



Commonwealth Nurses
and Midwives Federation



Conference Abstracts

Toward 2020:
Celebrating nursing and midwifery leadership

3rd Commonwealth Nurses and Midwives Conference
12–13 March 2016 London UK



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Day 1. Saturday 12 March 2016

Morning programme

0800–0900	Registration				
0900–0920	Welcome: Ms Ramziah Binti Ahmad, President, Commonwealth Nurses and Midwives Federation				
0920–0940	Welcome: Janet Davies, CEO and General Secretary, Royal College of Nursing UK				
0940–1000	Welcome and opening of conference: Ms Frances Day-Stirk, President, International Confederation of Midwives				
1000–1030	Keynote address: Professor Mary Chiarella, Sydney Nursing School, The University of Sydney Nursing and midwifery leadership: 200 years of making the extraordinary ordinary				
1030–1100	Refreshment break and poster presentations				
1100–1230	Leadership in clinical practice Chair: Ms Paula Hancock (Wolfson Theatre)	Leadership in policy and projects Chair: Ms Ramziah Binti Ahmad (Linacre Room)	Leadership in research and innovation Chair: Ms Julianne Bryce (Sloane Room)	Leadership in management and administration Chair: Mr Howard Catton (Willan Room)	Leadership in education and training Chair: Ms Hossinatu Mary Kanu (Council Chamber)
	14. Dr Heather Moore (Australia) Remoteness: The challenge of adapting a nursing model to fit	21. Mrs Angela Leonard (South Africa) Making the unseen practice of nursing visible – insights from Uganda	2. Mrs Emma Kwegyir-Afful (Ghana) 'Lift-Less' to prevent prematurity and low birthweight: A proposed trial in Ghana	58. Ms Phalakshi Manjrekar (India) Nursing leadership in the Indian scenario: Reaching out to the masses	12. Mrs Sharon Burnside (Northern Ireland) Level of questioning posed by nurse mentors during undergraduate nursing student clinical assessments
	87. Professor Pammla Petrucka and Dr Marie Dietrich Leurer (Canada) Hearing women's voices in Arusha and Ngorongoro Districts of Tanzania: Informing a maternal, newborn, and child health initiative	44. Mrs Loretta Crumlish and Ms Kate Keeling (Northern Ireland) Safeguarding children and young people attending the emergency department and children's wards	111. Dr Mabel Magowe (Botswana) Results of a task sharing survey for nurses and midwives in Botswana	106. Ms Helen Kirk (United Kingdom) Revalidation (recertification) of nurses in UK public health practice	86. Ms Linda Wylie and Ms Sarah Bandasak (Scotland and New Zealand) Utilising mobile technologies for CPD
	22. Mr Zurab Elzarov (Sudan) UNAMID 'Call A Midwife' Initiative – reducing maternal mortality in Darfur	51. Dr Ruth May (United Kingdom) The 'Stop the Pressure' campaign	33. Ms Anuradha Perera (Sri Lanka) Food myths and level of nutrition among antepartum women In Sri Lanka	100. Mr James Avoka Asamani (Ghana) The role of nurse managers' leadership styles in nursing practice in Ghana	94. Dr Sunita Lawrence (India) Virtual learning: A path to enhance midwifery judgement
	112. Ms Minnesha Yasmine (Australia) Making pregnancy safer: Inspiring clinical leadership to reduce maternal and infant morbidity and mortality	50. Mr Michael Koroma (Sierra Leone) Ebola virus disease containment: Crisis management in a rural setting	8. Mr Geoffrey Axiak (Malta) Nutritional screening in the elderly and its implications toward primary, secondary and tertiary care	82. Mrs Lana Jones-Sandy (United Kingdom) The importance of clinical audit in maternity	40. Ms Helen Chen (Singapore) Developing capabilities: Collaboration between the acute and long term care sector

Day 1. Saturday 12 March 2016

Afternoon programme

1230–1330	Lunch and poster presentations				
1330–1400	Chairperson: Ms Ramziah Binti Ahmad Plenary speaker: Mrs Peggy Vidot, Principal Secretary, Seychelles Ministry of Health				
1400–1430	Chairperson: Ms Ramziah Binti Ahmad Plenary speaker: Lynn McDonald Nightingale's mentoring of early nursing leaders				
1430–1600	Leadership in clinical practice Chair: Professor Kathleen McCourt (Wolfson Theatre)	Leadership in policy and projects Chair: Mrs Rosemarie Josey (Linacre Room)	Leadership in research and innovation Chair: Mrs Angela Neuhaus (Sloane Room)	Leadership in management and administration Chair: Mr George Saliba (Willan Room)	Leadership in education and training Chair: Mr Paul Magesa Mashauri (Council Chamber)
	46. Ms Sharon Salmon (Singapore) Nursing leaders in the field: Infection control and Ebola outbreak response in West Africa	6. Mrs Charlotte McArdle and Mrs Angela Reed (Drury) (Northern Ireland) Delivering care: Nurse staffing in Northern Ireland – from policy to practice	54. Mrs Perpetual Ofori-Ampofo (Ghana) Contraceptive knowledge and use among in-school adolescents in a peri-urban Ghanaian District	3. Dr Adelaide Ansah Ofei (Ghana) Perceived and preferred leadership behaviour of nurse managers at the unit level: A mixed method approach	28. Mrs Carol McCorry and Mrs Dawn Ferguson (Northern Ireland) A model of support for existing sign off mentors
	49. Mrs Anne-Marie Sanderson (Northern Ireland) Preventing delirium using the acronym GHOSTMIND	18. Professor Laurie Gottlieb (Canada) Strengths-based nursing: Reclaiming nursing values to meet the challenges of 21st Century health care	64. Mr Haruna Tirah (Ghana) Postpartum family planning uptake: Understanding provider and potential family planning user behaviour	19. Dame Professor Donna Kinnair (United Kingdom) The critical role of supernumerary ward leaders in delivering better patient care	42. Mrs Jennifer Solomon (Grenada) The utilization of the Objective Structured Clinical Examination (OSCE) in assessing nursing students in Grenada
	98. Dr Annatjie Van Der Wath (South Africa) The wounded healer: Nursing care shaped by personal experiences with gender-based violence	96. Mr Howard Catton (United Kingdom) International systems of nurse revalidation: Observations for the UK	89. Dr Mariatha Yazbek (South Africa) The measurement of pain during the first stage of labour	97. Ms Janet Davies (United Kingdom) Global lessons from a partnership between two national nursing organisations	37. Miss Hema Chaturika Nuwansala (Sri Lanka) Attitude and practice regarding MRSA among BSc nursing students in Sri Lanka
	62. Professor Neltjie Van Wyk (South Africa) Becoming the mother of a child with disabilities: A systematic review	11. Ms Karen Koh Wei Ling (Singapore) Effectiveness of advanced practice nurse-led telehealth on readmissions amongst patients post AMI	4. Mr Yakubu Salifu (Ghana) Socio-cultural and service-related factors influencing tuberculosis treatment adherence in a Ghana district	46. Dr Oslinah Tagutanazov (Swaziland) A holistic care model to facilitate quality of life for pregnant women living with HIV	52. Dr Ruth May (United Kingdom) Stop the pressure: Student conferences – a new generation of nurse leaders
1600–1630	Refreshment break and poster presentations				
1630–1700	Chair: Professor Kathleen McCourt (Wolfson Theatre) Plenary speaker: Ms Linda Lewis My leadership journey: Twenty-six years using the Magnet® model roadmap				
1630–1730	Chair: Professor Kathleen McCourt (Wolfson Theatre) Plenary speaker: Marie-Claire Pellegrini and Mr Eric Grech Therapeutic humour in clinical practice: Leading with humour				
1730–2000	Welcome reception hosted by the American Nurse Credentialing Centre				

Day 2. Sunday 13 March 2016

Morning programme

0800–0900	Registration and poster presentations				
0900–0920	Welcome: Ms Jill Iliffe, Executive Secretary, Commonwealth Nurses and Midwives Federation (Wolfson Theatre)				
0920–0940	Plenary speaker: Catherine McCarthy, CEO Medical Aids Films Transforming lives: Learning through innovative media				
1040–1000	Plenary speaker: Ms Joy Kemp, The Royal College of Midwives UK Global Midwifery Twinning Project				
1000–1030	Plenary speaker: Professor Dickon Weir-Hughes and Dr Catherine Stoddart From locally excellent to internationally exceptional: Sharing learning from Oxford University Hospitals				
1030–1100	Refreshment break and poster presentations				
1100–1230	<p>Leadership in clinical practice</p> <p>Chair: Professor Kathleen McCourt (Wolfson Theatre)</p>	<p>Leadership in policy and projects</p> <p>Chair: Mrs Rosemarie Josey (Linacre Room)</p>	<p>Leadership in research and innovation</p> <p>Chair: Ms Hossinatu Mary Kanu (Sloane Room)</p>	<p>Leadership in management and administration</p> <p>Chair: Mr George Saliba (Willan Room)</p>	<p>Leadership in education and training</p> <p>Chair: Mr Paul Magesa Mashauri (Council Chamber)</p>
	<p>63. Professor Neltjie Van Wyk (South Africa)</p> <p>Two male nurses' experiences of caring for female patients after intimate partner violence: A South African perspective</p>	<p>30. Mrs Pamela Shaw (United Kingdom)</p> <p>Health visiting: Leadership and best practice in the 21st Century globally – a personal Journey and the power of networking internationally</p>	<p>92. Dr Marian Traynor (Northern Ireland)</p> <p>Are we getting the right people into nursing? Using Multiple Mini Interviews in nursing</p>	<p>56. Miss Patricia O'Callaghan and Mr Robert Tumusiime (Northern Ireland and Uganda)</p> <p>Fostering nursing leadership across international borders</p>	<p>103. Ms Cheryl DeZotti (Australia)</p> <p>The utilisation of a web based platform to deliver professional development to nurses</p>
	<p>32. Ms Xiaoli (Julia) Zhu (Singapore)</p> <p>When can I be free from my miserable leg? A qualitative study of patients' experience of chronic leg ulceration in primary health care in Singapore</p>	<p>102. Ms Poma Rebecca Effah (Ghana)</p> <p>Nurses as leaders in developing a new and sustainable mental health workforce</p>	<p>27. Ms Nisha Nedd (Trinidad and Tobago)</p> <p>Redefining the role of Emergency Medical Technicians toward increased effectiveness and efficiency in the Accident and Emergency Department</p>	<p>5. Dr Adelaide Ansah Ofei (Ghana)</p> <p>Management practices of nurse managers in the Ghana</p>	<p>88. Ms Jane Connell and Ms Paula Puawe (Australia and Papua New Guinea)</p> <p>Midwifery education and leadership capacity building in the Highlands of PNG: Working together</p>
	<p>109. Mrs Jennifer Solomon (Grenada)</p> <p>Simulation, nursing, midwifery and leadership</p>	<p>59. Miss Chew Huang Juvena Gan (Singapore)</p> <p>Nurse led spontaneous awakening trial (SAT) protocol on mechanical ventilated patients in coronary care unit</p>	<p>35. Mr Oswald Benimana and Dr Robinson Ssebuufu (Rwanda)</p> <p>Clinical documentation audit on a surgical ward in a tertiary health care institution, Rwanda</p>	<p>79. Dr Cheryl Adams (United Kingdom)</p> <p>The Institute of Health Visiting: A powerful new model for public health improvement</p>	<p>81. Mrs Anne Finn and Mrs Majella Doran (Northern Ireland)</p> <p>Developing a self-sustainable model for advanced communication skills training in Northern Ireland</p>
	<p>99. Ms Hsu Fung Cindy Chua (Singapore)</p> <p>Advanced Practice Nurse led outreach service in the acute care setting: A pilot study</p>	<p>61. Dr Di Lamb and Dr Lizzy Bernthal (United Kingdom)</p> <p>Developing a culture of research and publication within nursing</p>	<p>107. Ms Julianne Bryce (Australia)</p> <p>New standards celebrate nurses in general practice</p>	<p>91. Datin Paduka HJH Suraya Noraidah (Brunei Darussalam)</p> <p>Nursing profession in a changing world: Challenges and aspiration for Brunei Darussalam</p>	<p>83. Dr Maria Cassar (Malta)</p> <p>Reach-out education: Using online teaching to reach out to qualified nurses in the clinical field</p>

Day 2. Sunday 13 March 2016

Afternoon programme

1230–1330	Lunch and poster presentations				
1330–1400	Chair: Professor Kathleen McCourt (Wolfson Theatre) Plenary speaker: Ms Fleur Anderson, WaterAid Healthy Start: How we can address the water, sanitation and hygiene crisis together				
1400–1430	Chair: Professor Kathleen McCourt (Wolfson Theatre) Plenary speaker: Dr Deva-Marie Beck, International Co-Director, Nightingale Initiative for Global Health Leadership to achieve public concern, commitment and action: Toward a healthier world for everyone				
1430–1600	Leadership in clinical practice Chair: Mrs Paula Hancock (Wolfson Theatre)	Leadership in policy and projects Chair: Mrs Julianne Bryce (Linacre Room)	Leadership in research and innovation Chair: Mrs Angela Neuhaus (Sloane Room)	Leadership in management and administration Chair: Ms Ramziah Binti Ahmad (Willan Room)	Leadership in education and training Ms Hossinatu Mary Kanu (Council Chamber)
	90. Mr Azharuddin Haji Ahmad (Brunei Darussalam) Implementing Malay Islamic Monarchy concept in neurosurgical and maxillofacial nursing practice in Brunei Darussalam	67. Dr Cheryll Adams (United Kingdom) Using fellowship creatively to lead practice improvement and change	55. Miss Furong Wang and Mrs Chitra Chakaravarthy (Singapore) Use of normal saline solution for periurethra cleaning before urinary catheterization	29. Dr Hitoe Kanai (Japan) An overview of the Nightingale-KOMI Care Theory and System	85. Mrs Maria Dimitriadou (Cyprus) Learning in the clinical setting and nursing student satisfaction
	75. Ms Wee Joan Yong (Singapore) Clinical alarms	71. Dr Marie Dietrich Leurer and Dr Pammla Petrucka (Canada) Exploring infant feeding practices among the Olbalbal Maasai, Tanzania	104. Ms Kathy Evans (Australia) Collaboration in maternity care to improve perinatal outcomes in maternal and newborn resuscitation throughout Victoria, Australia	70. Mr Joseph Nkwain (Cameroon) In the footsteps of Nightingale in Cameroon	25. Dr Joyce Hendricks (Australia) The new PhD supervisor
	93. Dr Sunita Lawrence (India) Rights-based model: Rhizome for midwifery care	7. Mrs Angela Reed (Drury) (Northern Ireland) Recording care	110. Dr Mabel Magowe (Botswana) Assessment of the integration of HIV and AIDS into nursing and midwifery curricula and clinical practice in Botswana	76. Ms Lin Yok Tang (Singapore) Handover process	113. Ms Rosemarie Josey (Bahamas) Nurturing and launching the new generation of nursing and midwifery leaders
1600–1615	Chair: Ms Ramziah Binti Ahmad (Wolfson Theatre) Closing comments: Ms Frances Day-Stirk				
1615–1645	Chair: Ms Ramziah Binti Ahmad (Wolfson Theatre) Closing plenary speaker: Dr Judith Shamian, President, International Council of Nurses Global leadership inside and outside nursing and health				
1645–1700	Closing ceremony and refreshments				

Poster presentations

Mrs Melanie Murray (Australia)

Linking patient safety to clinical practice: The insight of new graduate registered nurses

Mrs Helen Elliott (United Kingdom)

Taking the leadership when asking about domestic violence and abuse

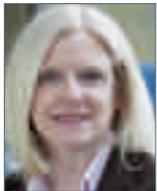
Welcome



MALAYSIA

Ms AHMAD, Ramziah Binti

Ms Ramziah Binti Ahmad was elected to the position of President of the Commonwealth Nurses and Midwives Federation in 2014. Prior to that she was the CNMF Board Member for the new Asia Region transferring from her position of CNMF Board Member for the Pacific Region, the first person from Asia to hold this position. Ms Ahmad was previously President of the Malaysian Nurses Association.



UNITED KINGDOM

Ms DAVIES, Janet

Ms Janet Davies was appointed to the position of Chief Executive and General Secretary of the Royal College of Nursing UK in July 2015. Prior to her appointment, Ms Davies was Director of Nursing and Service Delivery at the RCN for nine years and prior to that, Chief Executive of the Mersey Regional Ambulance Service.



UNITED KINGDOM

Ms DAY-STIRK, Frances

Ms Frances Day-Stirk was elected President of the International Council of Nursing (ICM) in 2011. She is a former member of the executive management team of the Royal College of Midwives in the UK responsible for professional standards, policy education, research and international relations. Her professional interests include organisation of maternity services, women's choice in place of birth, homebirth, and newborn care.



AUSTRALIA

Ms ILIFFE, Jill

Ms Jill Iliffe has been Executive Secretary of the Commonwealth Nurses Federation since 1 April 2008. Under Ms Iliffe's leadership, the CNF has undergone transformational change in providing leadership and support to national nursing associations in Commonwealth countries.

Keynote speakers



AUSTRALIA

Professor CHIARELLA, Mary

Professor of Nursing, Sydney Nursing School, The University of Sydney

Nursing and midwifery leadership: 200 years of making the extraordinary ordinary

This paper will examine the work of nurses and midwives across the two hundred years since Florence Nightingale's birth, specifically looking at the role models that she bequeathed us in terms of practice, theory and research. In particular it will examine how nursing and midwifery manage to make the extraordinary ordinary, the intolerable tolerable and the unbearable bearable, through their interventions, their arts and their sciences. The paper will go on to explore the extent to which our ability to demystify the theatres of life that are nursing and midwifery care may in some ways have contributed to our lack of visibility on the health care stage in the past. However, in particular the paper will look forwards: to the type of leadership that will be needed for future dialogues and discussions, both with governments and more importantly the community, in order to meet the UN Sustainable Development Goals. It will argue that the ability to demystify is the key to these dialogues and discussions, and that nurses and midwives are ideally placed to drive these goals.



