birth to their babies in their villages without medical care or oversight. Hence the birth mortality for both mothers and babies is very high. Roughly 1,500 women die in childbirth every year in PNG and infant mortality rates are similarly high with 45 babies out of every 1,000 dying. By comparison, in Australia approximately 25 women die within 40 days of giving birth and only three babies die for every 1,000 live births.

To reduce this high death rate, the PNG Government and Health Department is aiming for pregnant women to have at least four antenatal visits during their pregnancy and to give birth in a hospital or a medical centre near their village.

Some core people from the villages are trained to become Village Birth Attendants (VBAs). These people liaise between the health authorities and pregnant women. They assist them to attend antenatal visits and to get the women to a medical centre or a hospital to birth their baby. VBAs are frequently medically untrained people. Because of extreme isolation or other circumstances women often don't get to a medical facility to give birth so it is important that the VBAs have some knowledge of neonatal resuscitation.

Helping Babies Breathe (HBB) is an evidence-based educational program to teach neonatal resuscitation techniques in resource-limited areas. It is an initiative of the American Academy of Pediatrics (AAP) in collaboration with the World Health Organization (WHO) and several other global health stakeholders. Worldwide, an estimated 717,000 newborns die each year from intrapartum-related causes and the inability to breathe immediately after delivery.

"The Golden Minute" is a key concept of the Helping Babies Breathe program. Within one minute of birth, a baby should be breathing well or should be ventilated with a bag and mask. The Golden Minute protocol identifies the steps that a birth attendant must take immediately after birth to evaluate the baby and stimulate breathing. HBB provides basic instruction on newborn resuscitation such as drying and rubbing the baby for tactile stimulation, clearing the airway and using bag and mask ventilation methods to help a nonresponsive baby to breathe. It also teaches about the hazards of prolonged suctioning and the importance of delaying cord clamping so that ventilation can be established before cutting the cord. The curriculum provides instructions on how to assess the baby's chest movement to boost effectiveness of bag mask ventilation and identifies steps to take when ventilation is ineffective.

*Teaching Health Care workers HBB*

An aim of teaching HBB is to give birth attendants in low resource countries the essential skills of newborn resuscitation. The goal is to ensure that at least one person who is skilled in neonatal resuscitation is at the birth of every baby. Our group was able to give this basic training to nursing students in Goroka Hospital, some health care workers in a health centre near Goroka and a group of VBAs from villages around Goroka.

Evaluation of previous HBB training in low resource countries

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*Cont. from page 9*

has shown that there is a significantly improved neonatal resuscitation knowledge and skills in trainees. However, skills declined more than knowledge over time. Ongoing skills practice and monitoring with more frequent retesting and refresher trainings are needed to maintain neonatal resuscitation skills.

*Teaching VBAs HBB. All photos by permission*

These results were confirmed with the staff we trained. Some of them had been trained previously and were knowledgeable on the topic, but needed refresher practice skills. VBAs related experiences where they had put their previous training into practice and had saved a baby's life.

I found this trip a valuable learning experience and made some new friends. At times it was hard to experience the reality of birthing practices in a country so close to Australia that has so few resources. I saw babies and children in the hospital that would survive in Australia with our many resources, but they die in PNG due to birth complications or illnesses that cannot be treated because of the inadequate availability of medical resources.

Despite this reality, the people were so warm, happy and friendly. They were so grateful that we could come and do training with them and offer them some of our knowledge and expertise. I felt that we could make a small difference and that ongoing support and training will enable the people of PNG to become more self-sufficient in the future. In return I was able to learn to appreciate the resilience of a people who do the best with the few resources they have. They make the most of any given situation and always appreciate any assistance that can be given.

***Robyn Schmid***

## Neonatal Nursing Research Special Interest Group

### *Research SIG at the Annual Conference*

I can't believe another year has passed and the conference is over. What a great conference; such a variety of speakers and presentations! I was excited to be a member of the team judging posters. Well done to everyone! It was especially nice to see so many first-timers presenting their projects. It was great that much of the research was focussed on improving outcomes by including or supporting the infant's families through simple interventions or programs. Other posters discussed many of the issues we are all challenged by in neonatal units across Australia. Congratulations to everyone who presented especially the first-timers!

