**Educational Event for The Aboriginal and Torres Strait Islander People**

**Clinical Reasoning Cycle**

Clinical reasoning is typically a process whereby professional nurses involve in the development of a distinct comprehension of a patients’ ongoing status and develop a constructive healthcare plan. This process encompasses a couple of steps to provide the most efficient patient treatment, such as figures and facts, fathoming the criticality of the situation and the devising of a health plan. In the end, the evaluation of the final result and the reflection of the pattern and nature of the outcome for additional learning. This report can also include Levett-Jones’ reasoning cycle besides the 8 steps, and the way it increases the value to the results in the nursing practice (Henderson, 2014).

Clinical reasoning can be taken as the focal point of clinical/nursing practice again and again. The central principle at the base of this statement is the fact that nurses take a significant role in a considerable proportion among the judgements together with the decisions made in line with healthcare settings. Also, they are involved within clinical thought sessions on a day to day basis, which does not just need complex thinking abilities, together with a combo of personal abilities, skills and knowledge. By successfully applying the clinical reasoning capabilities nurses gain constructive results, but, nurses face failure as well. Nonetheless, failure allows them to gather knowledge for use in the future (Meissner, 2011).

The 8 fundamental steps of the clinical reasoning cycle as designed by Levett-Jones (2012) include considering the patient condition, gathering cues and information, processing of information, problem identification, goal establishment, taking action and outcome evaluation.

**Considering patient condition**

For an effective and precise decision, it is crucial to take into consideration the necessary data concerning the condition, the effects, the appearance of the condition and others. Health experts and professional nurses require making several decisions that consider their knowledge and judgement in various situations, that cannot be solved using textbook or research knowledge. Nurses often take clinical reasoning sessions that are moral reasoning sessions that end up helping them to consider the patient situation as well as the health status prior to advancing in the decision making process. Clinical reasoning should generate from a concerned and caring stance that should be developed by nurses to take care of the patients and improve in their careers.

**NHPA Target Group to Be Addressed**

The major central place for all the Australian Islands between mainland New Guinea and Cape York is Thursday Island. The population in 2011 was recorded to be 2610, with the majority (64.6%) being Aboriginal and Torres Islander people (“Diabetes Australia,” 2015a). There are broad cultural, social and historical factors that underwrite to the spread of diabetes within the population of the Aboriginal and Torres Strait Islander people, together with proximal health threat factors. After age-adjustment, in 2012-13, the Islander people had 1.2 times more likelihood to be obese and overweight, 1.2 times more chances of having high blood pressure; 1.8 times more likelihood of having abnormal high density lipoprotein cholesterol, 1.9 times more triglycerides, and 2.6 more times to smoking than the non-indigenous Australians (Lee-Koo, Henry, & Mathur, 2014). These indigenous people were less likely than non-indigenous people less likely to follow daily fruit intake guidelines by 0.9 times and 0.8 times less daily vegetable intake. In the same period, the people had almost 5 times more chances of contracting diabetes than the underweight and normal weight, (4% as compared to 19%); while at the same time, those with high blood pressure were thrice as likely to have diabetes as those without high blood pressure (24% vs 9%) (*Australian Aboriginal and Torres Strait Islander health survey: updated results, 2012–13.*, 2014)

**Gathering information and cues**

The aboriginal and Torres Strait Islander people experience diabetes prevalence of high proportions in comparison to other mainland Australians, a situation that calls for considerable consideration. In this step, we review the information and data regarding the history and the prevalence of diabetes type II in the Aboriginal and Torres Strait, as well as former medical assessments undertaken about the condition. Getting statistics about the particular condition was a concern in the development of this report (Meissner, 2010).

**Process Information**

This step involved several sub-steps including interpreting and the analysis of the information and understanding the relationship between the occurrence of type II diabetes and the setting of the Aboriginal and Torres Strait. Next, discrimination of the information is done, involving refining of the valuable information from the collection of data, while recognizing the existing inconsistency and the extraction of the crucial gaps from among the gathered clues. Next, relating the data is carried out thus discovering the existent patterns or relationships of the condition and the natives. The next sub-step involves combining inference, matching and prediction that requires the practitioner to deduce and consider alternatives and consequences.  When matching, a comparison of the data from the mainland Australia is compared to the current health data collected from the Aboriginal and Torres Strait people to provide an expert reasoning process when forecasting possibilities.

**Diabetes issues/risks related to Aboriginal and Torres Strait Islander people**

Various studies have varying estimates of the incidences of diabetes in the local communities, ranging from 4% to 33%. In 2013, National estimates of the diabetes prevalence among this population ranged from 9% to 11%, indicating thrice the likeliness of having diabetes compared to the non-indigenous Australians. By 2012, the young ones of this population had 8 times more likeliness for the 10-14 yr. olds and 4 times more for the 15-19 yr. olds to have type 2 diabetes. In 2013, Diabetes was the second leading cause of the deaths in these areas (“Diabetes Australia,” 2015b). The hospitalization rates due to complications as a result of type 2 diabetes were approximately 6 times more for the Islanders than the non-indigenous. In the same period, type II diabetes caused 10 times more renal complications in the Islander people than the non-indigenous, with seven times more chronic kidney disease and cardiovascular disease complications from type II diabetes as compared to the non-indigenous (Lalor E et al., 2014).