SEYCHELLES

Mrs VIDOT, Peggy

Principal Secretary, Seychelles Ministry of Health

Ms Peggy Vidot is currently the Principal Secretary for Health in the Seychelles Ministry of Health. Prior to taking up that position she worked as a Health Adviser at the Commonwealth Secretariat for many years. A former President of the Commonwealth Nurses Federation, Ms Vidot is a champion of nursing. She identifies strongly as a nurse and her presentation will outline her leadership journey and the lessons she has learned along the way.



CANADA

Dr McDONALD, Lynn

Lynn McDonald is Professor Emerita at the University of Guelph, Ontario Canada. She is an anti-tobacco activist and former member of the Canadian House of Commons. Dr McDonald is the editor of the 16 volume Collected Works of Florence Nightingale.

Nightingale's mentoring of early nursing leaders

When Florence Nightingale's first training school for nurses opened in 1860 at St Thomas' Hospital, London, it was intended to be the base for bringing in a new conception of nursing throughout the world. Nurses and matrons, indeed, were soon sent out with the new knowledge, skills and standards to start trained nursing elsewhere in England, and soon after that to Scotland, Ireland, Australia, the United States, Canada, Europe, India and other countries. By the time of Nightingale's retirement in 1900, more than 175 health-care institutions had received nurses or matrons (or a team of both) trained at her school, or otherwise mentored by her. This paper focuses (1) on the leadership given by the nurses Nightingale mentored. Major nurse leaders have been chosen as examples, from several countries, including acute care hospitals, workhouse infirmaries and district nursing (home visiting). (2) The mentoring process itself is examined. Nurse leaders often encountered opposition at their hospitals, including investigations on their management practices and (at least threatened) dismissal. They had to contend with poor resources and difficulties in recruiting staff, sometimes ill health and discouragement. Nightingale was resourceful in providing help, calling in favours owed her (to use on hospital administrators), practical gifts, advice, sympathy and affection. (The letters to her by troubled nurses and matrons are deeply moving.) The material is drawn from research done by the author for The Nightingale School and Extending Nursing, volumes 12 and 13 in the Collected Works of Florence Nightingale, published sources to date unused by nurses and nursing academics. The author is the director of the 16-volume (peer-reviewed) Collected Works. She is a former Member of Parliament, when she authored Canada's Non-smokers' Health Act of 1988, the first national legislation in the world to establish smoke-free work and public places.



USA

Ms LEWIS, Linda

Ms Linda Lewis was appointed CEO of the American Nurse Credentialing Centre in 2014. Prior to that she had been Director of the ANCC Magnet® Recognition Program since 2013.

[My leadership journey: Twenty-six years using the Magnet® model roadmap](#)

Having a global model of excellence for nursing was never in my vision, nor in my strategy when I first became interested in leadership. Rather, it was a need to change the way things were being done in the organization because nursing was just “reacting” to others and “burning out” as the consequence. This time frame was late 1980’s. Little did I know the United States was enthralled in a nursing shortage that had never been experienced before in its history. There were many experts (consultants) who were being engaged in our hospitals to “develop” a plan for nursing, interestingly, these experts were not nurses, they were finance experts, productivity experts, and others, but not nursing.

The presentation will share with the audience the twenty-six years of leadership skills developed and successfully used to create cultures of strength in nursing and interprofessional teams that propelled the organizations for sustained and nationally-recognized for quality and excellence success. This personal journey has been mentored through the work and the principles of Magnet®. These “Fourteen Forces of Magnetism®” are the foundation for excellence in leadership and continues today as the sustained infrastructure for the global nursing model, the Magnet Recognition Program®. As the Chief Officer for ANCC (American Nurses Credentialing Center), leading this international evolution of the ANCC credentialing programs, the audience will learn about this global model for nursing and have the opportunity to help shape the future.



MALTA

Ms PELLEGRINI, Marie-Claire

Mr GRECH, Eric

Mater Dei Hospital, Tal-Qroqq, Msida, Malta

[Therapeutic humour in clinical practice: Leading with humour](#)

Introduction: Humour and laughter are being increasingly used in a variety of therapeutic situations. Research into the use of therapeutic humour tells us it has the power to motivate, alleviate stress and pain and improves one’s sense of well-being.

As a part-time stand-up comedienne as well as a Deputy Charge Nurse and a part-time comedic actor as well as a Senior Staff Nurse, we were able to develop the potential for using humour systematically, by finding the funny side of situations with patients, their families and other colleagues.

Literature Review: The benefits of therapeutic humour are numerous, laughter being compared to an ‘inner jogging’ as it increases heart rate, improves blood circulation and works muscles all over the body. The impact of stress on personal health has led to humour being incorporated into the workplace. The cost of burnout and stress related illness accounts for a significant amount of sick days across the health profession. Humour improves employee creativity, communication and wellness, which results in organizational renewal and greater effectiveness.

Projects: A range of projects can be initiated to show employees how to introduce humour into their professional life.

At Mater Dei Hospital in Malta, every so often a ‘dress down day’ is held where employees are freed from the constraints of their uniform while donating something to charity.

In 2014 the Mater Dei Entertainment Committee was founded and the first talent show was set up which consisted of humorous skits, songs and dance. Another of this kind is in the works for 2015.

In 2010, the Clown Doctors were set up, an NGO of like-minded people who underwent rigorous training in order to entertain patients and staff alike in the paediatric wards.

Conclusions: Humour and laughter is a useful caring tool. We can increase the amount of laughter in the workplace, as well as promote its use with patients.



UNITED KINGDOM

Ms KEMP, Joy

Global Professional Adviser, the Royal College of Midwives UK

[Global Midwifery Twinning Project](#)

This is an exciting time for midwives worldwide as the centrality of midwifery in addressing maternal and child health outcomes is increasingly acknowledged (Lancet, 2014; UNFPA, 2014). Midwives can prevent about two thirds of deaths among women and newborns and the returns on investments in midwives and midwifery services are the best buy in primary health care (UNFPA, 2014). A strong professional midwifery association is one of the 'three pillars' of a strong midwifery profession (ICM, 2011).

Globally, partnership working between country contexts is being promoted to address health challenges and to strengthen health systems (APPG, 2013; Crisp, 2007; DH/DFID/NHS, 2014). Twinning is one such type of partnership; applied more traditionally to towns, cities and schools, the value of twinning is increasingly being explored between professional associations, institutions and health educators. The World Health Organisation (2001) describes twinning as a formal and substantive collaboration between two organisations.

The International Confederation of Midwives (ICM) promotes twinning of its member associations. Twinning can promote the sharing of ideas, skills and learning from each other through the exchange of information and can provide opportunities for peer support and mentoring, leading to strengthening of professional education, regulation and practice (Cadee, 2013). Reciprocity is an important aspect of twinning; a mutually beneficial relationship in which both partners give and take (ICM, 2014). It is more about this relationship than the resources partners may or may not have. It is important that the work partners choose to do is of a collaborative nature where a common ground is created for sharing ideas and experiences.

A founding member of the ICM, the Royal College of Midwives (RCM) has a long history of global involvement and increasing experience of twinning partnerships with sister midwifery associations across the globe. The RCM recently completed its three-year Global Midwifery Twinning Project with Cambodia, Nepal and Uganda, all countries with a high burden of maternal and perinatal mortality and morbidity. This multi-country partnership project was funded by the UK Aid/THET Health Partnerships Scheme from 2012 to 2015 and the RCM successfully recruited 67 UK midwives to undertake volunteer placements during the project.

In her presentation, Joy Kemp, the RCM's Global Professional Advisor, will outline the successes and challenges of the Global Midwifery Twinning Project and share news of other twinning projects recently established.



UNITED KINGDOM

Professor WEIR-HUGHES, Dickon

Professor Dickon Weir-Hughes is an independent consultant and is Head of the Magnet® Recognition Project at Oxford. Professor Weir-Hughes is Chair of NANDA and was previously the CEO of the UK Nursing and Midwifery Council.

AUSTRALIA

Dr STOODART, Catherine

Dr Catherine Stoddart is the Chief Nurse for Oxford University Hospitals and was previously the Chief Nursing and Midwifery Officer for the State of Western Australia.

[From locally excellent to internationally exceptional: Sharing learning from Oxford University Hospitals](#)

Oxford University is the oldest university in the English-speaking world and has taught students since 1096. The associated group of hospitals also have a phenomenal reputation and have developed numerous nursing and midwifery initiatives over many years. The group includes a significant number of highly specialised services. Nurses and midwives at Oxford are drawn from a significant number of countries, including many Commonwealth countries.

The purpose of this presentation is to describe a recent voyage of discovery in developing a Vision for Nursing and Midwifery for Oxford University Hospitals, to share good leadership practice and inspire others. Specifically, we will describe the process of engagement and discovery, involving staff at all levels from junior nurses and midwives to Board members, the decisions we took and our way forward, including our aspiration to become Magnet accredited hospital. We will describe, in detail, the process of agreeing priorities and what those priorities are for the practice and professions of nursing and midwifery at Oxford.

Whilst not every health care organisation would be in a position to seek Magnet accreditation, the process of developing a Vision for Nursing and Midwifery we will describe could be used in any health care setting in any country and we hope that attendees at this session will be able to use our learning in their own leadership practice.





UNITED KINGDOM

Ms ANDERSON, Fleur
CEO Water Aid

Healthy start: How can we address the water, sanitation and hygiene crisis together

More than 1,400 children under five die each day from causes linked to lack of clean water and adequate sanitation, and poor hygiene practices – that’s one every minute. ‘Healthy Start’ is a global campaign to stop these preventable deaths and focus on the need for all healthcare facilities to have water, sanitation and hygiene facilities.

Sepsis is the leading cause of neonatal mortality and can be prevented by hand washing, cleaning the baby in clean water and making sure the instrument used to cut the umbilical cord is clean.

Currently, healthcare facilities are being seriously hampered by their lack of access to safely managed water, sanitation and hygiene practices, making the role of nursing and midwifery and providing quality care in developing counties incredibly difficult, and in many cases, impossible.

The World Health Organisation and UNICEF estimate that 42% of healthcare facilities in Africa do not have access to an ‘improved’ water source within 500 metres and have issued guidelines for WASH in healthcare facilities. Nurses and midwives are able to speak from positions of credibility and experience to local, national and international decision-makers about the need for government investment and donor aid programmes to strengthen national WASH systems so that no healthcare facility lacks clean water, sanitation and hygiene. Members of the CNMF can lead the way in championing the need for adequate WASH in healthcare facilities, and practicing and promoting good hygiene behaviours.



CANADA

Dr BECK, Deva-Marie
International Co-Director, Nightingale Initiative for Global Health

Leadership to achieve public concern, commitment and action: Toward a healthier world for everyone

Florence Nightingale was steeped in the activist civil society leadership of her times by her maternal grandfather William Smith. He was a staunch abolitionist, serving in Parliament with his friend William Wilberforce, to pass the revolutionary legislation of 1807 to abolish the slave trade.

Nightingale learned early of these abolitionists’ strategic actions – to transform British public opinion into moral concern for the tragic exploitation of indigenous peoples of colour – to overcome Britain’s profitable position as the world’s leading beneficiary of the slave trade and to become its principal opponent.

Nightingale acquired both skills and insights from this abolitionist campaign – to apply toward the general betterment of society by increasing public concern and moral commitment to action for the health of peoples everywhere – in the vast British Empire and beyond. She influenced the farthest reaches of Asia, Latin America, the Islamic World and Africa. Although her ‘sick-nursing’ is still most-remembered today, she called her global work ‘health-nursing’ and envisioned it to be fully achieved – “far beyond what I have done” – by nursing leaders in the coming centuries.

Long after the Crimean War (1856), she remembered the soldiers she had served – directly inspiring the creation of the International Red Cross and drafting the British government’s document to craft the First Geneva Convention, which thus inspired the formation of the League of Nations and today’s United Nations.

Nightingale’s communication skills and tireless outreach caused NIGH’s founders, in 2001, to wonder “What would Nightingale have done with a fax machine?” Today we ask, what can the world’s estimated 30+ million nurses and midwives achieve – in Nightingale’s name – to become the civil society leaders of our time – using our communication skills to raise the moral bar of public concern, commitment and action toward a healthier world for everyone – during her Bicentenary in 2020 and beyond.



CANADA

Dr SHAMIAN, Judith

President, International Council of Nurses

[Global leadership inside and outside nursing and health](#)

This presentation will cover the global leadership role of nurses and midwives both inside the profession and in the wider sphere of health and international policy. Dr Shamian will discuss the contribution that nurses can make to strengthening health systems and achieving the Sustainable Development Goals. The presentation also underlines the contribution that nurses can make to the internationally agreed objective of universal health coverage as a means to achieving better health outcomes for all people. Highlighting two major pieces of policy – the WHO Global Strategy on Human Resource for Health: Workforce 2030 and the Strategic Directions for Strengthening Nursing & Midwifery 2016 – Dr Shamian will encourage nurses to take a leadership role in high level policy development and work with other international agencies, governments and industry to align our agendas and values in order to achieve quality healthcare for all.

Dr Shamian will highlight the reasons why nurses and midwives should become competent in policy, and how they can achieve this competency. She will describe ICN's leadership programmes which are helping to build nurses' capacity for leadership and develop the skills to speak effectively about and lobby for their positions. The presentation will also discuss the gap between science and policies; the importance of evidence based research by nurses and midwives; the need for reforming nursing competencies; and the importance of graduate level education for nurses.

The presentation will conclude with a call for nurses and midwives to take a leading role and make an impact on policy at the local, national and international level.

Leadership in clinical practice



14. AUSTRALIA

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Remoteness: The challenge of adapting a nursing model to fit

Remoteness will always persist as a significant challenge when providing a responsive sustainable health service to aboriginal communities in one of the most geographically dispersed populations in Australia. Health facilities are small and lack the benefit of economies of scale when compared to health districts with larger populations and health amenities. Geographically isolated, the reality for nurses working in the community is that we live over 800kms from our nearest tertiary hospital (a comparable distance as between London and Geneva) and approximately 400kms from our nearest town, both of which can only be accessed by air. From a 10 bed hospital and primary health care centre health care challenges in this remote aboriginal community focus on providing day to day medical care, managing medical emergencies and assisting community members adopt lifestyle changes that will reduce their likely burden of disease. Such health challenges are exacerbated by socio economic and cultural factors that impede self- management of all but the simplest of health needs. Challenging workplace circumstances however provide opportunities for unexpected, unprecedented and innovative health outcomes. The nurses I work with have addressed this challenge through the adoption of new philosophies and a model of care that provides opportunity for community engagement in an environment where community members are enabled to make lifestyle changes. Much has previously been written about the health anomalies between indigenous and non- indigenous Australians. This paper will explore the challenges and outcomes as nurses strive to find the nursing model that most 'fits' the health needs of this small aboriginal community. The journey will take us from emergency focused care to one that includes primary health care concepts and a genuine desire to know and understand the people of the community in which we live and work. Included in the journey is the realisation that cultural differences must be acknowledged and partnerships established if we are ever to succeed in closing gaps in health status in a meaningful way. The health stories of several community members will be discussed and the way in which both they, and their families, dealt with the situation when they found themselves in the role of 'the patient'.



22. SUDAN

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UNAMID 'Call a Midwife' initiative: Reducing maternal mortality in Darfur

In 2011, UNFPA published a report on "The State of the World's Midwifery", which indicated that the 2013 maternal mortality rate per 100,000 births for Sudan was 2,054. This is compared with 306.3 in 2008 and 592.6 in 1990. The number of midwives per 1,000 live. In 2013, UNAMID and the North Darfur State Ministry of Health signed a Memorandum of Understanding on training 50 village midwives in North Darfur. The overall objectives of this joint project was to reduce the insufficiency of maternal health services across the remote and isolated communities; empower people "at-risk", especially pregnant women and other vulnerable community members; and reduce the maternal mortality and child mortality cases in the identified communities. Fifty women were selected by the SMOH Reproductive Health Department from various localities in North Darfur, based on the gaps identified during the needs assessment in those areas. The project was implemented within twelve months of intensive theoretical and practical sessions covering a wide range of issues related to reproductive health. At the end of the project, the trained midwives were deployed to their respective localities to provide midwifery services to 20,000 people in North Darfur state. Based on the success of the initiative, similar projects are currently being implemented in West Darfur and Central Darfur states. Reducing maternal mortality is one of the major challenges to the healthcare system in Darfur. In the current circumstances, UNAMID and other international organizations should continue to invest in reducing the maternal and child mortality rates in Darfur, by mobilizing the existing resources and advocating for availability of all services that are directed toward improving the maternal health in the region.



32. SINGAPORE

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When can I be free from my miserable leg? A qualitative study of patients' experience of chronic leg ulceration in primary health care in Singapore

Background and Research Question: Chronic leg ulceration significantly reduces quality of life. The challenge for health professionals is to maintain the effectiveness of interventions, enhance compliance rates and prevent recurrence. There is knowledge from overseas but what are the experiences of Singapore patients with chronic leg ulceration?

Methods: A qualitative design including semi-structured, optionally audio and/or video-recorded, in-depth interviews with eight participants in the primary healthcare setting chosen to provide maximum variation of demographic background and ulcer experience. Interviews, lasting up to 60 minutes, were transcribed verbatim, coded according to issues identified by the participants and analysed thematically. Ethic approval was obtained from La Trobe University, Australia and the National Healthcare Group (NHG) Domain Specific Review Board (DSRB), Singapore.