As the Research SIG meeting was the last session of the conference, we decided the meeting would be very low key, aimed to give members the opportunity to meet Professor Linda Johnson through a conversation about conducting and publishing an audit. Fortunately for our SIG, Professor Denise Harrison also joined Professor Linda Johnson at our meeting, both being amazing role models for anyone interested in a career in research. Thank you to all the members who attended, your feedback has given me some great ideas to take back to the Committee about resources for our webpage. We are also currently looking into having our own Facebook page. Suza Trajkovski and I were the Research SIG representatives at this year's SIG table; it was great meeting all the members who stopped by our table. I enjoyed chatting and getting to know everyone!

In this issue I would like to introduce Dr Suza Trajkovski, a new member of the Research SIG Committee.

Dr Suza Trajkovski is a Lecturer in the School of Nursing and Midwifery at Western Sydney University. She has over twenty years of experience in clinical practice, management, education and research. Her scholarship and research focuses on neonatal nursing, family centred care, parent/nurse experiences, collaborative care and cultural needs of migrant and refugee families.

***Margaret Broom***

## NSW Neonatal CNC Column

# The importance of why? Great nurses ask the question…

**Jo-Ann Davis**

Acting CNC Newborn Services, Neonatal Intensive Care Unit, JHCH

As a child I used to drive my parents crazy, with that one repetitive question. Like every other four-year-old I wanted to know, why? Why do I have to go to bed now? Why do I have to brush my teeth? Why can't I push my sister back if she pushes me first?

As it turned out for me that part of my character never left. I have always been one to question and it has resulted in sometimes being in trouble over the years, typically as I reached my parents' and teachers' maximum frustration levels. However mostly it just allowed me to challenge and feed my curiosity and knowledge. I always wanted to know more, and frequently asked but why? Why do we have to do it like that? Why don't you do it this way? Why can't we try a different way? Why won't it work if you do it that way? Why? Why? Why?

Luckily I found my career pathway in nursing, and for once, when I asked why, I was not met with an exhausted groan, or an exaggerated eye-roll. This time I was praised for asking the question. My lecturers and health care colleagues responded with a twinkle in their eye - this girl is asking why. It turned out that this one question is one of the most important questions to ask in health care.

I began my nursing career in the year 2000, at John Hunter Hospital in Newcastle. Initially my nursing career began with adults, but I transitioned into the world of neonates a few years later, and this turned out to be the best decision I have ever made. I had found where I was supposed to be in my career. Recently I have had the pleasure of experiencing a new senior role, in a relief opportunity as the CNC for Newborn Services for John Hunter Children's Hospital and the Hunter New England Local Health district. It turns out the title is as big as the role. Can you guess which question has begun to rear its little head again?

**So why is it important to ask why?**

It goes without saying clinical skills in nursing are obviously important, but critical thinking is at the core of being a great nurse. No longer do we perform task based nursing activity; the role of the professional nurse has grown alongside the evolution of critical thinking in nursing. Critical thinking skills are vital in nursing because they are what we use to identify, analyse, prioritise and define our key decisions that can save babies' lives.[1] Neonatal nurses provide critical care around the clock, every day, and know that these critical thinking skills can mean the difference in survival for neonates in our care. Isn't it then up to us as a cohort to enhance and grow these key skills?

So what is critical thinking? Critical thinking is the disciplined, intellectual process of applying skilful reasoning as a guide to a belief or action. In nursing, critical thinking for clinical decision making is the ability to think in a systematic and logical manner with openness to question and reflect on the reasoning process used to ensure safe nursing practise and optimal quality care.[1] Critical thinkers, when developed in the professional practitioner, are characterized as habitually inquisitive, trustful of reason, well informed and diligent in seeking relevant information, and persistent in seeking results.[2]

So what are some of the characteristic benefits of critical thinking?

**Critical thinking is reasonable and rational**
Critical thinkers do not jump to conclusions. As nurses, we interpret, investigate and evaluate.

**Critical thinking is reflective**
We're back to thinking the matter through, evaluating the facts and evidence.

**Critical thinking inspires an attitude of inquiry**
A nurse who thinks critically wants to know how the body works and why it responds the way it does to disease, treatment and medications.

**Critical thinking is autonomous thinking**
Critical thinkers are not easily manipulated, they don't just do it a certain way because "that's how we have always done it".

