



ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

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INSIDE

**Celebrating nurses
and midwives**

Shaping the perception
and understanding of
nursing and midwifery

Leading with intent

Creating experiences
to influence change

When health

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Annie Butler
ANMF Federal
Secretary

I'm writing this editorial just two days after the Fair Work Commission (FWC) handed down its decision for the final stage of the Aged Care Work Value Case (Stage 3), where it has determined that direct care aged care workers, for work value reasons, should receive award rates substantially beyond the 15% increase determined in Stage 1. Personal care workers/assistants in nursing will receive further increases on award rates, with some receiving up to 28% increases on award rates.

While the FWC has deferred its decision on appropriate rate increases for registered and enrolled nurses working in aged care (this is because the ANMF has a second work value application before the FWC for the entire Nurses Award) to consider all employees covered by the Nurses Award at the same time, the FWC has indicated that it will seek to address historical gender-based undervaluation of nursing and midwifery work.

The FWC concluded that the federal award system had failed to set minimum award rates of pay which properly recognised the addition to work value affected by the transformation of nursing into a profession and proposed a benchmark to be considered in the second application.

These successful outcomes are very much due to the hard work of ANMF members but have also now become more achievable because of the recent series of changes to the Fair Work Act. The most recent amendment, part 2 of the Closing the Loopholes Bill, officially titled *Fair Work Legislation Amendment (Closing Loopholes No. 2) Bill 2023*, passed through Parliament in February.

This amendment equips the Fair Work Commission (FWC) with tools to champion gender equality and job security. Notably, it empowers the Commission to issue equal remuneration orders, either independently or upon application, to rectify pay disparities for work of equal or comparable value.

In addition to the work value cases, a targeted review of Modern Awards, which is also before the Commission, will see further developments in guaranteeing job security and gender equity.

The implications of this review will be significant for many ANMF members, as it seeks to mandate the elimination of gender-based undervaluation of work and the provision of workplace conditions facilitating women's full economic participation.

This requirement will include provisions ensuring parity between part-time and full-time work, creating a better balance between work and caring responsibilities.

The ANMF, alongside the ACTU and other unions, has been pivotal in the changes made to the Fair Work Act.

The results of these endeavours join a long list of accomplishments made by the ANMF over the decades.

This year we mark the 100 year anniversary of the Australian Nursing & Midwifery Federation. We plan to hold celebrations and reflect on ANMF's achievements in the *ANMJ*, *ANMJ* online and events.

As we celebrate 100 years since the formation of the ANMF, we reflect on the remarkable strides made for nurses, midwives, and carers by the union, contributing significantly to the improvement of Australia's healthcare system.

Without question, the commendable work of our predecessors over the past decades has underpinned the work the ANMF is achieving today.

It's clear we remain at the forefront, advocating for professional conditions that benefit those who play a crucial role in the healthcare of all Australians.

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Transfer your ANMF membership

If you are a financial member of the ANMF, QNMU or NSWMA, 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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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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Wage case recognises historic undervalued work of aged care nurses

The Australian Nursing and Midwifery Federation (ANMF) has welcomed the Fair Work Commission's (FWC) further recognition that the work of aged care workers has been historically undervalued in its Stage 3 decision for the aged care industry work value case.

The FWC concluded that for 'work value reasons', award rates for direct care employees should be increased substantially beyond the 15% increase determined in Stage 1.

Some ANMF members were set to receive up to 28% increases on award rates (inclusive of the interim increase, ANMF Federal Secretary Annie Butler said.

"We are pleased that the FWC recognised that the 'federal award system has failed to set minimum award rates of pay which properly recognise the addition to work value affected by the transformation of nursing into a profession'."

The FWC proposed a benchmark to address this historical, gender-based undervaluation. ANMF members, union officials and academic experts gave evidence that the work performed in aged care had changed dramatically over the last two decades. The evidence that the work has become more complex due to the higher needs and greater acuity of aged care residents and people receiving care at home was accepted.

The FWC deferred further pay rises for registered and enrolled nurses in the aged care sector for consideration in a separate application made by the ANMF for all



Annie Butler, ANMF Federal Secretary

employees covered by the Nurses Award. The ANMF would progress its second application to achieve the best outcomes for its members across the nursing workforce, Ms Butler said.

University review backs paid clinical placements for nursing and midwifery students

The federal government should provide financial support to nursing and midwifery students undertaking mandatory clinical placements as part of their courses, the Universities Accord final report has recommended.

After receiving "strong feedback" from students about the burdens imposed by unpaid work placements, which include having to forego paid work to complete unpaid placements, and relocating away from home, the report called on the federal government to fund paid placements in key industries including nursing, care, and teaching, to ensure 'placement poverty' doesn't discourage tertiary participation and prevent successful course completion.

"Providing financial support for placements is essential to ensure that enough students can meet their placement requirements without falling into poverty and there are enough skilled graduates for future jobs," the report said.

"The Review is recommending that industry and employers make reasonable contributions to the costs of providing placements as they benefit from the pipeline of qualified people to fill jobs, and that the Government provide financial support for students undertaking placements in key industries including nursing, care and teaching."

At the ANMF's 16th Biennial National Conference in October last year, delegates from across the country passed a motion



calling on the ANMF (Federal Office) to lobby both federal and state governments to support the future nursing and midwifery workforce by securing funding for mandatory clinical placements integral to their courses.

In its 2024-25 pre-budget submission, the ANMF called on the federal government to fund placements for nursing and midwifery students undertaking clinical placements as part of their courses, fund meals, travel, and accommodation allowances for students of nursing and midwifery while on clinical placement, and fund clinical facilitator positions in public hospitals to assist in increasing the number and quality of clinical placements.

NMHPA announces first health competition winners

Nurse Midwife Health Program Australia has announced the winners of its first ever competition, advertised in the last *ANMJ* (Jan-Mar 2024), asking nurses, midwives and students of the professions for their best health tip for 2024.

“We were excited to see so many entries from nurses, midwives and students offering their health tips, ranging from those on personal self-care including nutrition, sleep and shiftwork to suggestions on how to manage the emotional toll and pressures of the job,” said NMHPA Deputy Implementation Director Mark Aitken.

The three lucky winners received a \$150 gift voucher:

Annie, student nurse:
Chronic health – ask for help

Srijana, nurse:
Leave work at the end of a shift

Frankie, midwife: Take a breath

You can visit the winning health tips at nursemidwifehpa.org.au

Government to pay superannuation on paid parental leave

In a landmark win for unions, the Albanese Government has committed to paying 12% superannuation on Commonwealth Paid Parental Leave from 1 July 2025.

The reform, set to be costed in the May Budget, will benefit about 180,000 families annually and, according to the government, boost retirement incomes.

The ANMF welcomed the much-needed super boost, saying it will greatly benefit nurses, midwives and assistants in nursing (AINs) who have suffered inequity through loss of super while taking time out of the workforce to have children.

“For over a decade, the ANMF has fought long and hard for PPL, better super and other

entitlements to help achieve gender equity in the workforce, which is why we applaud the government for taking this important policy decision,” ANMF Federal Assistant Secretary Lori-Anne Sharp said.

“Women comprise 89% of the Australian nursing and midwifery workforce, who, on average can retire with up to 40% less super than men – and that must change if working women have any chance of reaching a secure retirement with a comfortable standard of living.”



ACTU Assistant Secretary, Joseph Mitchell, flanked by union members, including ANMF (ACT Branch) member Anjana, left, celebrating the historic announcement at Parliament House in Canberra.

The ACTU said the change would rectify longstanding inequity that costs women thousands of dollars in retirement savings, contributing to the stark gendered retirement gap.

“So many women retire with far too little, and this is going to

make an enormous difference for hundreds of thousands of women and families every year, who will no longer miss out on vital contributions to their nest egg while they are taking parental leave,” ACTU Assistant Secretary Joseph Mitchell said.



Lori-Anne Sharp
Federal Assistant Secretary

Know your superannuation entitlements – Positive reform on the horizon

Members may be aware that one of the many roles of the ANMF includes advocating and lobbying for improvements to superannuation benefits for their members. After all, following a working life in the caring profession a dignified and comfortable retirement is well deserved.

The superannuation guarantee (SG) is governed by law and is the percentage employers must pay on your earnings to your nominated super fund. Currently this percentage is 11%, due to increase to 11.5% on 1 July 2024 and 12% on 1 July 2025. It is also worth noting that same day super will be introduced at this time on 1 July 2025. Effectively this means your employer will be required to pay your SG to your nominated super fund the day you get paid rather than monthly or quarterly which is common practice currently. This means your super savings can be working for you immediately. Any additional existing improvements on the legislated amount or other conditions are usually covered in various public or private sector enterprise bargaining agreements (EBAs).

In March this year the Federal Government announced that they will pay the superannuation guarantee (SG) on the commonwealth Paid Parental Leave (PPL) from 1 July 2025. Currently at 18 weeks however scheduled to increase to 26 weeks by 2026. ANMF members covered under a public sector EBA may already have access to this entitlement under their various workplace agreements, but it is not universal and many members working in the private sector can miss out.

This is very welcome news, especially given that women on average can retire with up to 40% less superannuation than men. We know the gender pay gap, time out of the workforce attending to caring responsibilities and other existing structural inequities that contribute to women retiring with less super savings than men. This significant policy reform will play a part in correcting that imbalance.

ANMF members via their activism and dedication to improving retirement outcomes for women must be recognised and congratulated for this win and other improvements that have been made to superannuation in recent years. I fondly recall taking many ANMF members to Federal Parliament to lobby on improvements to superannuation for women over the years. I will always remember on one occasion

late last year when an ACT ANMF member, who was 36 weeks pregnant with their fourth child accompanied us to Parliament to walk the long halls convincing politicians why it was important that SG is paid on PPL. Unfortunately, this member will not benefit directly from the recent reform announcement yet has helped shaped positive policy reform for future generations to benefit from. The essence of what being a unionist is all about.

Other improvements to superannuation ANMF members have fought for and won, include securing the legislated pathway to 12% SG by 1 July 2025 and the successful removal of the \$450 cap which saw workers who worked across multiple sites that earned less than \$450 having no requirement for a superannuation payment. This disproportionately affected women and those working in the aged care sector.

Whilst there is more work to be done in improving women's retirement savings, it is important to recognise the great work of ANMF members in significantly influencing superannuation policy and driving change. By standing up, educating colleagues in their workplace, organising, and sharing individual stories with politicians in power, positive reform was achieved. This takes commitment, strength and courage, and future generations will benefit from their tireless work.

I wish to pay tribute to the late Senator Linda White, and previous National Assistant Secretary of the Australian Services Union (ASU) for 25 years who sadly passed away recently. Through her time at the ASU and in Parliament, Linda was a tireless advocate for meaningful reform to make super fair for working women. The ANMF and its members worked often in partnership with the ASU and SDA, both female dominated unions to improve superannuation outcomes for women in retirement. Linda was a great friend and ally to the ANMF and had many talents, rising and developing future activists was high among them, may her legacy live on.

Vale Linda White.



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PLACEMENT POVERTY

ANMF calls for paid clinical placements for nursing and midwifery students

A growing number of undergraduate nursing and midwifery students nationwide are voicing concerns about the financial and social challenges triggered by hundreds of hours of mandatory unpaid clinical placements. **ROBERT FEDELE** investigates.

Griffith University midwifery
student Erin Pereira
Image by Jamila Toderas





Midwifery student Erin Pereira. Photo: Jamila Toderas

Erin Pereira, a former banker turned aspiring midwife, found inspiration in the remarkable work of midwives during the birth of her first child.

Now in her final year of a Bachelor of Midwifery at Griffith University in Brisbane, she faces the financial challenges shared by many nursing and midwifery students across Australia due to mandatory unpaid clinical placements.

Undergraduate students are typically required to complete a minimum of 800 hours of unpaid clinical placements, and for those pursuing double degrees, it increases to over 1,500 hours.

This year, Erin will clock up 400 clinical placement hours. Unlike many students who complete placements at numerous clinical settings, often at short notice, her posts remain fixed at the Toowoomba Hospital's maternity unit, where she gains hands-on experience two to three days per week throughout the year. Additionally, Griffith midwifery students, including Erin, must undertake Continuity of Care Experiences (CoCEs), shadowing women during pregnancy, birth, and six weeks postpartum.

Living in Gatton, a rural town, it takes Erin about 40-minutes to drive to the Toowoomba Hospital. She estimates it has cost her about \$9,000 each year to complete clinical placement hours. These costs include fuel, parking, uniforms, clinical tools, and food expenses. With two young children, childcare

expenses amounting to \$15,000 annually significantly contribute to her out-of-pocket costs.

To manage financially, Erin continues working part-time in banking. She acknowledges the crucial support of her partner, a truck driver, without which, she says, completing the degree would be nearly impossible.

"The attrition rate in midwifery is quite bad. A lot of students drop out, and I know a lot of it is due to the fact that it's such an expensive degree to get through, with huge placement hours," says Erin.

Erin believes nursing and midwifery students should be paid for clinical placements, suggesting that it would alleviate financial pressures, making it easier for them to complete their degrees and enter the workforce.

"Griffith sets us up so well in terms of our skills, but what we're providing to the hospital is, essentially, just unpaid labour," she says.

POVERTY ON PLACEMENT

The financial and social impacts of lengthy, mandatory, unpaid clinical placements for undergraduate nursing and midwifery students are increasingly evident.

A 2021 study, titled *The financial challenges for Australian nursing students attending placement-based work-integrated learning*, surveyed 2,359 nursing students from nine universities.

"Providing financial support for placements is essential to ensure that enough students can meet their placement requirements without falling into poverty and [that] there are enough skilled graduates for future jobs."

AUSTRALIAN UNIVERSITIES ACCORD
FINAL REPORT

The study revealed that 79% of participants faced financial hardship due to unpaid clinical placements, with 65% unable to work during placements. Common barriers included travel costs, lack of affordable accommodation, childcare expenses, and lost wages.

'I had to drive 400km round trip most days, as it cost too much for accommodation', said one student.

Participants employed various strategies to cut costs, such as choosing placement locations with low or no-cost parking, or where they could stay with family/friends. Students often parked "far away from the hospital so that I would not have to pay parking, this was typically a 20-minute walk and very risky at night".

The study also highlighted students' perceived lack of university support, particularly in finding accommodation. Researchers noted that some international jurisdictions provide nonrepayable bursaries or scholarships to assist students financially.

A more recent "Poverty on Placement" survey conducted by Griffith University's Student Representative Council (SRC) and Postgraduate Student Association (GUPSA) uncovered similar findings.

Despite recognising the benefits of clinical placements, 95% reported a major drawback: a significant impact on financial wellbeing. Almost all respondents (97%) experienced a loss of regular income during unpaid placements, and nearly half reported complete loss of income, impacting their ability to pay rent and bills. Expenses, including fuel, parking, tolls, and

childcare, increased for 80% of students during placements. Other barriers reported included lack of placement flexibility, inadequate university support, and inconsistent placement quality.

