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ANMF **2024** PRIORITIES

INSIDE

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Annie Butler

ANMF Federal Secretary

In the latter part of last year, ANMF delegates from across the country assembled in Sydney for our Biennial National Conference (BNC).

The conference is a vital forum for nurses and midwives to engage in robust discussions on issues of national significance to our professions. Resolutions debated and determined by the BNC's delegates are pivotal in setting the course for the ANMF's priorities in the next two years.

Pleasingly, I was not only inspired by the conversations held at the two-day event but also genuinely thrilled about the transformative work that lies ahead of us, spurred by the resolutions we have passed.

As we embark on a new year, the ANMF is already in motion, translating these resolutions into tangible actions that will yield positive outcomes for our professions.

Among the ANMF's endeavours is a focus on nursing, midwifery, and care worker reform, crucial to safeguarding our future workforce as well as addressing evolving healthcare needs and patient outcomes. This will include developing strategies to enhance the recruitment of nurses and midwives, especially new graduates, and, most importantly, improving retention in all settings.

The ANMF is also actively engaging in developing a range of strategies and will continue to lobby the government as it undertakes the Scope of Practice Review which aims to support nurses and midwives to work to their full scope of practice.

This includes championing the expansion of Midwifery Group Practices, enhancing education, and removing barriers for Nurse Practitioners – all integral steps toward providing accessible and affordable primary healthcare to every Australian.

In addition, the ANMF will continue its support for the Government initiatives designed to strengthen Medicare to better meet patient needs.

Last year's transformative shift in aged care, with sweeping reforms implemented by the Albanese Government, included mandated 24/7 presence of registered nurses, care minute targets, and funded increased wages sector-wide. While these reforms mark progress, challenges persist, notably the absence of mandated care minutes for enrolled nurses. This oversight has led to a reduction in EN shifts and concerning attempts by employers to reclassify them into lower positions.

The ANMF continues to pursue the inclusion of mandated minimum EN minutes, emphasising the pivotal role ENs play in ensuring safe and high-quality care. Throughout 2024, we will collaborate with, and lobby as necessary, the Government to mandate specific EN direct care minutes, reaffirming the indispensable role of enrolled nurses in the aged care workforce.

Our focus will also extend to advancing wages, building on the 15% increase achieved in 2022 during the Fair Work Commission's hearings.

The ANMF continues to advocate for economic justice, addressing the persistent gender pay gap plaguing many of our female members. With a national gender pay gap of 13.3%, projecting a 26-year timeline for closure, our commitment to advocacy remains unwavering.

The Albanese Government's 2023 initiatives, including improvements in childcare, parental leave, and workplace legislation, are commendable steps. However, challenges endure, especially for many women in part-time work who may have little retirement savings, leading to the possibility of poverty in later years.

While the recent *Secure Jobs, Better Pay Act* reflects a commitment to fair work objectives, pay equity, transparency, and superannuation reforms, the ANMF will also push for mandatory super contributions during parental leave and advocate for retirement adequacy benchmarks, ensuring enduring equity for women. The ANMF will also be working to support the *Closing Loopholes Bill*, part of the federal government's workplace reform, that addresses issues in the Fair Work Act. The legislation focuses on making wage theft a crime, setting minimum standards for gig workers, defining casual work, and protecting first responders with PTSD. It also aims to stop businesses from exploiting loopholes used to undercut the pay and conditions of workers, and supporting workers experiencing domestic violence, so employers cannot discriminate against them.

More details about all of these priorities can be found in this issue's feature on page 8.

As we stand on the cusp of a new year, the ANMF remains steadfast in its mission. The journey ahead is filled with challenges, but it's also laden with the promise of change. We will persist, we will advocate, and we will tirelessly work towards a future we all deserve.

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If you are a financial member of the ANMF, QNMU or NSWNMA, you can transfer your membership by phoning your union branch. Don't take risks with your ANMF membership – transfer to the appropriate branch for total union cover. It is important for members to consider that nurses who do not transfer their membership are probably not covered by professional indemnity insurance.

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AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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REGULAR COLUMNS

FEATURE

FOCUS

The *ANMJ* acknowledges the Traditional Owners and Custodians of this nation. We pay our respects to Elders past, present and emerging. We celebrate the stories, culture and traditions of Aboriginal and Torres Strait Islander Elders of all communities. We acknowledge their continuing connection to the land, water and culture, and recognise their valuable contributions to society.

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‘Force for Change’: ANMF’s 16th Biennial National Conference sets agenda

Nurse, midwife and care worker delegates from across the country convened in Sydney last October for the 16th Biennial National Conference, mapping out the key priorities for the Australian Nursing and Midwifery Federation (ANMF) moving forward.

The conference theme, ‘A Collective Force For Change’, symbolised the union’s growing impact, evidenced by wins such as long-overdue aged care reforms, and equally, the work that remains to advance the professions.

Debate spanned various topics, including workforce reform, aged care, gender equity, increasing access to healthcare, and education.

One of the key resolutions called on the ANMF to lobby governments to provide payment for nursing and midwifery students during clinical placements to ease the financial burden they face. Additionally, delegates requested the ANMF lead a national campaign to address workforce shortages across the country, including improved recruitment and encouraging return to practice, and to engage with the federal government and NMBA to secure recognition, regulation, and registration of Assistants in Nursing (AINs).

Guest speakers at the conference included Australia’s Chief Nursing and Midwifery Officer, Alison McMillan, Assistant Minister for Health and Aged Care, Ged Kearney, CATSINaM CEO, Dr Ali Drummond, and Secretary of the Australian Council of Trade Unions (ACTU), Sally McManus. Prime Minister Anthony Albanese also made a special address to delegates, which took place just two days before the historic Voice to Parliament referendum.

Mr Albanese, who highlighted his government’s action of commitments, including RN 24/7 in nursing homes, told delegates few professions shape people’s lives like nursing and midwifery.

“You are the largest union in this country and that’s because you understand that together, your clout is much more than speaking as just individuals, which is why unions are important, which is why the work of this union matters and why my government will always listen to you,” he said.

Night shift workers need support to manage weight and metabolic health conditions

Work based policies must be designed to target barriers that night shift workers face when managing weight and metabolic health conditions, according to a Monash University-led review.

Published in *Obesity Reviews*, the review, led by the Department of Nutrition, Dietetics and Food at Monash University, investigated the barriers that night shift workers face in enabling them to make healthier lifestyle choices.

Barriers identified in eight studies in Australia, Sweden, Nigeria, the USA, and Botswana included time constraints and stress, work routines and cultural norms, work-related fatigue and limited healthy food options at night, and lack of meal breaks.

Lead author Corinne Davis, PhD candidate from the Department of Nutrition, Dietetics and Food at Monash University, said the fatigue and disruption to routine that often accompanies working at night is challenging for night shift workers and that it must be made easier for them to choose healthier food options.

The review also analysed data from 12 intervention studies in Europe, Australia and Canada. It found the studies targeting weight management behaviours for night shift workers demonstrated limited weight loss results, with only one intervention reporting a clinically significant weight loss result. The existing interventions had largely focussed on addressing only a limited number of barriers faced by night shift workers.

Authors called for more research that takes into consideration the complexities of shift work and consideration of weight loss approaches that account for timing and quality of food intake, as well as exploring the impact of sleep quality for night shift workers on weight management.

NEW WEBSITE COMPILES EVIDENCE ABOUT FAMILY, DOMESTIC AND SEXUAL VIOLENCE

The Australian Institute of Health and Welfare (AIHW) has launched a website dedicated to reporting on family, domestic and sexual violence.

For the first time in Australia, the website brings together over 30 national data sources on family, domestic and sexual violence and highlights data and information gaps.

Statistics from the AIHW show that more than half (55%, or about 285) of assault injury hospitalisations in 2021–22 involving children 0–14 years, where the perpetrator was specified, were FDV-related.

Among hospitalisations for FDV–related injuries in 2021–22, the most common perpetrators were parents (72% or about 205) among children aged 0–14, domestic partners (74% or about 600) for females aged 15–24, and other family members (58% or about 165) for males aged 15–24.

Family and domestic violence is also one of the main reasons that women and children lose, or are at risk of losing, their home.

Over half (54% or 23,300) of children aged 0–9 who were supported by specialist homelessness services in 2021–22, had experienced family and domestic violence. The majority (71%, or about 13,400) of young people 15-24 years who had experienced FDV presented to a service alone, with nearly four times as many females (10,700) as males (2,700).

Other data sources provide further insight on the experience of family, domestic and sexual violence among children and young people.

Data from the Australian Bureau of Statistics 2021–22 Personal Safety Survey indicate that 13% of adults had witnessed partner violence against a parent when they were children. More people (12% or 2.2 million) had witnessed violence against their mothers than towards their fathers (4.3% or 837,000).

The evidence on the website will be used to inform national initiatives to address family, domestic and sexual violence, including early intervention and assistance for children and young people, and monitor changes in service use and outcomes over time.

Australia spent almost $48 billion on health system response to COVID-19

Australia spent almost $48 billion on its health system response to COVID-19 from 2019-20 to 2021-22, according to a report from the Australian Institute of Health and Welfare (AIHW).

During the period, the country's estimated spend of $47.9 billion to tackle COVID-19 represented 7.2% of total health spending.

Health spending from 2020 to 2022 was 2% higher than expected. While excess mortality was 4% higher than the expected mortality, the 5th lowest excess mortality compared to 30 other countries.

"Health spending spiked less sharply in Australia than in many other Organisation for Economic Co-operation and Development (OECD) countries during the first three years of the pandemic. Australia also had one of the lowest excess death rates compared to other countries," said AIHW spokesperson Geoff Callagan.

The report shows the Australian Government spent an estimated $35.1 billion and states and territories an estimated $11.9 billion on the health system response to COVID-19. Governments spent $27.9 billion on primary care – including $6.1 billion on the vaccine rollout – and $10.5 billion on public hospitals.

Individual Australians spent an estimated $878 million on COVID-19-related services and items, such as rapid antigen tests ($597 million), personal protective equipment and respirators ($224 million), sanitiser ($56 million), prescription medications for COVID-19 treatment ($1.3 million) and out-of-pocket spending on general practitioner services related to COVID-19 ($100,000).

Lori-Anne Sharp

ANMF Federal Assistant Secretary

Summer couscous salad with endless variations!

As we embark on a New Year and what has become a tradition over the last few years, once again I would like to share a favourite recipe of mine with ANMF members. This one is a much loved, healthy and easy to follow recipe. It promises to impress and hopefully won't break the weekly food budget.

I hope you had a safe and happy festive season comrades, I hope you got some well-deserved rest after another very busy year as well as all that you do making a positive impact on the lives of others.

INGREDIENTS

3–4 cups of cooked Couscous (prepared as per packet instructions) Remembering once hot water added to fluff with a fork to avoid any clumps, helps achieve a light and fluffy texture.

4–5 tbs of cumin onions (prepared earlier, see below for separate recipe, its super easy)

Crumbled fetta

Spinach leaves

Lemon juice, salt and pepper to season

Toasted almonds or walnuts for garnish

METHOD

Add the ingredients to the couscous, toss gently and garnish with toasted almonds or walnuts to serve!

CARAMELISED ONIONS

To make caramelised onions, thinly slice 3 onions, lightly fry in generous amount of olive oil and add 3 teaspoons of cumin. Take off heat, place lid on and allow to sweat. These are great on toast and can be kept in the fridge in a glass jar for weeks.

TIPS

I have included spinach in this recipe, but you could easily replace with rocket, chargrilled zucchini, beans, asparagus, roasted red capsicum or a combination of many. You choose, this recipe is so versatile and makes the perfect left-over meal to take for lunch the next day … if there is any left, of course!

Experiment with different types of couscous, such as whole wheat couscous or pearly couscous for varied texture and flavours.

When preparing couscous, you could use chicken or vegetable broth instead of water for added flavour.

Food styling and photo by Erika Budiman
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Photo taken at the ANMF's Biennial National Conference held in October 2023, where delegates help form the union's priorities for the next two years.
Back row – Lee Collison, WA, Andrew Ostler, Tasmania
Middle row – Lisa Bourke, ACT, Sharon Horn, SA
Front row – Bernadette MacDonald, NT, Skye Romer, NSW, Ashleigh Sullivan, Qld, Roxane Ingleton, Vic
Photo: Sharon Hickey

ANMF 2024 PRIORITIES

Building on the achievements made in 2023, the ANMF stands ready to embark on another year of dedicated efforts, addressing a comprehensive set of priorities in 2024.

The priorities aim to create better conditions for nurses, midwives and care workers, as well as improve the health and aged care systems in which they operate, as ROBERT FEDELE and NATALIE DRAGON report.

NURSING, MIDWIFERY, AND CARE WORKER WORKFORCE REFORM

Nursing and midwifery workforce reform in Australia is essential for adapting to changing healthcare needs, improving patient outcomes, addressing health disparities, and ensuring that the right number of skilled professionals are empowered and enabled to provide timely and high-quality care.

It demands strategic planning, improved education, and policy changes to help build a sustainable workforce that meets the increasing demand for healthcare services.

Challenges to achieving this outcome include addressing undergraduate nursing and midwifery student attrition rates. The Australian Nursing and Midwifery Federation (ANMF) has identified that students not being able to work while undertaking mandatory clinical placements is part of the problem.

"Clinical placements are often demanding, requiring students to dedicate significant time, money, and resources to gain hands-on experience in healthcare settings. Typically, students complete 800 hours of unpaid placements throughout their degrees," ANMF Federal Secretary Annie Butler said.

"This limits their ability to work part-time jobs to support themselves, causing untold financial and emotional strain."

Feedback from the ANMF's state and territory branches suggests some of the most common problems with the current system include a lack of affordable student accommodation, a lack of support to facilitate travel to placements, especially in rural and regional areas, and lack of support from clinical placement providers and preceptors.

"This year, the ANMF has committed to lobbying both federal and state governments to provide funding to pay nursing and midwifery students while on clinical placement to safeguard our future workforce," Ms Butler said. "Paying students undertaking clinical placements will help ease the financial stress and burden they currently face and, importantly, allow them to remain enrolled and committed to their studies as they strive to join the workforce."

The growing need to attract and retain skilled nurses and midwives is also high on the ANMF's agenda.

Fostering a satisfied and engaged workforce is now paramount for the sustainability of the workforce, and the ANMF is actively engaged in developing a range of strategies to tackle these issues. This will include developing strategies to enhance the recruitment of nurses and midwives, especially new graduates, and, most significantly, implementing strategies to improve retention in all settings, particularly in rural and remote areas, by exploring incentives like allowances.

The National Nursing Workforce Strategy is poised to provide a future-focused national direction for the profession to ensure it continues to meet the evolving care needs of Australian communities.

Additionally, the implementation of strengthening Medicare reforms, including the independent Scope of Practice Review, is underway. This review is exploring ways to unleash the full potential of primary healthcare professionals, allowing them to work to their full extent of skills and training. The focus is on the system changes and practical improvements needed to enhance productivity and deliver safe, affordable patient care.

A joint response from peak nursing organisations in Australia, including the ANMF, highlighted shared issues and offered insights into maximising the impact of the Scope of Practice Review. Key recommendations included prioritising patient/consumer-centred care, ensuring access to the best care from all healthcare providers, especially nurse practitioners, advocating for funding reform, and supporting ongoing education and professional development for primary healthcare nurses and midwives. Additionally, removing existing barriers preventing access to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS) by nurses and midwives will prove crucial to enabling them to work to their full scope of practice.

"Supporting nurses and midwives to work to their full scope of practice will enable equitable access to safe and affordable primary healthcare for all Australians," Ms Butler said.

"Working to and expanding their scope of practice by incorporating new areas of clinical work and education offers nurses and midwives the opportunity for expanded career pathways and progression, increased job satisfaction, and reduced burnout and attrition."

Jocelyn Hofman, NSW aged care registered nurse. Supplied: NSWNMA

AGED CARE REFORM

Following years of neglect, significant aged care reforms in 2023 marked a turning point in the nation's commitment to ensuring the delivery of safe and high-quality care for our elderly Australians.

The Albanese Government implemented sweeping reforms across the sector, highlighted by pivotal legislation mandating the presence of a registered nurse 24/7 in every nursing home. Additionally, they introduced mandatory care minute targets for aged care facilities, stipulating an initial minimum of 200 minutes per resident per day, of which 40 minutes must be provided by an RN. The government also allocated $11.3 billion to fund increased wages across the sector in response to the Fair Work Commission's Interim decision as part of the ANMF's ongoing Aged Care Work Value case.

Fundamentally, these reforms, championed by the ANMF over many decades, signify a genuine effort to enhance the standard of care provided to elderly Australians. They also recognise the critical role and contribution of dedicated and skilled nurses and carers throughout the sector.

"We now have an opportunity to create a system that guarantees safe and high-quality care for elderly Australians living in nursing homes. Improved staffing levels and better pay will also drive the recruitment and retention of highly skilled aged care workers, ensuring the sustained success of these transformative reforms," ANMF Federal Secretary Annie Butler said.

Although these reforms represent significant steps forward, there are still challenges to overcome in effectively implementing these changes.

One of the biggest is the absence of mandated care minutes for enrolled nurses (ENs) within the recently introduced staffing requirements, legislated in response to recommendations from the landmark Aged Care Royal Commission.