**Critical thinking includes creative thinking**
Nurses demonstrate original ideas for day-to-day problems.

**Critical thinking is fair thinking**
It is not biased or one-sided.

**Critical thinking focuses on deciding what to believe or do**
Critical thinking is used to decide on a course of action; make reliable observations; draw sound conclusions, solve problems; and evaluate policies, claims, and actions.[3]

So what's the next step? How can we develop these traits in nurses, is it inherent or does it come with experience? To develop your critical thinking skills we can as nurses:

*Ask questions*, and never be afraid to admit a lack of knowledge. Questioning for critical thinking skill development should always start or end with words such as: explain, why, what, describe, how, show, when, and who.[3]

*Seek answers* by actively investigating a problem or situation.

*Self-reflect* on our own thinking process and the ways we reach our conclusions.

*Suspend judgement*, demonstrate open-mindedness and a tolerance for other cultures and other views.

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*Be a life-time learner*, indulge in your own intellectual curiosity always seek ways to continue learning.

*View your patients with empathy*, as a person, a fellow human being, someone's family.

*Seek out a mentor* with a wealth of experience to gain from.

*Join professional organisations*, to benefit from a bank of role models and networking opportunities.

For nurses, this is not a new trend. Without even being aware of it nurses critically think their way through every day. This brings me back to my initial point, of asking questions. No longer should we as nurses be scared to ask what we often defined as 'silly'; we prefix our questions with "silly question I know but…" Why do we do this? Is it 'silly' to ask the question that may impact on our babies and families' lives?

How often do we feel the relief as a learner, whatever the format, at an in-service, a training day, a lecture, a conference, when one brave soul asks the question most of us want to ask? In fact almost a third of participants in the room are often wondering the same thing.[4]

Without critical thinking and questioning many of the important advancements in neonates would not have occurred. From it we have seen the growth of expert clinicians, nursing leaders and nursing research activity. Critical thinking isn't new to nursing but it never gets old. So channel your inner four-year-old and remember to start with the question, why?

So thinking back on how starting out with the CNC relief position and how this one little question has helped me … I came into the CNC role thinking how was I going to do this? How will I know what to do? How will I know if I am meeting the needs of the role? Thankfully I had my little friend, 'why', in my back pocket. What I have realised over this time is that the 'why' question builds into a critical thinking pathway: once you start that ball rolling, momentum follows.

I believe Anne Frank says it best: "The word 'why' not only taught me to ask but also to think, thinking has never hurt anyone, on the contrary, it does us all a world of good".

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## Farewell to Denise Kinross

Denise Kinross has dedicated her nursing career to the world of neonates for over 40 years. Now, sadly this year Denise decided to hang up her suction catheter, gloves and stethoscope.

Denise was working over in London in 1977 to gain further experience in her midwifery career when a temporary position in NICU was offered to her. Whilst her original intention was to return to midwifery, she was soon hooked on neonatal care.

Denise moved alongside the Mater Hospital Neonatal Nursery into the new NICU unit developed when the John Hunter Hospital was first opened in 1991. After many years as a Clinical Nurse Specialist, Denise transitioned into the District CNC role for the Hunter Valley in the late nineties. Originally this encompassed five Maternity and Newborn sites to each of which Denise provided all the education and clinical support. She also spent much of her time developing all of the clinical guidelines for the NICU, which the district sites also utilised for safe care of their newborns. Over time Denise's role in the district grew from the original five hospital to now 15 Maternity ad Newborn sites across Hunter New England Local Health District, all before the introduction of the clinical education roles across these sites. During this time Denise has presented hundreds of educational programs to not only HNELHD, but also the Mid North Coast LHD and the North Coast LHD. An interesting fact is that Denise has travelled so many kilometres over her years that she could have lapped the circumference of Australia, TWICE!

Denise was always so passionate about passing on her knowledge and improving the care we provide to newborns. Some of her great achievements have been, alongside Jane Davey, the writing of the program for the NSW College of Nursing Graduate Certificate program which many of us NICU nurses completed over our careers. She was the lead for the Midwifery-led Baby Check program which she wrote and taught at many sites across NSW. In addition to this Denise was also a con-joint Lecturer at Newcastle University.

Denise has also been a key member of many professional groups over her career. She has been involved in many research activities alongside the NSW Neonatal CNC group and she has been an active member and past president of the ACNN.