Close to one-third of respondents had to relocate for placements, which, for one student, involved paying \$2,000 in accommodation alone.

“I know people living out of cars or in tents because they cannot afford rent. Then we’re being told to finish our degree, we need to complete 1,000 hours of placement, approximately six months of unpaid work”, one respondent said.

Meanwhile, 93% of respondents reported that unpaid placements were detrimental to their stress levels, with 81% saying it affected their mental health, 76% sleep, and 66% general health and wellbeing.

Tellingly, over 99% of students supported paid placements and/or financial support

to address poverty, wellbeing, and attrition rates. Calling for urgent reform, the report, led by Dorinda Harvey-Bravo, urged universities and governments to significantly increase their support for students required to undertake placements.

La Trobe University’s Student Union (LTSU) released a study last year, *Student Placement Poverty*, reflecting similar challenges.

Key findings indicated that 52% of students struggled to pay for rent, food, bills and medicines during placement, while 16% faced accommodation issues. Nearly a third of students said they weren’t given enough notice regarding their clinical placement location and roster, with 10% handed less than a week to make arrangements.

La Trobe’s students also called for fully-funded placements, like other jobs, a

minimum of eight weeks’ notice for placements, and not being required to travel more than one hour from their homes to complete placement. They also recommended improved communication and support, including an orientation pack with key information to enhance students’ preparedness.

“Even though this [midwifery] is a job that I love and want to do for the rest of my life, the training was absolutely unbearable while trying to stay afloat financially.”

**NURSING/MIDWIFERY STUDENT
CATHERINE SHEARWOOD**

CALLS FOR GOVERNMENT ACTION

Professor Karen Strickland, Executive Dean of Nursing and Midwifery at Edith Cowan University in Western Australia and Chair of the Council of Deans of Nursing and Midwifery (Australia & New Zealand) says universities have been engaging with both state and federal governments to address these pressing issues faced by students.

In its submission to the Australian Universities Accord, a government funded review aimed at driving lasting reform in the higher education system, CDNM outlined its vision for the future of placement arrangements and work-integrated learning (WIL).

The council highlighted the prevalent issue of ‘placement poverty’ experienced by a significant number of nursing and midwifery students while on WIL, particularly when the placement is situated away from their homes.

“Students then not only cannot earn but have the added expenses of travel, accommodation, and subsistence while simultaneously maintaining their home expenses. There are few scholarships available to support non-medical students,” CDNM explained.

CDNM’s recommendations included the introduction of WIL bursaries/scholarships for nursing and midwifery students, such as Austudy while on placement, with additional support for those undertaking WIL in rural/remote locations and for rural students undertaking a metropolitan placement.

Professor Strickland cites similar successful overseas models, such as those in Scotland, where students receive about \$20,000 annually, non-means tested, and additional support for placement-related costs. She expressed

confidence in the government’s commitment to addressing the issue, evidenced by its inclusion in the Australian Universities Accord Final Report, released last month. Included among 47 recommendations for change, the Final Report calls on the Australian Government to work with higher education providers and employers to introduce payment for unpaid placements, including government financial support in the areas of nursing, care, and teaching, to ensure ‘placement poverty’ does not deter tertiary participation and completion.

“Providing financial support for placements is essential to ensure that enough students can meet their placement requirements without falling into poverty and there are enough skilled graduates for future jobs,” the review said.

Professor Strickland stresses CDNM is advocating for a bursary/stipend to support students, as opposed to ‘paid clinical placements’, to protect students’ status as learners and prevent them from being perceived as mere employees or apprentices, and treated as just another “pair of hands”.

“We want to preserve students’ right to learn while they’re on placement and not be seen as part of the workforce, so that they are there to learn and work with the registered nurse.”

Further, Professor Strickland says CDNM is not solely focused on financial barriers but is actively addressing challenges related to preceptorship for students. This includes tackling issues like inconsistent quality and many students feeling like a burden on time-strapped clinicians. CDNM plans to launch a national preceptorship course this year to enhance the understanding and benefits of preceptorship.



ANMF RALLIES FOR CHANGE

At the ANMF’s 16th Biennial National Conference in October, delegates from across the country passed a motion calling on the ANMF (Federal Office) to lobby both federal and state governments to support the future nursing and midwifery workforce by securing funding for mandatory clinical placements integral to their courses.

The ANMF’s Strategic Lead Workforce & Federal Professional Officer, Jane Douglas, says students face escalating challenges due to the current clinical placement system.

“One of the biggest issues is that students are dropping out because they can’t afford to finish their clinical placements,” she says.

“Many can’t get to clinical placements. They’re told they’re going to a certain place the week before, which might be hours away. So, they have to try and find accommodation at short notice.

In December, the ANMF made a submission to the Australian Government’s National Nursing Workforce Strategy, emphasising the pivotal role of clinical placement reform in addressing recruitment and retention challenges. The submission highlighted various issues, including gaps in collaboration between education providers and healthcare settings, limited on-site support, inflexible rostering, and the absence of a consistent educational program for aspiring clinical facilitators.

“Significant work is required to help the clinical placement experience function and ensure students have access to fiscally supported learning so they can afford to attend,” the ANMF argued.

Ms Douglas says securing federal government funding for nursing and midwifery students undertaking mandatory clinical placements remains crucial. By alleviating financial burdens, more students will persist and successfully complete their courses.



ANMF (Vic Branch) Secretary Lisa Fitzpatrick speaking up for paid clinical placements at the 16th Biennial National Conference last October. Photo: Sharon Hickey

WHERE IS THE JUSTICE FOR STUDENTS?

La Trobe University graduate Catherine Shearwood recently completed her ‘demanding’ four-year Bachelor of Nursing/ Midwifery degree, encompassing more than 1,800 hours of mandatory unpaid clinical placements.

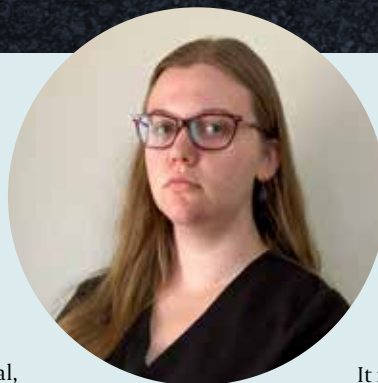
The 22-year-old, who has secured a graduate midwife position at a major Melbourne hospital, starting in May, admits that had she been aware of the challenges and sacrifices related to the course, she might have reconsidered enrolling.

Financial struggles were a constant companion throughout her degree, forcing her to make tough choices, such as deciding between buying lunch or reloading her Myki card. Car parking fees presented a major hurdle, forcing her to resort to parking at train stations and unsafe locations, due to the fact she “simply couldn’t afford it”.

To get by, Catherine worked at Woolies for half her degree. In her third year, she took on a role as a Registered Undergraduate Student of Midwifery (RUSOM).

“Even though this [midwifery] is a job that I love and want to do for the rest of my life, the training was absolutely unbearable while trying to stay afloat financially,” she reveals.

Looking back, Catherine feels grateful that as her finances dwindled, her parents stepped in to cover her grocery bills and



essential medications. Midway through her degree, she also sold her car to cut down on fuel and on-road costs.

As a midwifery student, Catherine also had to follow 10 pregnancies from start to finish, on top of 1,800 hours of placements and university classes/study, meaning for four years straight, she was unable to achieve a healthy work/life balance.

It meant missing out on socialising with friends and family due to the relentless demands of the degree, exacerbated by what she considers a lack of practical support from the university and clinical placement providers.

“When I wasn’t at placement, work or uni, I was going to appointments and using what should’ve been my holidays and personal time to attend appointments and births,” she says.

“During one placement, I spent a total of 18 hours across two days at two different hospitals attending births on my days off, meaning I did 7-8 days in a row, all completely unpaid.”

Despite her struggles, Catherine expresses optimism about the ANMF’s national push for paid clinical placements. She hopes that reforms to the system will make it more viable for the next generation of nurses and midwives.

“If they want to entice new nurses and midwives into the professions, they need to make the training worthwhile.”

International Day of the Midwife and International Nurses Day

Every year, the International Council of Nurses (ICN) and the International Confederation of Midwives (ICM), respectively, lead global celebrations for International Day of the Midwife (5 May) and International Nurses Day (12 May).

The 2024 International Nurses Day theme is:
Our Nurses. Our Future. The Economic Power of Care.
The theme for International Midwives Day is:
Midwives: A vital climate solution.

To celebrate the days, *ANMJ* journalists **NATALIE DRAGON** and **ROBERT FEDELE** explore how nurse-led and midwifery-led models add economic value to the health of our nation.

Nurse-led vascular access team

A unique Queensland first, nurse-led vascular access team is reducing catheter-associated complications and improving the patient experience.

Sunshine Coast Hospital and Health Service's vascular access surveillance and education (VASE) service sees specially trained nurses insert peripherally inserted central catheters (PICCs) guided by ultrasound.

"Years ago, this was traditionally a procedure that was done by medical officers. Now, nurses do it. This model is very cost-effective, mobile, more efficient, means the patient doesn't have to be exposed to radiation, and can be used immediately," said Leanne Ruegg, VASE Clinical Nurse Consultant.

The service started in 2009 with bedside insertion (confirmed by chest x-ray) and expanded to use the ECG method in February 2016, negating the need for a chest x-ray. PICCs are confirmed using a sensor that tracks a magnetic tip relative to the heart and placed at the Cavo-atrial junction.

"We were the first nurse-led team in Queensland to utilise and clear using this technology. The beauty of it is we get a referral, we go to the bedside, and we insert it in the patient's room," said Ms Ruegg.

"For instance, you might have a patient who is not recovering well from abdominal surgery, and they've been prescribed TPN, and they need a central catheter. Beforehand, we would go and insert the catheter, and then they would need to wait for a chest x-ray and then a medical officer to review the chest x-ray. Whereas with this model of care, we go in and 98% of the time we can clear it at the bedside. Using the model, you can now get a PICC line inserted at 3pm, cleared by 4pm, and TPN can be up within an hour."

The insertion of a PICC means patient care can be continued in a non-inpatient setting, such as Hospital in the Home and outpatient clinics, which helps improve bed utilisation and patient flow.

"When we get a referral for a PICC, we do a patient assessment to ensure that they're getting the right device at the right time. Or we might recommend another form of vascular access device that might be more appropriate for that patient, so we do a full assessment. It's all about the patient."

The nurse-led team does surveillance of invasive devices and yearly reviews of all central venous catheters. "We are the clinical expert when it comes to the care and maintenance of these devices as well as the dressings, and the bungs that we use etc. We act as a consultation service for the wards if there are any issues like excessive bleeding or concerns if lumens block," said Ms Ruegg.

A retrospective analysis of 661 PICC insertions study, found the VASE nurse-led service demonstrated minimal infection and thrombus complications. "We reported lower rates of catheter-related bloodstream infections and catheter-related deep venous thrombosis than other previously published studies, and I'm really proud of that," said Ms Ruegg.

The low complication rate has been attributed to the highly experienced nurses in the team, the use of a standardised insertion bundle, and the tip navigation/confirmation system.

"The results are reassuring and a clear indication of the benefits of nurses working to top of scope," said Ms Ruegg.

She said the concept of a nurse-led service clearing PICC lines requires a cultural change.

"Stakeholder consultation and getting the backing from the radiology team was vital for us to get it off the ground, and obviously, it takes a big load off them not having to do elective PICC insertions. The support from clinical and senior medical staff played a significant role in our success."

Despite some advanced teams in Australia, the vascular access specialty is still an emerging nurse specialty compared with Europe, with extensive nurse-led models beyond PICC line insertion. Ms Ruegg is travelling to the UK in June to visit two NHS Trusts with successful models of care for brachial port insertion being used in women with breast cancer.

"I'm always exploring and forever trying to improve how we do things because research, evidence and practice evolves all the time."

For more information, visit:

Clinical Excellence Queensland Improvement Exchange:
clinicalexcellence.qld.gov.au/improvement-exchange

Reference

Ruegg et al. Peripherally inserted central catheter-associated complications: a retrospective review of a nurse-led peripherally inserted central catheter-insertion service. *Vascular Access* 2020; 6(1):16-19. DOI doi.org/10.33235/va.6.1.16-19







Improving maternity care for First Nations women through midwife-led models

Sydney's Westmead Hospital initiated Midwifery Group Practice (MGP)/caseload care, a decade ago, providing pregnant women with continuity of midwifery care.

This gold-standard maternity care involves a team of midwives ensuring consistent care throughout pregnancy, birth, and the postnatal period. The demand for this model has grown, highlighting its effectiveness and satisfaction for both midwives and women.

"We started with six midwives, and the demand from women [to access the model], and also midwives [to work in the model], has continued to increase," says Midwifery Unit Manager Carolyn Hilsabeck, who oversees the hospital's range of midwifery-led models of care, which also include a Maternity Antenatal Postnatal Service (MAPS), and home birth.

As midwife-led models of care have expanded at Westmead, so has the recognition that certain groups could benefit more than others from targeted care. With improving maternity care for First Nations women and babies linked to Closing the Gap, Carolyn says the midwifery unit, supported by the Western Sydney Local Health District, established Dragonfly Midwifery, providing MGP/continuity of care for Aboriginal and Torres Strait Islander women and babies.

The model, which began running in late 2021, includes direct access to a known midwife, pregnancy check-ups, support through labour and birth, and care for up to six weeks postnatally.

Currently, four midwives, including two Indigenous midwives, lead the program, which supports about 80 births annually, with midwives allocated around 25-30 women per year, ensuring that their often complex medical and social needs can be met.

Carolyn says women aren't automatically allocated into Dragonfly and can choose to access the model of care if they believe it might suit their needs. She reveals that many women are cautious at the beginning but quickly become comfortable once they get to know and trust midwives.

Broad evidence shows that continuity of midwifery care leads to better outcomes for women and babies. For example, a 2016 Cochrane systemic review of research into midwife-led continuity models versus others for childbearing women, found women who received midwife-led continuity models of care were less likely to experience intervention, experienced fewer preterm births and neonatal deaths, and were more likely to be satisfied with their care.

Westmead's ongoing evaluation of Dragonfly echoes the findings, including a reduction in the preterm birth rate and low birth rate since the program was established. Women have also reported feeling more culturally safe being cared for by a known midwife they can trust.

Indigenous midwife Ngaire Denton, who has worked in Aboriginal health throughout her nursing/midwifery career, joined the close-knit Dragonfly team for two years.

"My biggest driving force [for coming on board] was if you look at the Closing the Gap targets in terms of changing health outcomes for Aboriginal people if you are going to be serious about making a difference, then it needs to start from preconception and pregnancy care," says Ngaire.

While it isn't a requirement to be Indigenous to work in the Dragonfly program, Ngaire suggests that it adds an extra layer of trust to the relationship.

"Anything that's Indigenous-led is going to be more successful because we understand the issues first-hand. It's really quite empowering for the women as well."