As of last October, residential aged care facilities were legally required to provide a daily average of 200 care minutes per resident, with a minimum 40 minutes provided by a registered nurse, and the remainder by enrolled nurses and care workers. However, legislation failed to outline how the remaining daily average care minutes should be distributed among ENs and care workers.

Consequently, the unique role ENs play in aged care has increasingly come under threat as some providers explore loopholes within the legislation.

Last year, the ANMF conducted a nationwide aged care survey to understand the impact on ENs following the reforms. Key findings revealed instances of ENs being incorrectly told by colleagues or employers that no funding was allocated for ENs, a noticeable reduction in EN shifts, and reports of employers attempting to reclassify them to lower positions, such as PCWs. Some ENs, as seen in the high-profile Southern Cross Care Tasmania case, even faced redundancy.

Since the formation of care minutes legislation, the ANMF has argued for the inclusion of mandated minimum EN minutes, emphasising the need for clear specifications regarding the role and its key contribution as part of the essential skill mix required to ensure safe and high-quality care.

During 2024, the ANMF will continue lobbying and working with the government to mandate specific EN direct care minutes to ensure enrolled nurses remain a valued and critical component of the aged care workforce.

Another focus for the ANMF in aged care involves expanding upon the significant win achieved in advancing wages across the sector through the Aged Care Work Value case before the Fair Work Commission. In 2022, the FWC handed down an interim 15% increase on award rates, which took effect on 30 June 2023. Building on the momentum gained, the ANMF represented aged care members during Stage 3 hearings of the case held last December, calling for additional increases on award rates.

Underpinning the extensive range of aged care reforms underway involves empowering the voices of everyday aged care workers during implementation. This is essential to ensuring transparency and accountability, particularly in instances such as providers meeting minimum direct care minute targets.

"It is imperative that nurses and care workers at the grassroots level become vocal advocates of the system," Ms Butler said.

"They should feel empowered to speak out when something is amiss because, far too often, we have witnessed providers manipulating the system, neglecting the primary goal of ensuring quality care."

INCREASING EQUITY IN ACCESS TO HEALTHCARE

Ensuring equitable access to healthcare means that every Australian, irrespective of their socio-economic status, geographical location, or other factors, has the capacity to access essential health services when and where they need them.

The Australian Nursing and Midwifery Federation (ANMF) is actively involved in a range of strategically aligned initiatives to achieve this goal, such as reviews, taskforces, and advisory groups.

Last year, ANMF Federal Secretary Annie Butler was appointed to the Strengthening Medicare Implementation Oversight Committee, established to guide comprehensive reform measures shaped by the Strengthening Medicare Taskforce Report and set against the Primary Health Care 10 Year Plan. In the 2023-24 Budget, the Albanese Government allocated $6.1 billion to strengthen Medicare. This included $3.5 billion to triple bulk billing incentives, facilitating free GP consultations for children under 16, pensioners, and concession card holders, and $445 million for the Workforce Incentive Program to increase payments to support multidisciplinary care. Expanding the nursing workforce to improve access to primary care, including improving patient care through MBS nurse practitioner services and the removal of legislated collaborative arrangements, was another key action.

"The Government has committed to harnessing the full potential of nurses, nurse practitioners and midwives, which will enable them to maximise their training, education and skills in delivering the essential care required by people," ANMF Federal Secretary Annie Butler said.

Other integral components of strengthening Medicare reforms include the establishment of the MyMedicare voluntary patient registration payment model. This innovative approach paves the way for blended funding models that tailor healthcare services to better meet patient needs. Under this model, patients can register with their preferred practice, GP, and care team, ensuring more coordinated, continuous healthcare, and easier access to specialists for managing chronic and complex health conditions.

"A stronger Medicare system that provides all Australians with timely access to preventative care, early intervention, and effective chronic disease management, has the potential to significantly reduce the burden of disease, prevent complications, and improve overall health outcomes," Ms Butler said.

The government's Scope of Practice Review, another key recommendation from the Strengthening Medicare Taskforce Report, similarly seeks to identify and eliminate barriers preventing health professionals from working to their full scope of practice in primary care.

In its submission to the review, the ANMF outlined key enablers government, employers and regulators must address to enable health practitioners to work to their full scope.

These include:

- Funding reform – Moving away from subsidised fee-for-service models that have resulted in the privatisation of primary healthcare and towards block and blended funding and employment models which support nurse-led care, such as the ACT Walk-in Clinics.
- Midwifery Group Practice (MGP) and midwifery-led continuity models of care, which improve health outcomes for women and babies, should be expanded.
- Increasing primary healthcare theory, simulation and workplace learning in pre-registration nursing and midwifery education programs.
- A cultural system change to ensure ENs are more effectively utilised, including initiatives to educate healthcare staff and employers on the scope of practice of ENs.
- Funding for increased numbers of nurse practitioner positions in primary care, including aged care, which would greatly reduce ED admissions, ambulance costs and hospitalisations.
- Remove funding barriers for NPs so they can work to their full scope of practice.

According to the ANMF, the greatest risk to primary healthcare and community access lies in the potential that everything remains the same, and profit-based models, controlled by medical practitioners and other private providers, become the accepted norm.

"Such models will result in increased government spending to support private business models with increased out-of-pocket costs for people seeking healthcare," the ANMF argued.

Dhelkaya Health Midwifery Group Practice midwife April Jardine with mother Siena and baby Gloria. Photo credit: Chris Hopkins

PROGRESSING GENDER EQUITY IN 2024

As of 2023, Australia's national gender pay gap stands at 13.3%, translating to women earning $253.50 less per week than their male counterparts. Projections suggest it will take another 26 years to close this gap.

Supporting ANMF's predominately female membership, the union has strongly lobbied over many years for changes to support equality and close the existing disparity.

While recently, there has been momentum addressing the lack of a national policy to rectify diminished earning capacity throughout a woman's lifetime, ANMF Federal Secretary Annie Butler said there still remained persistent inequalities between women and men that needed addressing urgently.

"The actions of the government to improve equity for women are to be commended, yet there is much more that needs to be done. Women remain more frequently engaged in casual and part-time work and continue to face additional hurdles contributing to the gender gap in retirement savings. Presently, numerous women find themselves in poverty during their later years, with the next generation of women also at risk."

During 2023, the Albanese Government's progress towards the economic equality for women, included improved childcare accessibility, an extension of government-funded Paid Parental Leave from 18 to 26 weeks, industrial relations reforms, and investments in housing and women's safety.

Recent workplace legislation has also introduced 10 days of paid family and domestic violence leave annually for full-time, part-time, and casual employees covered by the National Employment Standards.

During 2023, many of the changes determined by the *Secure Jobs, Better Pay Act* came into effect. The Act aims to enhance gender equality by making it an object of the Fair Work Act, strengthening equal pay assessments, establishing expert panels on pay equity and care, outlawing pay secrecy clauses, and including gender equality and job security in the Fair Work Act's objects.

Starting early 2024, gender pay gaps for employers with 100 or more workers will be publicly disclosed on the Workplace Gender Equality Agency website, fostering transparency and encouraging gap closure.

The Fair Work Commission gains more authority with new expert panels on gender pay equity and the care and community sector.

Additionally, reforms in relation to superannuation guarantee will see the rate increase from 10.5% to 12% by 2025.

While superannuation reforms are welcomed, Ms Butler said the ANMF will continue to actively pursue further amendments, pushing for mandatory superannuation contributions during all periods of parental leave.

"We will also push for the implementation of a retirement adequacy benchmark that ensures equity for women and calls for a fair distribution of super tax concessions benefiting women."

In other recent changes to improve inequity, the Fair Work Commission (FWC) was given more scope to address the gender pay gap with the establishment of two new expert panels on gender pay equity and the care and community sector.

The FWC will conduct a review of the seven most commonly used awards. The first priority is to ensure that modern award wages are appropriately set in regard to gender equality and the elimination of undervaluation of work.

The review will also consider whether the terms of modern awards appropriately reflect job security and access to secure work across the economy. This will include provisions around rostering, guaranteed shifts, and permanent, part–time, and casual classifications within the award.

The ANMF, which has long campaigned for these provisions, will persist in actively pushing for increased workplace flexibility for nurses, midwives, and personal care workers, a significant number of whom are women balancing multiple work and caregiving responsibilities.

Ms Butler said there continues to be an urgent need for genuine access to flexible work arrangements.

"Some members have been forced to reduce their hours, or have had to transition to casual roles, or in some cases have resigned due to denied flexible work options."

"Over the next 12 months and beyond, the ANMF made momentum in improving equity for women achieved."

There is much work to be done but we will continue to advocate for women to ensure they have the equity they deserve and free from poverty."

IR REFORM: CLOSING THE LOOPHOLES ON UNFAIR PAY AND CONDITIONS

Last year heralded the next stage in the federal government's workplace relations reform agenda to close the loopholes that undermine pay, security and safety for workers.

The Closing Loopholes Bill is the third tranche of industrial relations (IR) legislation to be pursued by the Albanese Labor Government since being elected in 2022. It is an omnibus Bill with 18 proposed amendments to the Fair Work Act 2009.

"The ANMF broadly supports the objectives of the proposed legislation," said ANMF Federal Assistant Secretary Lori-Anne Sharp. "In our view, the current Fair Work Act is inadequate in many ways and this Bill goes a long way to addressing some of those inadequacies."

The legislation contains four main elements – making wage theft a crime, introducing minimum standards for gig workers, closing the loophole used to undercut the pay and conditions of labour hire workers and properly defining casual work so casuals are not exploited.

In particular the ANMF supports better support for first responders with Post Traumatic Stress Disorder (PTSD), by requiring insurers to presume PTSD was caused by the job. There are also protections for workers experiencing domestic violence, so employers cannot discriminate against them.

The Bill offers some protections for workers against unscrupulous businesses who continue to use loopholes to drive wages and conditions down, such as when Qantas in 2020 replaced their baggage handlers with lower-paid workers.

It also provides a definition for casual work to help stop the exploitation of employees working regular shifts for long periods of time being kept on as 'casual' and missing out on sick leave and other entitlements of full or part-time employed workers.

The Closing Loopholes Bill has been referred to the Senate Education and Employment Legislation Committee, which has held public hearings and is due to report its findings by 1 February 2024.

The ANMF, along with other unions, has given evidence at the hearings, particularly around amendments to improve union delegates' rights. The ANMF seeks an industrial framework where workplace delegates can be supported to more effectively advance the industrial interests of the union members they represent.

"Our delegates are the lifeblood of our movement. They do so much to build harmonious workplaces where they identify and resolve issues, but the law currently does little to support them in this role," said Ms Sharp at the public hearing in Melbourne.

Making delegates' rights clauses standard in awards and enterprise bargaining agreements will be a real game-changer, said Ms Sharp.

The Bill will shift the culture in workplaces where delegates who raise issues on behalf of their colleagues are not ignored. In addition, the ANMF and unions are recommending that delegates be allowed to participate in an induction with a new worker and for training for new delegates.

"Workers need strong representation during a cost-of-living crisis. The protections provided for delegates are vitally important to ensure that worker representatives are able to fulfil their role and effectively represent the interests of all union members. Strong and protected worker representation is key to providing stable and cooperative workplaces," Ms Sharp said.

From left to right: ANMF Federal President, Sally-Anne Jones, ANMF Federal Secretary, Annie Butler, Prime Minister, the Hon Anthony Albanese MP, ANMF Federal Assistant Secretary, Lori-Anne Sharp and ANMF Federal Vice-President, James Lloyd at ANMF's National Biennial Conference last October.

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Beyond the bin: The fight for a greener future in the war on waste

By Kathryn Anderson

The ABC's War on Waste series firmly placed the nation's attention on Australia's waste issues and solutions. It sparked local and national systems change in the country.

After a five-year hiatus, a new season recently aired highlighting how far Australia's come against the war against food, plastic and fashion waste. The new season investigated Recycling Australia, brought to light new waste topics, challenged the lack of corporate accountability towards their own waste, and explored what the government can do to curb the waste tide.

Craig Reucassel, the producer and presenter of the series, recently spoke about the challenges and solutions to reducing waste and creating a healthier planet in a recent conversation with Nina Gbor, founder of Eco Styles and the Director of Circular Economy and Waste Program at The Australia Institute.

ON PLASTICS

During the discussion, Craig suggested plastic usage remained at epic proportions. Further saying that Australia's current plastic recycling rate was about 13%.

Craig said while phasing out plastic had been touted as the ideal solution to address the issue, Australia was not ready to stop its use without sustainable alternatives.

Other plastics, such as bioplastics, have often been suggested as a solution to reducing plastic in landfills, but Craig argued its usage was complex and not straightforward.

"Sometimes they're better, sometimes they're worse. If I'm cutting down an enormous forest to plant corn to turn into bioplastics that I'm then going to use for one second and throw out in the same way, it's not effective in any way.

"So right now, I think we're at the stage where we need to fundamentally massively reduce how much plastic we're using."

According to Craig, we are constantly increasing the amount of plastic in the market where, in many cases, it is unnecessary. "There are cases where plastic has a role in increasing food life, but generally speaking, there's a lot of plastic that there is very little role for. So we need to be reducing that."

Further, Craig said that we had to ensure circularity with plastic.

"At the moment, it's predominantly virgin plastic. Dig it out of the ground, turn it to plastic, use it once or twice, maybe for a couple of minutes and then landfill it or just as bad, burn it."

ON CLOTHING WASTE

Australia imports about 1.42 billion garments a year for a population of around 26 million people. Two-thirds of clothing ends up in landfill, which is approximately over 200,000 kilograms, which makes Australians the second biggest consumer of fashion textiles in the world per capita.

Craig believes deconstructing the entire fashion industry could be the solution to reducing garment waste.

"The problem, in a sense, is that there's an enormous industry in the world. It has enormous power and influence and advertising power in that it essentially just promotes the churn of clothing."

"So if you look at it, we are increasing how many clothes we're making, but our utilisation, how often we wear them, is going down - so it's that churn which is the problem."

Additionally, clothing is becoming cheaper, which means the value has gone out of it, Craig said. "And because the value has gone out of it, we just dispose of it. So it is becoming the single-use plastic."

When filming the War on Waste series, Craig said people on the streets were shocked to discover that over two-thirds of clothes are now made of plastic, fossil fuels, nylon and polyesters.

He also said people thought they were acting sustainably if they wore cotton or wool clothing.

"But that's not really the answer because energy use [of cotton and wool] is worse than if you bought nylon and polyester. Water usage is way worse if you're buying cotton, and emissions wise, wool is worse than the others as well."

Craig said hemp was the only material that seemed good on all those fronts. "But it's 0.1% of the global market."

Craig argued that the best way to act sustainably was to extend the life of clothes.

From a policy perspective, some countries are trying incentives to repair clothes because currently, it costs more to repair clothing than it does to buy new, he said.

Other ways of reusing clothes were cloth swaps, which Craig said was a great way of getting the social element back into reusing clothes.

MICROPLASTICS

Craig said around 60% of clothing is made of plastic, and over 50% comes from polyester, which could harm our health.

When filming War on Waste, Craig said his body was analysed for microplastics. What surprised him was that most of the microplastics he ingested were threads of clothing microplastics.

"When you look at the sediment on the bottom of the ocean, that kind of stuff, there's a lot of microplastics from clothing, so it's entering us, it's entering our system."

Craig said it was early stages in terms of what the health effects of microplastics had on our bodies. While scientists do not have the answers yet, there has been much concern about the impacts.

"And it's not necessarily just the plastic, but the enormous amount of chemicals that go into making plastic could be a problem. Some studies show that plastic carries bacteria, for instance, that might cause concern.

"So it's a question of the current amount of microplastic in me. I'm not freaking out, but we are seeing an accumulation of it in the environment, and that's going to continue unless we actually find some kind of solution. So yeah, it's not a positive story."

CHANGE

Craig believes change comes from people getting interested, such as getting together with groups in the community doing activism, such as contacting the local councils, being part of a group that is campaigning for change, and voting against the people who are against sustainability and climate change.

"That's where the change actually fundamentally comes from – trying to make change within the workplace. It's the community activism that brings the real change."

Textiles damaging impacts

15KG
of clothing purchased by Australians per person per year

10%
of what has been donated is actually sold in charity and op-shops

227,000
tonnes of clothing are sent to landfill in Australia each year

98
million tonnes of non-renewable resources are used in the textile industry each year

93
billion cubic metres of water annually for textile production

13%
of the total material input in the textile industry is recycled after clothing use

Synthetic fabrics can take
HUNDREDS
of years to decompose

The Australian Fashion Council 2022 Report.

Registered Nurse Kaitlyn Cooke, realised the environmental toll of disposable PPE after using 50 sets during a single shift caring for a COVID-infected baby.

"I thought, this is actually really bad for the world. There's got to be a better way we can do this," said Kaitlyn who was based in Tasmania at the time.

This sparked her determination to find a more sustainable solution.

Kaitlyn's search for eco-friendly alternatives proved challenging, especially as she uncovered alarming statistics about the longevity of disposable masks in landfills.

"Some of the numbers were quite astounding to me. Each mask takes 450 years to break down, and we used 129 billion masks per month during COVID," she said.

Motivated to develop a better solution, Kaitlyn spent two years researching and experimenting to create an environmentally friendly yet protective mask. Her journey involved a series of trial-and-error attempts to find materials that would be protective and meet the criteria for bacterial filtration and splash resistance.

After much perseverance, she discovered the right combination, resulting in a TGA-approved mask that was not only protective but also 100% compostable, breaking down in just 180 days into organic matter.