Denise has spent her career working in the world of neonates, and has influenced their care from a local level in Newcastle,

to a district level across Hunter New England Health, and across the state of NSW, but more than that Denise will be remembered for her warm, caring, open personality and the genuine friendships she held with colleagues. We were all lucky enough to celebrate her retirement with friends from NICU, regional NSW, Maternity, Medical, and Sydney past and present colleagues in her favourite place amongst the vines in the Hunter Valley. Farewell Denise, we thank you, and the families and the babies thank you!

***Jo-Ann Davis***

Acting CNC Newborn Services
Neonatal Intensive Care Unit, JHCH

## Neurodevelopmental Care Special Interest Group

### *Turning Purple in 2018!*

**Nadine Griffiths**

On the seventeenth day of November we celebrated World Prematurity Day, the day that provides an opportunity to honour preterm infants and their families. The day is synonymous with the colour purple and globally buildings are lit in the colour purple to raise awareness to the facts:

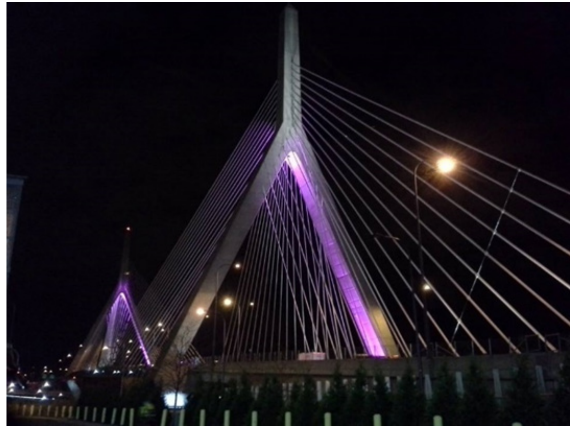
- Worldwide 5 to 19 per cent of babies are born before 37 weeks (WHO, 2015); in Australia 8.6 per cent of all births are preterm (AIHW, 2016)
- Approximately 15 per cent of all babies born will require care in a SCN or NICU (AIHW, 2016)
- Globally there are increasing rates of prematurity (WHO, 2015)

The NDC SIG would like your support to see if we can light up multiple Australian monuments/buildings in the colour purple on 17 November 2018, raising awareness of preterm birth and the work we do in the NICU. If this is something already occurring in your state or this is something you would like to support, please contact us so we can start planning and campaigning in the months ahead!

In other NDC SIG news the minutes from our first teleconference have been recently circulated to members of the NDC and we are working through our priorities for our first 12 months as a special interest group. In early 2018 we are hoping to survey the members of ACNN to establish your perceptions and practices in relation neuroprotective developmentally supportive care – keep an eye out for the survey link! If you would like to join the NDC group contact us via: ndcsig@acnn.org.au Our next teleconference is planned for February 2018 and we will be having our first face to face meeting and workshop at the National Conference in 2018.

We would like to promote any neurodevelopmental education opportunities that are available to external staff in your unit or state. Forward an outline of the program, location, cost and dates and we will promote your program via the NDC SIG page on the ACNN website.

*All photos by permission*



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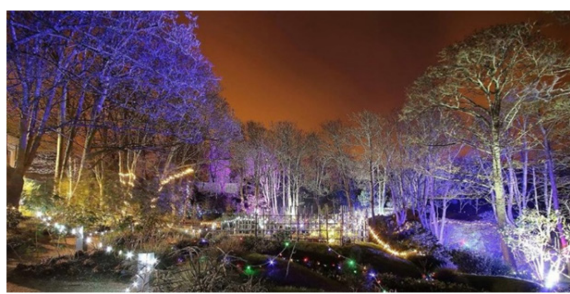

*Waterford, Ireland*

*Modena, Italy*

*COMMUNIQUE*

**CoNNMO Member Meeting – Friday 6 October 2017**

*Representing the national interests of nurses and midwives in all sectors of the health profession*