While Dragonfly is still working towards creating a bigger presence within the community, and among midwives, Ngaire believes it is making a practical, frontline difference.

"My motivations come from a place of just wanting to see better for my people, and I really believe that starts from preconception and pregnancy care," she says.

As Dragonfly spreads its wings, Carolyn says it continues improving and adding services. For example, a relationship has been established with a local radiology service that bulk-bills pregnant women. Tapping into the hospital's fundraising arms, the program can also help women financially by supporting them in purchasing prenatal vitamins, for example, or food.

Having worked at Westmead as a midwife for over three decades, Carolyn has seen the growth and acceptance of midwife-led models of care, such as MGP, across the profession. However, there's still a long way to go to ensure all women have access to such models.

"You have to have the support of the executive," she says.

"Our Deputy Director of Nursing is on board and willing to take risks and expand the model. What I see from other services who often ring me and ask me for advice is that unless you've got someone who understands continuity of care and the benefits of it, it's not going to get anywhere."



Midwife Ngaire Denton at Westmead Hospital.



James Lloyd

ANMF Federal Vice
President

The economic power of nursing care

On 12 May we will celebrate International Nurses Day 2024, themed: *Our Nurses. Our Future. The Economic Power of Care.* This will highlight the multifaceted impact of nursing on economies, emphasising the undeniable economic value generated by the compassionate care nurses provide worldwide.

The economics of care and compassion are how much our profession contributes to the overall economic health of our nation. However, this is not well-recognised in our profession or the wider community.

This year's theme aims to reshape the perception and understanding of nursing as not only a profession that provides quality care, compassion and advocacy but also a driver of economic and social development. Nursing is often undervalued and underfunded despite being the backbone of the healthcare system.

Traditionally, economic discussions in healthcare have centred around costs, expenditures, and budgets. However, the International Nurses Day 2024 theme challenges this perspective by shifting the focus to the economic value generated by the care nurses deliver.

The economic power of care encompasses the direct and indirect contributions of nursing to the overall health of populations and the financial wellbeing of nations.

As the backbone of healthcare systems worldwide, nurses contribute significantly to disease prevention, health promotion, and education. By preventing and managing chronic disease, promoting healthy behaviours, ensuring timely healthcare interventions, and being the leaders of multi-disciplinary teams, nurses play a significant role in reducing health costs and increasing the efficiency of the healthcare dollar.

A healthy population is a productive one, and nurses are at the forefront of creating and maintaining the health of a society. As caregivers and health educators, we empower individuals and communities to adopt healthy lifestyles, which ultimately reduce the economic burden of preventable chronic health conditions and diseases.

Additionally, the economic power of care ultimately influences workforce productivity, helps reduce absenteeism, and further fosters a more robust and resilient labour market. The economic investment in nurses and the care we provide leads to enhanced social and economic wellbeing.

The economic power of care is also evident in the innovative and efficient healthcare delivery models championed by nurses. With advancements in technology and a focus on patient-centred care, nurses contribute to streamlining healthcare processes, reducing unnecessary hospitalisations, and improving the overall efficiency of healthcare systems.

As advocates for patients' rights and quality care, nurses influence healthcare policies and practices. Our active participation in shaping healthcare policies ensures that resources are allocated efficiently, promoting a sustainable and economically viable healthcare system. The economic power of care, as exemplified by the nursing workforce, goes beyond individual patient care to influencing systemic changes that benefit all of society.

Nurse practitioners are an example of how the nursing profession can provide cost-effective care. They often work in primary care settings to provide comprehensive and holistic patient care. NPs can help expand access to healthcare services, especially in underserved or rural areas where there is sometimes a shortage of primary care providers. By providing timely and efficient care, NPs can help reduce unnecessary emergency department visits and hospitalisations, which can be costly to the healthcare system. NPs provide high-quality, comprehensive care in an economical manner, leading to improved access to care and better health outcomes. This is not to say that GPs do not have a vital place in a primary healthcare system; however, NPs need to be recognised that they can take on the burden of primary healthcare and lessen the burden of GPs whilst still working in a multi-disciplinary system.

Nursing is not often recognised as one of the largest segments of the healthcare workforce in our country. Through our salaries earned and spent, we contribute to national economic stability. The collective wages of nurses represent a significant portion of overall healthcare expenditure and contribute to the economic activity of the healthcare sector. We, therefore, contribute to consumer spending, supporting local economies through the expenditure on goods and services.

In summary, the economic power of nurses is significant and continues to grow as the demand for healthcare services increases. Our contributions to healthcare delivery, advocacy efforts, career mobility, and entrepreneurial ventures all add economic influence and highlight the importance of recognising and valuing the work of nurses in society. Nursing has the potential to generate even greater economic value and growth if it is adequately invested in and respected for its rights, roles, and responsibilities.



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References

1. Australian Universities Accord Panel. Australian Universities Accord Final Report. Australian Government. 2023. Available online: education.gov.au/australian-universities-accord/resources/final-report
2. Grant-Smith D, de Zwaan L. Don't spend, eat less, save more: Responses to the financial stress experienced by nursing students during unpaid clinical placements. *Nurse Educ Pract.* 2019;Feb;35:1-6.
3. Usher K, Fagan A, Brown JA, Mather C., et al. The financial challenges for Australian nursing students attending placement-based work-integrated learning. *Collegian.* 2022;29(2):354-60.
4. Graj E, Sheen J, Dudley A, Sutherland-Smith W. Adverse health events associated with clinical placement: A systematic review. *Nurse Educ Today.* 2019;May;76:178-90.
5. Koch J, Everett B, Philips J, Davidson PM. Is there a relationship between the diversity characteristics of nursing students and their clinical placement experiences? A literature review. *Collegian.* 2015;22(3):307-18.

Paid university clinical placements are essential

Implementing paid clinical placements for nursing and midwifery students is a moral imperative as well as strategically essential for a resilient healthcare future.

Australia's healthcare system relies heavily on a strong and skilled nursing and midwifery workforce. With an ageing population and increasing and more complex healthcare demands, maintaining a reliable stream of well-trained graduates is critical. However, major hurdles exist.

One challenge is the lack of financial support for students during their mandatory clinical placements. 'Placement poverty' is a genuine disincentive for many students and can be challenging for even the most committed. The ANMF has committed to addressing this pressing issue and promisingly, the recently published Australian Universities Accord Final Report recommends that Government work with education providers and employers to provide payment for unpaid placements, including government financial support for placements in the areas of nursing, care, and teaching.¹

The NMBA stipulates at least 800 hours, however nursing and midwifery students can often spend around 1,280 hours of their degree completing mandatory clinical placements in hospitals, aged care facilities, and other healthcare settings. Placements are critical for bridging gaps between theoretical knowledge and practical skill application and give students valuable exposure to real work environments and teams.

Because these placements are currently unpaid, students must juggle financial burdens with the demands of their education. This creates several challenges. Financial pressures can force students to prioritise paid work over placements. This leads to less time spent learning and engaging with patients and can compromise the quality of their practical training.

Balancing studies with paid work to support themselves during unpaid placements can be incredibly stressful.²

Financial strains can lead to exhaustion that impacts academic performance, health and wellbeing, and potentially overall education outcomes and career choice.^{3,4}

Students from disadvantaged backgrounds can be discouraged from pursuing nursing and midwifery due to the financial limitations resulting in poor equitability of access. Poor diversity within the nursing workforce can negatively affect the quality of care provided to different communities.⁵

Providing financial support through paid clinical placements can address these challenges and offer many benefits. With financial worries alleviated, students can better focus solely on their studies and placements resulting in enhanced learning, improved academic performance, and higher graduation rates. By paying students, individuals from all backgrounds can pursue nursing and midwifery regardless of their socioeconomic status. This fosters a more diverse healthcare workforce equipped to meet the needs of a multicultural society. By removing the need to juggle multiple responsibilities, students can benefit from deeper engagement with their learning and improved clinical skills. Graduates are then better prepared to enter the workforce and provide quality patient care. Financial support can also make nursing and midwifery a more attractive career option. This will help attract and retain talent, alleviating the current and future nursing and midwifery shortages in Australia.

The benefits of paid placements extend beyond financial. By valuing and supporting students through financial remuneration, healthcare institutions demonstrate their commitment to fostering the next generation of new graduates. This fosters a sense of professionalism and belonging, motivating students to stay engaged and ultimately choose careers in nursing and midwifery.

Several pathways can be explored for implementing paid clinical placements. These could involve: government funding allocated to universities or healthcare institutions to provide high quality placements, partnerships between government, universities, and healthcare institutions to share the financial burden, and developing a system where students receive a percentage of the funding currently allocated to healthcare facilities for Teaching, Training and Research (TT&R) activities.

Investing in paid clinical placements for nursing and midwifery students should not be viewed as an expense but a strategic investment in Australia's future healthcare needs. This initiative has the potential to alleviate workforce shortages, promote a diverse and well-trained workforce, and ultimately, ensure the delivery of high-quality healthcare to all Australians. By recognising the value of nursing and midwifery students and providing them with the essential support they deserve, we can ensure a healthier and more resilient healthcare system for generations to come.

Teaching comprehensive health assessment of older people: The impact on nursing practice in residential aged care

By Sandra Cowen, Jo-Anne Rayner and Deirdre Fetherstonhaugh

In Australia, the proportion of older people living permanently in residential aged care services (RACS) has increased by 8.3% between 2012 and 2022.¹

Most residents are aged ≥ 85 years and have high care needs relating to cognition and behaviour (68%), assistance with activities of daily living (68%), and complex healthcare (58%).¹ Due to their frailty, these people are at risk of harm if high-quality care is not provided.²

Recently, this risk was highlighted by the Australian Royal Commission into Aged Care Quality and Safety (the Commission), which identified that up to a third of all older Australians living in RACS experienced poor-quality care.³ Recommendations from the Commission include the provision of high-quality residential aged care, delivered based on clinical assessment;^{3, p234} and that continuing education and training of the aged care workforce must be relevant to direct care.^{3, p287}

OVERVIEW OF THE ISSUE

Nurses are the largest clinical workforce of registered health professionals in Australia.⁴ As such, nurses need to be skilled and confident in assessing older people, who comprise the largest group of health and aged care recipients. However, nurses are not always taught how to undertake Comprehensive

Health Assessments (CHA) of an older person in their undergraduate education.⁵

PROJECT OUTLINE

To address this need, the Comprehensive Health Assessment of the Older Person (CHA) workshop was designed in 2011 to upskill nurses to be more confident and better informed about conducting full 'head-to-toe' assessments on older people (≥ 65 years). This three-day workshop consists of eight learning modules, namely: clinical reasoning; communication; musculoskeletal system; nutrition, metabolism and elimination; cardiovascular system; respiratory system; cognition and perception; and psychosocial assessment. Evaluations of this workshop have consistently found increased knowledge and confidence in the nurses immediately after the workshop. However, the long-term (up to two years) impact on care practice was unknown.

This study aimed to determine if nurses working in RACS who completed the CHA workshop report changes in their care practice from six months up to two years post-completion and what barriers there are to undertaking CHA in RACS.

METHODS

This study used a mixed methods descriptive design and involved two phases. Phase 1 was an online survey. All nurses ($n=366$) who had completed a CHA workshop between 2018 and 2019 and had given their contact details were sent an email with information about the study, a link to the online survey, and an invitation to participate in Phase 2 if eligible (working in a RACS).

Phase 2 involved semi-structured telephone interviews with a sub-sample of nurses working in a RACS. The interviews (which could be in addition to, or instead of, completing the online survey) explored self-reported levels of confidence after completing the CHA workshop and experiences using CHA in RACS. The interviews were audio recorded and transcribed. Interview data was thematically analysed.⁶

The findings presented a combined analysis of the survey and interview data from nurses working in RACS.



RESULTS

Seventy-one surveys were returned. After excluding ineligible (currently not working or not nurses) and incomplete surveys, 60 were analysed using descriptive statistics. Of the 60 surveys received, 24 were completed by nurses working in a RACS. Twenty-two were female; 14 were registered nurses (RNs), six were endorsed enrolled nurses (EENs), and four were enrolled nurses (ENs).

Thirteen nurses (10 RNs and three EENs) who worked in a RACS participated in an interview, 12 of whom were female.

INCREASED CONFIDENCE IN CONDUCTING A CHA ON AN OLDER PERSON

Survey responses indicated that most nurses working in a RACS (n=19, 79%) were confident, very confident or extremely confident about undertaking a CHA of an older person before the workshop. This increased to 100% immediately and up to two years after the workshop (Table 1). However, there was a decline in the number of nurses who reported feeling very or extremely confident in undertaking a CHA between the immediate and two-year post-workshop period.

Table 1: Confidence in undertaking CHA (n=24)

	Not at all	Confident	Very	Extremely
How confident were you about undertaking CHA before your workshop training?	21.8% (n=5)	70.8% (n=17)	4.2% (n=1)	4.2% (n=1)
How confident were you about undertaking CHA immediately after completing your workshop training?	-	16.7% (n=4)	70.8% (n=17)	12.5% (n=3)
How confident are you about undertaking CHA right now?	-	37.5% (n=9)	54.2% (n=13)	8.3% (n=2)

Interview participants also reported feeling more confident undertaking a CHA of an older person after the workshop. A contributing factor to this increased confidence may have been due to their reported lack of education on CHA of the older person during their formal education.

- Post-workshop, I would say I had far more confidence in my ability to understand and follow through with what I needed to do and the way I needed to do it. I'm far more confident about picking up

something and going ahead (EEN).

- I don't remember when I was doing my course anything really being specific for the older person (EEN).
- Not on an older person specifically. We did do assessments but not a comprehensive health assessment (EEN).

CHANGES TO CARE PRACTICE

Eighteen survey participants reported that the frequency at which they conducted a CHA had changed since the workshop, and



Sumina Shrestha undertaking a comprehensive health assessment of Charlie Wells, a resident living in residential aged care.

most (n=11, 61.1%) reported it had increased. Interview participants reported changes in their care practice when assessing the older person, including 'looking more deeply' during assessments and having a desire to 'put the pieces together'. A CHA was commonly undertaken as part of 'regular routine admission practice', if nurses 'noticed a health concern', or they are responding to a medical alert or a 'red flag'.

- I don't often do a head-to-toe. Occasionally, I'll help with an admission, but I'm usually assessing someone who has deteriorated (RN).
- You don't have to do all of it because that's not what you are targeting. You just go through that area where, you know, when someone has chest pain, for example, then I will be targeting there (RN).
- It's more specifically targeted when you see something. But just generalised going through doing assessments without a targeted reason – no, I probably don't have the time for that (EEN).

Both survey and interview responses indicated that nurses were more likely to undertake focused assessments rather than

a full head-to-toe (CHA) assessment in RACS. 'Knowing the resident' meant they could recognise when there was a deterioration in a resident's usual or 'normal' state of health.