Sustainability in health champion

Yet what sets Kaitlyn's masks apart is her firsthand understanding of their impact on users, gained from her experiences as a nurse during the pandemic.

"I think because I'm a nurse and because I lived through the pandemic and had to wear these [masks] for sometimes 18 hours a day, I know the effects that they had on the end user.

Kaitlyn conducted breathability and skin irritation studies and also looked at studies on microplastics to ensure her masks were user-friendly and aimed to address issues like headaches, brain fog, and skin irritation.

In pursuit of her mission, Kaitlyn left her nursing career and founded her company, Eco Defend, to focus on mask production, education, and healthcare sustainability in Sydney. She's determined to raise awareness and change the culture in the healthcare industry, emphasising that it's not just about selling a product but also educating and managing waste effectively.

Kaitlyn's efforts have paid off, with her products receiving positive feedback from trials in pharmacies and clinics. She is now engaging with hospitals and procurement teams to better understand their needs.

Her ultimate goal is to expand her range of compostable healthcare products.

"I think being in the industry and seeing what's currently used; I know what I can and can't play within that space. Some things I'll never be able to change, unfortunately, but there are recycling streams that can be used as well."

For nurses and midwives looking to make a difference in sustainability, Kaitlyn's advice is simple yet powerful: "Keep trying, don't limit yourself, and believe in your cause."

To find out more, go to: **ecodefend.com.au**

Healthcare sustainability *tips and hints*

PLANT THE LOOK

I worked in a ward and often administer IV medication to patients. While preparing IV medication and looking at the cute IV medication bottle, an idea came to my mind …why not recycle the bottle and make it something useful? I then started collecting the bottles, ensuring labels are off and bottles cleansed thoroughly. Recycled IV medication (Tazocin) bottles used for plant propagation, I turned the empty IV medication bottles into propagation bottles, which is perfect to be used for water propping plants as it is clear and you can easily see the process and growth.

Joy Mendoza

AVOID WASTED ENERGY

When a room is empty, closing the blinds, unplugging any unused appliances and shutting off the lights is an easy way to avoid wasted energy.

Margo Belmount

VEGAN SHOES

Switch your shoes to Vegan footwear. Considered environmentally friendly, these shoes do not require animal farming, which can be a significant source of greenhouse gas emissions.

Ellen Smith

Sustainability tips or questions

We don't need to reinvent the wheel to find ways to reduce our impact on the planet.

One lucky contributor will also receive an e-voucher for a $50 Solmate refillable sunscreen applicator. The applicator, made out of certified ocean bound plastic, is a mess-free roll-on ball and a removable base for easy refill.

So not only will you use less new plastic, you are also reusing existing plastic waste! Just add your favourite sunscreen!

Contact ANMJ with your tip at climateactionforhealth@anmf.org.au

HEATING MATERNITY MILK BOTTLES

With used blue bowls that are collected in theatre, we wash them and reuse them on the maternity ward to heat milk bottles in.

Emily

Tips have been edited for space and clarity

More sustainability resources can be found at: anmfvic.asn.au/healthenvironmentalsustainability

Leadership and Management: Not one and the same

By Natalie Dragon

Leadership can often be mistaken with management and the two do overlap. But while leadership and management in nursing and midwifery share some similarities, they are two distinct roles.

"The biggest difference is that while we have leadership skills inherent in all of us, management is more of a learnt process", says RN and Academic Kate Hurley who oversees the Leadership and Management Major of James Cook University's (JCU) online Master of Nursing.

"Good leaders do not have to be managers but managers have to be good leaders," says Ms Hurley.

"Everyone is leading in their own way even if they don't realise it", says Ms Hurley who has diverse clinical experience and has been in managerial and education roles for the best part of her nursing career.

"Leadership is a constantly evolving process. You have certain skills as a novice health practitioner built into your day-to-day practice through engagement with patients, families, and colleagues.

"As we mature, the way we utilise our skills and the context in which we lead changes. The development of these skills and our confidence in applying them to our role evolves."

Anyone can be a good leader if they display certain attributes and set a positive example for others. Some common traits of good leaders include being approachable, open, optimistic, and compassionate. Effective clinical leaders contribute to creating a healthy, functional, and supportive work environment.

"Effective leadership is critical to trust and respect, collegiality, and workplace engagement. Good leadership leads to positive health outcomes and a healthy workplace culture," says Ms Hurley.

On the flip side, ineffective leadership can lead to poor workplace culture and workplace inefficiencies, which can impact staff satisfaction and retention.

Ms Hurley suggests three key attributes that provide balance as an effective leader.

Compassion: leaders create an emotional connection, taking people with them. Evidence shows people are more willing to follow the lead if they feel connected.

Resilience: having emotional and mental strength, a positive mindset. When things go wrong, people turn to a leader to pave the way. Good leaders have an ability to adapt quickly and strive under pressure.

Honesty: Showing honesty and being vulnerable to share past failings and inadequacies demonstrate that you're not perfect, you make mistakes and you learn from them.

There is a need to step away from the pervading culture in nursing and midwifery of perfectionism which doesn't exist, argues Ms Hurley and leaders demonstrate the way to do this. "People are already reluctant to own mistakes. If leaders can cultivate trust so people feel comfortable to share openly, they will feel safe to disclose errors and learn from their mistakes. This approach creates openness and transparency."

"People inevitably make mistakes – we're human. No one goes to work wanting to make a mistake. Nursing has a skewered idea about justice and equality. There's this culture of wanting to punish", concurs Melbourne public sector ICU nurse manager Nel.

Nel argues that people can only work well if they're being cared for themselves.

"It's really important to take the time to encourage the people you work with. As a manager, it's about recognising those differences in your staff. You come to work every week day so you get to see a fair proportion of your staff."

While leadership is something inherent, management is based on qualifications and experience of years in the role, says Ms Hurley.

"To manage effectively, you need to have had exposure in that context first. You cannot lead a team effectively if you are unable to relate to their experiences - you're setting yourself up for failure. You need to be able to understand the crux of what that team is, likes or needs."

Management also requires the skills and experience to deal with challenges such as workplace conflict. Effective nurse managers address conflicts or problems as they arise and support collaboration and open communication.

"Management requires putting out fires and having developed an approach that is going to work best in your context. You've got to have walked in the shoes of those you're managing."

World-renowned author and speaker Simon Sinek concurs, presenting at the International Council of Nurses Congress in 2023, he said: "I think we have to know what the job is as a manager before we start acting in it."

Three skills that managers need in the healthcare environment, says Ms Hurley are: communication, innovation and engagement.

Communication: Collaborate and share information with your team, encourage open discussion and be prepared to hear feedback. Staff need to be heard and appreciated. How people feel about change is constantly evolving. Listen to what is happening on the floor and how any changes that are being implemented are being received.

Innovation: Healthcare managers drive change in the workplace. Managers need to keep up with evidence-based practice to deliver high quality care. Empower your staff and encourage and support your team by role modelling innovative behaviour. Build up the capabilities of people in your team who want to make change and improve practice – the evolution of our profession should be a shared responsibility

Engagement: Don't switch off – it's easy to become trapped at your desk and busy with meetings. Empower your team by engaging them regularly. If you're managing people build positive team culture with connection and engagement.

Reflection is a really good tool for both leaders and managers to monitor how they're going in the role, says Ms Hurley. "It encourages you to identify weaknesses and learn from your mistakes. People often say they don't have the time to reflect, but it's important to set aside time to look at your growth and appreciate where you've come from and see where you're going."

The Leadership and Management Major in JCU's Master of Nursing covers four topics: Leading and Managing in Health, Ethics and Health Management, Business and Finance for the Health Manager and Conflict and Dispute Resolution in Healthcare.

For more information, visit **jcu.edu.au/online-courses/master-nursing**

By Natalie Dragon

Sweating Bullets, Mopping Blood

An eyewitness account during 11 years as a volunteer midwife

An antenatal clinic in South Sudan

Heather (left) in Mogadishu Somalia

'Start where you are, use what you have, do what you can' is the adage Heather Sadiechild Harris subscribed to for 11 years working as a midwife across the globe.

There were no shiny machines going ping to depend on where she was. There was no smooth-running health infrastructure. Indeed there was very little except hands and hearts and grim determination to do the best with what was available.

Ms Harris began her nursing career in 1966 and completed her midwifery training in 1970.

She worked in various hospitals in Australia and presented at numerous conferences on midwifery practice.

Known to many as the 'Boob Whisperer', she was an IBCLC (International Board Certified Lactation Consultant) for 25 years with her last fulltime position in Australia as a CMC Lactation Consultant at The Women's in Melbourne.

At age 52, Ms Harris found herself seeking greater purpose in her life. "I had sort of run out of oomph. I'd thought I cannot do this anymore. I'd travelled quite a lot. I like being in unfamiliar and unusual environments around other cultures. So the kids stayed at home and off I went."

She joined Médecins Sans Frontières, and subsequently made eight separate projects across war torn countries including Sri Lanka, Nepal, Ivory Coast, Sudan and Somalia from 2001-2012. On average, each mission lasted six to nine months.

Harris' recent book *Sweating Bullets, Mopping Blood* is a firsthand account drawn from her journals.

"I kept a diary. I had no intention to write a book. Before I went I imagined it might have been like the rolling credits of M*A*S*H but it's not like that, she laughs. "When I first arrived in Sri Lanka my eyes were on stalks. 'What are they doing?' 'What about…?' In a couple of weeks I could understand their methods – when you have nothing, when there's no buzzer and there's no one to come running in a Code Blue. If there's an obstruction or something similar you have to get that baby out.

"Over there it's just you and the team. Sometimes there was a doctor with obstetrics experience, other times not. I learnt to do vacuum extractions, deliver breeches, twins, triplets, confirm ruptured ectopics. In places like the Ivory Coast there were many ruptured ectopic pregnancies."

Women's lives were particularly difficult in many places, Ms Harris said. "In southern Nepal, frequently the mother-in-law decides the most opportune time for when her daughter-in-law should give birth. Though very poor, they gather their scant rupees and buy ampules of oxytocin to induce labour and inject the pregnant girl until she has contractions. At some point the uterus becomes tonic and no oxygen can get through to the fetus so there can be a high rate of IUFD as well as a high rate of postpartum haemorrhage.


Prem baby with mum in Sri Lanka

"We do our best but the neonatal death rate can be high. There's malaria, anaemia, intense poverty, and very large families with early childbearing – girls can be giving birth at 14 years of age."

Ms Harris who contracted malaria four times, credits her resilience to work under pressure in extreme conditions with few resources to being raised on a farm in Western Victoria with no home heating or cooling, where she "learnt how to roll with the punches".

> ***"It deepened my abilities as a midwife and transformed me as a person. You cannot impose a Western template in these places."***

"One day in the Ivory Coast we received a young woman in shock with a ruptured ectopic pregnancy needing immediate surgery. However the electricity went off. Our very capable Ivorian surgeon simply donned a head torch and got to work. He just said 'Edda! I look like a miner!' and then operated in a bellyful of blood with a head torch. The sucker broke down but he didn't bat an eyelid. She survived. Just as he closed up the electricity came back on. She recounts being evacuated in the Ivory Coast in the book, but says she never really felt in danger.

"In Somalia, I was teaching a basic obstetric emergency course to midwives, nurses and doctors who would come to the Paradise Hotel where we were stationed.

"We occasionally made 'flash visits' in which we were given 10 minutes notice to visit the hospital which was basically a tin shed. When the gates opened a pickup truck would be there with six young men draped in bullets and AK-47s sitting in the back. We climbed aboard our land cruiser which would follow the truck and another pickup truck similarly loaded would follow us behind. This was our safety escort. Rebels and guns were common."

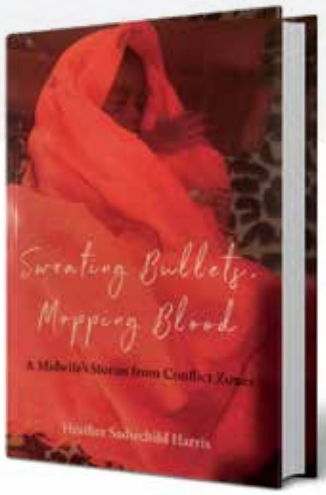
Ms Harris considers herself "fortunate and privileged to have had this life-changing experience".

"It deepened my abilities as a midwife and transformed me as a person. You cannot impose a Western template in these places. You must be respectful and there's so much they will teach you. I learnt that even if I'm worried on the inside to stay calm on the outside – to walk and talk slowly even if someone is bleeding to death."

She says she has learnt gratitude for the life she has been blessed with in Australia.

Now aged 74, Ms Harris only retired last year from her private home visiting service for mothers and babies. She lives in Coburg, Melbourne nearby to her two children, and four grandchildren.

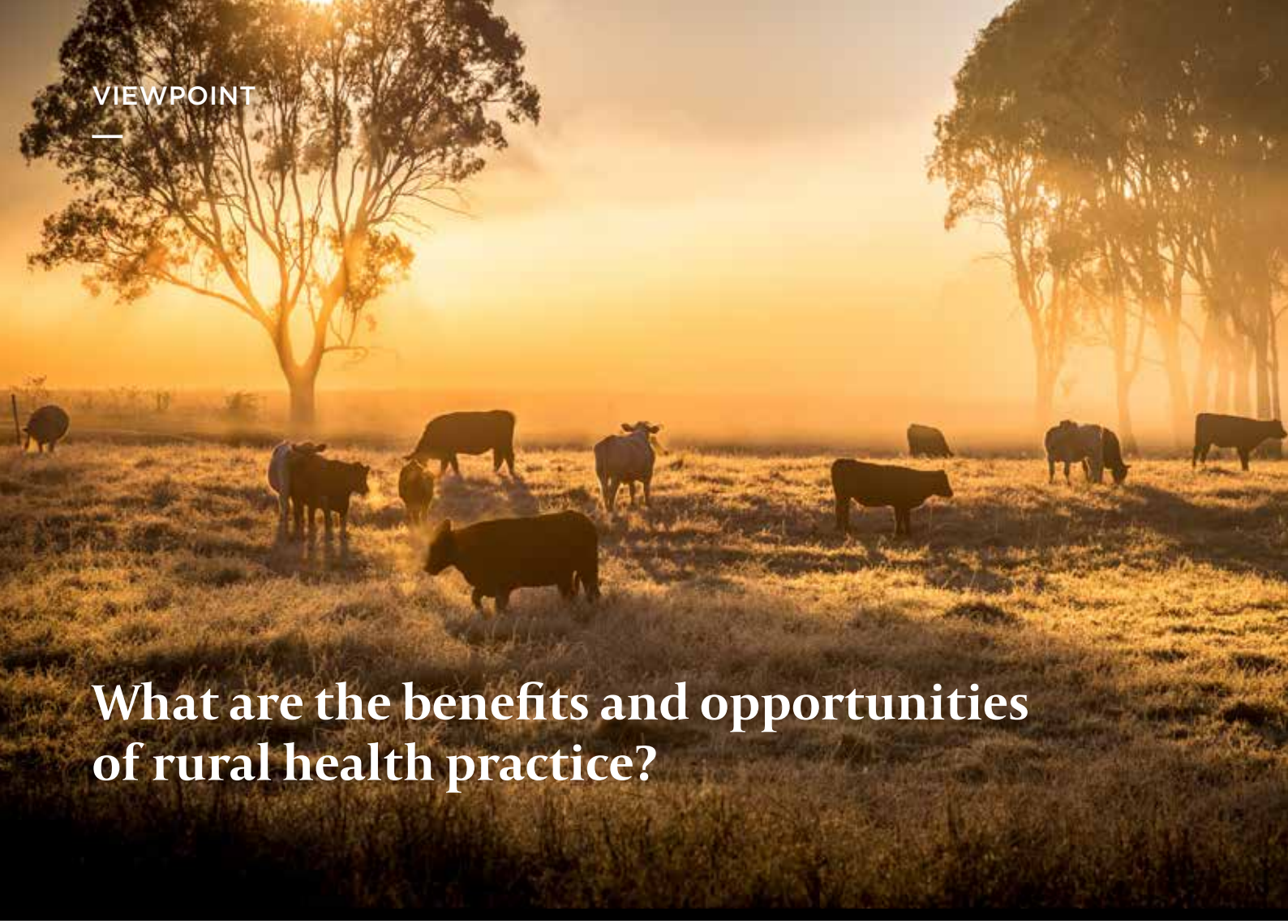
Ms Harris says anyone wanting to work as an overseas volunteer nurse or midwife should have stamina for the work. "It's fulfilling work but you put in a lot of hours. I would also say you need to be mature minded, steady-headed, able to think on your feet, prepared to learn and stay calm under pressure. You need to be flexible and go with the flow. Until you get an overview of the project after you arrive, keep your eyes and ears open and mouth closed – except to ask lots of pertinent questions.



Sweating Bullets, Mopping Blood
is available at
bookstore.bookpod.com.au

Cost: $29.95 (AUD)
Paperback: 208 pages
Publisher: Heather Harris
ISBN: 9780975176368


Prem baby in South Sudan



What are the benefits and opportunities of rural health practice?

Elise Ryan

Elsie de Klerk

Elyce Green

A call to capitalise on strengths-based approaches to rural health discourse

Rural health practice provides clinicians with a litany of personal and professional opportunities and benefits.