Results: Four interlinked themes were identified: physical impact (pain, discomfort, inconvenience); psychosocial wellbeing (embarrassment, loss of self-esteem, frustration, and depression); family consequences (lack of support, self-blame) and concerns about ulcer progression (unpredictable healing, hope).

Discussion and Conclusion: For the participants, pain was the main concern that 'drives me crazy', suggesting that their pain was not well managed. It resulted in significant psychosocial issues (including suicidal intent) and other consequences (e.g. relationship issues), of which health professionals might not be aware of, that led to ulcer recurrence. Prompt access to advice, treatment and holistic care by multidisciplinary teams in the event of accidental trauma, skin changes or breakdown could lead to a more positive outlook and improved outcomes. Further research on factors specific to Singapore, such as climate and family culture, is recommended.



46. SINGAPORE

Ms SALMON, Sharon

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Nursing leaders in the field: Infection control and Ebola outbreak response in West Africa

In December 2013, Guinea, Liberia and Sierre Leone experienced their first case of Ebola Virus Disease. Now in its second year, with over 20,000 affected it is 50 times larger than any other Ebola outbreak. Health services are provided in very difficult circumstances normally, hence controlling this outbreak is a major challenge. While currently there appears improvement it is questioned whether eradication can be fully achieved. Over the last 12 months on 3 occasions, National University Hospital at the request of the World Health Organization: Global Outbreak Alert and Response Network has deployed an infection prevention and control (IPC) team to Liberia to provide technical assistance. The small team included an experienced Assistant Director of Nursing and provided high level advice in IPC and case management, wrote policy, undertook health facility analyses, and provided simulated training supporting the most affected areas in the field. During these demanding and intense circumstances nursing lead specific IPC response measures to assist with outbreak control and also provided field training and mentoring to an infectious disease physician trainee learning field outbreak management.



49. NORTHERN IRELAND

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Preventing delirium using the acronym GHOSTMIND

Cardiac surgery in Belfast is carried out in a single centre, and provides a total of 1100 procedures per annum for the population of Northern Ireland. Following surgery patients are expected to spend 24hrs in intensive care before moving to high dependency care (HDU). Slower recovery rates can lead to other surgeries being cancelled due to a lack of beds. Patients suffering from delirium make up a significant proportion of our long stay patients. Delirium represents an important and growing area of clinical practice. Behavioural and psychological symptoms of delirium include agitation, psychosis, aggression and a variety of inappropriate behaviours. These symptoms are among the most complex, stressful and costly aspects of care and a contribution to morbidity and prolonged hospital stay (Barr et al 2013).

Research shows that there is a lack of awareness of different types of delirium among healthcare professionals in up to 66% of cases (Cadogan et al, 2009). This has a direct impact on the outcomes for patients. Within the unit, a team was created and motivated by MSc research completed by a clinical sister in the field of Delirium. The delirium team was created to improve the care and management of patients suffering from the condition, and through this work a tool was formulated to support continuous improvement in the care of patients with Delirium. To aid in the diagnosis of Delirium, the assessment tool (CAM-ICU) is used in daily practice, though as with many conditions, prevention is better than cure – therefore the Delirium team has proposed and introduced the acronym “GHOSTMIND” as an aid-memoir to support staff in the prevention of Delirium. The aim of the Delirium Team is to communicate the paradigm shift needed to fully institute tailored treatments for patients and their families in dealing with the symptoms of delirium.



62. SOUTH AFRICA

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Becoming the mother of a child with disabilities: A systematic review

Objective: The aim of the review was to appraise completed qualitative and quantitative reports on the challenges of mothers of children with disabilities regarding their own transition to motherhood.

Background: The transition to motherhood starts early in pregnancy and is completed when the mother feels competent in caring for the infant. Becoming the mother of a child with disabilities is more demanding than becoming the mother of a child without disabilities. The mothers have to learn to cope with the complex needs of the disabled child.

Methods: A review of the literature was carried out through, first, a computerized search strategy to identify relevant studies from selected databases and, second, quality appraisal and thematic analysis of selected studies.

Results: The transition to motherhood of children with disabilities takes place in the inside world at home, the outside world external to home and the ‘going-between’ world of travelling between the two worlds.

Conclusion: The mothers are challenged at home to integrate normal mothering with technical care of their children. In the outside world they often struggled to ensure that their children got the necessary professional care. Travelling between their homes and healthcare services posed many problems.

Recommendations: Nurses should ensure that care is coordinated and delivered in one centre to prevent the many problems that the women experienced with travelling to fragmented services.



63. SOUTH AFRICA

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[Two male nurses' experiences of caring for female patients after intimate partner violence: A South African perspective](#)

Background: South Africa is perceived to be one of the countries with the worst reputation regarding the occurrence of intimate partner violence. The women who suffer from serious physical injuries are admitted to emergency care units and their first contact with healthcare is through the nurses in these units. Emergency care nurses become secondary victims of violence due to their exposure to the pain of assaulted patients. Female nurses tend to identify with these patients as some nurses are in similar relationships. Not much research has been done on the challenges that male nurses face when they are confronted with abuse of women inflicted by males.

Methodology: In this case study with a phenomenological research methodology two African male emergency care nurses were interviewed.

Findings: The participants experienced a dichotomy of being-in-nursing and being-in-society and had been confronted with the conflicting roles of being men (the same sex as the perpetrators) and being nurses (the carer of the victim). They tried to manage the situation by using the 'self' to care for the patient and to be a problem solver for the patient and her partner or husband.

Conclusion: The authors conclude that society expects men not to be in a caring profession and nursing is still a female-dominated caring profession that finds it difficult to move away from its engendered and caring image. The participants experienced role conflict when they took care of female patients who have suffered intimate partner violence.



75. SINGAPORE

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[Clinical alarms](#)

Clinical alarm safety is one of healthcare's most intractable problems. Alarm fatigue develops when a staff is exposed to excessive alarms and subsequently becomes desensitized to them. This would have a direct impact on patients' safety when a life threatening alarm is ignored due to alarm fatigue. Improving alarm safety requires a systematic review on alarm management. It also requires careful selection of alarm setting criteria for each clinical care area followed by customising alarm settings according to patients' need in the specialty area. This involves a multi-disciplinary team to review the alarm limits or triggers and volume levels. For a holistic approach, nurses, physicians, clinical engineers, risk management managers and hospital administrators were included in this hospital-wide project.

Besides the logistical review and adjustments, staff education is also an important aspect that the team looked into as staff needed to understand how to monitor and manage these alarms or systems. The nurse manager in charge has to ensure staff are adequately trained and ascertain staff's knowledge and competency. Staffs are highlighted on the safety culture of the importance of audible volume levels to ensure actions could be taken promptly for patients. An alarm algorithm is developed on clinical alarm setting tiers as well as "Reporting of Life Threatening Alarm with Safe Deactivation of Less Significant Alarms in ICU, HDU and NICU". This helps staff to have a clear direction of the escalation strategies on what need to be done for the safety of patients



87. CANADA

Professor PETRUCKA, Pammla

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Dr DIETRICH-LEURER, Marie

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Hearing women's voices in Arusha and Ngorongoro Districts of Tanzania: Informing a maternal, newborn, and child health initiative

Background: Globally, women and children die of preventable and/or treatable causes which require simple, proven, low-cost interventions. Mama Kwanza Socio-economic Health Initiative (MKSHI) is a maternal newborn child health (MNCH) initiative in resource-challenged settings in Arusha and Ngorongoro Districts. The project provides health capacity building and training in an effort to support the most vulnerable members of society. Through provision of basic MNCH services and socio-economic supports, MKSHI aims to improve health outcomes and enhance the safety net for target populations.

Method: The MKSHI baseline assessment was a mixed method approach to inform the project's development, implementation, monitoring/evaluation, and ultimate sustainability. Through surveys, focus groups and interviews the assessment created an overview of opportunities and challenges, outlined capacities and potential areas of growth, and reflected on priorities and possibilities for MNCH in this context. This study engaged the community to articulate a preferred future for MNCH.

Findings: The study yielded 45 themes/subthemes and a number of lessons learned. Three main lessons learned were from the words of the women. First "What took you so long to come?" reflects many issues are longstanding and remain unaddressed. Second, "How do we know what you know?" reflects the desire for knowledge and understanding of evidence by clients, communities, caregivers, and policy makers. Third, "How will it change for our daughters?" is a passionate plea for a better future connecting women through generations as a solid foundation for MNCH programs.

Practice Implications: The baseline assessment not only provides a promising approach to inclusion of vulnerable populations in development projects, but provides unique insights into the perspectives of women and caregivers. The imperative to engage stakeholders, especially reproductive aged women, was emphasized throughout this process. The ubiquitous desire for health information and evidence 'literacy' was revealed, challenging those working across sectors and with vulnerable populations.



90. BRUNEI DARUSSALAM

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Implementing Malay Islamic Monarchy concept in neurosurgical and maxillofacial nursing practice in Brunei Darussalam

The concept of 'Melayu Islam Beraja' is the National Philosophy of Brunei Darussalam. The values of the concept have been applied in the daily practice and aspects of patient care. This presentation is a reflective account of the implementation of the concept of 'Melayu Islam Beraja' at the neurosurgical and oral maxillofacial ward. This session also demonstrates the appreciation of the values of the philosophy in the care of patients under the specialty through actual scenarios and day to day events. The application of the concept is broad and is not limited to only patient care however also influences the work organization. As the concept of 'Melayu Islam Beraja' being the pride of the nation, there is great potential for the concept to be developed as an added value in the practice of nursing in Brunei Darussalam.



93. INDIA

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Rights-based model: Rhizome for midwifery care

Introduction: The woman being a person deserved the fundamental rights to be healthy and access of health care within reach. Yet women do not enjoy basic health rights. Access to midwifery services can save millions of women's lives each year.

Rights-Based–Model of midwifery care can be applied in bridging midwifery and women's health rights. The major women's health rights need attention of midwifery care from womb to tomb concept. Women health rights are: Right to equitable, ethical, accessible quality health care; health care that respects women's dignity, individuality and diversity; complete accurate information on health care; self-determination and active participation in health care decision; honour the normalcy of women's life cycle events; appropriate use of interventions and technology during childhood, adolescence, childbearing, childrearing, birth control, abortion, menopausal and for current for potential health problems; individualized methods of best evidenced based care; consultation, collaboration, referral as needed for optimal health care; survival, liberty, education, security, free from all forms of discrimination; to be free of cruel and degrading practices; and right to sexual and corporal integrity.

Right-Based-Model of Midwifery care in protection of women's health rights describes the links between the midwifery practices which focus on the promotion of basic health rights of women through set codes. These are: fundamental standards of woman-central-midwifery practices; accessible quality midwifery care for each woman; respect and kindness for self and others; value the diversity of women in care; value informed decision making; safety in midwifery care; ethical management of information; a social, economically, technologically, ecologically sustainable environment promoting health and well-being; and development of non-discriminatory women's health policy.

In conclusion, rights-based-model of midwifery care begins with primary attention to the nature of relationship between the women seeking midwifery services, consider the corresponding responsibilities and inherent in protecting health rights.



98. SOUTH AFRICA

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The wounded healer: Nursing care shaped by personal experiences with gender-based violence

Background: Nurses' own belief systems regarding gender-based violence play a role in the provision of care to patients exposed to gender-based violence. The high incidence of gender-based violence in South Africa implicates that many nurses had personal experiences with gender-based violence. Emotional distress stemming from nurses' personal experiences might pose a barrier to care for patients exposed to gender-based violence.

Research question: How does nurses' personal experiences with gender-based violence shape the care provided to patients exposed to gender-based violence?

Methodology: Qualitative data obtained from unstructured interviews with nurses working in emergency units in South African hospitals were analysed using Giorgi's descriptive phenomenological method.

Findings: Based on their own suffering and experiences of healing, some participants encouraged patients to reveal their experiences with gender-based violence, while others attempted to address the patient's guilt feelings and generate hope. Previous experiences were, however, not always beneficial, as the efforts to help constantly interrelated with and served as a reminder of own experiences rendering participants to experience powerlessness and self-doubt while interacting with the patient. A response based on her own experiences might also reflect the nurse's own need more than that of the patient.

Conclusion: Nurses' personal experiences with gender-based violence affect the emotional care provided to patients exposed to gender-based violence. Own emotional wounds become a source of healing as nurses use what they have learned through their own exposure to violence to heal others. On the other hand "wounds" that have never healed are associated with emotional distress, a lack of self-awareness and a lack of self-regulation, phenomena that might impede nurses' empathetic and caring abilities.



99. SINGAPORE

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[Advanced Practice Nurse led outreach service in the acute care setting: A pilot study](#)

Background: In recent years, the patient occupancy rate and the number of beds in the critical care units have heightened considerably. As a result, clinicians are pressurized to discharge patients to general wards. The premature discharges escalate the potential of critical care readmission within the same hospitalization stay. Thus, this leads to increased patient's length of stay, morbidity and additional costs.

Methods: The advanced practice nurse (APN)-led outreach service was initiated in March 2012 to follow up patients and families who were discharged from the surgical high dependency unit (SHDU). The purposes of the service are to monitor patients' conditions, provide care/treatment after they were transferred. In addition, it provides an opportunity for the APNs to explore the patients' psychological well-being, and to provide any information, support and referrals, if needed to the patients and next of kin.

The aims for this study are to evaluate the effectiveness of the APN-led outreach service and to examine the patients' characteristics and their reasons for readmission.

Discussion: The study's results will provide useful information for APNs, healthcare providers and administrators to develop effective strategies to decrease a critical care readmission rate and enhance the quality of care. Moreover, the service also augments the visibility of the acute care APNs and their valuable contribution to the nursing profession. Lastly, this presentation will also explore the journey towards setting up the service, as well as the challenges and barriers encountered.



109. GRENADA

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[Simulation, nursing, midwifery and leadership](#)

The presentation will summarize the importance and impact of simulation to the practice of nursing and midwifery; describe the role of simulation in developing leaders and improving practice and list the steps you can take develop your skills in simulation. As the art, science, and practice of healthcare simulation expands and is supported by research findings, the ways in which simulation is used to support practice is expanding as well. This presentation will share some of the ways in which simulation is supporting education and thus practice and improved patient outcomes. Also shared will be the ways in which the use of simulation links to leadership in the fields of nursing and midwifery and how you can enhance your leadership role and position by integrating simulation into your practice.



112. AUSTRALIA

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[Making pregnancy safer: Inspiring clinical leadership to reduce maternal and infant morbidity and mortality](#)

The Commonwealth Nurses and Midwives Federation (CNMF) contributes to improving health by fostering access to nursing and midwifery education, thereby strengthening clinical leadership in providing best practice care. In partnership with national nursing associations and Ministries of Health, the CNMF conducts grant funded education and training for nurses and midwives on a range of issues, including maternal and infant health.

As we reflect on the progress made in line with the Millennium Development Goals and the current state of maternal and infant morbidity and mortality, focus turns towards the global health vision for 2020 and beyond. The 'Making Pregnancy Safer' workshops complement this vision, by providing evidence-based updates so that nurses and midwives are better equipped to provide safe care in a range of maternity settings.

The workshops are an intensive three day program covering global health care initiatives, antenatal care, normal labour and birth, complications of pregnancy, postnatal care, care of the neonate, family planning, and caring for women with special needs. Each workshop welcomes approximately twenty to thirty participants, and the learning methods include a mix of short videos, formal presentations, group work, self-reflection, group activities, practical exercises and questionnaires.

Exposure to resources available to improve and enhance nursing and midwifery practice is an important component of the workshops, and key resources are made available to ensure information can be shared within workplace teams. Workshop evaluation takes place over time using structured participant feedback. 'Making Pregnancy Safer' workshops have previously been conducted in Sierra Leone and Zimbabwe and most recently been conducted in Lesotho and are next planned in Malawi and Tanzania.

Leadership in policy and projects



6. NORTHERN IRELAND

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[Delivering care: Nurse staffing in Northern Ireland – from policy to practice](#)

Appropriate nurse staffing has been the subject of significant research over the last ten years providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes.

The Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) managed and facilitated a project structure on behalf of the Northern Ireland Chief Nursing Officer (CNO), to develop a policy framework for nurse staffing levels. The work resulted in production of a system for use in general and specialist medical and surgical wards across Health and Social Care (HSC) organisations to determine funded establishments.

The methodology included a literature review of approaches to workforce planning, advice from international experts, benchmarking of a range of factors impacting on nurse staffing within 145 wards across the region and agreement of ranges for nursing: bed ratios for the clinical areas defined.

Through a collaborative approach led by the Chief Nursing Officer across stakeholders, including NIPEC, PHA, nurse leaders, staff side organisations, commissioners and patient advocates, agreement was reached on an approach to determine nursing funded establishments for clinical practice.

Production of the final framework included consensus on: 100% supervisory status of the Ward Sister/Charge Nurse; key quality indicators sensitive to nursing work load to evaluate efficacy of the staffing levels, and establishment of biannual monitoring and reporting through professional accountability from Executive Directors of Nursing to the CNO

The published framework was made policy by the DHSSPS in January 2014 and implemented by Trusts and the PHA/Health and Social Care Board (HSCB) by March 2015. This resulted in an investment of twelve million pounds in nurse staffing across NI.



7. NORTHERN IRELAND

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Recording care

Accurate record keeping practice linked to the provision of safe, effective, person centred care has been a subject addressed in public inquiries over the last 10 years in Northern Ireland and is recognised across professions as an essential responsibility within the role of all registrants.

The Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) led a strategic collaboration with the five Health and Social Care (HSC) Trusts in NI with the overarching aim of improving nurse record keeping practice.

The methodology was constructed following a review of literature exploring approaches to achieving and sustaining improved standards of nurse record keeping practice. A pilot project testing an improvement methodology over an eight month period achieved 34% improvement across indicators in a bespoke audit tool sensitive to nursing practice in this area.