- I might target (like especially the resident of the day), I might go in and find out some more information – do an assessment – it's usually only one system – it's usually not the whole thing (RN).
- It's if the person, not necessarily deteriorates but it's just different from their norm. It's knowing your residents and knowing what their norm is (RN).

THE IMPACT OF UNDERTAKING A CHA ON AN OLDER PERSON

Despite reporting that they commonly undertook focused assessments rather than a CHA, both survey and interview participants reported that they often detected changes in the health status of the older people they assessed because of undertaking a CHA. This included the detection of deterioration, a new illness or being more alert to possible complications.

- Unusual bradycardia in a 91-year-old resident, which was caused by heart block (RN).

- Assessment discovered that an increase in falls for a resident was the direct result of a poorly managed foot wound (EEN).
- Breast cancer during an assessment of skin integrity (EEN).
- Resident's delirium was not advancing dementia but merely dehydration (EEN).
- In conducting a neurological assessment, it was discovered the resident had reduced movement that was due to previously undiagnosed osteoarthritis (EEN).
- I had a resident come back from a cancer operation on his leg, and when I was checking out the leg, I felt the heat in it, and I suggested that we needed to follow this through because I was concerned it was a clot and it turned out that there was (EEN).

Once changes were detected, participants reported they were able to refer the issue to other health professionals or manage it themselves.

- Contacted the nurse in charge. Spoke to resident and family if appropriate. Contacted doctor for further review (EEN).

- Bowel management reporting charts reviewed – found that diarrhoea reported by resident only and no staff observation. Staff were then instructed to view all bowel motions and charts using the Bristol Stool Chart (RN).
- Fluid intake recording commenced; alternative drinks offered. Delirium resolved (EEN).

BARRIERS TO UNDERTAKING CHA IN A RACS

Despite detecting changes in the health status of older people following a CHA, participants reported barriers to doing this in RACS. Both survey and interview participants reported barriers to conducting CHA with the most common being 'existing workload' and 'time'.

- Workloads do not always permit the time to conduct CHA (EEN).
- Time constraints on RNs often mean assessments may not be able to be completed in one shift, and the staff member may not work again for several days (RN).
- The workload for an RN is huge and does not allow adequate time to do CHA as frequently and as comprehensively as would be desirable. We don't have all the equipment we need, particularly vital signs equipment that is user-friendly. Having a more manageable workload would be better suited for doing CHA more regularly and thoroughly (RN).
- Time, time, time. Look, the ratios are starting to improve, but then you could be an RN with 80 residents and expect to cover the lot, and you just don't have time. I know that sounds awful, but if you were doing a full top-to-toe skeletal assessment, it's just not going to happen. You've still got everything else to do. You've still got pills to give out, you've still got other people to help, you've still got catheters to do (RN).

Some participants also reported the lack of adequate equipment as a barrier to undertaking a CHA of an older person.

- The aged care home I work in only really supports equipment for baseline observations (EN).
- We don't have all the equipment we need, particularly vital signs equipment that is user-friendly. We get the hospital's old and worn-out machines and equipment instead of new equipment (RN).
- Yeah, well, if it's working [laugh]. In my workplace, we don't get new equipment. We get the hospital's old equipment. Occasionally, you might get some new things. Stethoscopes, I've got my own. I try and bring my own things just to make sure I can do a proper assessment (RN).

OPPORTUNITIES TO ADDRESS NURSING PRACTICE

The findings indicate that the CHA of older people's education and training can positively impact nursing practice in RACS and the older people living there. Older people living in RACS have complex care needs that require an informed, skilled, and fully resourced-

workforce. Nurses working in RACS who complete the three-day CHA workshop have increased confidence to undertake CHA and a willingness to look more closely when assessing older peoples' health conditions. They are also more likely to detect changes in health status in older people and refer these to other healthcare professionals. However, nurses working in RACS are time-poor due to heavy workloads and lack the resources to incorporate a full CHA as part of routine care practice.

Consideration should be given to the inclusion of routine CHA of older people in RACS policy and procedures. Additionally, nurses working in RACS should be supported through professional development to undertake further education, such as the CHA workshop, and by time allowances and organisational resources to undertake CHA of older people as part of routine practice.

CONCLUSION

In line with the broader literature on continual professional development outcomes for nurses working in RACS,^{7,9} nurses participating in this study reported having increased confidence after completing the CHA workshop and making changes to their care practice when assessing older people. Additionally, the finding that nurses are more willing to 'delve deeper' when assessing older people after completing the CHA workshop indicates they were willing to change their care practice when they have increased knowledge and skills. Nurses undertaking CHA detect changes in the health status of older people in their care that can be referred to other health professionals. However, nurses are still more likely to undertake focused assessments as part of routine practice, which they report is due to the barriers of insufficient time, increased workload, and the lack of working equipment.

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References

1. Australian Institute of Health & Welfare. *GEN Aged Care Data. Fact sheet 2021. People-using-aged-care-fact-sheet_2022.pdf*. Available from: (gen-agedcaredata.gov.au)
2. Hillen JB, Vitry A, & Caughey GE. Disease burden, comorbidity, and geriatric syndromes in the Australian aged care population. *Aust J Ageing*. 2017 Jun; 36: E14-19. doi: 10.1111/ajag.12411
3. Pagone G, Briggs L. Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. Canberra: Royal Commission into Aged Care Quality and Safety. 2021 Mar 1. Available from: agedcare.royalcommission.gov.au/publications/final-report
4. Australian Government. Department of Health and Aged Care. Summary Statistics, Nursing and Midwifery Professions. 2023 Jun 13. Available from: Summary Statistics, Nursing and Midwifery Professions (health.gov.au)
5. Fetherstonhaugh D, Rayner J, Solly K, Beattie E, Harrington A, Jeon Y-H, Moyle W, et al. Teaching the care of older people in Australian nursing schools: Survey findings. *Collegian*. 2022 Dec; 29(6):873-79. doi: 10.1016/j.colegn.2022.02.007
6. Braun V, Clarke V. One size fits all? What counts as quality in (reflexive) thematic analysis? *Qual Res Psych*. 2020 Aug 12;18(3): 328-52. doi:10.1080/14780887.2020.1769238
7. Lee CC, Tseng HC, Wu LP, Chuang YH. 2020. Multiple brief training sessions to improve nurses' knowledge, attitudes, and confidence regarding nursing care of older adults with depression in long-term care facilities. *Res Nurs Health*. 2020 Jan; 43(1):114-21. Doi: 10.1002/nur.21997
8. Kelly J, Jayaram H, Bhar S, Jestro S, George K. Psychotherapeutic skills training for nurses on an acute aged mental health unit: A mixed-method design. *Int J Ment Health Nurs*. 2019 Apr; 28(2):501-15. doi: 10.1111/inm.12555
9. Surr C, Gate C, Irving D, Oyeboode J, Smith SJ, Parveen S, Drury M, et al. Effective dementia education and training for the health and social care workforce: A systematic review of the literature. *Rev Educ Res*. 2017 Oct; 87(5):966-1002. doi: 10.3102/0034654317723305

Leading with intention

As leaders we need to create experiences on purpose to influence change. What does this mean and how do we go about it? NATALIE DRAGON talks with midwife and health service improvement coach Jane Stanfield.



Jane Stanfield argues it's not outside anybody's realm to influence.

"It can be done within what you're already doing but we do need a different perspective or broadening of your perspective to do it. Nobody needs any more work to do and nobody needs any more standards to achieve, we need to know how to influence within our core business or practice."

INVEST IN NON-CLINICAL DEVELOPMENT

Begin to see from early on in your career that nonclinical development is professional development.

"If I had one message for our current and future generation of nurse and midwife leaders, it's to look at literature outside of healthcare. What I've noticed with nurses on the floor is they think that professional development, if it's not clinical, it's not relevant.

"You get taught that clinical knowledge is so important but then we (nurses) feel like we don't have the tools or know how to recognise and influence system decisions when the opportunity arises.

"Of course, you need to be clinically competent, and you might put 75-80% of your CPD time and funding to clinical if clinical is where your heart is but put 20-25% to wider professional development so that you understand the big picture.

"Once you've got that, once you understand that there is a big picture out there, then you have greater understanding of how to influence and be 'part of the solution' (energising) rather than the perpetual sense of 'doing battle' (de-energising) that just burns us out further."

Ms Stanfield suggests: The Harvard Business Review; Neuroleadership Institute, Positive Psychology; Compassion Focussed Therapy (including Self Compassion); and follow relevant politicians and associations on social media.

REDEFINING THE NARRATIVE

If as clinicians or in leadership and management we believe that meetings or gatherings where the relationships, interactions, strategies and planning happen, are secondary, then nothing's ever going to change, says Ms Stanfield.

"We often put meetings a very low second under clinical care, which is a decent value to have in one sense. But if our leaders and managers cannot attend and commit to valuable meetings, then the status quo remains. The people who are at the meetings set the direction.

"If we don't prioritise what is important (which may be strategic meetings), then nothing changes. And the irony is that by not attending you're actually handing over your power to others who are present. So often the narrative of nurses is that we're disempowered, underappreciated and undervalued. And I don't negate that. But if you don't attend where people are giving you a platform, then you're not going to be heard, and you're not prioritising that strategic perspective. The only way our 'voice will be heard' is if we are actually there.

"Nurses on the floor are always going to be busy. But if we're being strategic, if we're thinking months and weeks out, then part of it is to put it in your diary and months and weeks out, organise the roster, rearrange the clinic, whatever it might be. Remember it IS important and influential to be there."

Do the best you can, but also maybe it's the story and the narrative that has to change, suggests Ms Stanfield.

"You might say that the story and the narrative in nursing is that meetings are a waste of time and that they're taking away from the important work, which is clinical.

"But if the story and the narrative is that meetings are strategic, give us a voice and mean we have some influence – then that might change the perspective we take on meetings."

TAKING THE OPPORTUNITIES

It's really significant to differentiate between what we can't control and what we can control, the latter is what we can influence, says Ms Stanfield.

"I don't think we play in that field often enough as clinical nurses. What can you influence if you keep stepping in?"

"As Stephen Covey puts it in his *7 Habits of Highly Effective People*, if you keep stepping into your circle of influence, your circle of influence expands.

"Step by step along the way in my journey, I've just expanded my circle of influence. I haven't forced anything. I haven't been massively goal driven. I've let it emerge. I've set my direction and I've come to positions where I can influence people. I think if each of us as nurses is stepping into a position of influence just that little bit wider than where we're actually clinically practising, then you could see a real shift."

THE BIG PICTURE

If we don't know what's happening politically, we're not there to influence, says Ms Stanfield.

"If we spend two hours a month becoming aware, we've got the influence. For example, With the current reforms to Medicare, and interest in nurse practitioners, we're there.

"If clinical nurses with a specialist in wound dressings know what's going on with Medicare, boom, they're out of whatever's holding them back and setting up practice with the right people over the next five years. It's keeping that balance between the minutiae of what our specialty is and the big picture politically and health system wide."

FOCUS ON FLOW AND WASTE

Influencing change often still happens randomly, so what are the purposeful levers to pull to shift an experience? Or if you're in a position of leadership, what are the concrete levers you can pull to drive a culture?

According to Ms Stanfield, the four areas you influence in any business are: safety and reliability; team vitality; client patient experience; and efficiency and effectiveness (flow and waste). "What I say in clinical real nurse terms is – does it flow, and does it reduce waste?"

"The CEO wants to know that it flows, reduces waste, and is safe and reliable. The patient wants to know that they'll feel safe, that it flows, but it's reliable. And your teammates want to know that it flows, that they'll be off on time and that they'll enjoy working there.

"So, you can influence whoever you happen to be sitting in front of because you can articulate it quickly. And those four pillars, just about guaranteed will match any strategic plan in most health systems. And that's all that clinical nurses need to know. Use that narrative with your argument and you're in."

Jane Stanfield has 30 years' experience in clinical midwifery and clinical governance, culture and leadership and health administration. She coaches leaders and teams to implement local, relevant culture change. Her leadership series includes staying well, neuroleadership, mindfulness, culture, emotions, leveraging strengths and strategic planning, alignment and accountability.

For more information, visit:
janestanfield.com or call Jane on
0402 012 397 for customised coaching
or team workshops.



Kristen Wischer
ANMF Senior Federal
Industrial Officer

Secure jobs and gender equality form the basis for the Modern Award Review 2023-24

In December 2022, the Fair Work Act was amended to add two new objectives that need to be taken into account when deciding if awards meet the standard required of contemporary industrial relations.

The new matters that the Fair Work Commission (FWC) must consider are whether provisions of awards improve access to secure work and achieve gender equality.

As a result of these changes, the Minister for Employment, the Hon Tony Burke asked the FWC to conduct a review of modern awards to assess whether current award provisions meet the new objectives. In response, the FWC has commenced a process known as the *Modern Awards Review 2023-24*. The review has started with research being conducted and discussion papers circulated for response. Two streams of the review are of particular interest to the ANMF. The first is 'Job Security', and the second is 'Work and Care'.

The ANMF will argue that any measure that increases job security will also help to achieve gender equality. FWC research confirms that nursing is amongst the most highly gender-segregated occupations, and midwifery is the most segregated. Nurses and midwives are also more likely than the average Australian worker to work part-time and have caring responsibilities.

The Job Security stream is looking at award clauses to assess whether they promote secure work. The ANMF has identified a number of clauses in the Nurses Award, which we say fall short of what is required for employees to know they are protected from the uncertainty of insecure work. There are many areas where improvements are sought. However, the treatment of part-time work under the Nurses Award is of particular concern to the ANMF.

The current operation of the award, widely used in enterprise agreements, requires employees and employers to agree on the number of hours to be worked. However, that arrangement can be varied by written agreement. This clause intersects with the overtime clauses of the Nurses Award, which provide that overtime is only payable for hours worked in excess of an ordinary full-time day.

This effect is that a part-time employee can be asked to do additional hours, sometimes on short notice and when it is hard to refuse. This creates an incentive for employers to seek an initial agreement for low hours' contracts and to benefit from the flexibility to ask for additional hours to be performed without paying overtime. The impact for part-time employees is that

their employment becomes more casual-like, with higher levels of unpredictability about the working week. This, in turn, impacts things like making childcare arrangements, planning activities, and even being able to demonstrate regular income to obtain a loan or rental property.

In the review, the ANMF will seek to address this problem in several ways. We will ask that:

- Part-time hours contracts should reflect the actual work to be done;
- Part-time hours be reviewed regularly, and if they are not reflective of the initial contracted hours, there is an option to amend the contract;
- Work performed more than contracted hours be paid as overtime; and
- Any incentive to employ casual employees ahead of permanent employees should be removed from the award.

The 'Work and Care' stream is set up to identify award conditions that support employees in meeting their caring responsibilities. This could range from creating a new provision in awards to allow time for breastfeeding to improving access to carer's leave. The review is also looking at employment status, including whether part-time work provisions could be improved.