Despite this, it is far more likely that society will read, see, or hear about the challenges of rural health practice and living. The purpose of this brief commentary is to raise awareness among those discussing rural health that a strengths-based approach to rural discourse is achievable and desirable. The benefits and opportunities associated with rural health practice and living in a rural community will be discussed, and strengths-based approaches to discourse exemplified.

The dominant deficit discourse surrounding rural health is a phenomenon that has been a concern for over a decade[1-3] and continues to persist. Ironically, many of the people making constituted efforts to promote rural health are commonly (and likely subconsciously) using deficit discourse. Reasons for this irony are suggested by Fogarty et al.[4 P4] to be due to the "tenacity, subtlety and pervasiveness of deficit discourse, its currency in the present political and social climate, and a limited consciousness among policy makers and health practitioners that they are reproducing deficit discourse."

Out of necessity, the deficit discourse related to rural health is used to leverage arguments for funding, resources, and awareness of rural and remote healthcare needs, and has resulted in increased federal funding strategies and programs to address rural workforce challenges.[1,5-8] Unfortunately, this deficit discourse may also perpetuate the exact issues it is used to describe and furthers the current trend to use perceived limitations to discuss rural health. A review of current academic literature demonstrates that the words 'issues', 'challenges', 'maldistribution' and 'disparities' are prominent in publication titles and many articles are focused on fixing rural 'problems'.

There are many benefits associated with rural health practice, such as a broader scope of practice,[14-16] friendly, relaxed atmosphere at work,[15] opportunities for career development,[1,14,17,18] cross-cultural service delivery,[1,6,18] diversity of caseload,[1,6,14,16,18,19] belonging to the local community,[1,6,16,18] ability to effect change,[18] enhanced continuity of care,[6,17,19] and increased team-based practice.[14,16,18] There are also a multitude of financial incentives and scholarships to entice people to practice in rural and remote areas.[20,21]

In Australia, the 'tree change' movement and the COVID-19 pandemic increased the metropolitan exodus with a net of 43,000 people moving from capital cities to regional areas in 2020, which is

the largest quarterly net loss for the capital cities since records began in 2001.[9,10] The movement of people away from Sydney in particular had begun prior to the COVID-19 pandemic, however with more people working from home, pursuing affordable housing, and seeking a relaxed country lifestyle, the number of people moving to regional towns is higher than ever before.[10,11] Rural living offers many attractive lifestyle factors, such as opportunities to connect with the natural world, belonging to a community, optimised work-life balance, relatively affordable cost of living, increased space and time for children and hobbies, an affordable housing market, and unique job opportunities.[11-13,23]

Keeping these benefits and opportunities of rural living and practising at the fore is key for a strengths-based approach to rural discourse. The basic principle of strengths-based theory and practice is that every individual, group and organisation has strengths.[22]

Researchers who use strengths-based approaches begin by identifying these strengths and use them "to frame their work within a positive paradigm and build upon the available strengths."[22, P733]

Strengths-based methods imbue more than positive talk – they hold key conceptual elements that should underpin discourse.[4 P5] Strength-based research frameworks described by Fogarty et al.[4] provide a conceptual typology of the strength-based approaches used in the Aboriginal and Torres Strait Islander health and wellbeing sector. Whilst Bourke et al.[1] discussed workforce retention and policy making based on positivity in rural practice, championing the communities themselves, and understanding true context in rural health.

Clinicians can apply embedded frameworks in our practice, one example being asset-based community development (which focuses on community-led and community-based transformation and progress)[24,25] primarily used in psychology and social work. These frameworks demonstrate that strength-based discourse is achievable and that there are several methods to support its integration into the rural health conversation.

Strength-based rural health discourse is integral for the promotion and progression of rural health practice. The benefits and opportunities of rural practice and living can be utilised as a positive foundation to launch from. Creating a positive rural health discourse could benefit communities and clinicians working and living rurally by attracting development and investment opportunities, promoting equal resource distribution, and encouraging more people to move to regional areas.

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Paul Yiallouros

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Empowering employees

Australia's new labour laws bring long-awaited protections

In a significant stride toward fair and just workplaces, the Closing Loopholes Bill proposes to usher in a wave of comprehensive labour reforms aimed at bolstering protections for workers across various sectors. These transformative laws would address a range of issues, from eradicating exploitative practices in the gig economy to ensuring better rights for casual workers seeking permanency.

Below is a snapshot of the Closing Loopholes proposed changes to the *Fair Work Act 2009* (Cth)

BETTER PROTECTIONS FOR EMPLOYEES:

The new laws will set a new definition for 'employment' making it harder for any employer to trap a worker in a sham contract where the employee is told they have no rights to minimum wages and conditions.

BETTER PROTECTIONS FOR GIG ECONOMY WORKERS:

The gig economy is currently unregulated and rife with exploitation and safety issues, particularly for workers who rely on food delivery apps for a living.

The new laws will empower unions to win rights for these workers, including fair pay, insurance and deductions.

BETTER PROTECTIONS FOR CASUALS:

Casuals who work regular hours for the same employer will be given rights to become permanent if they want to.

This will give these workers access to permanent employment entitlements, such as a stable work roster, annual leave, sick leave and redundancy pay, among other things.

OUTLAWING WAGE THEFT:

Companies short-changing their workers has become endemic in Australia, particularly in the agricultural, cleaning, food processing, hospitality and retail industries.

For these companies, underpaying workers is part of their business model.

If a worker steals from the cash register, they are (rightly) guilty of a criminal offence, but if a business intentionally underpays a worker's wages, there are no criminal repercussions.

The new laws set penalties at $93,900 for breaches of the law, and even higher penalties of $939,000 for 'serious contraventions' of the law.

Employers who intentionally steal from their workers can also face criminal charges.

Employers can be separately fined up to three times the value of an underpayment, making the business model of exploitation no longer viable.

WORKPLACE HEALTH AND SAFETY:

Under the new laws, first responders who experience PTSD will no longer need to prove their psychological injury was caused by their line of work, making it earlier for them to access ComCare claims.

Silica dust from synthetic kitchen benchtops is killing Australian tradies, so the new laws will start treating this deadly product in the same way that we treat asbestos.

To protect workers from being killed, the new laws will create an industrial manslaughter offence for businesses who recklessly or negligently cause the death of a worker by failing in their health and safety obligations.

FAMILY AND DOMESTIC VIOLENCE:

Earlier this year, workers had a massive win when the law changed to include paid family and domestic violence leave in the National Employment Standards, a right long fought for by union members to protect workers fleeing unsafe relationships.

The new laws go further to prevent a business from taking 'adverse action' against a worker because that worker has experienced family and domestic violence.

RIGHTS FOR UNION DELEGATES:

Your workplace union representatives do a tremendous job in fighting for workplace rights, but in doing so, they can be hampered by malicious employers and be targeted because they volunteer to be a union delegate on behalf of their colleagues.

Ironically, employers make life difficult for delegates, despite the fact that delegates assist with resolving workplace disputes and make the workplace more harmonious and safe.

The new laws will allow delegates to speak to members freely about their workplace rights and provide access to training so they can represent workers better.

The new laws will also prevent an employer from ignoring or lying to a delegate when discussing workplace issues on behalf of all workers.

James Lloyd

ANMF Federal Vice President

Revolutionising healthcare: The impact of Artificial Intelligence in nursing and midwifery

Artificial Intelligence (AI) has emerged as a revolutionary force in diverse industries, and nursing and midwifery are no exceptions.

The integration of AI technologies has the potential to reshape healthcare delivery, improve patient outcomes, and enhance the efficiency of healthcare systems. But with AI's potential, there are also certain challenges and concerns that we need to consider.

What exactly is AI? It is the ability of computers to perform tasks that normally require human intelligence, such as learning, reasoning, and decision making.

For example, in healthcare, AI can be used to analyse medical imaging scans and X-rays to eliminate the risk of human error.

The media often refers to AI as a website called ChatGPT. This is a natural language processing tool driven by AI technology that can write an essay, compose a song, create a poem or even 'paint' in a particular style.

It could fool you into believing a human produced the results. But AI is not sentient - it is a combination of software and hardware that appears to have human-like intelligence and reasoning.

If carefully implemented, AI presents certain unique benefits for our professions, including:

- Relieving the burden of ever-increasing administration needs via automating routine tasks.
- Helping nurses make more accurate and timely diagnoses, potentially leading to better treatment outcomes.
- Analysing large datasets to identify trends and patterns not apparent to clinicians, leading to earlier detection of diseases and improved patient care.
- Streamlining administrative processes and reducing errors in diagnosis and treatment for cost savings in healthcare delivery, which can then be redirected towards better healthcare outcomes.

While integrating AI into nursing holds immense promise, it also presents certain challenges and ethical considerations. Privacy and security of patient data are paramount concerns, as AI relies on vast amounts of sensitive information. There are many examples of AI technologies that, due to poor design, did not perform as expected or promised.

For example, in 2021, a paper published in *Nature Machine Intelligence* explored the use of AI in diagnosing via medical imaging the COVID-19 virus. The dataset used to train the AI included patients imaged when lying down (eg. CXR CT scans). Those lying down were much more likely to be seriously ill, so the algorithm learned to identify COVID risk based on the person's position in the scan. Consequently, the AI model was flawed.

AI implementation requires caution and should not replace critical thinking - the core of nursing and midwifery. We must question, analyse, evaluate and judge what we hear or see. Critical thinking in healthcare is most crucial when new information is obtained and a quick decision is needed. AI is only as good as its programming and data that it has access to. Relying on AI and not thinking critically about every patient care decision could be problematic.

AI lacks empathy. This is a human quality. As well as critical thinking, empathy can direct how we provide care. Computers cannot provide nursing and midwifery values such as compassionate and patient-centred care provision and respect for diverse perspectives.

The implementation of AI in healthcare must involve nurses and midwives in its development. We are the largest and most trusted group of healthcare professionals and have direct and frequent contact with patients, parents and families. We have rich, nuanced and diverse knowledge and experience in clinical practice and education. Therefore, nurses and midwives should be involved in conceptualising, designing, testing, and evaluating AI technologies to ensure that they are relevant, useful, and acceptable for our practice and patient care. If AI is introduced with the involvement of our profession, then there is more likely to be a positive attitude towards it.

Importantly, nurses and midwives should also collaborate with other stakeholders, such as patients, researchers, developers, and policymakers, to ensure that AI technologies are ethical, legal, and safe.

Nurses, midwives, and healthcare institutions must approach AI integration thoughtfully, ensuring that ethical and regulatory concerns are addressed. Training and education will be essential to prepare nurses for the AI-augmented healthcare landscape. By embracing AI while preserving the core values of nursing and midwifery, our professions can harness the power of technology to provide even better patient care, ultimately leading to a healthier and more efficient healthcare system.

SOLIDARITY AND ACTIVISM:
The vital role of nurses and midwives in the union

Left to right, Cecilia Webster, Liz Barton, ANMF (Vic Branch) Assistant Secretary Paul Gilbert, and ANMF (Vic Branch) Secretary Lisa Fitzpatrick rallying for ratios in aged care.

Nurses and midwives, the backbone of healthcare, provide essential patient-centred care across the health system, yet experience diverse challenges. Active involvement in the ANMF's state and territory branches empowers them as advocates for change. This includes improving wages, safety, patient care, and influencing healthcare policy, benefiting both health professionals and people.

Retired Victorian registered nurses Liz Barton and Cecilia Webster share a lot in common. Both trained to become nurses at St Vincent's Hospital.

Both have links to Australia's wartime nursing heroine, Vivian Bullwinkel, who offered them advice and gave them inspiration as early career nurses entering the profession, particularly to always stand up for patients.

And both, after crossing paths unwittingly throughout their careers, would end up working in the same palliative care unit at Peninsula Health in Frankston.

But it's perhaps their longtime involvement in the ANMF (Vic Branch), as active, informed, union members, helping to lead campaigns promoting, defending and fighting for improved conditions across the professions, and the broader health sector, that solidifies their connection the most.

Cecilia, who took part in numerous ANMF (Vic Branch) led actions during her career, counts the 2011 'Respect Our Work' nine-month campaign, the longest industrial campaign in Victorian nursing and midwifery history, which included bed closures and stop work in a bid to protect nurse/midwife to patient ratios first achieved in 2000, as part of public sector enterprise agreement negotiations, as one of the more memorable wins.

"It was about protecting safe, quality, patient care," recalls Cecilia, of thwarting the then Bailleu Government's plan to remove ratios.

"And the only way you can get safe, quality, patient care is to have enough people to do the job. So, we knew we had to do whatever we could to save those ratios at the time."

Liz, a former ANMF (Vic Branch) job rep and occupational health and safety (OHS) rep of the year, agrees.

"We were determined to keep them [ratios] because what has happened over the years, the patients have become sicker, and they've got many more comorbidities, and you are flat stick all the time," she says.

Like many other active union members, Liz worked relentlessly to support the 'Respect Our Work' campaign, often sacrificing family time for the greater good. Back then, as Facebook was emerging, she used the new social media tool to help connect with members, communicate information, and mobilise action.

In years to come, the Andrews Government's historic Victorian Safe Patient Care Act was passed, paving the way for the state to become only the second jurisdiction in the world to enshrine mandated ratios in law. For Liz, it also offered the opportunity to contribute to shaping the inclusion of palliative care staffing levels within the ratios for the first time.

As colleagues on the palliative care unit, Liz and Cecilia also advocated strongly for safer working conditions and rights. By standing together, they helped address common work-place issues such as understaffing, heightened workloads, health and safety, infection control issues, and wages and conditions.

"It was becoming very dangerous, not just for us, but for the patients," recalls Cecilia, of the workload issues at the time.

"As a palliative care unit, we had 15 patients at the time, but you could have 10, 20, 30, or 40 relatives if someone's dying. All their families come in, and you've only got five nurses on a late shift. You just couldn't spread yourself, so you couldn't get all the work done, such as symptom management, pain relief, the basic care."

In more recent years, and even in retirement, Liz and Cecilia extended their union activism to another longstanding ANMF priority – aged care reform. The pair are key members of grassroots lobby group *Aged Care Reform Now*, a community of older people, families and friends, current and retired aged care workers, and others passionate about fixing the sector.

Both have advocated for aged care reform for many years, having been exposed to the shortcomings across the system through nursing and personal experiences with family members.

Cecilia, who has taken part in various aged care Inquiries and research projects since the problematic 1997 Aged Care Act was introduced, says the point of difference with *Aged Care Reform Now* is that it is focused on exposing problems, and finding solutions too.

Since it was established, the group has achieved influential change throughout the aged care reform process by writing research reports and making submissions to Inquiries.

As real aged care reform has finally begun to be implemented under the Albanese Government, highlighted by RN 24/7 and mandated care minutes legislation, *Aged Care Reform Now* continues to advocate for change.

"It's piecemeal," Liz says of the improvements.

"We're trying to undo the damage that was done by the 1997 Aged Care Act.

"The public, who don't have any involvement with aged care, all they see is the glossy brochures. They're looking at a retirement village picture. They're not looking at the reality of 80% of residents having cognitive disability, having Parkinson's, the falls."

According to Cecilia, the nursing profession always has to fight to be heard when it comes to their work and wellbeing. Unless nurses continue to be activists, things won't change.

"Nurses at the bedside, and in the community, they see it. They see the reality of poor management. They see the reality of not enough staff. They're feeling the effects of burnout, even pre-COVID, the burnout was already revealing itself and people were looking at leaving the profession. If nurses realised that they can change things, by engaging in the political process and lobbying policymakers about their work and speaking out, then maybe things could just be that little bit better."

Liz says she saw the difference that can be made first-hand when, in 2018, palliative care ratios were finally implemented through the ward.

"It was almost a state of shock – I didn't have to do unpaid overtime anymore," she says.

Aged care is a different, much more complex issue, however, due to system privatisation and the complexities of it being a federally legislated environment that will require lengthy ongoing activism.

After decades in nursing, both Liz and Cecilia maintain that the only way to achieve real workforce change is to join your union and become active members.

"They [nurses] should get involved because people who make policy about what you do, you've got to be able to stand up and say 'No, that doesn't work'. If it's not working, you need to stand up and say so. And you need to be able to be safe to do that," suggests Cecilia.

"Nursing is the best career. It's a lifelong career," adds Liz.

"You can change fields. It's intellectually stimulating. You get to work with a diverse group of people.

"But you have to be actively involved [in your union]. The fantastic thing about the ANMF (Vic Branch) is that we've had wonderful leadership and we've had generations of nurses who've said – we can do better."

Student feedback on clinical placements set to improve clinical experiences

By Colleen Ryan, Simon Cooper and Robyn Cant

The National Placement Evaluation Centre (NPEC) undertakes nursing and midwifery student placement feedback in order for stakeholders to provide improvements in clinical education.

The initiative to report the quality of nursing clinical placements is supported by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and the Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM) in answer to recommendations from a recent review of the future of nursing education in Australia.[1]

NPEC began collecting nursing and midwifery student evaluations of clinical placements in November 2022, via the generic Placement Evaluation Tool (PET) (see tools at **npec.com.au/clinical-placement-rating-tool/**). The three PET versions; PET student, PET midwifery and PET supervisor include 20 items measuring the quality of the clinical learning environment and learning support.

All PET versions are suited to desktop and handheld devices and take users less than three minutes to complete. PET tools are for use by Creative Commons Attribution 4.0 license.[2]

The data collected is available directly to approved registered users. Nominated stakeholders, representing education providers and host organisations, register and then activate an emailed authorisation link (see **npec.com.au/register/**). Data aggregates are reported and presented as graphs and downloadable spreadsheets. Ratings and qualitative remarks related to placement sites, settings and student year level are available.