Leading a successful regional funding bid to enable facilitation of the improvement methods, NIPEC and Trusts implemented the approach across 105 adult wards in the region alongside testing of a regional person-centred nursing assessment and plan of care document. NIPEC worked in partnership with senior nurse leaders in HSC Trusts to assure consistency, enabling benchmarking of practice standards and generating learning for subsequent improvement cycles, achieving an improvement of 30% across audit indicators.

Following robust evaluation, the successful methodology has been adopted into HSC Trust Executive Board safety and quality processes, including inspection criteria from the health care regulator and adaption has begun for a range of other care settings such as, children's, learning disabilities and mental health.



11. SINGAPORE

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Effectiveness of advanced practice nurse-led telehealth on readmissions amongst patients post-AMI

Background: Cardiovascular disease continues to be the leading cause death internationally. Acute myocardial infarction (AMI) is a rising concern as patients suffering from it are experiencing an increasing trend of frequent readmissions that implicates both effectiveness of healthcare services and patient's quality of life. It is critical to explore new strategies to minimize preventable readmissions to save hospital bed days and improve patient's self-efficacy to enhance quality of life after a life-threatening event.

Aim: To develop and examine the effectiveness of an APN-led telehealth rehabilitative programme as a transitional nursing therapeutic on readmissions and health related outcomes amongst patients with AMI post discharge.

Methodology: A randomised controlled trial will be adopted. A consecutive sampling of 172 patients with AMI will be recruited from National University Heart Center, Singapore (NUHCS). The participants will be randomised into two groups. The experimental group will receive APN-led telehealth rehabilitative programme upon discharge with the first contact within 7 days in addition to standard care. The 2-month telehealth service includes the use of electronic transfer of participants' vital signs progress from home to hospital and APN-led management through telephonic interactions and a "Heart Recovery" manual to encourage (1) personalised signs progress; (2) symptoms management; (3) optimizing evidence based medicines; (4) secondary prevention education and (5) any arising issues. The control group will receive conventional standard follow-up care. The data will be collected at the baseline, at the 1 month and 6 months.

Study Significance: To date, this would be the first study in Singapore that uses the combination of APN-led and telehealth services as a transitional nursing therapeutic intervention to evaluate its effectiveness on readmission rates and health related outcomes amongst patients with AMI post discharge. The study is currently in the implementation phase and has been awarded a Singapore Heart Foundation Grant.



18. CANADA

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[Strengths-based nursing: Reclaiming nursing values to meet the challenges of 21st century care](#)

Our current healthcare system is a disease-centric and deficit based system in which nurses are educated to focus primarily on what is wrong, missing, or not functioning. Nursing is often practiced as a set of technical activities and tasks without a strong nursing philosophy (Gottlieb, 2013). Strength-Based Nursing (SBN), both a philosophy and an approach, is an alternative paradigm that is gaining momentum worldwide.

SBN focuses on strengths – inner and outer strengths- from cells (biological) to citizen (personhood) to community (systems). SBN asks “what is working?”; “what is functioning?”; “what matters to this person, to this community?”; “what does the person/community do best?” SBN focuses on strengths to contain, minimize, or circumvent that which is diseased or not functioning. Focusing on strengths helps to motivate and create conditions in which the person/family feels more in control and is able to take greater charge of their health matters to achieve greater levels of health and healing

SBN builds on Nightingale’s legacy of health and healing, holism, laws of nature, and environment, and moves these ideas into the 21st century. SBN is built on four pillars: 1- Person/Family Centered Care, 2-Principles of Empowerment, 3-Relational Care grounded in collaborative partnership; 4-Innate mechanisms of health and healing. SBN is grounded in eight core values to guide actions.

This paper will describe: (1) the defining features of SBN with its underlying scientific basis, 2- how to create environments to implement SBN in practice with a focus on leadership and management, 3- the benefits of SBN for people, the nursing profession, and the health care system, and 4-SBN’s applicability to health care systems in both well-resourced and low resourced countries.



21. SOUTH AFRICA

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[Making the unseen practice of nursing visible: Insights from Uganda](#)

What nurses do every day can easily become habit and norm of practice. The deputy head of clinical nursing at by CURE children’s Hospital in Uganda, was keen to involve the hospital team in a facility wide practice development process to make current practice visible and find opportunities for developing practice. The Child Nurse Practice Development Initiative accepted the invitation to facilitate the process by tracking the pathway of care through the hospital articulating roles of both health care workers and parents and finding the opportunities for improvement.

The methodology was intentionally participative and data was collected using focus groups, interviews and observation. Graphic facilitation, a visual tracking method was used to gather data from multidisciplinary teams (nurses, doctors, social workers, physios and pastoral workers) on: how a child moves through the hospital; who they see; what happens along each part of the pathway; how people communicate and how parents are involved in care.

The staff actively engaged and contributed their perspectives to unpack the pathway of care. The outcome of the site visit to CURE is a bold graphic harvest which captures staff discussion and contributions to pathway of care. Tracking this pathway allowed the staff to see displayed their triumphs and ongoing social, physical and occupational challenges factors enabling family involvement. Insights gained from the visit to CURE will assist in better understand best practice models in local African contexts related to family involvement. The visual graphic harvesting helped to make practice visible and from these visible outcomes staff identified opportunities for refining current practice, these include triage and a clinical co-ordinator, to align their systems with parents rather than professional and independent team needs, to implement daily time schedules aligned with mothers/child needs, simplify documentation and role clarification.



30. UNITED KINGDOM

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[Health visiting: leadership and best practice in the 21st century globally – a personal journey and the power of networking internationally](#)

With increasing globalisation of nurse education, practice and research combined with nurse migration across the continent. Nurses need to now possess a global perspective as an essential nursing leadership skill. Society today is very diverse and this includes service users and providers, and because of this, nurses must be able to operate in such a way to embrace cultural influences into standard nursing practice and this includes networking with nursing peers across the globe.

This paper reflects on a personal journey and the need for more nurses to share best practice globally. Due to increasing demands from service users, expectations to work smarter with limited resources, combined with the challenges of changing demographics of society and nursing mobility and migration, it is important that nurses devote time to standardising global health leadership skills through networking opportunities and working with established nursing unions and regulatory bodies to help put structures in place to raise and maintain the standards of nursing practice, education, research and policies across the world. This is one of the ways to tackle some of the chronic diseases that are impacting all aspects of society. Networking with nurses across the globe has many benefits to nursing leadership as it enables sharing of how nurses from different cultures arrive at different decisions to impact patient care. It allows sharing of best practice in both the practice and educational settings from a global perspective. Health visitors have a key role as public health nurses in addressing the rise in non-communicable diseases locally and globally, as research shows it is a growing problem worldwide that cannot be ignored. This paper will highlight examples of how networking across the continent can enable all nurses to be equipped with the skills to lead in their field to improve the health of the population.



44. NORTHERN IRELAND

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Safeguarding children and young people attending the emergency department and children's ward

An average of 28,500 children attend Emergency Departments, WHSCT annually. Historically no robust mechanism for screening all children. Local, regional and national Child Death Inquiries repeatedly outline system failures as contributory factors in child deaths.

High risk area requiring intervention

- Robust screening tools and action plans required to identify children who are vulnerable, in need and at risk of significant harm.
- Identify and implement internal flagging system for hospital records ensuring effective sharing of relevant information.

Trust Action

- Safeguarding must be high priority – risk management, improving outcomes for children key focus areas.
- ED Safeguarding Pathway developed.
- ED/CAMHS Pathway developed.
- Monthly Safeguarding Meetings, ED/Paed.
- Pilot proposal developed, submitted and approval granted for 6 months PILOT commenced April 2010.
- Annual Cost:
 - 1 WTE Band 2 Admin, £20,418 Altnagelvin
 - 0.5 Band 2 Admin, £10,209 Erne.

Evaluation

- Evaluation after 6 months indicated improved outcomes, findings presented to Chief Executive, Directors, further funding secured to proceed.
- 2nd Evaluation, 18 June 2010–31 January 2011, improved outcomes secured recurrent funding.
- 86 children raised concerns and required further action. Two children had cases reopened by Social Services as a result of this screening process.

Outcome

- A more rigorous approach to universal screening via SOSKARE of all children attending acute hospitals.
- A more rigorous approach to screening of all children presenting with self-harm.
- Interface between acute services and social services strengthened.
- Notification pathway developed.
- Notification document developed for inclusion in ED chart, hospital records, copy to Social Services.
- Safeguarding Pathway/ED CAMHS pathway operational.

Action plan

- Children identified on SOSKARE reviewed by duty consultant, Social Services contacted if necessary, relevant information shared verbally, in writing on notification sheet, copied to social worker, copy filed in hospital/ED notes.
- Files for children under five are reviewed for previous attendance including patterns/frequency.



50. SIERRA LEONE

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[Ebola virus disease containment: Crisis management in a rural setting](#)

Ebola Virus Disease spread was first identified on May 24, 2014 in a village in the Eastern part of Sierra Leone. On June 13, 2014, the first EBV confirmed case was transferred to Marampa Chiefdom, where the St. John of God Catholic Hospital is situated. The hospital suffered a loss of 12 health workers, and the chiefdom experienced a mortality of over 300 persons and about 250 EBV survivors. So this study is to gather together the strategies used by the St. John of God Catholic Hospital and the health authorities to contain the spread of the EBV disease within the chiefdom.

Objectives of the study: The study aims to answer the following questions:

- What behaviors needed to continue to be addressed for Ebola?
- Containment and prevention?
- What were the roles of the traditional leaders and the health authorities in the containment of Ebola Virus spread in the Marampa Chiefdom?
- What strategies helped to contain and prevent the exponential spread of Ebola virus disease amongst poor rural population in the Marampa Chiefdom?

Methodology: This is a qualitative study that will collect information using in-depth interviews (IDI) and focus group discussions (FGD).

Study Area: The study areas will be eight sections in the Marampa hiefdom, Port Loko District in the Northern part of Sierra Leone.

Study Population: Community members including community and religious leaders, health care workers and traditional leaders

Sample Size: In-Depth Interviews: Data will be collected from a total of 200 key informants.

Focus Group Discussions: Group discussions (FGDs) per sections (seven sections). Each section will have approximately 10 to 12 informants.



51. UNITED KINGDOM

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[The 'Stop the Pressure' campaign](#)

In 2012 NHS Midlands & East launched a high profile campaign to raise awareness and support elimination of avoidable pressure ulcers in all care settings.

Engagement with all Trusts (Acute Mental Health and Community) across the region began with data collection on new pressure ulcers. Through this we could then start to measure the impact of the campaign.

The Safety Thermometer tool was launched across all Trusts in England through the national contracts. The tool measures 4 aspects of patient harm: Pressure Ulcer, Venous Thromboembolism, Falls and Catheter Associated Urinary Tract Infection.

A website was developed (www.stopthepressure.co.uk) and social media outlets (#stopthepressure and @STPressure) were created to develop a network of people who could support each other in their improvement work. In addition 'Stop the Pressure' game was also developed.

The Stop the Pressure campaign realised a 50% reduction in the prevalence of new pressure ulcers across the Midlands & East region. This was largely delivered by raising awareness and the measurement and prevention via an extensive communications strategy.

Achieving lasting results relies on sharing of experiences beyond the NHS into social care and the independent care providers to ensure no matter where someone is receiving their care, the same high standards of quality will be apply. A national nursing collaborative has been established with representation from a number of major NHS and Independent stakeholder organisations. Together work is underway to shape the strategy and determine the most effective ways to embed this practice in all caring organisations.

The Stop the Pressure campaign has become a vehicle of change and through the newly established Academic Health Science Networks this is an opportunity to sustain pressure ulcer prevention and achieve long term harm reduction for patients in our care.



59. SINGAPORE

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[Nurse led spontaneous awakening trial \(SAT\) protocol on mechanical ventilated patients in coronary care unit](#)

Background: Continuous sedation infusion is commonly necessary for mechanical ventilated patients to reduce anxiety and agitation. Ironically, sedation is associated with risks including delirium, prolonged mechanical ventilator days. This results in longer intensive care unit (ICU) and hospital stays. Growing evidences support nurse – led sedation protocols and daily awakening practice as a strategy to minimize patient’s exposure to the side effects of sedation. Herein, we describe how we implement and evaluate the impact of nurse led spontaneous awakening trial (SAT) protocol on mechanical ventilated patients admitted to coronary care unit (CCU) in a local tertiary hospital.

Methods: A collaborative effort between the nurses and cardiologist was carried out to revise the sedation guideline used in CCU and standardization of the choice of sedation used. The SAT protocol was designed and successfully integrated into clinical workflow for our nurses.

Data of 1 year duration pre and post nurse-led SAT protocol will be compared based on outcomes of include length of intubation, length of ICU and hospital stay The barriers and challenges for implementing nurse-led protocol in the unit were explored through questionnaires and audits.

Results and Conclusion: The study is in progress with anticipated completion by July 2015. The findings will be share at this platform.



61. UNITED KINGDOM

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[Developing a culture of research and publication within nursing](#)

The structure and quality of nurse education in the United Kingdom (UK) has been scrutinised for many decades, which has culminated in a significant shift from ward-based learning at certificate level to that at diploma or degree level being delivered in Higher Education Institutions. This professionalisation of nursing in the last decade of the 20th Century was influenced by major changes in Department of Health (DH) policy, which demanded that a sound evidence-base must be applied to nursing practice thereby replicating the model of evidence-based medicine. The requirement for care delivery to be evidence-based is built on the premise that a continual research programme to investigate, disseminate and implement findings will enhance decision-making in the clinical environment, thereby improving standards of care and patient outcomes. However, for this to be achieved there is an organisational responsibility to drive a positive research culture within nursing in order to effectively generate new knowledge and expertise.

This presentation will explore the nursing research culture in the National Health Service (NHS) and the strategies employed by the Defence Medical Services (DMS) for supporting its nurses to generate the high quality evidence that informs best practice. This includes the development of the Academic Department of Military Nursing which was established in 2013 to support nurses to engage in research and academia as well as to disseminate their work through publication. The presentation will discuss the practical ways by which a culture of research and evidence based practice has been developed within nursing to benefit patient care.





67. UNITED KINGDOM

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[Using fellowship creatively to lead practice improvement and change](#)

The Institute of Health Visiting (iHV) was established in 2012, supported by government, to strengthen the quality and consistency of UK health visiting services for the benefit of all children, families and communities. The core focus of its work is on education, research, quality improvement and developing leadership in health visiting.

The Fellows of the Institute of Health Visiting (FiHV) scheme, launched in 2014 and sponsored by the Department of Health, set out to identify, acknowledge and direct the professional potential of 150 exceptional health visitors who have made a real difference to health outcomes for children and families in England. The scheme aimed to liberate the talents of these expert and confident health visitors to be of significant benefit to their organisations and nationally e.g. helping to secure a smooth transition of their service as it moves to local authority (LA) commissioning in October 2015.

To become a FiHV, health visitors went through a rigorous selection process. They were able to demonstrate how they deliver excellence in practice and could be an inspirational leader in the profession locally, regionally and/or nationally in the future. iHV Fellows are from a variety of backgrounds – clinical practice, education and research, they ‘push the boundaries’, have an entrepreneurial spirit and were deemed capable to lead the next generation of health visitors.

FiHV’s undertook a special four-day leadership development programme before the conferment ceremony on 11 March 2015. Two months following their conferment we are seeing evidence of early impact and strategic influence e.g. participation and membership of national committees, employment in government, participation at local Health and Wellbeing Boards, presenting on the unique contribution of HVs, positively influencing the transition of commissioning to LAs and marketing health visiting to LAs, publishing research, even participation in a roundtable event at 10 Downing Street.



71. CANADA

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[Exploring infant feeding practices among the Olbalbal Maasai Tanzania](#)

Background: The Maasai of Olbalbal District, Ngorongoro Conservation Area live a traditional, pastoral lifestyle. Environmental and sociopolitical stressors, including climate change and a ban on cultivation, create challenges for nutritional adequacy. Such challenges result in poorer health outcomes compared to other Tanzanian ethnic groups, with Maasai children having increased incidence of diarrhoea and respiratory illness, and stunting/wasting. The World Health Organisation recommends exclusive breastfeeding for the first six months for optimal health including significantly decreased incidence of infant respiratory and gastrointestinal infections.

Method: The Mama Kwanza Project (Canadian International Development Agency & Green Hope Tanzania) operates health clinics in this region. In order to explore the insights and infant feeding practices of mothers with infants birth to six months of age, a local Maasai research team was hired to recruit women, conduct interviews in Maa, and transcribe the interviews into English. Structured, audiotaped interviews were conducted with 30 women in winter 2015.

Findings: Breastfeeding is traditional and normalised among the Olbalbal Maasai, with all mothers initiating lactation and planning to continue for at least two years. Lactation knowledge and skills are passed down generationally. No participants were exclusively breastfeeding during the first six months due to traditional practices and the belief their milk is insufficient and nutritionally inadequate due to maternal dietary deficiencies. Other research supports the existence of macronutrient deficiencies among this population.

Practice Implications: While increased exclusive breastfeeding to six months could reduce infant morbidity, such health promotion efforts must be sensitive to the unique cultural and contextual factors among these Maasai women. Additional challenges include high illiteracy rates and a lack of available health promotion materials, particularly in the Maa language. Education on the health benefits of exclusive breastfeeding must be balanced with programs that seek to address the nutritional deficiencies among pregnant and lactating women.