The ANMF will use the opportunity to respond to the Work and Care discussion paper to reinforce the importance of improving conditions for part-time employees under the Nurses Award. We contend that if the predominantly female nursing and midwifery workforce is better able to access regular, predictable part-time working hours, they will gain greater job security and be better able to meet any caring responsibilities.

Eliminating the risks associated with insecure work, together with strengthening conditions and entitlements that make caring responsibilities easier to manage, are important steps towards achieving gender equality.

The ANMF will actively participate in the *Modern Award Review 2023-24* as it provides an opportunity to tackle some long-standing problems with the Nurses Award. The new objectives of job security and gender equality provide the framework for much needed reform.

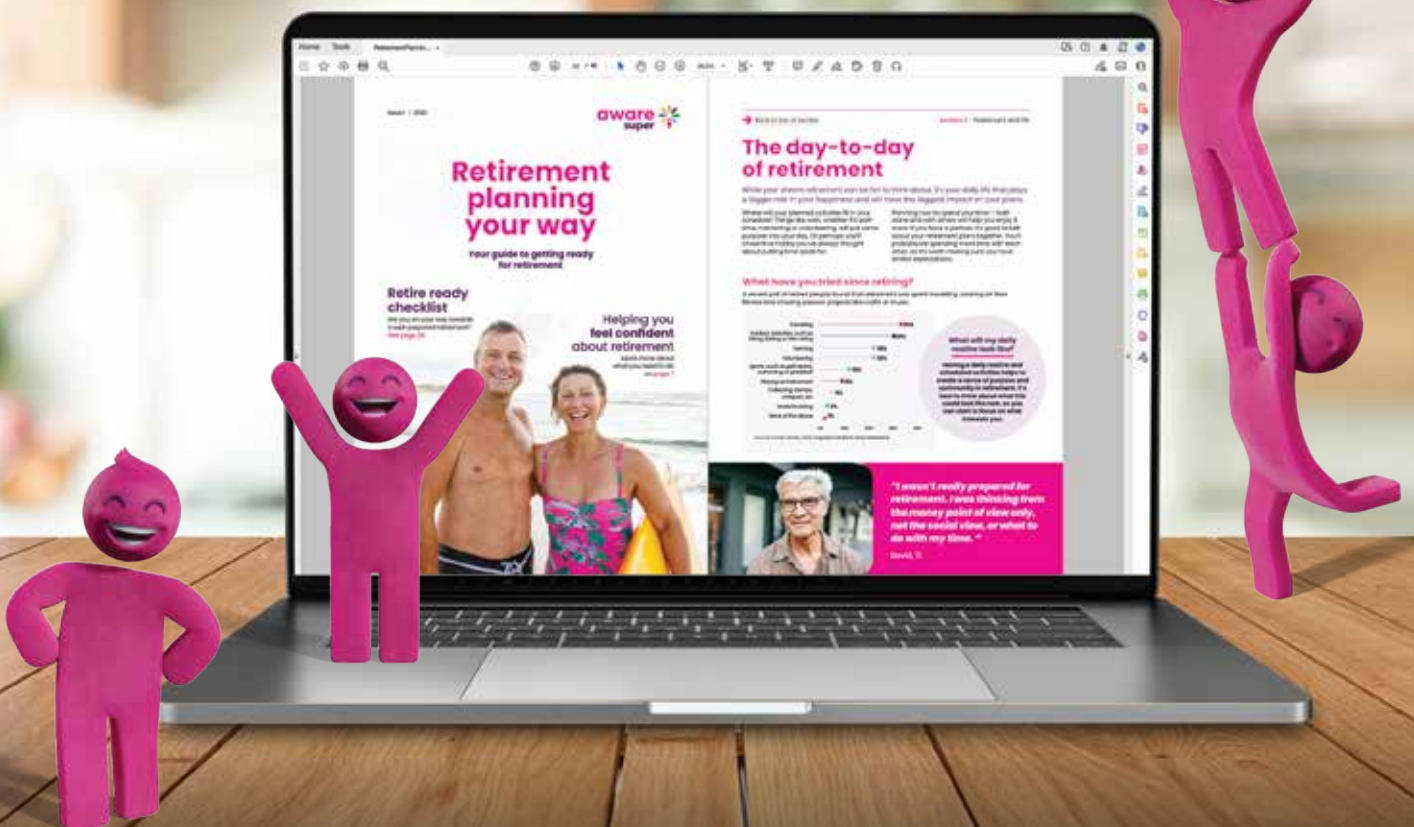
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Moving towards a circular economy to save the planet

By Kathryn Anderson

In contrast to linear economies focused on extraction, manufacturing and disposal, the circular economy is emerging as a sustainable alternative.



Achieving this transition requires a global paradigm shift in our resource management approach.

It entails fostering a system where products are designed for longevity, waste is minimised, and materials are recycled and reused, thereby promoting sustainability and reducing environmental impact.

Jo Taranto, co-founder and managing director of Good for the Hood, stands at the forefront of a transformative movement towards a circular economy. Over six years, she has orchestrated substantial changes within neighbourhoods, corporations, residents, and councils, all converging towards the ideals of a circular economy.

So what exactly is a circular economy? Jo defines it as “decoupling economic growth or prosperity from finite resources”.

“For me, a circular economy is about keeping value in the economy without having to have this cycle of extraction and waste- it’s basically redesigning the economy,” she says.

For Jo, circularity holds the key to addressing climate change.

“If we can solve circularity and if we can have a circular economy, we will have solved climate change. We will have worked out

how to manage embodied emissions, rely on renewable energies, and have robust economic growth.”

Despite more people acknowledging how broken the linear economic model is, Jo says achieving true circularity remains challenging. “Australia has achieved only around 5% of true circularity,” she says.

Jo believes the answer is to start thinking with a circular mindset and for individuals, communities, businesses and industries to collaborate to achieve circular outcomes.

Part of that mindset is a complete change of conversation around the value that we have in our products.

“It’s actually about caring for things in a slightly different way and actually starting to rethink what we have, how we use it, and how we care for it while it’s in our usership slash ownership.”

Jo suggests that instead of discarding products in landfills, try to repair and reuse them, for example, buying clothes from a thrift store.

“There’s something very powerful about keeping something going in our system longer, and it will eventually end up in a landfill, but if you can keep it circulating with the highest value, that is the very definition of a circular economy as a citizen’s behaviour.”

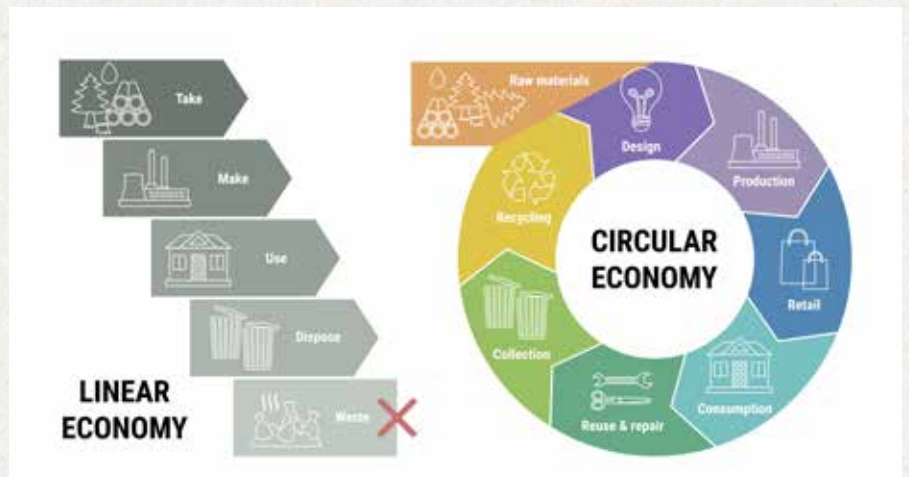
Recycling is also one of the most impactful things individuals can do to contribute to a circular society. But Jo says making sure that the end value or the place where those things are going still has value.

“We actually can’t solve any of this unless we have people taking the products we’ve finished using somewhere meaningful.”

We also need to install other circular behaviours, such as not just getting rid of one thing to replace it with something else.

“The perfect example is your takeaway food container. If we’ve suddenly phased out one and it’s just been replaced with a paper container, we haven’t really improved the circularity,” Jo says.

“Yes, the material is slightly less bad. And yes, it may have a better solution in the longer term if it goes into your food or organics collection and processing, but ultimately, we need to start looking at how we can encourage reuse behaviours for our citizens because whether you’re at work or home, that’s definitely where we should be looking.”



Additionally, Jo suggests people should think about waste hierarchy and products that don't fit in a circular economy before they purchase.

"So, refusing things that may be overpackaged and that doesn't really have a purpose.

"[Also, ask] where did this [product] come from? Where did the glass, the plastic and the material come from, and where will it go at its end of life?"

Equally, businesses must embrace circularity to ensure long-term sustainability.

"This absolutely should be part of the conversation they are having. It surprises me how many heavy industries, large emitters, and large businesses with the capacity to do a lot of good in the circular space just haven't gotten there yet," Jo says.

"They haven't started this conversation- they're sort of wondering how to attack it. And the only answer is to start mapping where your materials are flowing, start getting some metrics and data so that you can actually start pushing and leveraging what needs to happen."

Not only does transitioning to a circular economy involve a fundamental shift in mindset and behaviour, but collaboration across all levels of society and industry to promote sustainability and reduce environmental impact. "Ultimately, we can't do this alone," Jo says.

"If you're doing it on your own, you're doing it wrong," she says. "We need systems to change. We need people to say, right, that's broken. I can't fix that bit on my own, but I can go and start looking for solutions."

5 WAYS TO BECOME MORE CIRCULAR

- 1 Mindset shift and collaboration:** Shifting towards a circular mindset and fostering collaboration among individuals, communities, businesses, and industries is crucial for achieving circular outcomes.
- 2 Repair and reuse:** Instead of discarding products, repair and reuse them to extend their lifespan and keep them circulating in the system with the highest value.
- 3 Recycling with purpose:** Recycling is impactful, but ensuring that recycled materials have value in the end-use is essential for a circular society.
- 4 Encouraging reuse behaviours:** Encouraging reuse behaviours is vital, such as replacing products with sustainable alternatives and questioning the origins and end of life of products before purchasing them.
- 5 Collective action:** Achieving circularity requires collective action and system-level changes, with businesses and individuals working together to find solutions and drive change.

Gloves are off in fight towards circularity

Newcastle's John Hunter Hospital has been pioneering a circular economy approach in healthcare through its 'Gloves Off, Clean Hands, Safe for All' project.

The initiative, part of Hunter New England Local Health District's sustainability strategy to achieve carbon and waste neutrality by 2030, exemplifies the circular economy principles in action.

NSW Minister for Health Ryan Park said the project was significant in reducing glove overuse and minimising waste sent to landfills.

"By promoting judicious glove usage and emphasising hand hygiene, we're not only enhancing patient safety but also contributing to a more sustainable healthcare system," he said.

"Disposable gloves, while essential in certain situations, are often overused in clinical settings," explained Mr Park. "Through this project, we're encouraging

staff to use gloves only when necessary, thereby conserving resources and reducing environmental impact."

Mr Park said the project could reduce the amount of gloves used by health workers by millions annually, leading to significant environmental and cost savings, while also improving hand hygiene to keep patients safe.

"Wearing disposable gloves is a common behaviour in our hospitals, however there are occasions such as direct contact with intact skin and routine observations where clean hands can be used if staff aren't going to come into contact with a bodily fluid," he said.

"Research shows that when gloves are used only when needed hand hygiene improves, reducing risk of infections,"



Hunter New England Local Health District's Executive Director, Infrastructure and Planning, Dr Ramsey Awad, outlined the district's circular economy approach.

"The aim of the program is to significantly reduce unnecessary glove use by educating staff, similar projects at other hospitals are achieving reductions of up to 30%," Dr Awad said.

The pilot project, due to conclude in mid-2024, marks a significant step towards implementing circular economy practices across the district's healthcare facilities.



I turned unused drapes into blueys. I got 28 squares from one arm drape.
Liz

More sustainability resources can be found at:
anmfvic.asn.au/healthenvironmentalsustainability
Tips have been edited for space and clarity



I have used this idea (notice board) from the last ANMF Sustainability conference. Great tool to highlight our projects and educate staff and patients too.
Annette

Sustainability tips or questions

We don't need to reinvent the wheel to find ways to reduce our impact on the planet. Ask a question or share your sustainable at work and at home tips with the ANMJ so nurses and midwives nation-wide can do their bit to save the planet.

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Rebecca Millar

Rebecca Millar is a forensic mental health nurse and lawyer and is in the nursing program in the school of Health and Biomedical Sciences at RMIT in Victoria.

Entitlement to a title: The new frontier of the advanced practice debate

**Most people who complete a PhD can't wait to use the title 'doctor'.
If they tell you differently, they are probably lying.**

Whilst obtaining a PhD is typically celebrated in academic circles, its use in clinical settings has sparked debate over professional roles and titles. The advancement of nursing practice roles in clinical settings, often negatively referred to as 'scope creep', has prompted discussions about the appropriate use of titles in healthcare and the potential consequences of misrepresentation.

The title 'Doctor' is not protected under Australian law. What is required however, is that the person using the title does not mislead (either deliberately or negligently) a patient or other person into thinking that they are a medical practitioner. Doing so puts the professional at risk of breaching the National Law by allowing others to believe they have registration that they do not have.¹ Breaches of this nature can result in significant penalties imposed by Ahpra as well as potential criminal law offences relating to fraud and misrepresentation. Where penalties can include prison, the anxiety felt by nurses with doctorate qualifications, is understandable. Whilst clear guidance as to what titles relate to each health professional are provided for within the National Law,² the term 'doctor' is not prescribed – even for medical practitioners. The legislation very clearly and specifically protects titles such as 'specialist'³ and 'surgeon',⁴ however, remains silent on the term doctor. The National Law rather provides protection for the public by focusing on the actions of the health profession and ensuring that those actions are commensurate with the scope of practice of the health professional.⁵

Despite this, many medical professional bodies advocate for protecting the term 'doctor', especially in clinical settings.⁶ This debate has come to the forefront in America, where Nurse Practitioners obtain their degrees at a doctorate level. In June 2023, three Californian nurse practitioners filed an action in the US District Court Central District of California against the State (including against the state Medical Board President, the Executive Office of the Californian Board of Registered Nursing, and the Californian Attorney General) fighting for their right to use the

title 'doctor'.⁷ Supported by a not-for-profit law firm, they argue against institutional title appropriation and restriction of speech. This case comes on the back of the matter of Nurse Practitioner Sarah, a doctorate nurse practitioner who was excluded from nursing and ordered to pay thousands of dollars in fines for using the term – despite making it clear to her patients that she wasn't a medical doctor.

The pursuit of the 'doctor' title isn't exclusive to nurse practitioners. In Australia in 2022 Fellows of the Australian College of Physiotherapists gained the right to call themselves Doctors, vested upon them by the Physiotherapy Board of Australia.⁸ The Physiotherapy Board decided that only those who had knowledge and expertise at level 10 of the Australian Qualifications Framework (commensurate with doctoral degrees) were eligible.