Students can download their individual evaluations for future reference.

Currently, registered users are higher education institutes offering nursing and midwifery programs and healthcare facility clinical placement hosts. As of November 2023, more than 14,000 PET (Nursing), 500 PET (Midwifery) and 30 PET (Supervisor) reports have been lodged.

The PET (Nursing and Midwifery Student) data indicates a high rate of overall satisfaction with 89% rating their clinical learning experience greater than seven out of 10. However, ratings tend to be low in relation to orientation to the learning environment, the quality of received feedback and feeling valued.[3]

NPEC's data supports the findings of a study commissioned by the Council of Deans of Nursing and Midwifery Australia which called for systemic approaches to addressing the variance in quality of student learning experiences.[4]

The data has also assisted doctoral student, Mr Peter Stelfox, who is studying international nursing student experiences of clinical placement. Recently, Dr Areum Hyun commenced a post-doctoral fellowship examining clinical placements in the aged care sector.

The program's Director, Professor Simon Cooper said, "Encouraging students to complete an evaluation of each placement is important as this will enable future improvements in clinical educational practice. University clinical coordinators are encouraged to place the PET tool access (QR code or web link) in their placement software or learning management systems for students to complete just prior to a summative clinical assessment.

"Alternatively, PET responses increase if the links to the tool are provided five to seven days post the students placement completion date".

NPEC's future is supported through ANMAC and CDNM. The Centre plans to expand to Diploma of Nursing (2025) and paramedicine, followed by allied health. NPEC and the collected data are believed to be a world first in innovation in national benchmarking of quality and evaluation in healthcare student clinical placement learning.

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Jane Douglas
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Supporting nurses to work to their scope of practice

In October 2023, the federal government launched *Unleashing the Potential of our Health Workforce – scope of practice review*. The independent review will examine the barriers and incentives faced by health practitioners working to their scope of practice (SoP) in primary healthcare (PHC). The review aims to deliver better health outcomes for people as well as greater job satisfaction, recruitment and retention of health practitioners including nurses.

According to the International Council of Nurses, PHC is the cornerstone of health systems across the planet with equity and access essential to the health and wellbeing of all people.[1] In Australia, access to PHC has become more difficult, especially in rural and remote communities. Support for nurses to work to their SoP is key to improving people's access to PHC, but this requires funding and legislative reform. Nurses must remain engaged, professionally, and politically to identify and address the barriers that prevent and the enablers that allow them to work to their SoP in PHC.

Nurses already lead in PHC settings, working with communities, identifying needs, and implementing services. However, nurses' SoP is often restricted by approaches to healthcare funding, policies, service provision, and the requirement for collaborative arrangements between nurse practitioners (NP) and general practitioners (GP). People in Australian communities are feeling the result of this constraint due to a shortage of independent PHC providers. Nurses working as independent practitioners, under block funding (or similar) models, will increase the number of primary healthcare providers, giving the public a choice of practitioner and improving access to affordable and appropriate services, driven by a human right to healthcare, not profits.

So, what is SoP? The scope of a profession is established by the professional standards, codes and guidelines that establish the requirements for professional and safe practice. For nurses, these are set by the Nursing and Midwifery Board of Australia (NMBA) who advise that the foundational education of registered nurses (RN), enrolled nurses (EN), and NPs in Australia captures the full breadth of the scope of the profession at the graduate entry level. For individual nurses, SoP refers to what the individual is educated, authorised, competent and confident to perform in their role as a nurse. An individual nurse's SoP will vary and change, influenced by the setting in which they work, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.[2] In some instances, nurses have been unable to work to their SoP, and this has reduced their ability to undertake the work for which they were educated, leading to deskilling and reduced job fulfilment. It is also a lost opportunity to improve access to PHC.

Access to PHC has become increasingly difficult as medical practitioners choose to work in areas other than general practice and out-of-pocket costs to visit a GP spiral. Central to this deficit has been the establishment of GPs as the gatekeepers of primary healthcare and access to associated funding, with other disciplines locked out of providing the full scope of PHC services as autonomous practitioners and members of multidisciplinary teams. For example, nurses working in GP practices must work to a restricted scope of practice comprising activities related to specific Medical Benefits Scheme (MBS) items that the GP can claim. Changes to legislation, as well as jurisdictional and organisational policy reforms, are required, together with the need to raise public awareness about how nurses can offer a safe and affordable choice of PHC practitioner.

The delivery of PHC is not solely the domain of medical practitioners. Nurses offer innovative PHC programs in a variety of settings, including community nursing, palliative care, women's and sexual health, mental health, child and maternal services and so on. In many cases they would be better able to deliver holistic and comprehensive care if supported and funded to work to and expand their scope of practice, operating autonomously and with other practitioners. Nurses do not seek to be pseudo-medical practitioners but rather to apply their education, skills, and experience to deliver evidence-based, person-centred PHC based on the needs of the communities in which they work.

The SoP review is welcomed, and I commend nurses everywhere to become informed and involved. Visit the Federal Government's website to learn more and follow the articles in the *ANMJ*.

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Dr Micah D J Peters

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Things falling apart: Caring through crisis

Nursing, midwifery, and healthcare work are fundamentally about alleviating suffering. This can seem a Sisyphean burden particularly when locally and globally, there appears to be a constant state of crisis.

At the risk of drifting from my lane in research and policy, I want to write about dealing with continuous crises and (avoiding) hopelessness.

Worldwide nurses, midwives, and other health providers are working in active war zones, unfolding natural disasters, and regions with few to no resources to provide safe, effective care. Tragically, many are themselves under attack while they try to deliver care or protect their own homes and families from floods or fires. Many have no choice but to work in unsafe workplaces where violence is common and staffing is poor. Many Australian healthcare contexts are also fraught. Burnout and posttraumatic stress are rife in the workforce and there is a strong focus now on caring for the carers with many struggling through every day.

The news cycle, social media, lunchroom chats, and catch ups with friends and family can provide an ever evolving but distressingly repetitive parade of local and global crises. Some horrors put our own experiences in stark relief and make us feel fortunate in comparison. Other events remind us of the everyday dangers we must navigate such as bushfires and floods, increasing cost of living, disease outbreaks, and workplace hazards.

With life beset by both personal and broader struggles, it is understandably challenging to remain engaged or even aware of the plethora of distressing global and local issues. It is also difficult to feel hopeful that things will miraculously resolve. Most importantly however, it can sometimes be difficult to believe we're really making a difference.

To deal with this, one might borrow some wisdom from Buddhism. Although I am not particularly spiritual myself, these perspectives can provide an engaging alternative where all existence is inherently characterised by i) suffering and ii) impermanence, ie. "nothing stays the same". This implies a concept that can be challenging to accept, that is, no state or phenomena is permanent and that pleasure and happiness are themselves temporary. This concept can also help us to understand that losing hope might also be avoided by accepting that suffering too will pass.

Accepting impermanence can also highlight the value of caring, helping and protecting others, and working to minimise and alleviate suffering and death. This is because while suffering will 'happen anyway', our efforts are not wasted or meaningless because we can still influence and guide impermanence away from senseless destruction and to mindful acceptance.

From my perspective, working in health policy and research, and of course removed from the actual delivery of healthcare, many projects and issues can still seem ultimately unresolvable.

Will we perfect the health and aged care sector? Will everyone receive the right care in the right place at the right time? Will we halt climate change? Can we ensure everyone has access to affordable food and housing? Will we achieve world peace and gender equity?

While it's highly unlikely any of these things can be sustainably achieved, the last six years has taught me that our efforts in each of these areas have made improvements, both small and large. We have contributed to making many peoples' lives better, safer, and less painful. While suffering continues, our work has helped people and helps me to not lose hope in the world.

The everyday work of nurses, midwives, and all healthcare staff will not prevent *all* suffering. Nonetheless, your efforts are not wasted and the impacts it has on others' lives are significant. In the face of suffering it is important to focus on the things that we can change, and accept the things we cannot.

Every time you care for your patients or clients or work to solve the problems and injustices around us, you make the world a better place. Nurses, midwives, and carers do this every day, and you should take pride in your contributions.

By working towards doing what we can when we are able, and defining the world we would like to live in and share with others, we can make a difference, even if that difference is neither permanent nor universal. While we might not escape suffering completely or permanently solve the problems around us, we can certainly ease the suffering of many people. Transience means that we can and should change things for the better and not lose hope that our work isn't worthwhile.

Whistleblowers in nursing: Where are we at?

By Sonja Cleary and Rebecca Millar

Sonja Cleary

Rebecca Millar

Whistleblowing, previously rarely discussed in nursing literature, is acknowledged as a practice that can save lives.[1] Defined as "a current or former employee's reporting of unethical, illegal, or illegitimate wrongdoing in the workplace to parties inside or outside the organisation that may have the power to end the wrongdoing."[2]

There have been numerous instances where nurses have expressed concerns about the conditions in the aged care sector and felt compelled to report them.[3]

However, this issue is not limited to aged care alone. In 2005, nurse Toni Hoffman exposed numerous unsafe practices at Bundaberg Base Hospital, with her reports directly leading to public disclosure of the infamous surgeon Dr Patel's "botched operations."[4] More recently, in the previous month's issue, Justin Nixon shared his whistleblowing actions regarding declining standards and unsafe practices in cosmetic surgery.[5]

Empirical studies consistently show that many whistleblowers face negative consequences for their actions.[6-10] Eight out of 10 whistleblowers encounter some form of negative impact in their workplace.[6]

Despite this, whistleblowers continue to face sacking (and worse) for their actions.

Recent cases, such as the imprisonment of nurse Lucy Letby for murdering babies and the censure of consultants who raised concerns about her practices, highlight the challenges faced by whistleblowers.[11,12] Other clinician whistleblowers (two consultants and a junior doctor) were stood down and/or dismissed in the United Kingdom National Health Service (NHS) in the past 12 months after raising concerns. They lamented to *The Guardian* newspaper that even the Letby case may not change the culture of retribution for those who raise concerns.[13]

Cases like these demonstrate how much further we must go to protect whistleblowers. In Australia,

despite implementing the first whistleblower protection law over three decades ago, only one whistleblower has ever been awarded court-ordered compensation for the harm they endured.[6]

In situations like those involving Ms Hoffman, Mr Nixon, or the doctors in the Letby case, we might all aspire to have the courage to blow the whistle. However, it is important to acknowledge that there are numerous ethical factors at play that can create a moral dilemma. Whistleblowing presents a moral dilemma for healthcare professionals. Nurses often experience moral dilemmas when conflicting moral principles, such as loyalty to colleagues and healthcare services, privacy and confidentiality, and upholding professional standards and patient safety, come into play.[14]

For some, like Nixon, speaking up against injustice and unfairness, even when others remain silent, is an important value held close to his heart.[5] However, whistleblowing nurses face the personal retribution cost that will inevitably accompany any action that exposes injustice, even when the injustice may not directly affect them.[15]

Over the decades, nurses' views on whistleblowing have evolved. Previous investigations in the 1990s and 2000s questioned whether whistleblowing was "worth the consequences" and whether whistleblowers were "troublemakers or virtuous nurses."[16,17] Contemporary literature supports internal whistleblowing in nursing and recognises the many benefits, including increased patient safety, reduced costs, and increased staff satisfaction.[18,19] Although internal reporting has clear benefits supported by evidence, it is important to note that reporting outside the organisation carries greater risks. As a result, there has been a growing emphasis on providing legal protections to external whistleblowers in order to support and encourage them.

The overall goal of Australian public interest disclosure laws is ostensibly to protect individuals who disclose information, notably from other laws that otherwise would conflict with this purpose, such as confidentiality and defamation. Public interest disclosure law also attempts to put legal remedies for whistleblowers in place should they suffer reprisals for making disclosures.[20,21] However, Australia currently has a patchwork of laws, and legislative reform has been called for.[21]

Until recently, whistleblowers often faced isolation and fear during the reporting process.[22] The injustices whistleblowers face have been highlighted in a report by the Human Rights Law Centre, leading to the establishment of Australia's first legal project dedicated to whistleblowing.[6] The Whistleblowing project[23] promoted on *Radio National Law Report* on 29 August 2023[24] needs to be bookmarked by every nurse. It is important for nurses to seek legal advice and be aware of and seek solace in the protections available in their state or territory before blowing the whistle, a morally virtuous task that remains fraught with risk.

Authors

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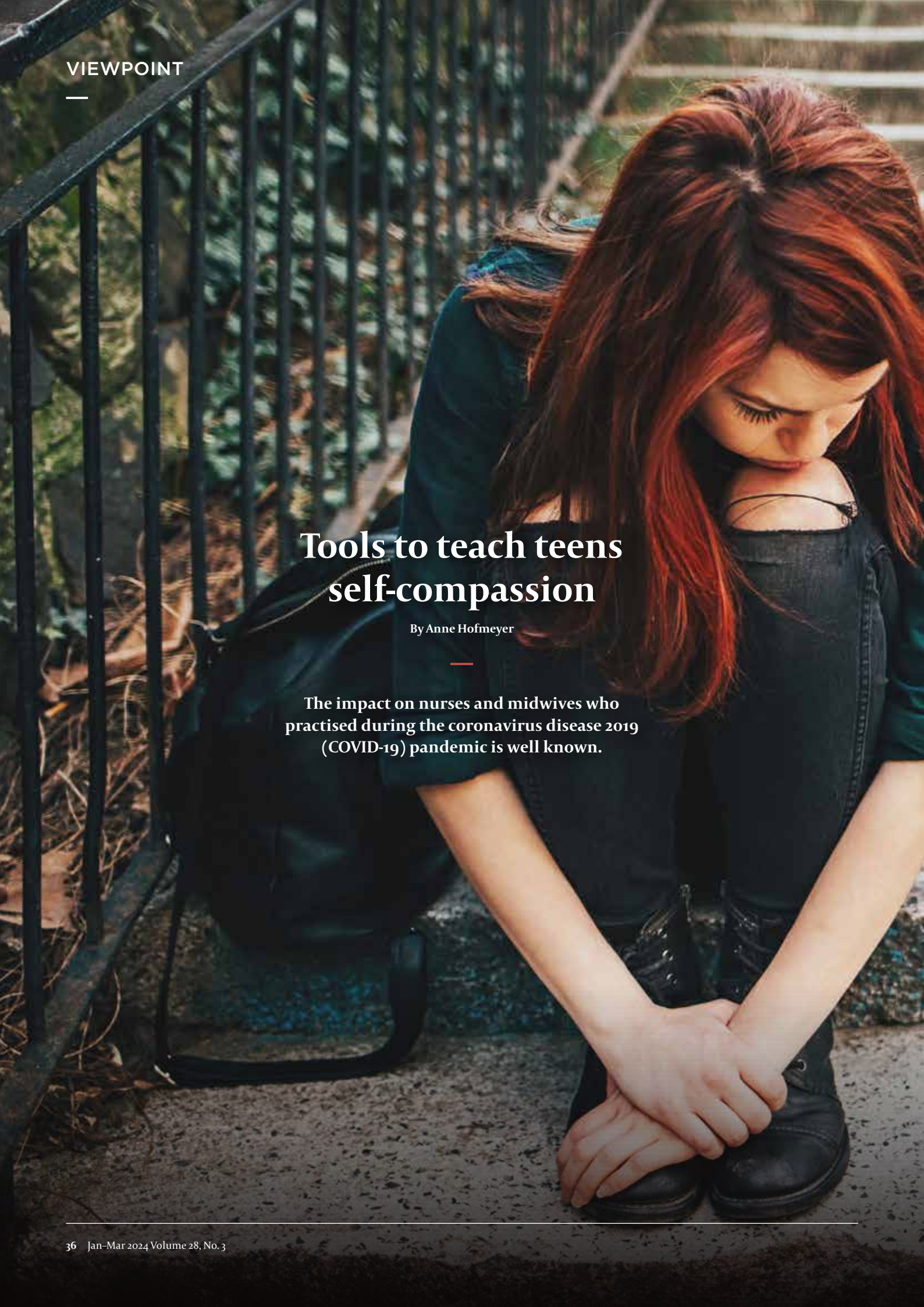

Tools to teach teens self-compassion

By Anne Hofmeyer

The impact on nurses and midwives who practised during the coronavirus disease 2019 (COVID-19) pandemic is well known.

Many were parents or grandparents, but less is known about how their children managed their anxiety as predictable routines were disrupted.

In New York, children wrote farewell notes to their parents who were practising as nurses because they were worried that their parents might catch the virus and die. Likewise, nurses slept in their cars, rather than going home to minimise the risk of transmitting the virus to their families.[1-2]

Globally, there were inspiring reports of nurses having the courage to act with compassion toward patients who were isolated, suffering, and dying without relatives at their bedside. Their acts of kindness, warmth and understanding were compassionate. Compassion is a sensitivity to the suffering in self and others and acting to alleviate it, rather than opting to avoid or ignore it.[2]

Nurses reported exhaustion and stress and looked for ways to recharge so they could continue to care for their patients, colleagues, family, and themselves.

Self-care strategies and treating oneself with kindness, warmth, and understanding (known as self-compassion) was widely promoted. Some healthcare organisations implemented strategies such as 'The Pause' and 'The Schwartz Centre Rounds'.