96. UNITED KINGDOM

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[International systems of nurse revalidation: Observations for the UK](#)

This briefing has been written to help inform the Royal College of Nursing's (RCN's) view on the proposed model of nursing revalidation in the UK by examining similar regulatory approaches across a selection of countries, including Australia, Canada (the provinces of Alberta, Ontario and Yukon), Ireland, Italy and Slovakia. These countries were selected for the following reasons:

- there is a significant amount of available literature which focuses on the experience and evolution of revalidation in several of these case studies – especially Canada and Australia
- the RCN enjoys strong communicative relationships with many of the professional nursing associations and trade union bodies in these countries. These insights have been invaluable in helping to direct the analysis of this paper
- the RCN is committed to ensuring that its international comparative work is genuinely global in scope. As such, this paper uses case studies which have immediate relevance to the UK but which also consider different cultural and political traditions.

In order to make the material contained in this report more accessible, the findings for each country case study have been presented around four key themes. These were identified from the results of an RCN member's survey in January 2014 which sought feedback on the Nursing and Midwifery Council's (NMC's) proposed UK revalidation model. These themes are:

- the use of third-party confirmation for fitness to practise
- the use of patient feedback
- minimum CPD requirements, and
- systems of audit and quality control.

Among the key findings of this paper were that the NMC's proposed revalidation model bears little resemblance to many of the international precedents explored. The report also found that many of the older revalidation models have gradually moved to a more autonomous, less prescriptive regulatory approach, such as allowing nurses to identify their own learning needs without a prescribed minimum number of learning hours. This was especially important, as a pressing concern for UK nurses about the new system is whether they will be able to meet the increased continuing professional development (CPD) requirement without any protected time and inconsistent funding support.



102. GHANA

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[Nurses as leaders in developing a new and sustainable mental health workforce](#)

A great leader, we believe is one who is successful despite the existence of realistic human challenges.

Nursing leadership is unique such that, the nurse leader is not only leading colleagues but also championing the cause of the client as well as relatives, friends and of the community as a whole. The professional nurse also mentors not only nursing students but other health professionals they encounter. As Ghanaian mental health nurses, we strive to take a lead in finding workable solutions to meet the ever changing needs of the populace.

Nelson Mandela once said "It always seems impossible until it is done". The Kintampo Project began in 2007, with the aim to improve accessibility to mental health services in Ghana by training two new cadres of mental health professionals namely; Clinical Psychiatric Officers (CPO formerly MAP) and the Community Mental Health Officers (CMHO). Mental health nurses have been involved in the project since its inception. The Kintampo Project owes much of its success so far to the nurse preceptors (Clinical supervisors) and to nurses who are tutors in the College.

From the outset, nurse preceptors facilitated the practice placement learning experiences for the adult learners. Nurses' unique leadership and organizational abilities continue to bring together varieties of learning experiences for the trainees. For example students have experiences in the courts, prayer camps, prisons, home visiting, delivering health talks and more.

When we, two experienced nurses became tutors, we further helped the Project by seeking to improve the skills of resident tutors. We now have skills in Curriculum development and in leading CPDs for the new cohort of practitioners.

Our exceptional skills in planning, organizing, facilitating, executing and implementing new ideas have been greatly improved by our interactions and capacity building experiences from our UK partners which have tremendously helped to sustain the Kintampo Project.

Leadership in management and administration



3. GHANA

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[Perceived and preferred leadership behaviour of nurse managers at the unit level: a mixed method approach](#)

A descriptive explorative mixed method approach was used to explore the perception and preferred leadership behaviour of nurse managers among nurses and nurse managers in the unit. The manager's style can be fundamental for subordinates' acceptance of change and in motivating them to achieve stated visions and goals and high quality of care. Nurse managers exhibit variable leadership behaviour but more inclined towards transformational leadership behaviour. Intimidation although present, its usage is not popular as relationship between nurses and nurse managers was that of a mother-daughter or father-son relationship. Creating a stimulating environment generates both staff and client satisfaction. There was contradictory evaluation of leadership instincts by the two groups whereas, nurse managers believed themselves to be assertive, proactive, etc., the nurses perceived nurse managers to be timid and lacked confidence in dealing with other professional groups. Nurses would prefer their leaders to be proactive, assertive, knowledgeable, insightful, tolerant, good listener and respected by all. Essential to the nurses is also mentoring by nurse managers. It is therefore significant that nurse managers are adequately prepared for this challenging and dynamic position of a nurse manager.

5. GHANA

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[Management practices of nurse managers in Ghana](#)

Nurses have a major role in providing high-quality care to patients. The nurse manager has 24-hour responsibility and accountability and is 'pivotal' to the delivery of effective, efficient and quality health care. However, many of the nurse managers play their roles without adequate formal preparation and have to battle with shortage of resources, especially staff as well as challenges from other health professionals in an effort to manage the unit. The study explored the perceived and preferred management practices of nurse managers at the unit level. Quantitative data was conveniently collected from 552 nurses in selected district and regional hospitals of Ghana Health Service and the Accra Psychiatric hospital all in the Greater Accra region. There was generally weak satisfaction of the practice of management and significant difference between perceived and preferred management practices. Nurses would prefer adequate formal preparation to the position of a nurse manager to ensure assertiveness, proactiveness, confidence, commitment and competence. Even though all the nurse manager variables played significant roles in predicting nurse managers' practice of management, experience as nurse has the most significant effect. The practice of management does not depend on just knowledge and skills in management and leadership but experience. It is hoped that nurses would be given the requisite formal preparation before ascending to this challenging position considering the demands of the unit.



19. UNITED KINGDOM

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[The critical role of supernumerary ward leaders in delivering better patient care](#)

Strengthening nurse leadership at all levels is an international nursing priority with many nursing organisations developing leadership roles and representation at national or board level. In the UK, ward nurse leadership became a top priority after the Francis Inquiry concluded that a series of patient deaths over a prolonged period of time at a hospital in Mid-Staffordshire had happened needlessly due to poor care.

Among its key recommendations for preventing a repeat of Mid-Staffordshire, the inquiry stressed the importance of strong nurse leadership from ward to board in order to drive up standards of excellence, support an open organisational culture, and deliver high quality and safe patient care. Since Francis, successive reviews in the UK have reinforced the need for empowered nurse leaders.

The RCN supported Francis's recommendation and believes that all ward management positions in the UK should be supernumerary with an explicit job focus on supervisory capabilities. A ground-breaking report by the RCN in 2009 called 'Breaking down barriers, driving up standards' pre-empted Francis's call for supernumerary ward leaders and its conclusions won endorsements from the Royal College of Physicians, the Royal College of Paediatrics and Child Health and the Royal College of Surgeons of England.

This paper further builds on the RCN's critical work in this areas and was prompted by a desire by the RCN to better understand how other countries have approached the theme of ward leadership and whether there are significant lessons in best practice which the UK might emulate.

This paper looks at how some other English-speaking countries have developed their ward leadership structures with the findings grouped around three key themes. These are clarity of role and responsibilities; effectiveness of succession planning, and managing realistic workloads.



29. JAPAN

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[An overview of the Nightingale-KOMI Care Theory and System](#)

Since the end of the 19th century, the nursing world in Japan has developed through education based on Nightingale's System. Numerous documents and biographies of Nightingale have been translated, greatly influencing Japanese nursing. In the 1960s, Notes on Nursing (2nd edition) was published and it remains the textbook used by most nursing schools and is read by many students.

I am a registered nurse in Japan and have a PhD based on my research into Florence Nightingale and her work. I have studied Nightingale's philosophy in depth over many years. I created the "Nightingale-KOMI Care Theory," which is an innovative nursing theory based on the results of my research. The word "KOMI" originates from "Kominami," my real name.

Nightingale-KOMI Care Theory comprises the following: True aims of nursing; Scope of Nursing; and a Methodology. In the True aims of nursing, I present the "Five Scales of Nursing," and I describe "what nursing is and what it is not."

The Five Scales are:

1. Support for the maintenance of life (including reparative processes).
2. Support that protects life from hazards.
3. Support that minimizes the expenditure of vitality.
4. Support that extends the power of life.
5. Support that fully utilizes a person's remaining health and power.

These Scales were developed based on Nightingale's thought. In practical nursing procedures, I utilize this system for the assessment of information, and for the evaluation of care. The KOMI Care Theory and related system in which I have fully reflected Nightingale's thought, has had a major influence on maintaining the quality of clinical nursing. This system is currently utilized both in the clinical workplace and in nursing education in Japan.

This presentation introduces and gives an overview of the Nightingale-KOMI Care Theory and System.



46. SWAZILAND

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A holistic care model to facilitate quality of life for pregnant women living with HIV

Prevention of Mother-to-child Transmission of the Human Immune Deficiency Virus (HIV) Programmes has been reported to reduce the rate of the vertical transmission of HIV. The purpose of this study was to develop a holistic care model that will serve as a framework for midwives facilitating quality of life for pregnant women living with HIV. These pregnant women come to know their HIV status through the provider-initiated testing and counselling for HIV approach hence the need to explore their experiences as regards their HIV positive status because of the stigma that is still attached to HIV and AIDS. The objectives of the study were: to explore and describe the experiences of pregnant women living with HIV, to develop and evaluate a model to facilitate the provision of holistic care by midwives to pregnant women living with HIV.

Phase 1 explored the experiences of pregnant women living with HIV. Phase 2 involved identification, definition and classification of the concepts, and Phase 3 the description and evaluation of the holistic care model. The research design was theory-generative, qualitative, exploratory, descriptive and contextual. A purposive sample of 19 pregnant women participated in the study and the sample size was determined by data saturation. The reasoning strategies included analysis, synthesis, inductive and deductive as described by Walker and Avant (2005), Burns and Grove (2009) and Chinn and Kramer (2008). Data was collected through face-to-face in-depth interviews. Trustworthiness was achieved according to the framework by Lincoln and Guba (1985). Data analysis was done according to the method of descriptive data analysis of Tesch in Creswell (1994:154-155). Concepts were identified from the data using inductive reasoning. The holistic care model was described and evaluated according to Chinn and Kramer (2008).



56. NORTHERN IRELAND AND UGANDA

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Fostering nursing leadership across international borders

Holy Innocents Children's Hospital (HICH) opened in July 2009 as a private not for profit hospital, located in Nyamitanga Uganda. It is supported with partners in Northern Ireland and for professional nursing leadership and financial assistance.

Leading change through people requires a vision which can inspire, encourage and motivate others to deliver. By working across international boundaries and by implementing evidence based models of nursing practice the senior nursing team have transformed the lives of children in the district of Mbarara.

The vision to develop a collaborative partnership to make a big difference in a small part of the world, the international partners share knowledge and expertise to mentor nursing staff. Within 5 years the hospital is now led by the Ugandan team and is an exemplar of good practice throughout the country emerging as a centre of excellence in Paediatrics and Child Health Services.

A system of clinical governance has become imbedded in the operational management of the hospital, providing assurance to the Ugandan board and international partners. The nursing team focus on quality and safety by delivering nursing care which is patient focused. They have achieved this by:

- Undertaking and actioning outcomes of environmental cleanliness audits.
- Nursing standards audit to monitor quality.
- Controls assurance implementation and audit of medicines management and pharmacy.
- Multidisciplinary Infection Prevention and Control committee responsible for maintaining and improving compliance against hospital standards.
- Family satisfaction survey to address any issues.
- Weekly morbidity and mortality reviews.
- Annual staff appraisal and development of personal development plan.
- Programme of continuous professional education.

This model of working has inspired transformational leadership across 3 continents empowering and enabling senior nurses to create something truly unique in the region.





58. INDIA

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[Nursing leadership in the Indian scenario: reaching out to the masses](#)

With a massive population of nearly 1.3 billion and the ratio of nurses and midwives as only 13 to 10,000 people, Indian Nursing/ Midwifery leadership is challenged to serve the healthcare needs of the Indian people.

India is spread widely over a vast 3,287,590 square kilometres, with 70 % of the population located in rural villages and 30 % located in the cities. The ultimate challenge of nursing leadership is to be able to serve in the basic health care needs of all Indian peoples by reaching into each and every pocket of the country – into the hearts of villages and from home to home, often by means other than public transport, such as via bullock cart, bicycle and on foot.

In today's Indian scenario, multi-plex hospitals, with major specialty units, are located only in the cities, available to only about 30 % in the urban areas. However, India's nursing leaders are striving to reach each and every corner of the country and meet the health needs of the masses who matter the most.

Also important to consider are the needs of the Indian female population – with concerns for issues from cradle to grave – from the still-used practice of female infanticide to the too-often-occurring but preventable deaths in pregnancy and childbirth, to the reproductive-health-literacy of Indian girls and women, as well as the needs of India's women elderly, as they cope with the diseases of aging.

Featured in this presentation are the several ways Indian nursing/midwifery leaders are working to achieve the multitude of these tasks, often at low or no cost to the people, including an innovative 'Mobile Health Clinic' approach developed by the author and her staff, in collaboration with the philanthropic contributions of Hinduja Hospital & Medical Research Centre in Mumbai.



70. CAMEROON

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[In the footsteps of Nightingale in Cameroon](#)

Florence Nightingale's works have influenced nursing leadership throughout its development in Cameroon. Nursing in Cameroon has evolved through the colonial period and the post-colonial period to the present.

The colonial period: The colonial period featured mobile health services with free medical treatment for colonial administrators, the military and religious leaders. After the First World War, health services expanded to the rural areas and medical and paramedical training commenced. The early missionaries established hospitals, mainly in rural areas. Nurses were trained 'on the job' in hospitals.

The post-colonial period: This period was characterised by a more formalised health service to replace the previous ad hoc system. Formal training was introduced and from 1960, following independence, the Government set up more divisional hospitals and health centres. These were however headed by medical practitioners or administrators who were not health practitioners. Nurses were not entitled to occupy these positions. Formal nurse training to diploma level began in the 1960's, initially headed up by doctors.

Present: Since 2000, nurses have become more organised and have been agitating to occupy senior positions in health. Nurse training schools are now headed by nurses. The curricula has been modified in line with current health needs and modern thinking about nursing care. Following recommendations by national nursing associations, departments of nursing are now functional in some states and private universities. They offer training to bachelor and masters level. Unfortunately there is still a long way to go. The post of chief nursing officer has very little influence. There is no directorate of nursing services in the Ministry of Health. Nurses in Cameroon are following the example of Florence Nightingale and are challenged to forge ahead to improve the quality of nursing care to the people of Cameroon.



76. SINGAPORE

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[Handover process](#)

Shift to shift handover is a major responsibility of Registered Nurses. It aids timely processing of information and is central in maintaining continuity of patient care and safe delivery. Participating wards switched from the Functional Nursing team approach to a Team Nursing model. Concurrent with this change in 2012, standardisation of handover process took place. The standardization process has been undergoing reviews in 2014 and 2015 for further refinement. The project aims to (1) examine and enhance existing process; (2) determine the strengths and identify the gaps in the process; and (3) continue with audits to check for compliance.

The standardisation criteria are:

1. Passing messages from Ministry of Health (MOH) circulars File, Nursing Quality Assurance file, Roll Call File.
2. Disseminating information from Roll Call Slides.
3. Briefing general reports of all patients and highlight areas requiring attention e.g. High Fall Risks, special instructions on patient.
4. Standard practice on handing over patients' documents systematically.
5. Going through Inpatient Medication Record.
6. Introducing staff to patient during handover.
7. Checking on 4Ds (i.e. Drip, Drains, Devices, Dressings).

Random audit based on above criteria was carried out in February 2014 and overall result was 82.4% compliance. Re audited again in August 2014, overall result dropped to 76%. In August 2014 and May 2015, further refinement was done to standardize the message files and to describe the 4Ds for example checking of device settings so that patient safety can be further enhanced. In order to ensure full compliance, monthly audit was done from September 2014 and the compliance was between 91% to 94%.

These audit findings indicate that handover sessions can be made effective by continuous audit and consistent effective communication to all staff by reinforcing the importance of standardised handover process to enhance patient safety and service delivery.



79. UNITED KINGDOM

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[The Institute of Health Visiting: a powerful new model for public health improvement](#)

The Institute of Health Visiting (iHV) was established in 2012, supported by the government in England, to strengthen the quality and consistency of UK health visiting (public health nursing) services for the benefit of all children, families and communities.

The iHV focuses its work is on education, research, quality improvement and developing leadership in health visiting. Such has been the success of the Institute in rapidly becoming a 'One stop shop' Centre of Excellence for health visiting practice that many employers have now taken the step of joining all their health visitors to the Institute with its membership growing rapidly to over 10,000 health visitors.

The growth of the iHV's activities in its short history has been somewhat organic responding to policy imperatives and focusing where it can have the greatest short-term impact, on education. Opportunities presenting themselves to the iHV through grants have allowed it to identify new methodologies for creating leadership in practice to promote a strengthening of local clinical practice, new confidence in the workforce and in turn significant innovation.

The presenter will use the case study of the iHV's Perinatal Mental Health (PMH) Champions to describe how a relatively modest investment has led to significant public health improvement in the services offered to mothers suffering mental illness in the perinatal period right across England. Furthermore how this has also led to new partnership working nationally and regionally with organisations similarly striving for health improvement in this important arena.



82. UNITED KINGDOM

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The importance of clinical audit in maternity

Despite evidence that supports the usefulness in identifying and assessing patient care and clinical outcome for patients, clinical audit in maternity remains challenging for hospitals in London. The Care Quality Commissioners (CQC) and Clinical Commissioning Groups (CCG) request evidence using clinical audits to assess the quality and standard of care for services patients receive in maternity and recognizes the importance. Healthcare providers must regularly assess and monitor the quality of the services provided. Most NHS organizations have a structure and guidance in place to implement clinical audit that fits under the strategy of clinical governance. Clinical governance was introduced in 1998; it is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care flourishes.

The role of the audit midwife is to work closely with clinical obstetric lead for maternity in identifying and prioritizing clinical audits using a robust system to ensure the local and national guidance are adhered to – ensuring continuous quality improvement; raising standards of care while minimizing the risk to patients. However, due to unprotected time, busy work schedules and clinical demands the relevance is often downgraded. Nevertheless the usefulness from what patient thinks of maternity services, assessing the local guidance – the results and recommendations from clinical audits often shows the need to continuously review our clinical practice. Some examples of clinical audits conducted varies from patient outcome, intrapartum care (Caesarean sections shoulder dystocia, perineal trauma, Induction of Labour, Diabetes in Pregnancy , Obesity in Pregnancy , Sepsis) , postnatal readmissions with hypertension and Maternity tariff coding.