**Office of the Commonwealth Chief Nursing and Midwifery Officer**

Liza Edwards, Project Manager gave an update as Debra Thoms was on leave. In late August, Deb accepted the position of First Assistant Secretary for Ageing and Aged Care Services. This is in addition to her role as Commonwealth Chief Nurse and Midwifery Officer (CCNMO). As CCNMO, Deb hosted a 2 day symposium in March on both advanced practice, and registered nurse and midwife prescribing. Two pieces of work following on from the symposium include: developing a national framework to support advanced practice; and exploring the progression of registered nurse and midwife prescribing in Australia. Deb Thoms is currently working with the Nursing and Midwifery Board of Australia (NMBA) and the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) on a discussion paper exploring potential prescribing models for registered nurses and midwives in Australia. The discussion paper will be circulated for public consultation later this month. Please visit the CCNMO website for further information: http://www.health.gov.au/internet/main/publishing.nsf/Content/cnmo-debrathoms

**Nursing and Midwifery Board of Australia**

Petrina Halloran, Policy Manager gave an update. The NMBA is currently working in association with the Australian and New Zealand Council of Chief Nursing and Midwifery Officers (ANZCCNMO) Chief Nurses on prescribing. A working group has been set up with representatives from both groups. They have reviewed the work that came from the advanced practice and registered nurse and midwife prescribing symposium, and drafted a discussion paper looking at the health professional prescribing pathway (HPPP) model, autonomous prescribing, prescribing under supervision and protocol prescribing. An 8-week consultation is being conducted for feedback on the proposed model and planned implementation. The Midwife Standards for Practice have been reviewed with the final document due to be released April next year. The NMBA is also about to review the national decision making framework. There will be a survey as part of this consultation. The Australian Health Practitioner Regulation Agency (AHPRA) now has a mobile friendly website which is easier for users to navigate. Graduates can also complete the majority of their application for initial registration online. The NMBA is currently calling for applications for appointment to the committee to oversee the assessment of overseas qualified nurses and midwives. The closing date for applications is 27 October 2017. Please visit the NMBA website for further information: www.nursingmidwiferyboard.gov.au

**Australian Nursing and Midwifery Accreditation Council**

An update was provided by Fiona Stoker, Chief Executive Officer via teleconference. The Australian Nursing and Midwifery Accreditation Council (ANMAC) reviews accreditation standards every 5 years. The ANMAC Registered Nurse Accreditation Standards consultation is currently underway with submissions due 22 October 2017. There is also a survey available online for stakeholders to provide feedback. ANMAC has been looking at the NMC UK model of accreditation services and the framework used by other accreditation councils in Australia, in particular the one used by the Dental Board. Both of these models have five standards. ANMAC may reduce the current number of standards to remove overlap. Any duplication in the standards will be looked at in the course of the RN Accreditation Standards review. ANMAC is updating the website and now has a quarterly newsletter. They are keen for more engagement with stakeholders in order to improve education standards. ANMAC will be seeking expressions of interest for expert advisory groups. The independent review of accreditation systems within the National Registration and Accreditation Scheme (NRAS) for health professions report is now available. CoNNMO members were encouraged to read the governance section and recommendations in the report. Submissions on the report are due 16 October 2017. Please visit the ANMAC website for further information: www.anmac.org.au

**Nursing and Midwifery Board of Australia Codes of Conduct**

Petrina Halloran, Policy Manager for the NMBA, presented on the release of the revised Codes of Conduct for Nurses and Midwives. The Board undertook a two year project to review the codes, which now incorporate professional boundaries. The codes of conduct support nurses and midwives in the delivery of safe practice as part of their professional role. They provide guidance for the public about the standard of conduct and behaviour they should expect from nurses and midwives. The codes assist the Board to protect the public by setting and maintaining standards to ensure safe practice. The review of the codes was informed by research, commencing with a comprehensive literature review. Mapping was undertaken against the current codes and a shared code of conduct used by other regulated professions. This was followed by analysis of notifications and complaints to identify key issues to address in the codes. Focus groups were held across the country. Working groups for both nursing and midwifery were established to provide specialist input throughout the review. An 8-week public consultation on the revised codes was undertaken.

The key recommendations that came from the literature review included that the code should: be modelled on those used by the other professions; condense the nursing and midwifery codes into one document; apply to nurses and midwives in both clinical and non-clinical practice; include professional boundaries; use more directive language; and, include guidance on bullying and harassment and use of social media. The NMBA has maintained a separate code for nurses and a code for midwives. Consideration will be given to moving to a joint code with other professions in the future. Petrina's presentation is available on the CoNNMO website. Please visit the NMBA website for a copy of the Codes of Conduct at www.nursingmidwiferyboard.gov.au.