Concerns have been raised about nomenclature for Doctors of Nursing from their inception, with Dracup et al. (2005) suggesting that it would be, at the very least, unhelpful for everyone a patient meets in the health system to be a doctor. In America, a movement against nurses using the title doctor was heralded by groups such as 'Physicians for Patient Protection' who release statements highlighting the risks to patients posed by Nurse Practitioners.⁹ Others argue that the title is reflective of the work and effort put into achieving the degree and that the status of doctor conveyed upon their PhD counterparts in academic settings should also be available to all nurses who have studies at that level.¹⁰

Ultimately, the debate over the use of the title 'doctor' reflects broader shifts in healthcare towards advanced practice roles and the evolving roles of non-medical practitioners. It also underscores the need for clarity and transparency in how healthcare providers are identified and the importance of protecting patients from misleading information about their qualifications and roles. As the debate continues, it represents a pivotal point in defining the roles and identities of healthcare professionals and will likely have ripple effects for practitioners worldwide.

References

1. Health Practitioner Regulation National Law Act 2009 (Qld) ss 116, 117.
2. Health Practitioner Regulation National Law Act 2009 (Qld) s 113(3).
3. Health Practitioner Regulation National Law Act 2009 (Qld) s 115.
4. Ibid.
5. For example, limitations on optical, dental, or spinal procedures (s121- s123) or the numerous prescribing limitations for nurses and midwives.
6. Gaddis G. Nurses with a Doctorate in nursing practice (DNP) should not call themselves "doctor" in a clinical setting. *Missouri Medicine*. 2022; 119(4): 314-320.
7. Jacqueline Palmer v. Rob Bonta, 523-cv-01047, (C.D. Cal.).
8. Australian Physiotherapy Association. College fellows can now use 'Doctor'. [Internet]. Australia: 2022. Available from: australian.physio/inmotion/college-fellows-can-now-use-doctor#:~:text=Doctor%20is%20not%20a%20protected,that%20is%20protected%20by%20law.
9. Physicians for Patient Protection. NP malpractice settlements on the rise, especially for NP owned practices. America: 2024. Available from: physiciansforpatientprotection.org/np-malpractice-settlements-on-the-rise-especially-for-np-owned-practices/.
10. Buppert C. Nurse practitioner's business practice and legal guide. Jones & Barlett Learning; 2020 Nov 2.

Collaboration between a hospital nursing education unit and a nursing school in Adelaide enhances nursing education for early-career nurses

By Caterina Feltrin, Claire James and Paul McLiesh

A collaboration between the Central Adelaide Local Health Network (CALHN) Early Career Transition Programs (ECTPs) team and the Adelaide Nursing School (ANS - University of Adelaide) has led to improvements in the delivery of education for early-career nurses.

It has also strengthened consistencies in the delivery of simulation training between undergraduate education and transition programs in nursing.

The ECTPs were developed in response to an increasing number of novice nurses joining CALHN. The ECTP includes the formalised Transition to Professional Practice Program (TPPP) and the Supported Programs, which provide the opportunity for all novice nurses commencing employment in CALHN to access clinical support and professional development.

Each program was designed to meet the educational needs of early-career nurses by providing a structured support program, including regular educational activities to facilitate their transition into the workforce and improve the delivery of high-quality patient care. The programs provided targeted, individualised education to over 400 early-career nurses in 2023.

While the educational opportunities provided for early-career nurses had broadened considerably throughout 2023, formal and informal program evaluations identified the need for increased support and education regarding early identification and management of clinical deterioration.

The ECTP team utilised a pre-existing professional connection with ANS to collaborate on a project to refine the delivery of teaching and clinical simulation

activities related to patient assessment and clinical deterioration.

The two teams worked together to focus on the design and delivery of simulation activities by providing educational support for members of the ECTP team regarding educational pedagogy and learning design. The project was an informal project that included the following activities:

- Preparatory sessions for the ECTP team about learning pedagogy and the theoretical basis of learning design and delivery.
- The ECTP team observed student nursing simulation activities delivered by Adelaide Health Simulation.¹
- The ANS staff observed teaching and simulation activities delivered by the ECTP before and after changes in the ECTP program.
- Collaborative sessions between the ECTP and ANS teams focussed on peer review of teaching and learning activities and how that knowledge could be incorporated into the ECTP team's work to refine the team's skills and confidence in delivering teaching activities.

Through those activities, educational modalities in CALHN were refined using simulated patients (SPs) across a range of simulations. Using SPs has increased learning immersion, with actors being able to provide practical, real-time feedback

and create better continuity between the undergraduate and ECTP programs. The use of SPs adds an element of realism for early-career nurses in the simulation, ie. an SP will simulate a full seizure that appears realistic and is confronting for the nurses. This requires early-career nurses to strengthen their ability to manage challenging scenarios more similar to real-world ones.

Observations of ANS simulation emphasised the importance and value of various structured debriefs from different perspectives to aid learning. As a result, ECTP session plans now include clearly defined time allocations for structured pre-brief, SP brief and debrief. Structured debriefing allows early-career nurses to reflect on the scenario, the SP can provide the 'patient' perspective of the nurses' performance, and the facilitator encourages the nurses to reflect on that scenario and identify learning objectives met. The ECTP staff facilitating the simulations reported increased confidence in managing the sessions and felt better able to create a safe learning environment with better learning outcomes.

Clinical nurse educators who are part of the teaching team report increased confidence in managing the delivery of a range of teaching activities, including the simulations. Clinical nurse educators are highly experienced clinicians but may not have formal educational experience. This type of collaboration has better equipped



them with the fundamentals of learning pedagogy that allows them to assist all members of the ECTP team in providing high-quality and consistent learning and simulation activities to early-career nurses.

As a result of the collaboration, there has been a noticeable improvement in feedback for teaching activities compared to previous years. Indicating that early-career nurses see the teaching structure as providing a safe and high-quality educational experience that is relevant and prompts reflection on their own clinical practice.

Working in partnership with ANS was important to allow for increased consistency in the design of the learning experience between the undergraduate nursing program and the ECTPs. The partnership led to a multitude of improvements, many of which were unanticipated. The increased awareness of

what is required of early-career nurses was valuable for the nursing school to refine how students in their final year of studies are prepared for that transition to practice. We encourage other sites to consider these types of collaborations.

In a separate project, the Health Simulation team at the University of Adelaide have a publication that provides a structure for how this can occur in a more formalised format.² Other examples of this type of collaboration can be found here.^{3,4}

Authors

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References

1. Adelaide Health Simulation. 2024 [cited 2024 11th Feb]. Available from: health.adelaide.edu.au/engage-with-us/facilities-services/adelaide-health-simulation
2. Davies E, Montagu A, Brazil V. Recommendations for embedding simulation in health services. *Advances in simulation* (London, England). 2023 Oct 6;8(1):23. DOI: 10.1186/s41077-023-00262-3.
3. Yi YJ, Lee H, Park K. The role of academic-practice partnerships from perspectives of nursing students: A cross-sectional study. *Nurse Education Today*. 2020 2020;106(01):89-104419. DOI: doi.org/10.1016/j.nedt.2020.104419.
4. Direko KK, Davhana-Maselesele M. A model of collaboration between nursing education institutions in the North West Province of South Africa. *Curatiosis*. 2017 Sep 22;40(1):e1-e10. DOI: 10.4102/curatiosis.v40i1.1670.

REFLECTION



Emergency Nurse Practitioner Letty Bastian

Mastering the art of listening

By Letty Bastian

My name is Letty Bastian, and I am an Endorsed Emergency Nurse Practitioner and Traditional Chinese Medicine Acupuncture student at RMIT University, Melbourne.

I have been working in emergency nursing for two decades, and over time, I have become curious about how our healthcare system is evolving. There is a growing conflict in nursing where our values and beliefs about caring for patients do not align with our everyday actions. For example, the emergency departments have become so busy that it is difficult to find space in your own mind to breathe, listen fully, and treat the patient with care. People turn to the emergency department when they are ill and actively give over their health to our hands. This is such a precious commodity to be holding. Yet we feel we deliver half the service to people we wholeheartedly want to do better for. The war cry for our profession appears to be, 'We don't have enough time to listen!'. Rather than carrying on with this story, I aim to change it.

I personally became restless in my career as I struggled with this problem. To cope with this mental tension, I began studying Nursing Philosophy. On this journey, I explored philosophers, writers, and poets who expressed ways to create peace with this problem. I noticed they all spoke about the art of listening. What does it mean to really listen to patients? What was the unspoken need of patients attending the emergency department that may improve their care? I heard a consistent undercurrent that patients want us to listen and give back control of their health and

how to heal. I would purposefully listen to a patient and would hear, "I want choice over the type of medicine that helps me heal. I want control over my body. Can you help me feel empowered and heard?" I wondered if actively seeking ways to listen to the patient and find ways to give back the patient ownership over their health would improve outcomes. Our current system is developed with good reason around treatment protocols. A protocol will always guide the direction for assessment and treatment, but we need to listen to the whole patient to develop a way to heal together.

I asked the hard question: as a Nurse Practitioner, how will I be a role model for other nurses and patients to provide this model of listening to healing? I researched various health models, and my interest in philosophy took me into Traditional Chinese Medicine (TCM), Acupuncture. I was impressed by how Chinese Medicine weaves the fabric of the whole person into the treatment. There is no segregation of the person into compartments, and you are trained to 'see' the patient and all they carry with them. The foundations of Chinese Medicine allow me to approach the art of listening to patients in a different way. I have become aware that in Western Emergency Medicine, we often talk 'at' the patient, drilling down to the medical basics. We ask specific questions to provoke key responses and use this for diagnosis. This

is highly successful in managing critical situations but not as useful in complex, chronic or distressed patients. I have been applying the TCM foundations to how I listen to patients in the emergency department and the results are astonishing. Applying the principles into practice only takes a few minutes, but it changes the patient's response to the situation. The TCM approach gives the person back their authority to say how they wish to be seen, heard, and treated. With this information, I can work alongside the patient and a beautiful healing interaction is allowed to happen, and it is extremely time efficient. I feel I can sustain my nursing career longer with these types of interactions; it is beneficial to both the patient and the provider. Perhaps we need to look outside of our Western framework to begin to answer some of the most pressing issues in modern nursing this century. For now, I will continue to master the art of listening and will take every opportunity to be quiet, listen to the undercurrent and find ways for patients to feel heard.

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Kiah Fleming

Virtual nursing care through a pandemic and beyond

By Kiah Fleming

RPA Virtual Hospital (rpavirtual) in Sydney Local Health District is Australia's first virtual hospital. The hospital has a vision for the future to deliver care in the community using the latest technology and preserve hospitals for those who need them most.

Since launching in early 2020, rpavirtual has provided virtual care for over 85,000 patients. Virtual care is delivered with multidisciplinary models including assessment and review, clinical consultation, remote monitoring, and care navigation. A clinician staffed care centre operates 24/7, with registered nurses able to manage clinical care and respond to deteriorating patients. Nursing staff make up the majority of the care centre workforce and are supported by medical staff and separate allied health clinics.

Nurses play a key role in the development and continued success of rpavirtual. They share the goal of delivering high quality patient care using technology and adapting to new ways of caring for patients. The breadth of nursing experience and clinical backgrounds from medical, surgical, and critical care areas has contributed to building a strong workforce. The workforce constantly evolves to meet demands of the service and patients. The initial small group of nursing staff with the Director of Nursing has grown into a permanent workforce moving away from seconded and displaced staff due to COVID-19 activity. Establishment of a complete nurse management structure with an Operational Nurse Manager, after hours Nurse Managers and Nursing Unit Managers. Specialised roles including paediatric nurses and midwives have addressed patient needs. Introduction of senior positions including a Clinical Nurse Educator to support nursing staff and Clinical Nurse Consultants has allowed unique care to be delivered to patients in the community. These roles have evolved with the highly skilled and passionate staff working in them and from experienced and committed rpavirtual nursing managers. This has allowed these new and unique virtual care nursing roles to develop. The visionary executive team support staff working remotely: statewide, interstate and overseas, which creates access to talent from a broader group, reduces travel time and improves work life balance for staff. Virtual care nursing staff have confirmed a consistently positive clinician experience of delivering virtual care in rpavirtual over the past three years as demonstrated through the completion of comprehensive annual surveys for three years

which nursing staff are invited to complete.

The nursing workforce is based on the requirements to deliver patient care and was initially in response to COVID-19 in the community and Special Health Accommodation (SHA), where over 64,000 patients received care from rpavirtual. After designing the first model of care for managing COVID-19 patients in the community (home setting and SHA) in NSW, rpavirtual was crucial in delivering care and decreasing pressures on the healthcare system. rpavirtual transformed from a small environment to a bustling and overflowing care centre, full of nurses and midwives caring for the full spectrum of patients from birth to aged care, from culturally and linguistically diverse backgrounds across SLHD, with varying clinical and social issues. In keeping up with the COVID-19 pandemic, rpavirtual nursing staff numbers rapidly increased to keep up with increasing patient numbers. The heightened anxiety and distress in the community along with the mix of staff in new environments created a challenging experience for all nursing staff. The positive from this experience was the development of a positive culture focused on staff health and wellbeing and fostered an innovative environment able to deal with frequent change.

Technology is a central focus for nursing staff to care for rpavirtual patients. Virtual care is delivered through video conferences, mobile phones, text messages, emails and wearable devices linking patients to nurses to monitor patients remotely. Care is documented using electronic medical records and communication is assisted using dashboards and journey boards, teleconference communication strategies to conduct virtual clinical assessments. The use of innovative technology however brings challenges for implementation. Navigating patient care through technology challenges has led to continuous development and contributed to the constantly changing healthcare landscape.

Technology enables on demand healthcare for patients, caring for patients in the comfort and safety of their own homes and reducing hospital associated risks. Technology enables staff to use a broad range of skills and adapt to diverse ways of delivering patient



Photo credit: Sydney Local Health District

care as well as access patients in remote areas to reduce need to travel and receive care in their own homes. rpavirtual nurses have an excellent ability to adapt to new systems and processes and respond to challenges using innovative solutions. The commitment from nursing staff to virtual care and the vision for the future in digital health has always ensured the delivery of high-quality care. Developing workarounds to ensure processes are efficient for nursing staff and patient safety has built close relationships with teams across Digital Health and Innovation and provided valuable lessons for future projects.

Moving beyond the pandemic, rpavirtual has a lot to look forward to. Over 7,000 people have received care through new models including acute respiratory conditions (including COVID-19), Virtual Surgical and Trauma Models, Virtual Nurse Assist and Midwifery support to two regional local health districts, Palliative Care Advice Line, midwifery-led models of care, Direct Observed Therapy for Tuberculosis, Sydney District Nursing joint care models, MediHotel and other virtual Emergency Department collaborations. The experiences of the pandemic and the broader establishment of rpavirtual have

allowed nursing staff to flourish in this new and unique environment and is reflected through sustained positive Patient Reported Experience and Outcome Measures.