Several factors contribute to the success of clinical audit in an organization. These include effective communication, staff engagement, empowerment and a sense of ownership. They also include the presence of adequate resources and support for training with a strong, dedicated audit team. Overall the aim is to ensure that the maternity services provided is safe, high quality and of good standard.



91. BRUNEI DARUSSALAM

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The nursing profession in a changing world: challenges and aspirations of Brunei Darussalam

Introduction: The nursing profession has seen many changes around the globe. In Brunei Darussalam meeting the country's health goal has been one of the top priorities of the Brunei Government through the Ministry of Health and associated agencies. Nursing as the biggest manpower form the very backbone of any health system and can be affected by factors such as alteration in the socio-economy, political and cultural factors which have impact in the way nurses function. Public scrutiny and continuous evaluation of society demanding high skilled, competent and knowledgeable nursing workforce that are culturally orientated towards the Bruneians culture and the state philosophy of Malay Islamic Monarchy have created a shift in the education and service paradigm can pose many challenges in providing high quality care. New findings in medical sciences and technology demanded different approaches to care delivery and nurses have to obtain the relevant knowledge to base the skills needed. Changes and emergence of trends in disease pattern, changes in the population demography of which Brunei Darussalam is no exception has created the need to addresses new pathways in the preparations of nurses. As the country venture into upgrading and building of new units within the health service, manpower becomes an issue in trying to meet service requirement. Some of these challenges will be discussed and the aspirations to enhance the profile of the nursing profession in Brunei Darussalam will be emphasised. There are still pending issues which must be addressed within the nursing profession such as capacity building for leadership development, specialisation and continuing education. The different approach to providing care has to accommodate aspects that are viable, safe and delivered competently.

This paper will discuss the challenges and aspirations of the Nursing Profession in Brunei Darussalam in meeting the current changes towards the provision of high quality care by advanced practice nurses.



97. UNITED KINGDOM

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[Global lessons from a partnership between two national nursing organisations](#)

In 2014 the Royal College of Nursing UK (RCN) and the Zambian Union of Nurses Organisation (ZUNO) signed a Memorandum of Understanding, undertaking to work closely together to develop a strong partnership and to learn from each other. The two organisations developed a pilot project together to support the development of nurse leadership in Zambia; to promote good clinical practice to improve patient care; and to strengthen ZUNO's capacity to shape the health policies that enable good practice.

In April 2015 the two-year THET funded 'RCN-ZUNO partnership project' began, with the goal that ZUNO can influence nursing policy and improve nursing practice in Zambia as it continues to develop as a professional organisation. It has a particular focus on theatre nursing, looking at the role that nurses can play in changing team dynamics. This paper outlines the successes and challenges of implementing the project from the perspective of both ZUNO and the RCN. It highlights what each organisation has learnt from each other and from the project. For ZUNO this includes learning in areas such as organisational development, nurse leadership and the role of nurses in decision making and policy making. For the RCN, the project will enable learning about our approach to supporting nurses in the UK.



100. GHANA

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[The role of nurse managers' leadership styles in nursing practice in Ghana](#)

Background: Nursing leadership is seen as a critical aspect of healthcare management since nurses represent the single largest group of professionals rendering up to 90% of the health care services. In the wake of a global nursing shortage, increasing healthcare cost and workload, it has become important for nurse managers to exhibit leadership styles that positively influence staff outcomes (job satisfaction, intention to stay and productivity). A number of studies have demonstrated mixed but significant relationships between nurse managers' leadership styles and nurses' job satisfaction, intentions to stay and productivity. However, enormous gaps still exist in the literature about which leadership style is appropriate for a developing country context of nursing practice. Since nurses need to be satisfied with their jobs, be retained at their workplaces (and the nursing profession) and be productive enough in to deliver quality care, this study examined the relationship between nurse managers' leadership styles and nursing staff job satisfaction, intention to stay and productivity.

Method: A cross-sectional survey design was used to collect data from 273 nursing staff in five hospitals in Eastern Region of Ghana. Statistical Package for Social Sciences (SPSS) version 18.0 was used for data analysis. Descriptive statistics, correlation and regression were the main statistical tools used.

Findings: The findings show that nurse managers used varying leadership styles depending on the situation but were more inclined to the supportive leadership style followed by the achievement-oriented leadership style and participative leadership style. Directive leadership style was the least used by Nurse Managers. Nursing staff exhibited moderate levels of job satisfaction, and Nurse Managers' leadership styles statistically explained 29% job satisfaction; only directive leadership style was not a significant predictor of job satisfaction. Intention to stay at current workplace which is often used as a proxy for staff retention was low among the nursing staff. More than half (51.7%) of the nursing staff intended to leave their current workplaces, 20% of whom were actively seeking opportunities to leave. Nurse Managers' leadership styles statistically accounted for 13.3% of staff intention to stay. Nursing staff believed that their own productivity had improved by 1.8% over the last six months and perceived to be 10% more productive than their colleagues on the same unit. Nurse Managers' leadership styles jointly explained only a small portion (6.9%) of the variance in perceived productivity. The findings of this study have implications for nursing practice, human resource management policies and capacity building of current and future Nurse Managers.



106. UNITED KINGDOM

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Revalidation (recertification) of nurses in UK public health practice

In response to public concern about standards in healthcare the UK proposed a new system for periodically checking nurses and midwives were keeping up to date with developments in practice. This proposal was given additional impetus after a Government sponsored review into serious failings in one hospital (the Francis Report).

The UK regulatory body for nurses and midwives (the NMC) proposed a revalidation model built on existing systems of appraisal and Continued Professional Development (CPD) portfolios. The proposed system was piloted in Public Health England (PHE) in 2015.

Aims: To establish whether a proportionate system could be introduced for checking the practice of nurses and midwives working in public health remains current.

Methods: A quarter of PHE nurses and midwives were invited to volunteer for an assessment of their records of CPD and appraisal against proposed and existing NMC criteria. Each volunteer had an appraisal and prepared an on-line portfolio.

Results: 40 nurses and midwives expressed interest in participating in the pilot. 26 completed the pilot (this number was significantly impacted by a decision by NMC to shorten the pilot period) and provided feedback. Of these 19 provided additional feedback in a post-pilot survey.

Conclusion: Revalidation, as it was proposed for the pilot, is practicable for nurses and midwives working in public health.

Leadership in education and training



12. NORTHERN IRELAND

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[Level of questioning posed by nurse mentors during undergraduate nursing student clinical assessments](#)

Practice based learning and assessment is fundamental to nurse education within the United Kingdom, with full responsibility and accountability for the assessment of pre-registration nursing students' clinical competence residing with nurse mentors (NMC 2008). An average of 22,859 nursing students undertake nurse training within the United Kingdom each year (RCN, 2013), so it is imperative that, in the interests of public safety, nurse mentors, as gatekeepers of the professional register, possess the necessary skills to make informed judgements on the competency of nursing students. For nurse mentors, a key skill is the ability to ask higher level questions, and to date, no UK studies have examined the questioning skills of nurse mentors.

This small scale study explored the level of questioning that nurse mentors use during undergraduate nursing student clinical assessments, in relation to Bloom's taxonomy. It also sought to identify if relationships exist between nurse mentors characteristics and the level of questions they ask?

A quantitative, descriptive survey design was adopted, with a purposive sample of all nurse mentors actively mentoring undergraduate nursing students across both community and hospital settings within one Health and Social Care Trust (HSCT) over a five month period. Data collection took place via an anonymous self-administered questionnaire. Ethical approval was obtained and research Governance procedures followed. Findings revealed that nurse mentors used predominantly low level questioning during undergraduate nursing students clinical assessments and no significant relationships were identified between nurse mentors characteristics and the level of questioning used.

It is recommended that nurse mentors are taught how to use high level questioning when assessing the clinical competence of undergraduate nursing students.

The results of this study will inform training programmes and initiatives, to optimise the level of questioning used by nurse mentors in the Trust.



25. AUSTRALIA

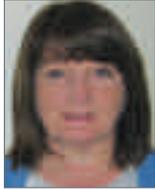
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[The new PhD supervisor](#)

The new agenda in academia is to be publishable or perish or the new catchphrase is to be discoverable or die. PhD students and their supervisors are encouraged to pursue the new PhD with publication. This type of PhD ensures that the student publish as they research and assists the supervisors in meeting research output targets required for academic workload points.

This different type of PhD challenges supervisors as reviewing and reworking publications to meet the standards of various academic journals requires a great deal of writing and editing work. This paper shares the experiences of supervising students through this type of research journey and reviews the PhD with publication and the pursuit of it in nursing academia.



28. NORTHERN IRELAND

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[A model of support for existing sign off mentors](#)

It is well reported that mentors are the gate keepers to the nursing profession (Andrews et al 2010, Brown et al 2012). Their decisions will have far reaching outcomes both for the profession and the safe and effective care of patients and clients. The introduction of the Nursing and Midwifery Council Standards for Learning and Assessment in Practice (NMC 2006, 2008) set in motion a process of developmental changes to the mentorship role. They clearly define the knowledge and experience a mentor should have before they can make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice and for sign off mentors to confirm that the student is fit for entry to the NMC register.

A group of Practice Education Facilitators in Northern Ireland developed an innovative programme which helped to prepare their sign off mentors for this new role.

The methods of delivery combined a blended approach using lecture and group supervision

Learning outcomes: The sign off mentors will:

- Have a clear understanding of the accountability and responsibility of their role.
- Be able to assess, provide feedback and create action plans.
- Be able to make sound judgments as to a nursing students knowledge, skill and attitude to be fit to practice safely.

Evaluation: Considering the challenges imposed by releasing staff attendance at all sessions were favourable. The sign off mentors valued the recognition and support for their role and positively welcomed this model of support. What was evident was the opportunity for peer support in similar situations; this would merit the recommendations as outlined in the NMC standards for learning and assessment (2006, 2008). Due to its success the programmes now runs alongside all the final practice placements.



37. SRI LANKA

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[Attitude and practice regarding MRSA among BSc nursing students in Sri Lanka](#)

Objective: The objective of the present study was to assess the attitudes and practices regarding MRSA among second, third and fourth year B.Sc. nursing students in University of Sri Jayewardenepura, University of Ruhuna and University of Peradeniya.

Methods: A descriptive cross-sectional study was conducted among 252 B.Sc. Nursing students at the above 3 universities. A validated self-administered questionnaire was used for data collection. Attitude and Practice categorized separately as poor, good and excellent. Data analysis was done in the SPSS Version 16.0 and Chi square test was used to determine statistical significance.

Results: Among the total of 252 students, nearly 45% were from University of Ruhuna, 28% were from University of Sri Jayewardenepura and 27% were from University of Peradeniya. The majority were females (71.1 %) and 28.9% were males. Out of the 252 participants, the majority had excellent attitude (59.5%) regarding MRSA whereas remaining participants had good attitude (40.5%) except for a very few students who had poor level of practice level (2%). There was a significant association between gender and the attitude level ($p=0.016$). There was no significant association between attitude level and academic year of the students. Nearly 46 % of students and almost 52 % of students had good and excellent levels of practice respectively regarding MRSA. There was no significant association between practice level and gender of the students. Nearly 52.5% of fourth year students, 54.8% third year students and 47.9% second year students had excellent practice level regarding MRSA. There was no statistically significant association between academic year and the practice regarding MRSA.

Conclusion: According to the findings of this study, the majority of the B.Sc. Nursing undergraduates of universities of Sri Jayewardenepura, Ruhuna and Peradeniya possess an excellent level of attitude and practice regarding Methicillin Resistant Staphylococcus aureus.



40. SINGAPORE

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Developing capabilities: collaboration between the acute and long term sector

There are two tertiary hospitals and four general hospitals in Singapore. In the next 3 years, more general hospitals will be built and completed. These hospitals employ the bulk of the licensed advanced practice nurses, registered nurses (RNs) and the enrolled nurses (ENs). National shortages of these licensed nurses remain. The long term care facilities like nursing homes face ongoing challenges in attracting the licensed nurses into their organisations as a result of reimbursement policies and the lack of career development and advancement opportunities.

At the National University Health System (NUHS), Regional Health System (RHS), one of the two (2) tertiary hospitals, we have embarked on a novel collaboration with a nursing home.

Five RNs were deployed (6 months) from the NUHS RHS to a private nursing home to complement their cohort of RNs. This support the nursing home to fulfill two (2) needs. Firstly, it provided them with the licensed care provider (the RNs) that is needed so that they can hire the non-licensed care providers (the nursing aids and healthcare assistants). Second, the deployed 5 RNs will be their 'fresh eyes' and trainers. These RNs will precept their nursing aids to prepare them for their licensing examinations (to be ENs) with the Singapore Nursing Board. The 5 RNs will, at the same time, identify and manage patient care practices that require improvements and revisions.

This collaboration allows the 5 RNs to gain exposure and experience in a long term care facility. This provides them the supervisory and teaching experiences in a long term care facility, which they may not have should they remain in the hospital. These 5 RNs will be rich resources for the NUHS RHS when the hospital embarks on building a long term care facility within its own campus in 2 years' time.



42. GRENADA

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The utilisation of the Objective Structured Clinical Examination (OSCE) in assessing nursing students in Grenada

The teaching and assessment of clinical competence for pre-registered nursing students is an essential requirement of a health professional's education. Providing fair and reasonable clinical evaluation is one of the most important and most challenging faculty roles (Billings and Halstead 2005). Additionally ensuring the newly qualified nurse is able to practice safe, efficient and effective care against the backdrop of rising expectations and a more autonomous role, is a core tenet in nurse education (Benner et al 2010). In nursing, there have been criticisms of the assessments on the clinical patient care units in terms of the absence of standardization, varying objectivity, patient safety, and time constraints due to competing agendas between practice and education (Duffy 2004, Bartfay et al 2004, Eldarir et al 2010). It has been argued that poor performance and lack of confidence among newly qualified nurses is the result of educational program's being focused more on academic achievement rather than practiced based education, with little preparation for the expectations of the workforce (Bradshaw & Merriman, 2008). Finally students feel they do not have enough practical experience when they qualify and are lacking in particular skills for the clinical environment (Bjorkstrom et al 2008). Consequently the OSCE is seen as the most objective evaluation of practical skills available in the assessment of trainees in Medicine as well as the Allied Health disciplines (Casey et al. 2009). This presentation describes the introduction of a ten station OSCE to pre-registration nurses in Grenada, covering the pedagogy behind simulation as well as the logistics involved with such an assessment.



52. UNITED KINGDOM

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[Stop the pressure: student conferences – a new generation of nurse leaders](#)

In April 2013 a student nurse tweeted the Regional Chief Nurse about the limited knowledge and training for student nurses around pressure ulcer prevention. What started as a tweet culminated in a 500 strong conference which was the launch pad of the forthcoming student nurse conferences across the country.

The conferences are student led from the initial concept to execution. Through the students creating discussion on social media sites like Twitter, they built a momentum and kick started a series of student led events.

The inaugural conference at Lincoln University saw 500 attendees and was accompanied by a strong social media presence resulting in a twitter reach of 330,000 and over 2 million timeline deliveries. Four further conferences followed across the country which combined have reached over 2,000 students with two more conferences scheduled this year. Each event mirrored the goals of the first event, to focus on raising awareness of the stop the pressure campaign and spread the important learning.

Students who led the conferences have been champions and role models to other students. They have done this in an extremely positive way, but have provoked reflection and influenced change in the values and behaviours demonstrated by many health professionals. It has been incredible to see such an impact on patient safety and inspiring to see student nurses take a lead in sharing this important information with their peers.

The development of www.stopthepressure.co.uk now provides a hub of helpful materials, tools and resources. A resource guide is being developed for Universities to access via the website if they are looking to host a conference.

The social media campaign has mobilised students to start their own interventions to improve pressure ulcer awareness. Student events are a success story through the engagement with the predominantly young workforce of our emerging future leaders.



81. NORTHERN IRELAND

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[Developing a self-sustainable model for advanced communication skills training in Northern Ireland](#)

Advanced Communication Skills Training (ACST) is an important component in the implementation of the NI Palliative and End of Life Care Strategy (2010) and also cited by the Cancer Control Programme (2008) and the Cancer Framework (2010) as essential training. Therefore professionals involved with complex communications should undertake a programme of ACST. The aim has been to develop a cadre of facilitators Regionally to make local delivery a reality and reduce overhead costs. To achieve this and build in sustainability, a programme of facilitator training has been developed.

Identified senior staff across the Region were supported to develop as potential ACST facilitators through an intensive facilitator preparation programme coordinated through NICaN and funded by Macmillan Cancer Support over a 3 year period. During this time two facilitators progressed to become ACST Train the Trainers facilitators/assessors which further strengthens the Regional sustainability model. Local actors were also trained to role play participant scenarios in both ACST and the TTT programme delivery.

To date 21 staff have completed the Train the Trainers programme, 11 are now accredited facilitators and a further 10 are currently undertaking the facilitators' development programme. It is envisioned that each of the 5 NI Trusts will have access to a cohort of accredited ACST facilitators and will be self-sustainable in programme delivery by 2016. A new learning resource in the form of a DVD has also been developed within the programme supporting staff to manage complex communication issues.

Prior to the current model ACST programmes for NI proved difficult to access and costly due to delivery being unavailable locally. Developing this programme has significantly reduced the cost of course provision and provided the Region with a pool of highly skilled ACST facilitators, most importantly the patient and family experience is significantly improved through effective sensitive communication delivery.