The Rounds fostered cultures of compassion and supported clinicians to re-connect to their sense of purpose that drew them to their work, and renewed compassion for patients, colleagues, and themselves.[2]

While the COVID-19 pandemic is no longer considered a global health emergency, the threat has not gone away, and the uncertainty and mental health challenges lingers for many. Notably, the widespread disruption of the pandemic, physical distancing, closures, and lockdowns prevented many face-to-face activities for children and grandchildren such as school attendance, sporting events, graduations, funerals, and other important faith and community rituals.[1]

Adolescence is a critical and often tumultuous developmental period in the lifespan.[3]

A study showed that anxiety doubled in young children and adolescents (teens) in year one of the pandemic. Pandemic-related stress was associated with greater loneliness, particularly in teens who spent more time on social media than before the pandemic.[3]

Dr Kristin Neff has been a pioneer in self-compassion research for over two decades.[4] She said self-compassion is treating ourselves with the same warmth, kindness, and understanding when we are struggling, as we would treat a good friend in similar circumstances. Individuals who are self-compassionate have better emotional wellbeing and experience less anxiety, shame, and self-judgement. They respond to their negative emotions in a balanced and supportive way, rather than engaging in harsh self-talk that is detrimental to their mental health.[4-6]

More recently, self-compassion has been examined in specific populations such as adolescents, athletes, immigrants and couples.[3]

Dr Karen Bluth showed that positive peer relationships, supportive social networks, and kind, soothing self-talk (self-compassion) are crucial factors in adolescence emotional wellbeing.[3,7-8]

Similar to adults, research showed many teens believed that harsh self-talk motivated personal performance. In fact, the opposite is true.[3]

Teens were worried about self-compassion because they thought it was a weakness, indulgence, or self-pity. It is important to clarify misconceptions when teaching self-compassion to teens.[7-8]

A challenge for parents is to detect when teens are struggling, and to find ways to help teens navigate the difficult road of adolescence. Parental self-compassion is critical in engaging with teens who are withdrawn, and may foster meaningful communication. Teachers and parents could use reputable programs to teach teens to manage worry, self-doubt, disappointment and hurt, and to relate to themselves with kindness. For example: the Mindful Self-Compassion for Teens (MSC-T)[6] program teaches skills in self-compassion and helps teens understand they are not alone in their struggles.

Program participants have reported decreased anxiety and stress and increased wellbeing.[6]

Arguably, we must teach children and teens to manage stress, cope better, and become kinder to themselves now, and in the future.[9]

In conclusion, teachers and parents could explore the following websites with teens to learn about the practice of self-compassion and various tools available to foster a sense of safety, inner coping, health and resilience:

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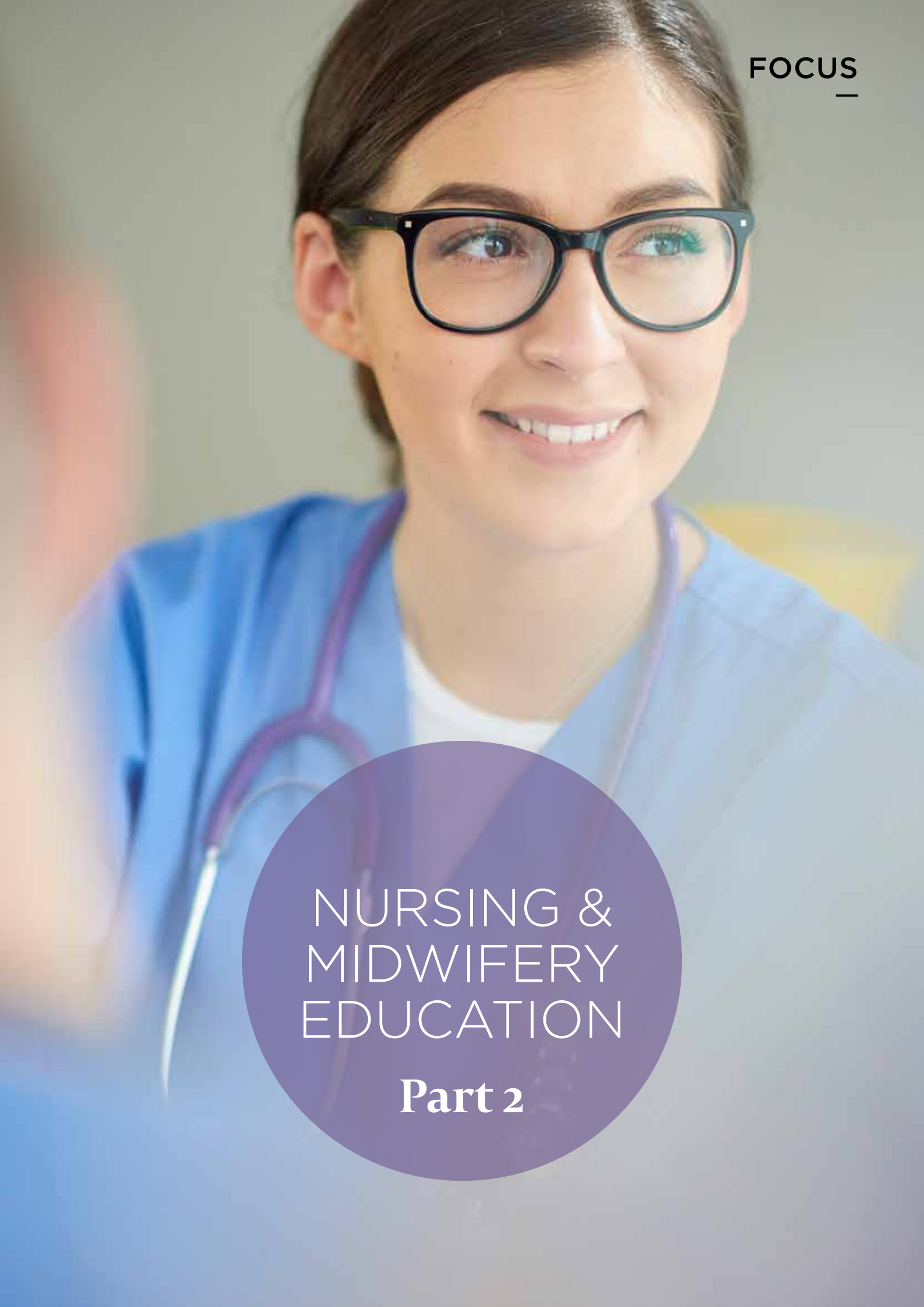

NURSING & MIDWIFERY EDUCATION

Part 2

RIPRNs … still providing quality care for rural and remote communities

By Sonia Girle, Kate Coman, Susan Muirhead, Danielle Jess and Belynda Abbott

With the recent transition of the national scheduled medicines (rural and remote) endorsement for registered nurses (RN) to 'state-based authorisations', it is timely to revisit what a "RIPRN" is and why education and training are so important to prepare RNs for this role.

RIPRNs (Rural and Isolated Practice Registered Nurses) are RNs who have undergone additional education and training via an approved course, which allows them to initiate medicines in rural and remote areas without a prescription. This practice is governed by a collaborative model that includes education and training, authorisation under state or territory medicines and poisons legislation, and evidence-based clinical guidelines in the form of the Primary Clinical Care Manual (PCCM).[1]

Rural and remote RNs in Australia require a comprehensive skill set that includes assessing, diagnosing, and treating acute medical conditions. They often report feeling unprepared for this role, yet health services expect them to fulfil it to meet the community's healthcare needs.[2]

Queensland and Victoria are committed to supporting the development of RNs to provide safe and quality healthcare in rural and remote communities.[1] The RIPRN course provided by the Cunningham Centre (Queensland Health) is currently the only course approved under these states' current legislation.

This program equips RNs with advanced history and physical examination skills, enabling them to make provisional medical diagnoses and work to their full scope of practice. The course includes clinical skills assessments utilising real-life case studies to exemplify how RIPRNs would assess, diagnose, and manage patients. It also explores advanced pharmacokinetics, pharmacodynamics, and safe medication practices specific to the medicines RIPRNs are legally authorised to use, including immunisations.[3]

While RIPRNs practice collaboratively with a range of other healthcare professionals, they can independently manage many conditions, including initiating and administering appropriate medicines. RIPRNs can autonomously manage a range of common presentations, from acute pain, wound repairs to impetigo and sexually transmitted infections.

In emergencies, when contacting a doctor is not immediately possible, RIPRNs can also initiate treatments like antivenom and antibiotics for meningitis.[1]

The RIPRN model truly enables RNs to practice to their full scope to contribute to meeting the health needs of people in rural and remote communities. This aligns with the United Nations Sustainable Development Goals, which include good health and wellbeing through equity and access to healthcare.[4]

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Developing and evaluating a clinical supervision training program for mental health nurses

By Nicholas Procter, Joshua McDonough and Kate Rhodes

The continued support for nurses through education and training is fundamental to the success and growth of the profession.

This is particularly relevant within mental health nursing, where staff often face complex and emotionally challenging circumstances. The past decades have seen a growth in interest and understanding of workplace support within mental health settings through formalised Clinical Supervision (CS).[1] CS typically involves facilitated discussion around topics of professional relevance and concern. With support from a trained supervisor, CS is a formalised, psychologically safe practice for reflective thinking and discussion regarding professional development issues, professional boundaries, caseload, decision-making regarding clinical issues, and staff interpersonal issues.[2] Research evaluating the benefits of CS has shown improved support for those working in mental health, developing deeper nursing competence and knowledge, and reducing burnout.[1]

Adequate training is required for individuals to be able to provide effective CS. CS provided without robust training is more likely to be inadequate, counter-productive, or potentially harmful to individuals and workplace cultures.[3] People who receive poor supervision are likely to provide poor supervision themselves.[4] However, their divergent views in professional circles and in the literature on how much training is required for mental health nurses to be proficient in providing CS.

In lieu of formalised national standards for training in Clinical Supervision, training is based upon varied and unsystematic recommendations, with little evaluation evidence published to support training programs.[5]

The Mental Health and Suicide Prevention Research and Education Group at UniSA have worked with several stakeholders to develop a statewide program providing CS training to mental health nurses employed across a range of practice settings. Supported by local, national, and international speakers, the online program includes seven interactive sessions covering the theoretical and practical considerations for implementing successful and sustained CS within an organisation. These sessions are supported by a guided workbook and homework activities linked to each session. We are currently completing a formalised evaluation that aims to investigate the program's effect over time on participants' confidence and competence regarding CS and identify workplace benefits and barriers to ongoing clinical supervision.

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What is important to registered nurses' success in the research component of a Master's degree?

By Rachel Cardwell, Beverley Copnell, Rachael Duncan, Gulzar Malik, Katherine Nelson and Cheryle Moss

The post-registration Master's degree for registered nurses is central to developing the professional workforce.[1,2]

The degree may consist of two core components, one being taught coursework and the other being research.[3,4] The coursework component usually offers subjects designed to advance knowledge and skills in a clinical specialisation or as advanced practice in nursing. On completing the coursework component, registered nurses will sometimes graduate with a graduate certificate or diploma as the award for their study in the specialisation.

The degree's research component is usually undertaken after the specialist coursework subjects have been completed. The research component is important to developing inquiry and research skills in registered nurses, and this qualification component may provide a pathway for entrance to doctoral study.[5] The research component of the degree may support registered nurses' leadership capabilities, skills in critical appraisal of evidence and research, and capacities to make change and improve practice in their workplace settings.[6,7]

While evidence about the importance of Master's degree study to the profession exists,[1,2] little is known about how nurse academics shape learning, undertake research supervision, and achieve successful outcomes for registered nurses in the research component of the degree.[8,9] La Trobe University has funded researchers to undertake a qualitative study that will investigate the practices and strategies that nurse academics use to achieve success in the research supervision of registered nurses enrolled in the Master's degree.

The study will recruit nurse academics from universities across Australia and New Zealand who are experienced, research supervisors. The plan is to interview them to discover their perspectives, practices, and insights into how they achieve success for registered nurses who are undertaking the research component of the Master's degree.

One of the research objectives is to explore supervisors' perspectives about the importance of research component education to the registered nurse workforce and to industry and to learn how these influence and shape their supervision practices. Another objective is to investigate what academic, research, professional and feedback literacies the supervisors seek to enhance through the research component of the degree. Findings from the study should assist further refinement of teaching and supervision in the research component of the Master's degree and clearer articulation of the expectations and likely outcomes for the healthcare industry and future nursing students. Additionally, the findings should assist university schools of nursing and midwifery in Australia and New Zealand further to develop the research component of the Master's degree and to support supervisor skill and role development further.

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Where clinical experience and community experience connect: A person-centred approach to workforce development

By Melinda Hassall, Gillian Meikle, Isabelle Purcell and Jacqui Richmond

The Fourth National Hepatitis B strategy has set 2030 as the goal for eliminating hepatitis B as a public health threat in Australia.[1]

While progress has been made, Australia is not on track to achieve this. This has led to a critical juncture in the sector, recognising the need to do something different to renew efforts towards elimination.

In Australia, an estimated 200,385 people live with chronic hepatitis B (CHB), of which only 72.5% are diagnosed.[2] Engagement in guideline-based monitoring significantly reduces the risk of negative health outcomes, and yet only 26% of people estimated to be living with CHB in Australia are engaged in care.[2] When left unmanaged, CHB increases the risk of liver damage and liver cancer.

Country of birth is a significant factor in CHB risk, and it is estimated that 70% of people living with CHB in Australia were born overseas.[2] Other priority populations include Aboriginal and Torres Strait Islander people, men who have sex with men and people who have ever injected drugs. This diversity must be considered in the development of training materials and education.

Education for nurses and midwives is critical to improving the number of people diagnosed and engaged in care. Effective and relevant education that is developed in a way that can be translated into practice, empowering the audience to act on information must be a focus. This is enhanced by training curriculums developed in partnership with people with experience working in the community sector.

Recognising this, ASHM deliberately developed a new course, ensuring multiple perspectives were engaged in the curriculum development process. 'Hepatitis B Clinical Update for Nurses and Midwives' is a two-hour webinar for nurses and midwives experienced in CHB who have accessed previous education. A national pilot course focusing on new and future treatment developments was held in June 2023. Future courses were planned to focus on different aspects of the nurses' and midwives' roles in delivering hepatitis B care.

Perspectives of nurses and midwives across all geographic areas lived experience of those with CHB and Aboriginal and Torres Strait Islander people is integral to ensuring a meaningful understanding of CHB and its impact on health and wellbeing. Including nurses and midwives working across various sectors reflects the diversity of where people living with CHB intersect and encapsulates the needs of a diverse audience. When developing this course, reflecting the education audience, these perspectives were included within a steering committee that led curriculum and program development, providing feedback at all key steps.

Community representation ensured that the format, structure and approach to the course design are more likely to be relevant and practical and incorporate person-centred care.

Nurses and midwives are vital in improving the care cascade for hepatitis B and increasing the number of people diagnosed and engaged in care. Ongoing education opportunities that embed the diverse voices of people living with hepatitis B will support this.

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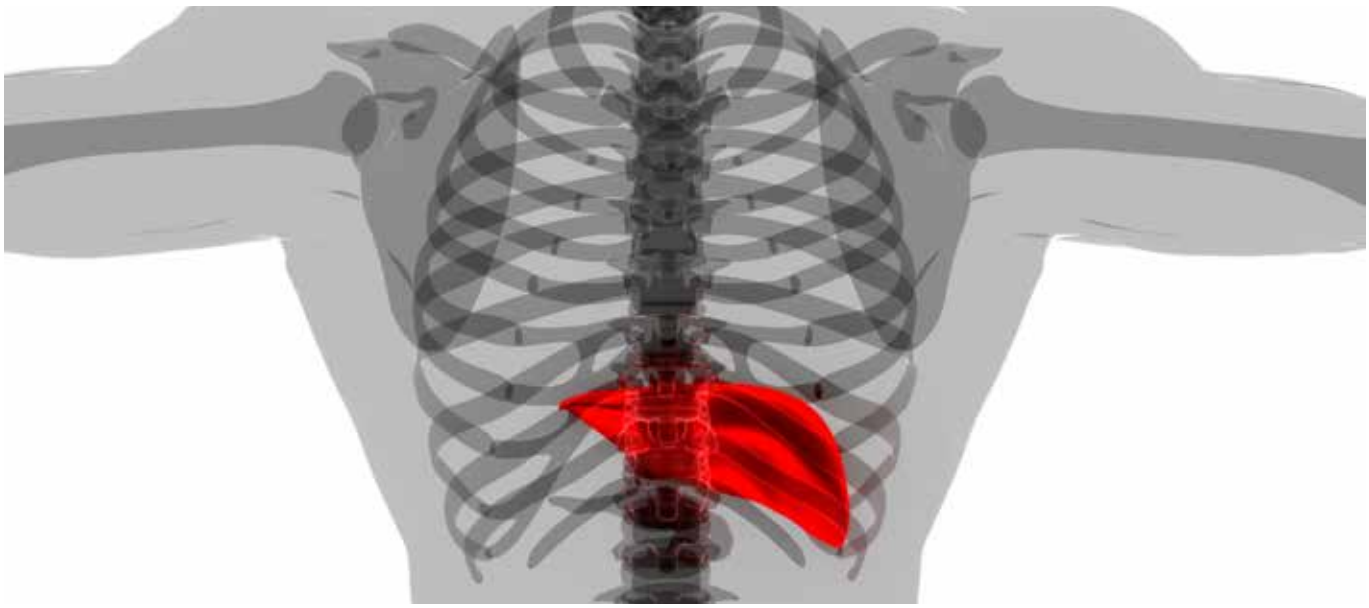

The significance of comprehensive data in empowering young adults with stroke: The role of clinicians

By Dinah Amoah, Carey Mather, Sarah Prior, Matthew Schmidt and Marie-Louise Bird

Stroke is traditionally associated with older individuals; however, over the past few decades, stroke rates in young people have been increasing (18-65 years).[1]

The impact of stroke on young people is devastating as they may live with the disability for many more years than older stroke survivors. The occurrence of stroke in younger individuals presents unique challenges in terms of diagnosis, treatment, ability to perform activities of daily living, psychological functioning, relationships and social interactions.[2-4]

It is also important to note that the younger cohort (≤ 30 years) differs from those above 30 years and tends to have different needs[5] in terms of making decisions about life roles such as studying and starting a career or family. Although this younger group of young adults with stroke possess unique characteristics, findings from the Australian study on supporting young stroke survivors through engaging messaging (SYSSTEM) study revealed no standardisation in categorising the ages of young stroke when reporting data, and some data did not separate the younger cohorts from the older young stroke survivors.