**The social, historical, and cultural contexts of Type II diabetes and the Aboriginal and Torres Strait Islanders**

The risk of getting infected with diabetes is not only influenced by the behavior of an individual, but also the social, historical, geographical, community, economic and cultural factors; alongside government health services and policies (“Diabetes Australia,” 2015c). Diabetes occurs besides a wide range of social, historical and cultural influences that determine the Aboriginal and Torres Strait Islander people health. The many health disadvantages that this population experiences can be traced to history, while the social and cultural influences perpetuate the current inequalities of their health (Minges KE et al., 2011).

These indigenous people were originally a hunter-gatherer community, a lifestyle they maintained until late in the 18th century, but major lifestyle changes occurred after the advent of the Europeans in 1788. The lifestyle activities formed around the seeking and consumption of renewable food and maintenance of domestic and spiritual practices changes with time. Negative traits in nutrition and physical activity hugely impacted the development of diabetes in the area, especially in the 2nd half of the 20th century. Records before 1923 proved that proved that the natives were lean and fit and didn’t suffer these metabolic conditions that were present in the European populations at the time, when the first case involving diabetes was identified in the population (*Australian Aboriginal and Torres Strait Islander health survey: biomedical results, 2012-13.*, 2014). Significant relationships have been found regarding the development and adoption of westernized lifestyles and diabetes among the Aboriginal and Torres Islander inhabitants (Minges KE et al., 2011).

Economic opportunity, social conditions and physical infrastructure play a part in determining the individual and community health. It is obvious when looking at the levels of education, incomes, housing standards, employment, racism, incarceration, connection to the mainland and access to services. The Aboriginal and Torres Strait people are substantially disadvantaged when compared to the mainland counterparts.

**Factors Leading to Diabetes within the Population**

Various biomedical and behavioral factors can raise the risk of type II diabetes development.  However, improving on these factors can lower the risk of the disease (“Diabetes Australia,” 2015c). These refer to the characteristics or exposures and behaviors that enhance one’s chances to develop an ailment. Multiple factors heighten the likelihood, as well as the severity of the condition and the chances of the development of complications and other conditions, compromising the efforts of provision of optimal care for the already infected.

The major risks can be split into the non-modifiable factors such as age and family. The modifiable factors can be changed through alterations of lifestyle and behavior and medical intervention. Activities such as tobacco smoking and poor nutrition elevate the risk of type 2 diabetes (Scott, Wang, & Hoy, 2014). Due to the high prevalence of these risk factors among the Aboriginal and Torres Strait populations, Type 2 diabetes finds high affinity, thus increasing the probability of its occurrence in the area compared to the non-indigenous. 66% of the people above 15 years are either obese or overweight in accordance to their BMI, thus proving to be 1.2 times more likely to be overweight and obese than the non-indigenous people.

 The obese adults over 18 years were found to be 5 times the more likely to be diabetic compared to the underweight and those of normal weight (*Type 2 diabetes in Australia’s children and young people: a working paper.*, 2014). 20% of the islanders aged eighteen years and above recorded high blood pressure of ≥140/90mmHg and higher. Those with high blood pressure were more likely to have diabetes than those without high blood pressure (*Australian Aboriginal and Torres Strait Islander health survey: biomedical results, 2012-13.*, 2014). Lifestyle changes, for instance lessening of obesity, increment of physical activity and nutrition and dietary improvements are fundamental to minimizing the risk of manifestation of type 2 diabetes. Additionally, breastfeeding has been proven to reduce maternal type 2 diabetes in later life (Chamberlain et al., 2015). Biomedical and behavioral risk factors consist of high blood cholesterol, tobacco smoking, poor diet, high blood pressure, overweight, physical inactivity, obesity. 42% of the islanders aged 15 years old and over smoked everyday which resulted to 11%of the existing smokers and 17% of the ex-smokers had diabetes as compared to 12 % among those who had never smoked (*Australian Aboriginal and Torres Strait Islander health survey: biomedical results, 2012-13.*, 2014).

**Establishment of goals**

Here, one synthesizes the presumptions and facts that make up the definite data about the people and the relationship to the condition.

**Taking action**

Here, we select one alternative and use it as an action course that aids us in delivering the most efficient treatment option available. We then decide the alternative in consideration of the latest data from the report (Daly & Ma, 2018).

**Evaluating outcomes**

In this particular situation, the present prevalence of Type II diabetes is evaluated and the people in the area are provided with alternatives for overcoming the illness, in the long run affecting the health equilibrium of the place. Giving alternative to the natives also allows them to overcome the situation in the future by referring to the alternatives of intervention (Meissner, 2011).

**Conclusion**

The extraordinarily high proportions of people with diabetes among the Aboriginal and Torres Strait Islander community reveal a wide range of social-cultural and historical factors, coupled with the influence of poor lifestyle choices and additional healthiness risk determinants. To ensure the best possibilities in nursing outcomes, evidence based nursing is necessary as a revolutionary step. Clinical reasoning is of significance in providing clinically relevant, practically sound solutions as alternatives for safe and effective nursing practice and impacting health outcomes to the maximum. Nonetheless, evidence is not sufficient to make decisions of clinical nature, thus systemic decision making capabilities and knowledge are required, since the data is collected from various people. It is crucial for professional nurses assess the advantages and dangers of taking a specific approach in type II diabetes management.

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