Keywords: Virtual care, digital health, telehealth, nursing, technology, pandemic.

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Empowering Indigenous student nurses: A cadetship journey towards healthcare equity

By Rebecca Doyle, Amber Wighton and Callan Battley

This piece reflects on the experience of an Indigenous Nursing Cadetship from the perspectives of an Indigenous Nursing Cadet, a Nurse Researcher, and an Executive Director of Nursing.

There is value in the opportunity to present individual viewpoints in collaboration as the authors believe in a genuine partnership between health services and Aboriginal and Torres Strait Islander health professionals to improve health outcomes for First Nations families.

It is widely recognised that cultural determinants of health are crucial in addressing health inequities. This includes Indigenous families receiving advice from Indigenous Health professionals and feeling welcomed and culturally safe in a clinical space that respects and responds

to differences. Approximately 8% of inpatients and 7% of outpatients presenting to a quaternary paediatric hospital in Queensland are children with at least one parent identifying as Aboriginal and/or Torres Strait Islander. This equates to about 100 children and young people on any given day.

Despite this, in 2020, only 1.29% of staff employed at the same hospital identified as Aboriginal and/or Torres Strait Islander. Initially, this was recognised as a key target in the organisation's nursing workforce plan. Also, this was set as a goal in a wider

health equity strategy aimed at improving recruitment and retention of Indigenous health staff across all streams. This was further supported by the appointment of inaugural Indigenous Nursing Cadets in 2021.

The cadetship program offered paid work placements in a fixed-term temporary part-time capacity for Aboriginal and Torres Strait Islander university students during full-time studies. Cadets needed to be minimum second year of studies and were required to work the equivalent of 456 hours per calendar year. They could roll the cadetship over to a second year if they are still a full-time student. Nursing cadets were employed at an Assistant in Nursing (AIN NG1) level.

The overarching goals of the cadetship program were to foster a culturally sensitive workplace, facilitate successful completion of studies, and promote the host health service as a preferred workplace for Indigenous health professionals. The cadetship aimed to facilitate and support relevant learning opportunities for the cadet within the scope of practice. It was also expected the health service would benefit from the cadet's cultural perspective by identifying areas of improvement and ensuring culture was at the centre of strategies developed to implement change. The health service also listened to expert cultural advice and considered the need for a pipeline of opportunities for a new or existing healthcare worker to enter the workplace.

From the perspective of an Indigenous nursing cadet, the structured support within the cadetship proved instrumental to both professional and cultural development. From a nursing standpoint, the program's framework ensured comprehensive support. The cadet benefited from guidance from their line manager and professionals across diverse nursing fields. There was also scope for the cadet to experience nursing in a variety of clinical settings and situations. This experience broadened the cadet's understanding and facilitated strategic alignment of personal and professional goals. This collaborative approach allowed for careful planning of clinical practice, academic pursuits, and alignment with future career goals post-degree completion.

Culturally, the cadetship demonstrated foresight by providing a cultural mentor who, as a registered nurse, facilitated the navigation of challenges within the existing healthcare system. This mentor was crucial in sharing the cultural load burden, particularly when faced with intricate, complex scenarios. Even during university

Culturally, the cadetship demonstrated foresight by providing a cultural mentor who, as a registered nurse, facilitated the navigation of challenges within the existing healthcare system.

clinical placements, the cadet continued to receive mentorship and support, which proved invaluable in navigating challenging situations and within the clinical setting.

The impact of the cadetship extended beyond personal growth, as the cadet actively participated in building the Indigenous nursing workforce both on a state-wide level and within the host hospital. The cadet effectively advocated on behalf of themselves, patients, and their families, ensuring that healthcare considerations embraced a culturally safe, holistic, family-centred approach. An example of this involvement included a contribution to creating a vaccination education course tailored explicitly for Indigenous healthcare workers, addressing a critical gap in healthcare education.

While the cadetship undeniably fostered personal and professional growth, areas for improvement emerged, notably the limitation of the scope of practice. Addressing this limitation is crucial to enhancing the program's overall effectiveness for future Indigenous nurses. Nevertheless, the cadetship proved instrumental in securing full-time employment and shaping a well-rounded Indigenous nurse prepared to contribute meaningfully to the healthcare sector.

The cadet was placed under the line management of a Nurse Researcher (NG7) attached to a paediatric specialist immunisation service within the hospital and health service. Together, the Nurse Researcher and the cadet identified learning goals each university semester, and with careful planning, learning opportunities were aligned with university modules. By liaising with nurse educators in relevant areas, the cadet was placed in various clinical areas throughout the health service for full or half-day supernumerary shifts. This provided exposure to different clinical scenarios and diverse patient cohorts. One limitation of the cadetship was the classification level of AIN. This prevented the cadet from practising clinical skills under appropriate supervision and within scope. The cadet was limited to observing procedures rather than applying learned skills with trained staff, which would have provided valuable learning experiences.

An advantage of the cadetship from a managerial perspective was the flexibility

in rostering. The program was structured to allow the cadet to complete the total hours for the year in any combination that was mutually suitable to themselves and the health service. This meant they could work more during university breaks and flex hours during high university activity like exam periods and practical placements.

The opportunity to work with an Indigenous Nursing Cadet as a line manager and clinical supervisor has been both personally rewarding and valuable at a service level. The perspective of healthcare through an Indigenous lens was vitally important in affecting positive change, and the cadet was able to suggest ways to make the health service more inclusive and welcoming to First Nations families. This occurred informally in conversation with colleagues and formally through involvement on various boards and committees. The cadet was able to share cultural values, strengths and differences with an inherent understanding of unconscious bias, which encouraged colleagues to explore and accept cultural differences respectfully.

From the Executive Director of Nursing Services perspective, at an organisational level, students, cadets, and early career nurses bring many benefits. While their skills and knowledge are still developing, they contribute an enormous injection of positive and curious thinking that has an intangible impact on the teams they work with and the care they deliver. An Indigenous cadet amplifies this benefit with the addition of cultural knowledge and expertise, which, combined with a curious, enthusiastic new professional, is incredibly impactful. The cadetship program is also a great barometer of the cultural safety of our work environment and our nursing care delivery. As a health service that values health equity, we have tried hard to create a direct link between cadets and health service executive as we value the cadet's cultural expertise and recognise it has helped us identify the challenges and opportunities facing health equity at our health service.

Overall, the Indigenous Nursing Cadetship program has exceeded expectations at the executive, line manager and cadet level. The program has achieved immediate goals of facilitating successful completion of studies and promoting the host health service

as a preferred workplace. The Nursing Cadet achieved high university results, delivered the graduand address at their graduation ceremony, and has successfully obtained a post graduate nursing position at the same health service. The program has also contributed more widely to the long-term goals of fostering a culturally sensitive workplace and identifying areas of improvement to enhance cultural safety.

A key organisational health equity strategy priority is strengthening the Aboriginal and Torres Strait Islander workforce. The cadetship program aligns with this strategy by contributing to developing career pathways for Aboriginal and Torres Strait Islander staff and supporting their leadership, value and lived experience. By considering the feedback of our Indigenous cadets at all levels, the program also supports inclusion of Aboriginal and Torres Strait Islander staff in decision making throughout the health service.

Aboriginal and Torres Strait Islander children in Queensland still have a higher mortality rate and shorter life expectancy than non-Indigenous children. As a paediatric state-wide health service, we are committed to improving health outcomes for Aboriginal and Torres Strait Islander babies, children, young people and their families by delivering sustainable, culturally safe, and responsible healthcare. The Indigenous nursing cadet program has been an integral step in encouraging us as an organisation to listen, learn and walk on the journey together.

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Naomi Riley

Federal Professional Officer

Stress of notifications

Earlier this year I had the privilege of representing the ANMF at a symposium hosted by the Australian Health Practitioner Regulation Authority (Ahpra) exploring the distress and stress experienced by practitioners involved in a regulatory process.

The symposium was part of a project undertaken by an Expert Advisory Group (EAG) commissioned by Ahpra and the National Boards in 2021 to explore practitioner distress while involved with the regulator.

In 2023, the EAG made 15 recommendations and proposed 33 actions to Ahpra to minimise the emotional impact on health practitioners of receiving a notification. These were based on qualitative research into the distress of health practitioners involved in a regulatory complaints process and can be viewed on the Ahpra website.

At the symposium, Ahpra discussed actions already taken in response to the EAG recommendations including mental health education and training for Ahpra employees involved in notification processes, improved case management, decreasing time to an outcome, and offering additional support to health practitioners identified at significant risk of mental ill health relating to regulatory processes. Despite support services being provided to health practitioners involved in a regulatory complaints process there is poor uptake. Research has demonstrated this is largely due to the stigma, shame, guilt and fear health practitioners experience when they receive a complaint. Often when practitioners think about being notified to Ahpra about their practice they assume worst case scenario – this is the end of my career, a poor perception of how the complaint will be managed by the regulator and concern that accessing support services for ensuing mental ill health will add to their regulatory woes through mandatory notification processes.

Take a moment to consider what receiving a notification would mean to you, how you feel about interactions with Ahpra, what you know about the notification process, who you would look to for support if you received a notification, and how you would respond to a colleague who has had a notification made about them. I think many can relate to the findings of the research when they contemplate these questions.

In 2022/23, 0.4% of all midwives and 0.5% of all registered nurses received one or more notifications. Of the notifications closed, 82% of those relating to

midwives, and 70% of those relating to registered nurses resulted in no further action.¹ These are very small numbers and perhaps surprisingly, many of the complaints were closed with no further action rather than career ending sentences. This is one example of how a misperception may add to the stress and distress of being involved in a regulatory complaint.

Ahpra emphasised they are working to humanise the way they perform their role and how they exercise their responsibilities. They are looking to health practitioner representative groups and mental health organisations to collaboratively develop strategies designed to support health practitioners navigate the regulatory system and overcome barriers such as misinformation to support services being accessed.

Some of the strategies explored included: regulation-specific education included in undergraduate preparation and transition to practice programs to improve perception of the regulator; dispelling myths regarding typical outcomes of notifications and increased understanding of mandatory notification processes; utilising health practitioner specific mental health supports such as the Nurse Midwife Support Service or navigator service; and, allocating support workers alongside regulatory processes such as social workers or those with lived experience.

A common thread throughout the day was that everyone – the regulator, stakeholder representatives and health practitioners – have a role to play in minimising the stress and distress experienced by health practitioners involved in a complaints process.

What can you do?

- Have a look at the 'About Notifications' page on the Ahpra website paying particular attention to the supports available (see below);
- Familiarise yourself with the stats on notifications and potential outcomes;
- Seek support for mental ill health as a priority over regulatory concerns; and,
- Advocate for positive practice environments.

For further information go to ahpra.gov.au/Notifications.aspx; nmsupport.org.au/

1. Australian Health Practitioners Regulation Authority (2023) Annual report 2022/23 retrieved 8 February 2024 from ahpra.gov.au/Publications/Annual-reports/Annual-report-2023.aspx#



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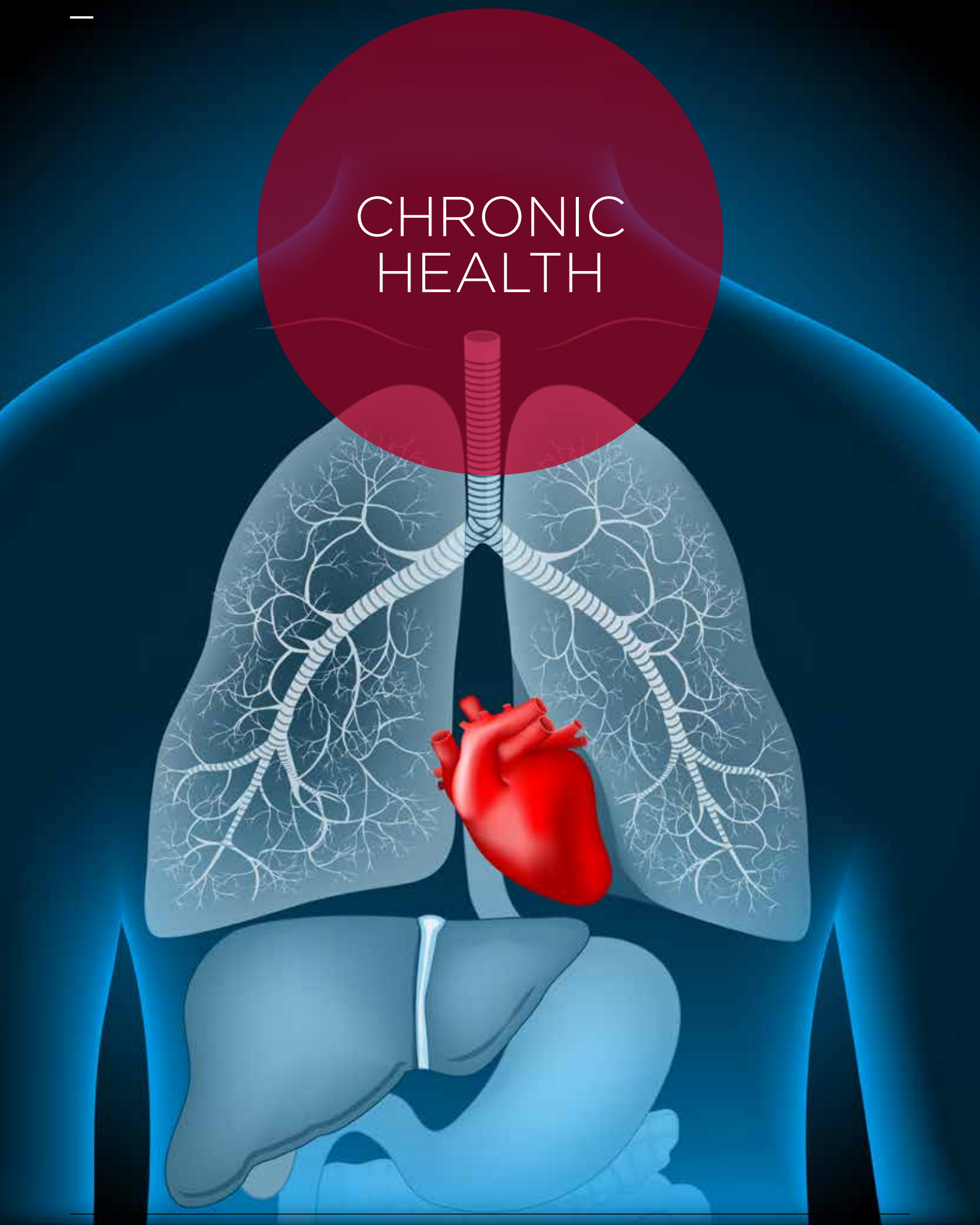
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CHRONIC HEALTH



The case for a wound-focused multi-disciplinary ward round

By Elizabeth Wallis, Sarah Sage, Kate Murphy and Ellen Lewis

The Royal Melbourne Hospital (RMH) GEM (Geriatric Evaluation Management) Wound Ward round model was developed in response to workflow changes during the COVID-19 pandemic.