So, the question is, how do clinicians educate young people with stroke if we do not know specific risk factors, clinical features, and preferred ways of self-management for young people with stroke, as differentiated by age groupings?

The significance of comprehensive data for clinicians cannot be overemphasised when educating people with stroke. Robust data on the specific risk factors, incidence and outcomes of young stroke play a crucial role in assisting clinicians in educating young people with stroke on tailored self-management and secondary prevention strategies.

The lack of a standardised approach to reporting data on young stroke hinders the ability to develop appropriate unique support that may be required. Nevertheless, the fact that there exist differences in the needs of young people and older people calls for a different approach to care and management.

Clinicians who understand the uniqueness of young people with stroke will be able to deliver person-centred interventions at every stage of their care, including education about their condition, rehabilitation options, and lifestyle modifications rather than providing composite care for all young people with stroke.

To better support young stroke survivors, we recommend that clinicians receive ongoing professional development opportunities on the epidemiology of young stroke, including how to support young people psychologically, physically, and emotionally to help provide age-specific assessment and management that will improve their quality of life and participation.

Healthcare professionals educate young stroke survivors on risk factors of stroke. Right to left: Dr Marie-Louise Bird, Joshua Bailey: Simulated stroke survivor, Dinah Amoah

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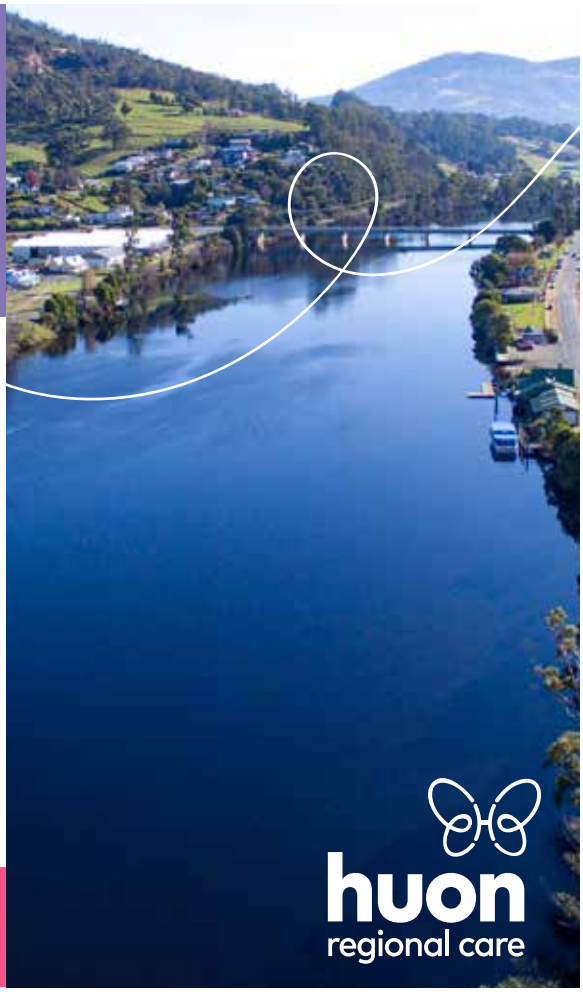

huon regional care

Discovering key factors that have influenced the motivations and practices of nursing academics

By May El Haddad, Rachel Cardwell, Rachael Duncan and Cheryle Moss

Nurse academics working in universities are an indispensable group in the nursing workforce.

Nurse academics provide requisite education and training of nursing students entering the professional workforce, crucial post-registration education of registered nurses for advanced and specialist practice, and research training for evidence-based practice. Additionally, nurse academics carry significant responsibility for progressing knowledge and evidence related to the nursing discipline. This is often achieved through undertaking team-based research projects, writing textbooks and papers for publication, and providing academic guidance through committee work and consultation.

To do this work, academics need to be highly motivated, have clear foci in their practices, and be committed to supporting the development of knowledge and skills in others.

It is not known how previous experiences with nurse leaders or encounters with others influence the way nursing academics themselves then go on to work with peers and the people that they are supporting and teaching. Investigating this phenomenon in the context of university-based schools of nursing and midwifery is important because previous experiences may be shaping and influencing the workplace practices, team engagement and teaching cultures of university nursing academics. What is known is that creating an environment where nursing academics can thrive is important for retention[1,2,3] and the construction of academic identity.[4] Local leadership and quality peer relationships may be important factors in achieving these workplace cultures in university-based schools of nursing and midwifery.

Collaborative research by nurse academics from the Sunshine Coast University and La Trobe University is currently being undertaken to discover underlying forces and dynamics in past experiences that are perceived to have influenced the motivations and practices of nurse academics. The study is recruiting nurse academics from universities in Australia. The plan is to interview them to discover their perspectives about how these past experiences have shaped their role investment and how they work as nursing academics.

Findings from the study should help understand how exposure to leaders and leadership practices, nurses in clinical practice, and other social and cultural influences may be shaping the philosophies of practice and workplace motivations of nurse academics. This knowledge will likely inform understanding of how professional culture is translated and projected into university work. It should also assist in insight into factors that support the development of academic identity and philosophies of practice. All of these insights will have implications for developing strategies to support academic workforce development and retention.

ACKNOWLEDGEMENT

The research is being undertaken jointly by staff from La Trobe University and the University of the Sunshine Coast.

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Restorative resilience clinical supervision: A retention strategy for graduate nurses?

By Debra Klages, Susan Webster and Matthew Johnson

The education of nursing and midwifery students in Australia, as in the rest of the world, has been devastated by the global pandemic.[1]

Indeed, nurses and midwives had been in "dire straits" due to conditions in healthcare which have affected their energy, morale, and physical and mental health, even before the onset of COVID-19.[2] In this paper, mental health nurse educators describe how they supported first-year graduate nurses amidst the pandemic during a clinical academic partnership program in regional Queensland.

The Australian College of Mental Health Nurses recommends clinical supervision as essential to mental health nurses' professional growth and sustenance.[3]

In Queensland Health, all first-year graduate nurses in mental health have access to clinical supervision. Nevertheless, regional Queensland mental health nurse educators identified that graduate nurses needed enhanced clinical supervision during COVID-19 and beyond.

The educators believed clinical supervision needed to encompass compassion satisfaction and resilience to workplace stressors. They reviewed contemporary literature and discovered the Restorative Resilience Model of Supervision, created to support midwives in the National Health Service in the United Kingdom (UK).[4] This supervision model assists health professionals in processing their traumatic workplace experiences, building resilience levels, and developing healthy coping strategies.[5] It has been effective with healthcare professionals providing complex patient care. Recent research in 2022 has demonstrated that resilience-based supervision improved nurses' ability to function during COVID-19.[6]

Mental health nurse educators from Rockhampton and Wide Bay developed an Australian version of the UK Restorative Resilience training manual. They used the Australian version of the UK manual to upskill themselves and their colleagues. Restorative Resilience Supervision was added to their curriculum, with individual and group clinical supervision for graduate nurses during the clinical academic partnership program.

The Rockhampton nurse educators reported that all graduate nurses in the 2022-2023 cohort completed their Graduate Certificate in Mental Health Nursing at CQUniversity. However, the most important outcome is that the nurses have remained employed in mental health nursing.

The authors recommend further research and suggest nurse educators consider the benefits of Restorative Resilience Clinical Supervision. In the interim, mental health nurse educators in regional Queensland offer one-day Restorative Resilience Clinical Supervision workshops for colleagues who wish to enhance their clinical supervision skills in compassion satisfaction and resilience.

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Nurse educator internships

By Lorraine Thompson, Judith Gonzalez, Annette Faithfull-Byrne, Colleen Johnston-Devin and Leanne Jack

Many health facilities risk losing a wealth of organisational knowledge and experience as the Baby Boomer generation moves into retirement.

To grow our talent pool and build a succession plan for our nursing staff, our organisation created a one-year internship program so that experienced clinicians could transition to a nurse educator role from clinical nursing practice.

The benefits of participating in the internship program are clear. Interns' experience working as a nurse educator without a continued commitment beyond the one-year internship period provides the intern with real-world experience to determine if clinical nursing education is a suitable career choice.

From an organisational perspective, the internship allows for assessing potential employee's ability to perform in the role and work within the nursing education team. An additional benefit to the organisation and employee is the experience gained by the individual in terms of stepping into a new role, having already been trained.

The transition into a new role can be challenging; therefore, support is built into the intern program. A professional development plan is tailored to each intern's needs, including core nurse educator's foundational skills and knowledge. Additionally, interns work in partnership with an experienced nurse educator who acts as their mentor. The intern receives individual coaching from their mentor in conjunction with other education team members, including administration staff.

Interns are coached on practical education skills such as creating, planning and delivering clinical workshops, creating educational learning resources, and participating in developing, delivering, and evaluating contemporary nurse education. The interns receive individual feedback on their teaching sessions to assist them in growing their confidence as their educational skills develop. Interns observe the application of theoretical frameworks such as Adult Learning Theory and Blooms' Taxonomy. They are encouraged to adopt an evidence-based practice approach to education and are asked to develop and implement an educational philosophy.

Nurse education governance and leadership aspects of the role are included in the internship as interns shadow the experienced nurse educators in strategic activities like leading Education Steering Groups, Education Planning, maintaining state-wide networks and engaging in research activities. Opportunities to observe an experienced nurse educator problem solve and role model best practices in reaching a sound, evidence-informed educational outcome in complex educational situations is a valuable 'real life' learning opportunity.

Our healthcare organisation has had several intakes of the nurse internship program, and as a result, some interns have been recruited into nurse educator positions. All interns have experienced a smooth transition into the role due to participation in the internship program and are now completing tertiary studies in education to continue their successful participation in the nurse education team.

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Water Immersion for Labour and Birth (WILB) overview of the program of research

By Lisa Peberdy, Mia McLanders, Lauren Kearney and Megan Barker

BACKGROUND OF WILB

Guidelines for intrapartum care focus on optimising women's natural physiology to birth, with health services urged to promote a positive birth experience through attending to informed decision-making, respectful maternity care and facilitation of autonomy and choice for women.[1]

Evidence strongly substantiates water immersion as a safe and suitable option for women to relieve labour pain.[2-4] Improvements, especially for low-risk women when using warm water immersion, include reduced regional analgesia,[2,5] increased mobility and control,[6] lower episiotomy rates with a decreased likelihood of severe perineal injuries.[7] No increased harm to neonatal wellbeing has been demonstrated when women use warm water for labour and birth.[2,8,9]

In 2021, there were 64,111 births in Queensland. However, only 1,969 (3.1%) of births occurred in water, with slightly more women (4,005, 6.3%) using warm water immersion for pain relief.[10]

BARRIERS TO PROVIDING WILB

The low uptake of this option in Queensland is likely the result of multiple complexities, including a skilled workforce to provide water immersion, hospital facilities with suitable birthing pools, practitioner bias toward this as a reputable pain relief option, and variations in local workplace policy and procedure which precludes a significant portion of women from accessing pools.[11]

Midwives provide one-to-one care for women during the intrapartum period and have a key role in advocacy and supporting women to access choices they prefer for pain relief and birth. Care providers' experience and confidence in facilitating water immersion for labour and birth (WILB) is a reported factor in whether women birthed in water or not – with a 10% increase for women who had a provider with more experience and confidence in facilitating water immersion and birth, compared to those who did not.[3]

EDUCATION PACKAGE

The Clinical Skills Development Service, Metro North Health, in consultation with hospital executives, consumers, educators and practising clinicians, has developed an evidence-based, e-learning package to support maternity clinicians in the facilitation of WILB and to standardise and improve the accessibility of education on water immersion and birth.

PROPOSED RESEARCH

This research will evaluate the impact of the e-learning and face-to-face education package for maternity clinicians in caring for women using warm water immersion for labour and birth (WILB) and has three phases.

Phase One: collate and synthesise local workplace procedures which provide guidance at hospitals within Queensland on WILB use through a 'Desktop' review.

Phase Two: investigate knowledge, attitudes, barriers and social norms of maternity health professional staff comparatively before and after participating in the e-learning and/or practical face-to-face waterbirth program.

Phase Three: measure rates of water immersion water births and clinical outcomes for women using water immersion water births compared to rates prior to the implementation of the e-learning and face-to-face education package across Queensland.

ANTICIPATED OUTCOMES

It is anticipated the findings will be used to target future behaviour change and ultimately improve the provision of women-centred care, birthing options and outcomes.

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La Trobe University Alfred Clinical School celebrates nursing and clinical queries to support a healthier tomorrow

By Gayle McKenzie and Sharon Bourke

The Clinical School (CS) at Alfred Health was the first CS established by La Trobe University in 2000. The location has enabled more students living in Melbourne's South-Eastern and Eastern suburbs to choose to study nursing and allied health degrees with La Trobe.

The Alfred Clinical School comprises a broad base of teaching focussed academics, teaching and research lecturers in nursing, hospital staff who lead advanced specialist postgraduate subjects and members of the schools of allied health. The Alfred CS site coordinator is a registered nurse. The CS enjoys a close relationship with the Baker Institute, which have research staff working within the Alfred CS open-plan office space. This proximity supports communication on clinical topics of shared interest across all health disciplines and multidisciplinary collaboration on ARCH (Academic and Research Collaborative in Health) publications.

The nursing academics at the Alfred Clinical School are involved in the undergraduate and postgraduate study programs delivered in person, online, or in a blended mode. These programs were successfully delivered to students even during the challenges of multiple COVID-19 lockdowns in Melbourne.

Collaborations between Alfred clinicians/educators and La Trobe staff (particularly in higher-degrees) allow a variety of evidence-based research projects to be undertaken, some of which include: *Newly graduated nurses' adoption of evidence-based practice in the clinical setting, projects on pain management, the role of the perioperative nurse surgical assistant, and the creation of a short course in medical imaging.* The current projects build on past enquiries to support undergraduate and postgraduate student success[1,2] and workforce needs.[3]

As we move forward to celebrating 25 years in 2025, we appreciate all the support from staff working within Alfred Health and the Baker Institute, as well as past nurses and allied staff who have contributed to our program. In finale, we thank all past and present students who are all contributing to people's health, whether in Australia or multiple countries around the world.

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La Trobe Nursing lecturers and Baker Heart and Diabetes Institute research staff at the Alfred Clinical School

Delivering culturally safe, culturally responsive, and inclusive end-of-life care

By Penny Neller and Patsy Yates

At the end of life, unique legal considerations can arise when caring for Aboriginal and Torres Strait Islander Peoples and people from other diverse health populations, such as LGBTIQ+, people from culturally and linguistically diverse backgrounds, and people with disability.

The End of Life Law for Clinicians (ELLC) training program has two new free online training modules to support nurses caring for Aboriginal and Torres Strait Islander Peoples and people from diverse populations, their families, communities, and support networks. Both modules highlight the importance of every person receiving end-of-life care that is:

- responsive to their preferences, values, and needs;
- respectful of the individual's culture, ethnicity, religion, identity, gender, sexuality, and bodily diversity;
- inclusive of the person and anyone else (eg. family members, support networks) the person wishes to be involved in decision-making;
- equitable and non-discriminatory; and
- Culturally Safe and Culturally Responsive.

Knowing the law relating to medical treatment decision-making, death and dying in these health contexts can help nurses and other health professionals to deliver optimal end-of-life, palliative and aged care.

CULTURALLY SAFE, CULTURALLY RESPONSIVE CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES, FAMILIES, AND COMMUNITIES

Aboriginal and/or Torres Strait Islander Peoples' unique and diverse cultures; connection to Country, family and community; and cultural beliefs and knowledge are intrinsically linked to maintaining health and wellbeing. These factors can profoundly influence approaches to death, dying and end-of-life decision-making. Also relevant are historical, social, economic, and health experiences, including the legacy of colonisation, past and continuing discrimination and trauma, and challenges accessing end-of-life care.

ELLC's training module on *Aboriginal and/or Torres Strait Islander Peoples and end of life law* focuses on end-of-life decision-making with First Nations Peoples, families, and communities. It was developed in collaboration with Aboriginal and/or Torres Strait Islander health professionals and stakeholders across Australia.