**Australian Digital Health Agency**

After addressing CoNNMO earlier this year at the May member meeting, Angela Ryan, General Manager of Clinical Programs at the Australian Digital Health Agency (ADHA) gave an update on activities in recent months. Following consultation, the national digital health strategy is now completed. Four key themes came from the consultation: the health system is difficult to navigate; people would like to access their personal health information on their smart phone (my health app); health care is difficult to access when needed, due to cost, location and availability of appointments; and the top activities consumers want to be able to do on their mobile device is to manage medications, track their health and request refill prescriptions.

Digital health is about giving consumers more control of their health and care, connecting and empowering health care professionals, and bringing together a seamless integrated view of digital health and health care. Having access to information brings enormous benefit to consumers and enables consumers to have more control of their health. The My Health Record is a summary view of a person's health information that can be shared securely on-line between the person and their health care provider to support improved decision-making and continuity of care. Following completion of the My Health Record opt-out trials in Nepean Blue Mountains and Northern Queensland, the opt-out model is now being rolled out to all Australians. The Australian Government has invested $374.2 million over years to ensure every Australian has a My Health Record, unless they prefer not to. If a person doesn't already have a My Health Record, a record will be automatically created for them in 2018, unless they choose not to have one. The ADHA is currently seeking expressions of interest to participate in their Clinical Reference Leads program. Details of the program and application process are available at: https://www.digitalhealth.gov.au/about-the-agency/careers/clinical-reference-leads-expression-of-interest.

Angela's presentation is available on the CoNNMO website. For further information, visit the Australian Digital Health Agency website: www.digitalhealth.gov.au

**Good governance, member engagement and growth**

John Peacock, General Manager, Associations Forum facilitated an interactive session on governance of associations, member engagement and growth. John first addressed CoNNMO members over ten years ago when he was engaged to facilitate a Strategic Planning Day to guide the work of the then NNOs. Since then CoNNMO has become a coalition, changed its name and logo, developed a strategic plan, and developed terms of reference. John consults with organisations on strategy, governance, board effectiveness, operations, restructuring and financial issues, as well as reviews of associations and charities. He has worked individually with many of the CoNNMO member organisations. John led discussion on the topics using a handout to guide practice. John's handout is available on the CoNNMO website. For further information, visit the Associations Forum website at www.associations.net.au

**Patient Safety and Leadership**

Carrie Marr, Chief Executive of the NSW Clinical Excellence Commission addressed CoNNMO members on the work of the Commission and the future focus of patient safety. The Commission provides leadership in safety and quality to improve outcomes for patients by developing and driving improvement initiatives in collaboration with consumers, clinicians, managers, and other health service partners. NSW Health has identified five strategic priorities, and nominated patient safety as the top priority. Carrie described some of the international models that are working well. The top five are in Sweden, the United States and the United Kingdom. As organisations, they have created themselves to be proactive and generative, relying on culture not policies and processes. These top organisations focus on culture, people, work flow, technology and organisation values. Highly reliable organisations: focus on being predictive and proactive; are open about failures; are not harm free, but harm does not disable them; emphasize learning; are obliged to act; are accountable; have a just culture; believe daily work practices produce safer care; and value teamwork and leadership. Carrie's presentation is available on the CoNNMO website. For further information, visit the NSW Clinical Excellence Commission website at www.cec.health.nsw.gov.au

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**Interactive Social Media session**

Melissa Sweet, an independent journalist, author and publisher with a focus on innovation in public interest journalism, gave CoNNMO members a guide to using social media, with a particular focus on using Twitter. Melissa is the founding editor of the social journalism project for health Croakey.org which focuses on covering social determinants of health, indigenous health, climate change and health and health policy. Further information on Melissa Sweet's work can be found on the Croakey website at https://croakey.org/.

Council report by the CoNNMO Chair and Secretariat is available on the CoNNMO website www.connmo.org.au

Member reports are available on the CoNNMO website www.connmo.org.au

# Save the date!

# Member Scholarships

## Apply now for 2018

The University of Tasmania is offering postgraduate nurses courses on a scholarship basis to members of ACNN. You can study specialisations in Neonatal Intensive Care nursing, or Special Care of the Newborn nursing, and receive a full scholarship on your HECS fees (subject to eligibility). Applications are now open for study in 2018, for more information see the UTAS website: www.utas.edu.au/health/study/acnn