83. MALTA

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[Reach-out education: using online teaching to reach out to qualified nurses in the clinical field](#)

This paper identifies the main some challenges experienced by the authors, all nurse educators, in the development and delivery of an exclusively online academic top –up programme for qualified nurses, through the use of an e-learning platform. The programme has been running for the past six years. It is a post registration programme for qualified health professionals seeking a baccalaureate qualification. Amongst other reasons, shortages of nursing staff in clinical fields often curtails the opportunity for nurses to pursue face-to-face post registration educational opportunities, and consequently this reality jeopardises their respective opportunity to top-up their academic qualification, which, in turn, is often a requisite to career progression. Against this backdrop, this online programme is providing a unique opportunity that overcomes the barriers to access education programmes, posed by staff shortages, on qualified nurses. This programme allowed nurses to pursue a programme of studies at one's own pace, in one's own time, away from the classroom. The authors' efforts to address the identified challenges are discussed, in view of flagging the measures which may need to be put in place by educators embarking on similar online teaching initiatives and parallel educational opportunities for qualified staff. This is done in the vein that despite the challenges the efficiency of online teaching has been remarkable. Over the last few decades, the instruction and development of critical thinking, decision making and literature appraisal skills have gained momentum in nurse education. The experience of the authors support the contention that online teaching and learning approaches have extensively facilitated the teaching of such skills.



85. CYPRUS

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[Learning in the clinical setting and nursing student satisfaction](#)

Background: Clinical education is an important component of the pre-registration nursing program in order for nursing students to be professionally certified. The acquisition of quality clinical experience within a supportive and educationally adjusted clinical settings is a significant concern for educational institutions. The level of satisfaction in their students is considered an important factor in the quality of the clinical learning environment. However, there is a scarcity of studies exploring nursing students' satisfaction in clinical learning environments.

Aim: To investigate nurse students' satisfaction in the clinical learning environment (CLE)

Method: A descriptive, correlational design was used. Data were collected using Clinical Learning Environment, supervision and nurse teacher (CLES-T) scale. 463 of all nurse students from three universities in Cyprus and working in hospital settings participated. Also, students' total satisfaction from their recent clinical placements was evaluated.

Results: The results generally showed that student nurse satisfaction with their practice environment has been related to all of its aspects, namely the pedagogical atmosphere, the leadership style of ward manager, the ward nursing environment, supervisory relationship and the role of the nurse teacher ($p < 0.001$). Further, nurse satisfaction is related to all of the individual items of the factors comprising the learning environment in hospital wards. Students who had a named mentor reported that they were more satisfied with the supervisory relationship. Also, the frequency of meetings with the NT and mentor in relation with the level of satisfaction is also be revealed with the first year students reporting that they were more satisfied than the more senior years.

Conclusion: The mentorship relationship was evaluated by the students as the most influential parameter in their satisfaction with the CLE. A pedagogical approach in students learning is pivotal in order for the appropriate learning outcomes to be achieved



86. SCOTLAND AND NEW ZEALAND

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Utilising mobile technologies for CPD



The world is experiencing an extraordinary phenomenon with the exponential growth of mobile communications not only in developed countries but also in resource poor countries. Mobile technology is allowing people to communicate across vast geographical distances inaccessible previously. The International Telecommunications Union (ITU) has identified that there are over 5 billion wireless subscribers, over 70% of whom live in low and middle income countries. The World Health Organisation is working with the ITU to support the utilisation of mobile technologies to benefit public health in areas such as telemedicine and remote monitoring (mHealth). This presentation will discuss the opportunities for utilising mobile technologies to bring health professionals (HP) together to network and exchange information through virtual conferencing.

The Virtual International Day of the Midwife (VIDM) has led the way in providing an annual free online international 24 hour conference. Now in its eighth year VIDM is organised by an international team of leading academics and midwives. Twenty four topics are presented by HPs from both developed and resource poor countries. Delegates can listen to and discuss the presentations from their own home, their clinical facility, their educational institution, or anywhere with a reasonable internet connection, on any computer, tablet or mobile phone. The delegate thus gets the opportunity to 'meet' experts in the field of maternity care at no cost. A virtual student café was introduced in 2015, offering students the opportunity to compare practice, educational expectations and network with students across the world. Social media is used to promote the conference and access remote midwifery communities.

This innovative annual virtual conference meets the increasing demand from HPs for quality continuing professional development. This is especially useful for HPs from resource poor countries.



88. AUSTRALIA AND PAPUA NEW GUINEA

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Midwifery education and leadership capacity building in the Highlands of PNG: working together



Papua New Guinea (PNG) is an island nation in the Pacific, is Australia's closest neighbour, and has the second highest maternal mortality ratio in the Asia Pacific Region. An Australian Government funded project, the Maternal and Child Health Initiative, was started in 2011 to address the problem. In an effort to raise the level of midwifery education in PNG the project placed experienced expatriate Clinical Midwifery Facilitators in all the PNG universities and colleges that educate midwifery students. The aim of placing these midwives into the PNG universities was for them to work alongside the PNG midwifery educators to increase the number and capacity of those educators and subsequently the number and quality of midwives graduating from those institutions.

Paula Puawe is Papua New Guinean and has been the Bachelor of Midwifery Course Coordinator at the University of Goroka (UOG) since the beginning of 2012. Jane Connell is an experienced Australian midwife and educator who has spent the last four years working with her UOG midwifery colleagues. The past four years have seen enormous changes in the midwifery curriculum and programmes both at university and national levels. Paula has been instrumental in orchestrating these changes and has emerged as a midwifery leader in PNG.

Paula and Jane have a close professional and personal relationship. In this presentation they would like to share some of their experiences of being the 'capacity buildee' and the 'capacity builder'. They discuss the challenges and successes they have faced over their time working together educating midwifery students in PNG and offer insights for the future of midwifery education in PNG.



94. INDIA

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[Virtual learning: a path to enhance midwifery judgement](#)

Worldwide, every minute of every day a woman dies somewhere in the world as a result of pregnancy or pregnancy related problems. UNICEF, 2006 stated that 90% maternal deaths occur in developing countries in comparison to developed regions of the world.

India accounts for more than 20% of the global maternal and child deaths, and also records 20% births worldwide. In the light of current levels it is suggested that countries with high maternal mortality ratio (MMR) aim to reduce at 75 per 100,000 live birth by 2015 to achieve Millennium Development Goal.

WHO 2004, reported that problems faced by midwives include lack of competency, lack of decision making skills in midwives to begin first line treatment, lack of appropriate referral and right place for referral. It is estimated that more than 80% of maternal deaths could be preventable through right actions and early referral.

Valuing education is one of the hallmarks of a profession. The development of one's profession and knowledge is an empowering experience. Preparing the nurse to make decision with the support of an expanding body of knowledge offers opportunities for continual growth and empowerment.

Virtual learning through tele midwives consultative linkages, on-line midwifery information, self-guiding multimedia package, twitter, face book, what's up, video-audio conferencing have been emerged for providing guidance in dilemma and strengthening midwifery skills.

Changes will continue in the health care system, continuing education to empower midwives to be proactive and not just reactive. Continuous midwifery education is essential, if midwifery is to have strong voice in shaping the changes in health care.

The major aim of this paper is to present an easily accessible, convenient, economical viable and self-operating modes of virtual learning for midwives at their work place in rural regions to enhance midwifery judgement.



103. AUSTRALIA

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[The utilisation of a web based platform to deliver professional development to nurses](#)

The Nurses for Nurses Network was created by two Australian Nurses as they recognised the outcome for individual patients was as good as the knowledge base of the individual nurse delivering the care.

The use of webinar technology in the establishment of a web based, low cost education and information sharing platform has proven effective in providing continuing professional development opportunities so that individual nurses are confident that their clinical practice reflects contemporary knowledge and guidelines.

The presenters of the webinars are from registered organisations and researchers who want to get the latest information concerning their speciality to nurses working in all clinical areas.

The web based platform provides immediate and simultaneous accessibility to the information by a large number of nurses regardless of geographical location or time zone.

Our data indicates that this web based technology has been embraced by the membership as its flexibility allows them to participate in education at a time, place and pace that meets their individual requirements. The Networks membership includes the Australian Defence Force, rural and remote indigenous and general populations, urban nurses along with international nurses from Asia and Europe.



113. BAHAMAS

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[Nurturing and launching the new generation of nursing and midwifery leaders](#)

Leadership skills can be developed and practice makes perfect. In this presentation, Ms Josey describes different leadership styles including her own servant and transformational leadership style. She outlines the seven principles of transformational leadership:

- Leaders are continually learning
- Leaders are people who serve others
- Leaders are positive people
- Leaders believe in their followers
- Leaders are informed
- Leaders are creative
- Leaders lead a balanced life and look after themselves.

The presentation emphasises the responsibility of current nursing and midwifery leaders to nurture and launch the new generation of nursing leaders; that leadership is passed on not owned. Cultivating a compelling vision, acting purposefully, embracing difference, actively caring, and stewarding the future

Leadership in research and innovation



2. GHANA

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Co-authors: [Professor Kimmo Räsänen \(Finland\)](#) and [Dr Jos Verbeek \(Finland\)](#)

'Lift-Less' to prevent prematurity and low birthweight: a proposed trial in Ghana

Background: Prematurity is the number one cause of death in children under five. Every year 20 million babies are born low birthweight with 96% occurring in developing countries. Causes are unknown and existing evidence is inconclusive as to whether heavy lifting is implicated. The work of Ghanaian women in the informal sector entails repetitive lifting and carrying with no ergonomic guidelines. In 2010, Ghana ranked 14th out of 184 countries with a rate of 14.5% in prematurity. The objective of this trial is to decrease prematurity and low birthweight among Ghanaian women by reducing their biomechanical overload. Our hypothesis is a reduction in heavy lifting among pregnant women will increase gestational age and birthweight.

Method: We propose a stepped-wedge cluster randomized controlled trial with a 3- component lift-less intervention consisting health education, a reminder card mimicking the colours of traffic light and shopping vouchers. Based on the intervention, midwives will advise participants about why, when and how to reduce heavy lifting. All ten clusters will begin in a control phase with routine ante-natal care and then randomized to the intervention phase in a staggered manner until the end of all the time points when each cluster will be receiving the intervention. Eligibility are; participant is exposed to lifting, pregnancy has been confirmed and is singleton. The outcomes will be the length of gestation, birthweight and the efficacy of the intervention.

Conclusion: To the best of our knowledge, there has been no randomized trial of this nature in Ghana. If successful, the proposed lift-less intervention will justify the need to modify the occupational and family environment of pregnant women to reduce prematurity and low birthweight. The intervention can be integrated into ante-natal services and replicated nationwide and the sub region.



4. GHANA

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[Socio-cultural and service-related factors influencing tuberculosis treatment adherence in a Ghana district](#)

One difficult problem of Tuberculosis (TB) control is non-adherence to anti-TB medications. Non-adherence to TB treatment leads to adverse treatment outcomes, increases morbidity and death, and contributes greatly to the problem of antibiotics resistance. Several factors accounts for TB treatment non-adherence. Understanding these factors from the perspective of the patients has not received enough attention in the Ghanaian context. This highlights the need for better understanding of these factors from that viewpoint. This study explored and described the patient-related, socio-cultural, and service-related factors influencing TB treatment adherence at Sekyere South District. A qualitative interpretive descriptive design was used to illuminate findings. Ten (10) semi-structured individual interviews were conducted until data reached saturation. Concurrent data analysis with data collection allowed emerging issues to guide selection of subsequent participants. The study found that patients who 'make up their mind' to complete treatment, have good family support, have knowledge on consequences of defaulting are more likely to adhere to treatment. Non-adherence was associated with fasting (religious or because of lack of food), conditions not improving after treatment, and discomforts associated with taking of the drugs such as dizziness and choking sensation were causes of non-adherence. The cultural meaning of TB as "Nsaman wa", belief of being well, and some unmet needs of patients also affected adherence adversely. Adherence is still a problem, and reducing stigma and educating the community is necessary. The study recommends the development of comprehensive, holistic and patient-centered treatment approach that incorporates good support systems, and adherence counseling to improve adherence.



8. MALTA

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Nutritional screening in the elderly and its implications toward primary, secondary and tertiary care

Objectives

- To highlight the importance of nutritional screening in elderly care institutions
- To demonstrate the outcomes of nutritional screening that is ongoing at S.V.P.R.
- To propose areas of improvement or implementation of new services that would be of benefit to the elderly population.

Methods

- Research literature search
- Ongoing nutritional assessments using the validated Mini Nutritional Assessment1 both for screening and assessment purposes
- Statistical analysis of the results of the assessments

Results: The nutritional analyses carried out during the past 2 years (2013 and 2014) show differing degrees of over- and under-nutrition in the elderly residents of St. Vincent de Paul Residence, with obesity and overweight decreasing and underweight increasing slightly by time.

Year	Number of residents	Over-weight (No)	Over-weight (%)	Under-weight (No)	Under-weight (%)	Normal (No)	Normal (%)
2014	1081	560	52	172	16	249	23
2013	1200	727	61	172	14	301	25

Conclusions

The presentation will highlight the importance of nutritional screening with reference to the results of the assessments carried out to date at S.V.P.R.

Recommendations

- Nutritional screening to be carried out in all Homes for the Elderly.
- Statistical data to be kept for comparison and record-keeping.
- Proposal of the setting up of new services related to nutritional screening.



27. TRINIDAD AND TOBAGO

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Redefining the role of Emergency Medical Technicians toward increased effectiveness and efficiency in the Accident and Emergency Department

Objectives: The implementation in 2009 of the placement of EMTs within the Accident and Emergency Departments of the Eastern Regional Health Authority (ERHA) in Trinidad and Tobago was investigated for its efficiency in terms of the use of the officers' skills as opposed to their job requirements. The gaps between their training and what was expected of them was determined by an examination of literature and interviews of both the EMTs and the nursing staff working in the emergency departments.

Methods: This research is a mixed method exploratory cross-sectional study, carried out at the A&E departments of the ERHA during the month of April, 2013. The subjects for the research were all EMTs (22) and all the nurses (36) assigned to the A&E department of the ERHA.

Results: Inter-hospital transfers were the only activity that showed some sort of effect on the departments as 33% of the nurses agreed that they now have more time and 42% stating that the ENAs are having more time for nursing care. The EMTs saw themselves as being effective; however, the majority indicated that they were not performing all the skills which they have been trained to perform. The responses of the nurses differed, showing that they (EMTs) were not effective in the A&E department and that retraining for increased effectiveness was needed. The majority of nurses (96%) and EMTs (60%) failed to identify the designated clinical supervisor appointed to monitor and supervise the EMTs. The absence and need for a written policy was also expressed by the nurses as well as EMTs.

Conclusions: The current practice for the acquisition of staff at the Eastern Regional Health Authority does not facilitate the retraining for new categories of staff, such as the Emergency Medical Technicians (EMT). The results of the study, however, suggest the need for retraining as the EMTs are presently not using their skills as trained and are, therefore, not being adequately utilized for the optimum function of the A&E department.

Recommendations: This study recommends the conduct of a full outcome evaluation into the EMT 2009 programme, development of a policy document to guide the acquisition of human resources inclusive of employees needing role change, retraining etc, and incorporation of the Kirkpatrick model as the method for retraining the EMTs to align their skills to (new) expected roles and responsibilities, as well as the organizational goals. This would be done by first identifying the organizational goals, which if achieved results in organizational effectiveness.



33. SRI LANKA

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Food myths and level of nutrition among antepartum women in Sri Lanka

This study was designed to find out the association of the weight gain to level of knowledge about nutrition, to find out the association of the weight to the birth weight of the child.

Healthy mothers (n=201) were selected from the antenatal wards of CSTH, Sri Lanka for the study over a period of 3 months. Who fulfilled the inclusion criteria was given a self-administrated questionnaire and their weight was measured. After the delivery, birthweight of infants was taken.

The mean weight gain during the course of the pregnancy was 12.78 (\pm 4.09) kg. The mean birth weight of infants among the study participants was 2963.18 (\pm 421.41) g.

More than 70% of them were found to have satisfactory or good knowledge on nutrition. Majority of the pregnant mothers avoid certain foods during pregnancy. Most of them consider pineapple (35.8%), prawns (11.4%), "kehelmuwa (plantain flower)" (9.0%), and unripe papaya (7.0%) are not good to eat during pregnancy. Their myths regarding avoiding these foods included that they would lead to miscarriage (14.9%), not good for the foetus (10.0%), and can give rise to antepartum bleeding (0.5%). 18.4% of them avoid certain foods without a specific reason. The relationship between weight gain and the birthweight of the infant was statistically significant ($p=0.015$).

In conclusion this study highlights the impact of proper knowledge on nutrition during pregnancy. Subjects avoid certain foods during pregnancy, because of the unnecessary fears, myths and cultural believes which should be corrected at primary care level. The importance of adequate weight gain during pregnancy to ensure a good pregnancy outcome and a healthy infant at birth was also reemphasized by the findings of this study.



35. RWANDA AND UGANDA

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[Clinical documentation audit on a surgical ward in a tertiary health care institution Rwanda](#)

Background: Clinical documentation audit is one of the quality improvement tool that is used to ensure that the diagnosis and management reflects the high quality of care that is given to the patients.

Objectives: To identify gaps in clinical documentation in patients' charts on surgical wards and devise a strategy to bridge them.

Methods: This was a prospective study carried out from July 2014 to February 2015 in the department of Surgery at the University Teaching Hospital, Butare (CHUB). CHUB is a referral teaching hospital in Rwanda. 50 files randomly selected were being evaluated each month for correctness of documentation according to Council for Health Service Accreditation of Southern Africa (COHSASA) guidelines. A pre-tested data collection tool was used. The components of the tool had minimum standards of patients' clinical documentation and these included Patients details, clinical information, and communication with patients, discharge information and overview of patient care. Nurses and Doctors were responsible for collecting data and correctness of filling the tool was cross-checked by the Matron and Head of Department of Surgery.