Topics explored include communicating with Aboriginal and Torres Strait Islander patients and families eg. when determining decision-making capacity and obtaining consent to treatment, collective decision-making, refusal of treatment, pain and symptom relief, and cultural considerations at the end of life.

SAFE, QUALITY, INCLUSIVE CARE FOR PEOPLE FROM DIVERSE POPULATIONS

ELLC's newest module, *Inclusive end of life decisionmaking with people from diverse populations,* focuses on end-of-life decision-making with people who are LGBTIQ+; people from culturally and linguistically diverse and/or refugee backgrounds; people with disability; and people with frailty.

People from these populations have unique and diverse identities, cultures, and life experiences. Some people may experience heightened vulnerability due to disparities in health and/or access to healthcare; a legacy of discrimination and unmet healthcare needs; exclusion from participation in decision-making; and negative experiences with health and care systems. This can create challenges to accessing end-of-life and palliative care and can influence end-of-life decision-making.

The module explores intersectionality, human rights principles underpinning inclusive care, identifying a person's lawful substitute decision-maker, participation in decision-making (including supported decision-making), and futile or non-beneficial treatment. Healthcare and legal considerations relevant to the focus populations are also examined.

ELLC TRAINING PROGRAM

In its 7TH year, ELLC is a national end-of-life and palliative care training program funded by the Australian Government Department of Health and Aged Care. ELLC is delivered by the Australian Centre for Health Law Research and Faculty of Health at the Queensland University of Technology.

ELLC comprises 13 free online training modules for nurses and other health professionals on capacity and consent, Advance Care Directives, substitute decision-making, withholding and withdrawing treatment, pain relief, and voluntary assisted dying. The modules include specific content for nurses, including tailored case studies and vignettes.

The training is complemented by End of Life Law in Australia, a free website that provides comprehensive information on decision-making laws in each Australian State and Territory.

Certificates of completion are available, and CPD may be claimed.

USEFUL LINKS

To register for the training, visit **ellc.edu.au**

End of Life Law in Australia: **end-of-life.qut.edu.au/**

Module 12 Aboriginal and/or Torres Strait Islander Peoples and end of life law: **cms.qut.edu.au/__data/assets/pdf_file/0008/1237724/ELLC-Module-12-flyer_final.pdf**

Module 13 Inclusive end-of-life decisionmaking with people from diverse populations: **cms.qut.edu.au/__data/assets/pdf_file/0009/1236924/ELLC-Diverse-Population-flyer_final3.pdf**

ELLC training curriculum 2023 – 2026: **cms.qut.edu.au/__data/assets/pdf_file/0011/1236566/ELLC-Training-curriculum-2023-2026-May_final2.pdf**

To register for the training, visit the ELLC training website.

For further information or to contact the ELLC team, email **endoflifelaw@qut.edu.au** or follow ELLC on Twitter @HealthLawQUT

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Supporting nurses from non-acute nursing backgrounds to rapidly transition to acute care environments

By Greer Stewart, Anna Davey and Renay Erwin

"This course allowed me the opportunity to take a step into the hospital section of healthcare, where otherwise it would have been extremely difficult as I had only worked in aged care."

Throughout Australia, non-acute nurses were included in the recruitment to staff COVID-19 Response Clinics. This cohort of non-acute nurses mostly came from backgrounds in aged care facilities and general practice clinics.

As COVID-19 clinics were ending, Gold Coast Health (GCH) saw an opportunity to transition this cohort of nurses into the acute care environment.

As educators, we needed to recognise that this would be a unique group of learners and would require very specific training and support to facilitate their transition into this environment. They were not newly qualified nurses. They did have experience. However, this varied among the group and was not reflective of what was required to work safely and independently in an acute hospital setting.

Adding to the complexity, rather than a couple of nurses that could have been managed locally, a substantially large influx of nurses needed to be accommodated into our service.

Compounding this was the urgency typical of pandemic initiatives, which meant there was a limited timeframe to develop a program suitable to transition nurses into the acute area.

The program development required rapid yet comprehensive collaboration between educators and key stakeholders. To accommodate the unique transition needs of this workforce, the program was designed to run over a condensed eight-week timeframe, drawing on existing educational resources from transition to practice programs. The program incorporated scaffolded educational and clinical support, workshops, skill stations, simulations, goal setting, reflection sessions, and formative and summative capability assessment.

The success of this program is reflected by the large cohort of these nurses who remain working with Gold Coast Health today. Sixty-two nurses were recruited to the program. Of these, 87% were retained at GCH, continuing with employment contracts.

Crucial to success was having a thorough understanding of the learners' current capability and their learning needs. This was a unique group, so it was essential that the learning needs analysis was collaboratively constructed with key stakeholders, which included educators, the recruits and the specialist clinical nurses form the diverse acute care areas across the health service. Learning needs were prioritised into two categories: firstly, the knowledge and skills deemed requisite before attending the wards, which could be delivered at a workshop and then the more practical skills which would be best learned on the wards with supervision and support.

The implementation of this program highlighted the role that nurse educators can play in breaking down the traditional barriers that have existed in recruiting new staff to the acute care setting. Balancing the organisation's requirements to build workforce capacity quickly with the needs of the individual learner is complex and requires strong educational leadership.

Innovations such as this program should be considered as an opportunity to address the pressing needs that many acute care hospitals currently face for rapid recruitment, training, and staff retention.

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Nurses develop Microcredential for digital health for the rural and remote health workforce

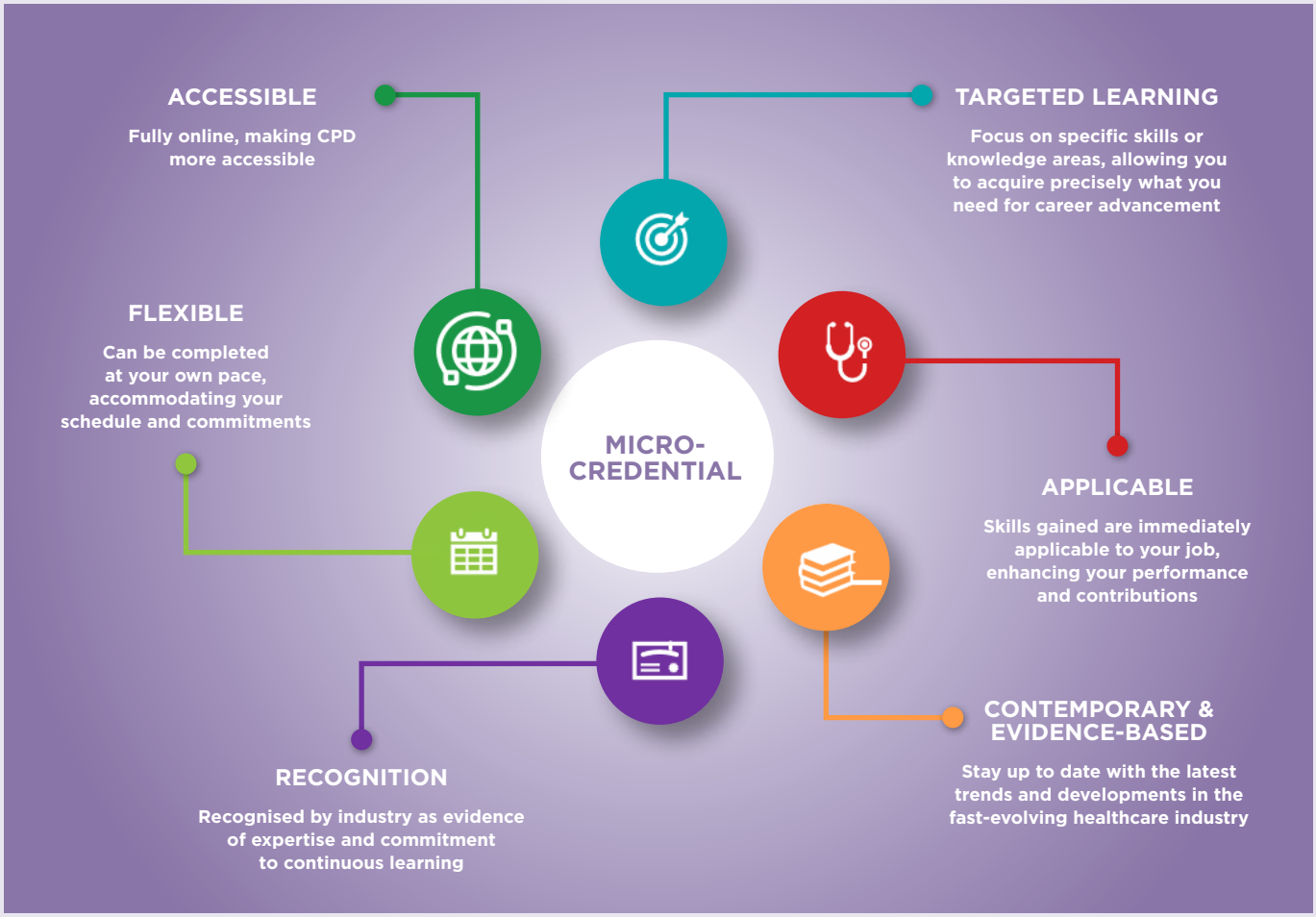
By Tracey Ahern, Pieta Shakes and Tracey Gooding

In Australia, nurses and midwives are required to maintain their commitment to life-long learning through continued professional development (CPD) to meet registration requirements.[1,2] In these current times, with rapid changes in health systems, technologies, a dynamic workforce, and the increasing health needs of people in the community, there has never been a more important time to devote to targeted life-long learning relevant to one's profession. What is evident is that currently those working in the health professions face several challenges accessing CPD that is of a high-quality, flexible, engaging, applicable to diverse learning preferences, and suitable to meet current learning needs.[3]

Microcredential courses offer short industry-aligned learning that can effectively address gaps in knowledge and skills needed to meet the dynamic nature of rapidly evolving workplaces and systems today.[4] These short courses attract learners seeking time-efficient, contemporary and relevant learning aligned with their career and learning needs.[5]

Recently researchers from the Northern Australian Regional Digital Health Collaborative (NARDHC)[6] contracted a team of nurse academics from James Cook University to create an online microcredential to equip health professionals with knowledge of emerging digital health technologies. The Digital Health for Rural and Remote Health Workforce Microcredential[6] was designed in alignment with the National Nursing and Midwifery Digital Health Capability Framework[7] and the National Microcredentials Framework[8], comprising three online units to be completed within six months, equating to approximately four hours a week over a 15-week period. Learners engage with contemporary multimedia content and activities allowing for consolidation and application of learning, specific to their workplace. The microcredential is fully funded, removing barriers related to costs for any health and allied health professionals and non-clinical staff working in healthcare to participate. Upon completion participants receive a certificate to evidence their commitment to this CPD.

The NARDHC[6] recognises the disparities in accessing timely healthcare delivery for people in Northern Australia and contends that digital health solutions can address challenges in remote management of health conditions for people living in regional, rural, and remote Northern Australia. However, gaining access to targeted learning opportunities for health professionals



to leverage digital technology capabilities that will transform healthcare delivery in these communities can be challenging. Microcredential courses like this offer opportunities for nurses, midwives, and other health professionals to build the knowledge and skills needed now to continue their efforts to achieve safe, quality healthcare delivery[7].

If you are looking to extend your digital health capabilities through appraisal of digital health tools to improve healthcare access, examination of your digital professionalism and leadership abilities, and analysis of complex problems related to implementation of digital health initiatives, this micro-credential might be the right fit for you.

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Support for nurses transitioning from clinical to academic roles

By Karen Silsby and May El Haddad

Calls to address the global shortage of nurses have been raised over the past decade.[1,2]

More nurse academics are needed to meet the increased demand for nurses globally. Nurse academics face many challenges when transitioning from clinical practice to academia, which impacts their retention.[3-5]

The World Health Organization[6] identified the lack of supply of nurse academics to support the demand for nurses who wish to enter the profession as a concern. A scoping review was conducted to explore the experiences relating to challenges and enablers with nurse academics transitioning from clinical to academic roles.

This review found that nurses who transitioned from the clinical setting experienced grief and loss,[7] role confusion,[8] and were unprepared for the transition.[9] Experiencing grief and loss related to losing their self-identity as a clinical nurse.[7] Role confusion was due to a lack of understanding of the academic role and the absence of clear role guidelines and related expectations.[8] Role confusion and the lack of knowledge of educational theory and practice further added to a sense of unpreparedness for the transition.[7-9]

Inconsistency in the support strategies offered to nurses transitioning from the clinical to the academic setting was noted throughout the literature. Orientation and mentorship were considered enablers for novice nurse academics commencing the role.[10] Forming support groups and the sharing of information improved the sense of belonging and enhanced the socialisation and confidence of novice nurse academics.[11] Other findings identified the use of critical reflection, which included reflection on feedback from peers and students to improve teaching practices, assisted with role transition.[4]

A better understanding of such challenges and enablers can assist with the transition of novice nurse academics in the future. These findings highlight some strategies that could be applied to ensure nurses are better prepared and supported for this role transition.

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Welcome to Healthy Eating

Each issue we will be featuring a recipe from Maggie Beer's Foundation, which ensures research, education and training will lead to better outcomes and the delivery of nutritious and flavoursome meals to our ageing population in nursing homes. Maggie's vision is not only to improve nutrition and wellbeing for the aged, but also for all who enjoy good wholesome food.

Lemon myrtle melting moments

These biscuits are devilishly moreish and pack in so much flavour, it can be difficult to stop at one!

INGREDIENTS

BISCUIT DOUGH

250g spelt flour
125g cornflour
250g softened butter
80g pure icing sugar
5g dried ground lemon myrtle

LEMON MYRTLE FILLING

60g softened butter
250g pure icing sugar, sifted
1g dried ground lemon myrtle
½ a lemon, juiced

METHOD

1. Preheat the oven to 170°C and line two large baking trays with baking paper.
2. Sift the flours together and set aside.
3. Beat together the butter and icing sugar until light and creamy, add in the lemon myrtle then slowly add in the sifted flours until the mixture is combined.
4. Take approximately 1.5 tbsp of the biscuit dough, roll into a ball and place on the baking tray. Flatten the ball out slightly and repeat the process until all the dough is rolled.
5. Gently mark the top of the dough with a fork then place into the oven and bake for 15 to 20 minutes or until the biscuit is lightly golden then set aside to cool.
6. Place softened butter, sifted icing sugar, lemon myrtle and lemon juice in a bowl and whip until creamy.
7. Transfer into a piping bag and pipe approximately a tablespoon of filling onto the prepared biscuit. Sandwich together with a second biscuit and repeat the process until complete.

Food styling and photo by Erika Budiman © pixelsandpaper.studio

We invite you to try and make Maggie's recipe.

Send a photo of you and your creation from this issue, and in a sentence, let us know what you liked about It. If we pick your entry, we'll publish it in the next *ANMJ* and reward you with a $50 Maggie Beer voucher. Send your entry to: **healthyeating@anmf.org.au**

Nicely done, Linda, on making Maggie's spring frittata published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"You gotta love Maggie! This frittata is full of goodness, so simple and so Spring! Deliciousness overload!" Linda says.

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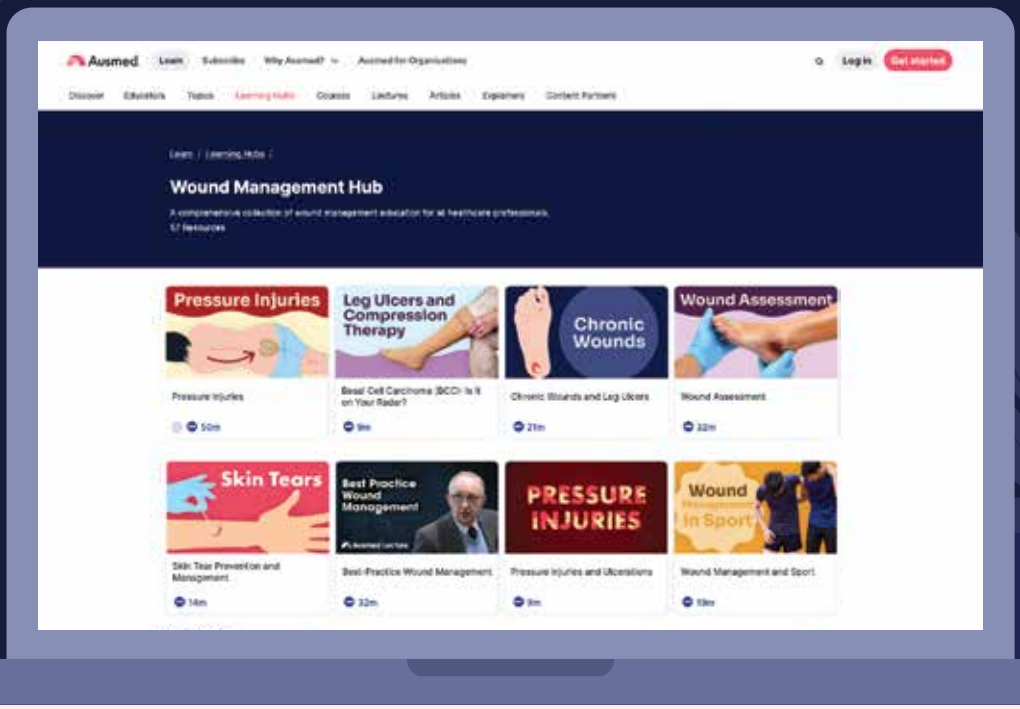

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