Results: The overall compliance score at the beginning, July 2014 to February 2015 was 34%, 40%, 65%, 64%, 71%, 75%, 81% and 89% respectively. COHSASA regards 80% and above as compliant with the health stands and therefore surgical ward was regarded as compliant for the month January and February 2015. For July and August 2014 we were no-compliant and from September to December 2014 we were partially compliant.

Intervention: Results were reported to the department and gaps were identified and fixed. The importance of clinical documentation was emphasized. New staffs were sensitized on how to fill in the files correctly.

Conclusion: The overall score for the surgical ward increased from 29% of the survey done in 2012 to 62% of the survey done in 2014. The surgery score also had an impact on the overall hospital score that improved from 24% in 2012 to 61% in 2014 and in general, the quality of care provided to patients improved.



54. GHANA

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[Contraceptive knowledge and use among in-school adolescents in a peri-urban Ghanaian district](#)

Background: Adolescents worldwide engage in risky sexual behaviours that result in pregnancy and STI's including HIV.

Contraceptive use among adolescents in Ghana has being found to be low although knowledge on contraceptives in most cases is relatively high.

Objective: This cross sectional study explored the knowledge and use of contraceptives among Senior High Schools (SHS) students (15-19 years) within the Ga South Municipality of Accra.

Methodology: The respondents, (401) were randomly selected from purposively sampled SHS's within the municipality. The study employed structured interview to solicit information on adolescent contraceptive knowledge, their sexual behaviour and contraceptive use. Data entry and analysis were done using SPSS 20.

Results: The data collected revealed respondents were very knowledgeable about condoms (97.5%). Out of the total 401 respondents, 109 (27.3%) had ever had sex with 72 (66.7%) having used a form of contraceptive at first sex with a modal age of 17 years. The mean and median age at first sex was found to be 16.6 and 17 years respectively. The logistic regression analysis revealed a significant association between awareness of contraceptives and the area of residence ($p < 0.001$). Adolescents in SHS 2 were more likely to have heard of contraceptives than their colleagues in SHS 1 (OR 0.43 95% CI 0.210 – 0.880). Those living in urban areas were also more likely to have heard of contraceptives than their counterparts living in rural areas (OR 0.33 95% CI 0.189-0.592).

Conclusion: Adolescents are aware of modern contraceptives especially condoms but know little about other modern contraceptive methods. Contraceptive use among adolescents who are sexually active is low. Ignorance about what to use, fear of side effects, the negative attitude of service providers and the difficulty in talking to parents about sex issues are the barriers to contraceptive use.



55. SINGAPORE

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[Use of normal saline solution for periurethra cleaning before urinary catheterisation](#)

Centrimide with Chlorhexidine Gluconate composite of 0.015% has been used to clean the periurethra prior to introduce indwelling catheter (IDC) in operating theatre, National University Hospital (NUH). It is stated in the hospital's policy to use normal saline or Chlorhexidine Gluconate to clean periurethra prior to introduction of IDC. However, according to literature review, Normal Saline or boiled potable water is effective as antiseptic solution to minimize Urinary Tract Infection (UTI). Normal saline is inexpensive and has minimal side effects and also non-irritating to periurethra. Therefore, a pilot project was conducted to implement normal saline for cleaning of periurethra prior to urinary catheterization for obstetric and gynaecology patients.

Methods: A convenient sampling comprising one group of 157 patients used Centrimide with Chlorhexidine Gluconate composite of 0.015% and another group of 108 patients used normal saline. Data was collected over a period of 3 months for each group. A UTI Monitor Form was developed to document diagnosed UTI by surgeon, and signs and symptoms of UTI.

Results: In the Centrimide group, one patient was diagnosed as having UTI by surgeon and no events occurred in the normal saline group.

Conclusion: Normal saline is as effective as centrimide for periurethra cleaning prior to IDC insertion. It is a cost effective practice and patient safety is not compromised. The surgical team supported the implementation of normal saline for urinary catheterization. The new practice will be spread to other disciplines in the operating theatres.



64. GHANA

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[Postpartum family planning uptake: understanding provider and potential family planning user behaviour](#)

Objectives: Postpartum family planning uptake has the potential to significantly reduce unintended pregnancies and maternal deaths in low and middle income countries (LMIC). The study aims to assess the effects of socio-demographic characteristics and to determine factors influencing postpartum family planning uptake.

Methods: A cross-sectional survey was conducted from January to March, 2014. I randomly selected 518 women age between 15 – 49 years attending postnatal care. Data collection was done by trained research assistance through face -to -face interviews using structured questionnaires. Frequencies and descriptive statistics were calculated, and bi-variate analyses were conducted using Chi Square analyses. The data were extracted for analysis using Stata 13.0. Variables that showed associations were further analysed using logistic regression model. All p-values were set at $p < 0.05$.

Results: There was high prevalence of postpartum family planning (67.7%) uptake. Postpartum acceptance of FP was significantly associated with parity ($p=0.001$) but not with level of education ($p=0.72$), religion ($p=0.06$), discussion number of children with partner ($p=0.06$) and Postpartum women with higher education (AOR=0.46; 95%, CI=0.20-1.05), Muslims (AOR=0.35; 95%, CI=0.9-1.29), women who discussed number of children with partner (AOR=0.56; 95%, CI=0.28-1.10) were more likely to refuse contraception while postpartum women with 3-6 children (AOR=5.9; 95%, CI=1.30-27.55) were 6 times more likely to use contraception.

Conclusions: Early provider contact with postpartum women has shown a greater opportunity of increased contraception. Parity is a single variable that influence family planning during the postpartum period. There is the need to develop interventions for early client-provider interactions during postpartum period to increase contraceptive methods use by focusing more specifically on immediate postpartum as conception could precede the return of menses.



89. SOUTH AFRICA

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[The measurement of pain during the first stage of labour](#)

Background: Midwives are responsible to assess pain during labour before providing pain relief. Labour pain is different from other pain as the pain may progress and intensify very quickly. Accurate and objective measures of labour pain continue to be scarce and the discrepancy in labour pain perceptions between parturients and health-care providers remains challenging. Various chronic and acute pain measurement tools are currently in use, but many problems are encountered applying these methods to the woman in labour.

Methods: A descriptive and exploratory multiple method research design was used to develop a multidimensional labour pain assessment instrument in three phases. The instrument, developed from literature, was refined with focus group interviews and open-ended questionnaires (in a Delphi Technique). The altered instrument was then tested in a private and provincial hospitals. A final instrument was compiled with guidelines how to implement the labour pain assessment instrument in nursing practice.

Findings: Comparisons between the focus group data and first Delphi round data brought forth valid clinical problems midwives might have experienced in practice if the initial instrument was used. The second Delphi round evaluated the alterations made to the instrument. The instrument was found to be a reliable measure of pain during testing in the labour wards.

Conclusion: The experts concluded the instrument to be a relevant tool that can measure and assist with labour pain control, assess the progress of labour and the condition of the patient, contribute to training, guide inexperienced midwives in pain assessment, serve as a research tool and initiate standards for pain measurement.



92. NORTHERN IRELAND

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[Are we getting the right people into nursing? Using Multiple Mini Interviews in nursing](#)

The challenge for any academic institution training future nurses and midwives is to select students who have those values and personal attributes best suited to such a professional course. This was made more imperative following the publication of the Francis report (2013)¹ and the suggestion that some of the reasons for the poor standard of care in hospitals was due to the fact that staff did not have the right values or the appropriate levels of professionalism. The study reported here took place in March 2015 and aimed to trial the Multiple Mini Interview (MMI) approach to recruitment with a group of first year nursing students (already selected using traditional interviews) as a requirement of the institution's Admissions, with a view to replace the existing interviewing process from 2016. The MMI, developed by Eva and his colleagues in McMaster in 2004², consists of a number of short stations designed to test specific competences, each station with a different examiner, making this a fairer process. Out of a cohort of 318 nursing students, 110 volunteered to participate in a study to evaluate the MMI method. Thirty two interviewers were drawn from both academic and clinical staff. Student (n=110) and interviewer (n=26) questionnaires and also the results from the seven MMI stations, along with the students' original interview scores were used to evaluate the MMI process. Initial results indicate the majority of students found the MMI a positive experience (86%) and one that helped them demonstrate their understanding of practical skills (71%) better when compared with their own interview for the course. Interviewers thought the MMI tested a wider range of applicant attributes than the traditional interview (92%) and that it is an appropriate way of assessing nursing applicants (81%). Further quantitative and qualitative analysis is currently taking place.



104. AUSTRALIA

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[Collaboration in maternity care to improve perinatal outcomes in maternal and newborn resuscitation throughout Victoria Australia](#)

Background: In support of the vision of the Governments Future Directions for Victoria's Maternity Services (2004) and the National Maternity Services Plan (2011) the Maternity Services Education Program (MSEP) has facilitated multidisciplinary maternity education for the past ten years in regional and rural Victoria, Australia. Over the last three years MSEP have collaborated with the Paediatric Infant Perinatal Emergency Retrieval service (PIPER) and Ambulance Victoria (AV) to offer a combined maternity emergency and newborn program where multidisciplinary teams respond to scenario's focussed on transfer of an unwell newborn and mother to a tertiary hospital within Melbourne.

Workshops are tailored to individual hospital needs, utilise on-site high fidelity simulation, teach procedural skills, clinical management, teamwork, decision making and communication skills. At a national level, Health Workforce Australia (HWA) strongly encourages the uptake of simulated learning environments in Australia (Health Work Australia 2010) across a broad range of health professionals.

Aim: To demonstrate specific on-site simulation skills and techniques and action list process used in the MSEP, PIPER and AV program which resulted in practice changes to improve perinatal outcomes.

Method: Demonstrate results via a five point Likert scale, pre and post surveys are completed anonymously and include a self-rating of how well the workshop assisted individual knowledge, skills and confidence to provide care for a mother or newborn requiring resuscitation, stabilisation and transfer.

Results: Analysis of the evaluation data will focus on clinical content of workshop and changes implemented to improve practice.

Discussion: Survey analysis will provide an ideal opportunity to identify components of the program that best meet individual and team learning required to support maternity care in regional and rural Victoria.



107. AUSTRALIA

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[New standards celebrate nurses in general practice](#)

Nursing in Australian General Practice has matured significantly in numbers and stature since competency standards were first published for this setting by the then Australian Nursing Federation, in 2005. A decade later, the Australian Nursing and Midwifery Federation has completed a project, with research partner University of Wollongong, and funded by the Australian Government Department of Health, to revise these standards.

This review, undertaken as a mixed methods study, used two on-line surveys of nurses and a series of focus groups conducted around Australia, to collect data. Hundreds of nurses gave generously of their time in participating in the research, reviewing the successive drafts and contributing to the new national standards. The final 22 standards are divided into four domains; 1) Professional practice, 2) Nursing care, 3) General Practice environment and 4) Collaborative practice. These standards outline the broad scope of practice of nurses working in this setting in Australia.

Professional practice standards are an important way of defining the role and scope of practice of a profession to both consumers and other healthcare professionals. So too they are a guide for curriculum development and measurement of performance.

In a positive policy environment offering enhanced funding opportunities for nurses in general practice, this is the ideal time to promote and celebrate their leadership role as articulated in these revised standards.

The new ANMF National Practice Standards for Nurses in General Practice describe best practice for registered nurses and enrolled nurses involved in, and being attracted to, this increasingly popular area of nursing practice. The role clarity they provide, will optimise the contribution of nurses to Australian General Practice. The standards are an exciting framework for advanced practice development and professional enhancement.



111. BOTSWANA

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[Results of a task sharing survey for nurses and midwives in Botswana](#)

Introduction: The Nursing and Midwifery Council of Botswana and the Botswana Nurses Union have been tasked to develop a task sharing and task shifting policy for nurses and midwives. In order to inform the policy process, the University of Botswana researchers conducted a study to explore the opportunities, barriers and policy implications for nursing and midwifery.

Methods: This descriptive cross sectional study consisted of a survey among 496 nurses and midwives selected through purposive sampling, from 10 health regions and 25 health facilities selected through simple random sampling. Qualitative face-to-face in-depth interviews were conducted among 12 policy makers, selected through purposive sampling. Ethical clearance was obtained from local institutional review board, and participants signed written informed consent. Quantitative data were analysed in SPSS using descriptive statistics. Qualitative data were analysed manually for themes and subthemes.

Results: A majority of nurses, 334 (70.3%) said tasks were shifted to them from other health professionals, and 436 (87.9%) never shifted tasks to non-nursing cadres. Many nurses, 359 (57.4%) said they experienced conflict over shared duties and they resolved this by "just doing the task". A good number of nurses were trained in HIV and AIDS care and performed a number of tasks in HIV and AIDS care, including counselling, screening and testing, care for HIV infected mothers and new-borns, family planning. Key informants emphasized the need for a legal framework, system strengthening to monitor the quality of care.

Discussion of the findings: The study has demonstrated the reality and necessity of tasks shifting and task sharing and corroborate with findings from the literature.

Conclusion and recommendations: Task shifting and task sharing are a reality in Botswana and nurses. Therefore training, supervision, coaching, mentoring, recognition and appropriate incentives are necessary to ensure quality of care.

110. BOTSWANA

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[Assessment of the integration of HIV and AIDS into nursing and midwifery curricula and clinical practice in Botswana](#)

Introduction: HIV prevalence remains high in Botswana, with little evidence of decline. Many prevention and care national programs are implemented by nurses and midwives, and therefore many training programs have been targeted to this cadre. However, there has been an observable gap in the distribution of the training and in service delivery. The Continuous Professional Development program developed by the Nursing and Midwifery Council of Botswana needed to integrate HIV and AIDS education and care. This study was intended to explore the status of HIV/AIDS content in in-service and pre-service curricula and clinical practice, in order to guide this integration and to scale up HIV and AIDS service delivery.

Methods: This descriptive mixed method formative research that triangulated document review, qualitative interviews and quantitative survey methods was conducted among nurses and midwives in selected hospitals in Botswana selected through purposive sampling. Qualitative data were content analysed for themes, and quantitative data were entered into SPSS for analysis and presented through tables and graphs.

Results: The results indicated that majority of respondents (76.9%) had attended fundamentals of HIV/AIDS, antiretroviral therapy management training ARV dispensing and HIV & TV infections co-management, HIV/AIDS counselling & testing, paediatric HIV/AIDS, HIV infant testing and PMTCT training for a duration of week or less each. Most respondents (82%) felt that the training covered substantial HIV and AIDS content they needed, and that the training was widely available to most of their colleagues. The content has been integrated into curricula for Health Training Institutions in Botswana.

Conclusion: HIV and AIDS information is dynamic; there is continuous employment and redeployment or transfer of nurses. Therefore, more effort by government is required to ensure continuous and adequate training with update courses to retain skills and provide new information.

Poster presentations



AUSTRALIA

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[Linking patient safety to clinical practice: the insight of a new graduate registered nurse](#)

Patient safety is a worldwide issue that should not be viewed as only the responsibility of the nurses at the bedside, rather the responsibility for all people in the healthcare system. Several studies have identified issues surrounding new graduate registered nurses (NGRN's) pertaining to safety in practice. In Australia, NGRN's receive some education in quality and patient safety during their undergraduate studies however, the impact and application of this education is not clear. This research plans to seek answers to the following questions:

1. What do RN's (as NGRN preceptors) know about patient safety?
2. How do these RN's apply their knowledge of patient safety to clinical practice?
3. What do RN's (as NGRN preceptors) think NGRN's know about patient safety?
4. What insight do NGRN's have in relation to patient safety?
5. Do NGRN's have insight about the physical actions associated with patient safety?

Semi-structured interviews will be conducted with NGRN's and preceptor Registered Nurses (RN's) to allow these nurses to express their knowledge and understanding of patient safety in their own words. To explore the knowledge and understanding of these nurses is to fill a gap in current literature, which has identified safety issues related to NGRN's practice, but not their insight into these safety issues.

The research will focus only on registered nurses in Australia, in particular the new graduate registered nurse (NGRN) and their knowledge of patient safety and how they relate it to their clinical practice.

Data collection will commence in late 2015 with concurrent thematic analysis of the raw data that will provide emergent themes to be included in a poster presentation.



UNITED KINGDOM

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[Taking the leadership role when asking about domestic violence and abuse](#)

The Crime Survey for England and Wales (2012–2013) estimated that 700,000 men and 1.2 million women had experienced some form of domestic abuse. This includes financial, sexual, physical and emotional abuse by a partner they were intimate with or a member of the family within the last 12 months (Smith et al 2012). Approximate figures have shown that out of every four women over the age of 16 years of age one had experienced some form of domestic violence (Smith et al 2012).

With two women killed every week in the UK, this has been highlighted as a major public health issue both nationally and internationally (Hester 2009). A study of ten countries by the World Health Organization (2012) indicated that between 15–71% of individuals were affected by domestic abuse.

This poster will explore some of the reasons women may not disclose domestic violence and the possible impact this can have on women and their children. The poster will also identify some of the possible barriers that can prevent nurses and midwives routinely asking about domestic violence and how this may be overcome with education and training.

Intended learning outcome

At the end of the session, participants should be able to:

- Identify some of the reasons why women may not disclose domestic violence.
- Discuss the possible long term effects experienced by women and children when the issue of domestic violence is not addressed.
- Explore the leadership role nurses and midwives could take when asking about domestic violence.
- Discuss some of the skills and competencies required when asking about domestic violence.

Notes

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Commonwealth Nurses
and Midwives Federation

3rd Commonwealth Nurses and Midwives Conference
Toward 2020: Celebrating nursing and midwifery leadership
Saturday 12 and Sunday 13 March 2016, London United Kingdom