It has successfully improved inpatient care, preparing complex patients for discharge and reducing duplicate referrals. Additionally, staff reported improved confidence in wound management, assessment, and relationships with other clinical team members.

Before the COVID-19 pandemic, RMH inpatients with complex wounds were referred to the Wound CNC for all wounds, ankle and above or podiatry for foot wounds. Many of these referrals resulted in duplicate referrals to both services for patients with complex lower limb wounds. Wound CNC and podiatry services also attended consultant-led rounds in other hospital areas. As part of the COVID response in 2020, some wards were closed at the Royal Park Subacute site, resulting in many patients having care provided in alternative settings.¹ This reduced bed availability within the Subacute setting at RMH but unexpectedly resulted in the more complex patient cohort being admitted to the GEM unit, resulting in an increase in referrals to the Wound CNC and podiatry services for complex wounds. This led to discussions within the GEM unit and the commencement of the Multi-disciplinary GEM Wound ward round to support staff and patients within the unit.

The design of the GEM Wound ward round was based on current Consultant ward rounds, which have clear roles, responsibilities and an understood process.² The round consists of a Wound CNC and Podiatrist who provide clinical leadership, a medical resident and a ward nurse: either an Associate Nurse Unit Manager (ANUM) or a Wound Resource Nurse (WReN). The round is designed to provide complex wound support to patients and staff.

The aims of the round were:

- Multi-disciplinary team review of diagnostics tests, wound aetiology and wound-related impact on rehab and patient goals.
- Standardised, joint clinical assessment of patients with complex wounds.
- Development of wound care goals and plan for discharge.

A positive secondary effect of the wound ward round is an opportunity to provide bedside education to the treating team, patients, and carers. The round provides an opportunity for staff to engage with



the clinical leads in a supported setting for wound assessment, complex wound and pressure care, as well as focusing on patient-centred care and goal setting.

Participating staff provided feedback that this collaborative approach with key staff present on the round has increased their sense of support with complex wound care needs and improved communication as concerns and questions are addressed without delay. This collaborative approach has also resulted in an increase in ward nurses volunteering to be WReNs. Local ward staff have also reported increased confidence in assessing complex wounds, commencing initial wound care plans and a reduction in the incidence of deterioration in complex wounds. The Wound CNCs and Podiatrists have noticed anecdotal improvements in wound assessments (identification of pressure injuries, pressure injury staging and identification of incontinence-associated dermatitis), initial management of pressure injuries and appropriate referrals with a reduction in duplicate referrals.

A wound specialist-led and clinically focused wound ward round ensures communication and patient-centred care when managing complex wounds in a subacute setting, enhancing support and ensuring dissemination of education and knowledge in a teaching hospital.

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References

1. Claire. E. 2020. 'Coronavirus outbreak forces Royal Melbourne Hospital to close wards, move patients offsite.' *ABC Online*; Friday 14 August 2020. Coronavirus outbreak forces Royal Melbourne Hospital to close wards, move patients offsite - ABC News. Accessed August 2023
2. Royal College of Physicians, Royal College of Nursing. 2012. *Ward rounds in medicine: principles for best practice*. London: RCP. [rcplondon.ac.uk/file/1398/download](https://www.rcplondon.ac.uk/file/1398/download) Accessed August 2023



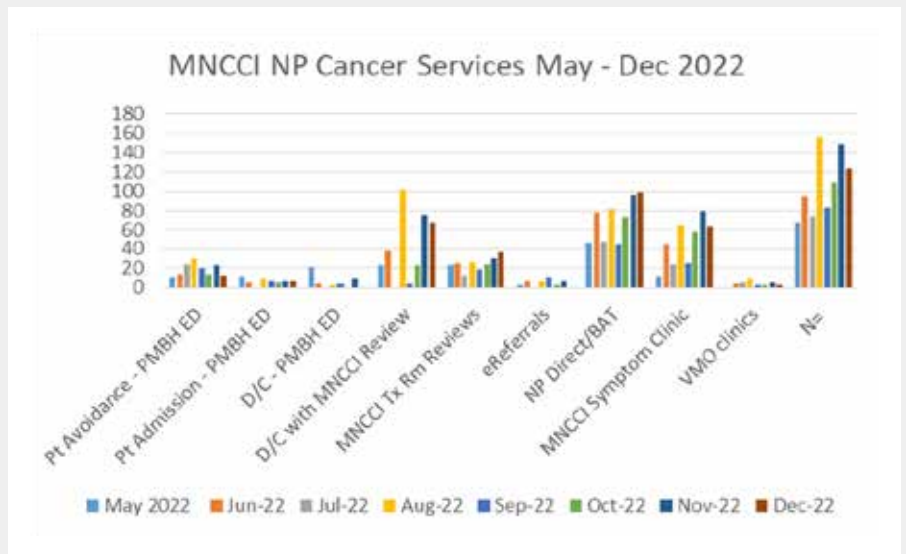
Flying a nurse practitioner project in regional cancer services – a six-month pilot

By Kirsty Baxter

In response to the increasing demand and acuity of patients requiring outpatient treatment for their cancer, the Nurse Practitioner Six-Month Pilot (NP Pilot) was established.

The NP Pilot commenced in May 2022 and provided a five-day service across Mid North Coast Cancer Institute (MNCCI) – Port Macquarie and Port Macquarie Base Hospital (PMBH) Emergency Department (ED) to provide an expert, autonomous advanced practice nursing service. The role targeted four service gaps within the MNCCI:

- Telephone Triage program – introduced utilising the UKONS Telephone Triage tool¹ to enhance ED avoidance.
- Symptom and Urgent Review Clinic (SURC) – structured sustainable nurse-led clinic for MNCCI PMBH.
- Nurse Practitioner led treatment room and clinical reviews.



- PMBH ED Fast Track service – collaboration with ED to facilitate instigation of treatment.

Referral criteria were established before launch. Patients included in the pilot had to be receiving active systemic treatment for their cancer and be experiencing one of the following criteria:

- Chemo-induced nausea and vomiting.
- Febrile neutropenia.
- Diarrhoea.
- Anti-Neoplastic Drug Therapy (ANDT) side effect.

- Immunotherapy/targeted therapy side effect management.
- Other treatment-related side effects

The NP Pilot established a model of care that maintained the patient as a sentinel focus whilst utilising all members of the Multi-Disciplinary Team to ensure efficient utilisation of finite resources. The pilot incorporated teams from both MNCCI and PMBH ED to identify and treat patients in a timely manner and to prevent further deterioration, which would require hospital admission and increased length of stay.

The pilot identified KPIs and specific targets, reporting clear data to support the need and utilisation of this position. Data collated from the six-month pilot highlighted:

- 855 patients accessed the service.
- 146 patients avoided presenting to ED.
- 50 patients were admitted under their treating cancer consultant from ED
- 22 of these individuals were discharged earlier under the care of the NP.
- 455 patients were treated within the MNCCI and returned home, 35 patients were directly admitted to the inpatient setting, avoiding ED.

The NP Pilot data has provided the team with evidence highlighting the significantly positive impact that it has had on this patient cohort. Data collated from a six-month period allowed us to evaluate the service and provide statistically significant evidence that the service has not only been utilised but also provides evidence of significant hospital avoidance for patients currently receiving active systemic treatment.

A peer evaluation of the service was completed following the initial three months of the NP Pilot, with a unanimous positive response to service KPI delivery. The data collected throughout this pilot highlighted the gap identified within our outpatient service was being fulfilled, along with increased patient, carer and colleague satisfaction.

The NP Cancer Services model could be replicated in any outpatient oncology service. The pilot can be replicated and extended to smaller regional hospitals to address the treatment disparity experienced by many of our cancer patients. The model allows cancer services to increase their capacity to provide holistic patient care. Data collated throughout this pilot has attracted permanent NaMo funding to continue this position.

Reference

Cancer Institute NSW. 2022. Telephone triage toolkit. eviq.org.au/clinical-resources/telephone-triage-toolkit (Accessed Feb 2023).

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How can I engage older people living with chronic lung disease in a community-based exercise program?

By Rebekkah Middleton

Chronic lung disease is a complex yet common condition seen regularly in older people in acute and community healthcare settings.

Following acute care, people with chronic lung conditions are referred to either hospital-based or community pulmonary rehabilitation programs. This is important as recommended in evidence-based clinical practice guidelines. Once pulmonary rehabilitation is complete, community-based exercise maintenance programs are often recommended, such as *Lungs in Action*, a program run in a local community centre through Lung Foundation Australia.

Physiological data is often collected in such programs, but the experience of older people with chronic lung disease involved in a community-based exercise maintenance program is lacking. Research was conducted using qualitative group interviews with a semi-structured interview guide to explore the experiences of older people living with chronic lung disease. Fourteen participants (eight females, six males) aged 64-86 years were interviewed. Data were analysed using reflexive thematic analysis. Three themes emerged from the data: *motivation, authentic social engagement, and sustainable achievement*.

Participants expressed *motivation* associated with perceived health benefits and from the trainer's motivation and encouragement. Authentic *social engagement* enabled an environment of trust, understanding, fun, and friendship. This was created through sharing experiences with other participants in the *Lungs in Action* program. Feeling more confident within self and able to accomplish physical tasks, which made daily living more manageable, featured highly in participants' responses, indicating *sustainable achievements*.

Community-based exercise groups enable peer support environments for people with chronic lung disease to maintain physical fitness, connect with others, form friendships, and have fun. Implications for the nursing profession rest in understanding the experiences of individuals and leveraging motivation, authentic social engagement, and fostering personal achievement to promote and facilitate successful referral to community-based programs. When nurses know the benefits of community-based programs such as *Lungs in Action*, they can instil confidence, promote self-efficacy, and therefore contribute to improved outcomes for those living with chronic lung disease.

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Co-researchers

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Federation University nursing students had field experience in health promotion activities in resource constrained settings of Indonesia

By Muhammad Aziz Rahman

When people migrate to Australia, they don't leave their culture behind, which impacts perceptions of health and wellbeing, healthcare-seeking behaviour, management of any health issues and overall health outcomes.

Those sociocultural factors are important determinants of health and wellbeing. Sometimes, it's a bit challenging to understand patients' behaviour if nurses don't realise such determinants. With a view to providing in-field experience to Australian undergraduate nursing students and correlating theories learnt in their 'Health Promotion' course, the 'Public Health Study Abroad Program Indonesia 2024' was conducted by Federation University Australia in January 2024. The program aimed to assist students in understanding the concept of public health at individual and community levels, not only in terms of healthcare settings but also in health-seeking behaviour, social

determinants, distribution of risk factors and cultural context.

The program was designed so Australian nursing students had the opportunities to interact with healthcare providers, patients and community members in primary and tertiary healthcare settings in Indonesia, which assisted them in realising the challenges in developing countries and in regional and remote settings of Australia.

Each day of the trip was quite busy with many planned activities to understand the health promotion issues in Indonesia. The team visited a primary healthcare centre and district health service office, a public and a private tertiary care hospital, an Islamic boarding school, and a community mental health nursing home; they got the opportunity to interact with healthcare providers and senior public health professionals, patients and community members. The team also visited a popular radio station, Suara Surabaya, where they understood the role of media and communications in improving awareness of health and wellbeing. A team of UnAir students always accompanied the FedUni team in all field activities and worked as interpreters.

At the end of the trip, students from Federation University Australia and Universitas Airlangga worked together to present a day-long seminar reflecting on the lessons learned through this program. All the students examined specifically three important determinants of health and wellbeing within Indonesian contexts such as religion, gender and socioeconomic status. It was an interesting session attended by students and faculty

members across different disciplines of Universitas Airlangga.

It was also an excellent opportunity for the nursing students to build connections and networks with the students from Universitas Airlangga. Almost all of the students termed this trip as a 'lifetime opportunity' which provided them with a unique experience of understanding the impact of different determinants of health and wellbeing. Lessons learned from this trip will assist them in their professional practice when dealing with patients from multicultural settings in Australia.

The program was led by Professor Dr Muhammad Aziz Rahman and accompanied by Dr Biswajit Banik (Senior Lecturer of Public Health) and Ms Nicole Coombs (Lecturer of Nursing). A total of 16 undergraduate nursing students participated in the program. The program was hosted locally by Universitas Airlangga, Surabaya, Indonesia, which had worked as a valuable partner of Federation University Australia for many years. Professor Santi Martini, Dean of Faculty of Public Health, was the local lead and Ms Zida Husnina, from the Faculty of Public Health, was the local Program Coordinator. In addition, the Faculty of Nursing, Faculty of Vocational Studies and World University Association for Community Development (WUACD) partnered with the Faculty of Public Health to support this program in 2024.

Author

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The team of Federation University visited an Islamic Boarding School at Surabaya, Indonesia to understand the health promotion activities delivered through a religious organisation. Photo credit: Professor Dr Muhammad Aziz Rahman, Federation University Australia.



Nurses are the key to a remote prescribing program and increasing hepatitis C treatment access

By Jana Van der Jagt and Sonja Hill

Since 2016, direct-acting antivirals (DAAs) for treating hepatitis C have been progressively listed on the S85 General Schedule. The current pangenotypic regimens have a short treatment duration, minimal side effects, and cure rates of over 95%.¹

There are many barriers for people living with hepatitis C accessing treatment, including stigma and discrimination, locating a prescriber, long appointment waiting times, distance, and cost. To achieve Australia's target to eliminate hepatitis C as a public health threat by 2030,² an increase in screening, testing and treatment in priority populations and settings utilising innovative models of care is needed.

Nurses are integral in identifying people at risk, offering testing, linking them to care, and providing treatment. To overcome patient barriers, the *NSW Hepatitis C Remote Prescribing Program*, funded by NSW Health and coordinated by ASHM, was established in 2020. The program utilises a nurse-led and patient-centred model of care. Nurses perform the hepatitis C assessment and work-up and then refer the patient remotely to participating medical practitioners and authorised nurse practitioners who review the patient's information and prescribe treatment. Several resources have been developed and/or tailored to facilitate the efficient exchange of clinical information and virtual prescribing.

Nurses educate patients on transmission, prevention, harm minimisation, treatment adherence and potential side effect management. Once treatment has been prescribed, nurses either inform patients when their medication is ready for collection or take the medication to the patient and provide individualised



Nurse and patient consult outside an outreach van on the Mid North Coast NSW

treatment support. They also arrange for testing four to 12 weeks post-treatment completion to assess treatment response and any follow-up needed.

Over the past three years, the program's nurse-led model of care has demonstrated highly successful outcomes, enabling over 210 patients to be treated and has proven broad application across a wide range of settings, including General Practice, Alcohol and Other Drugs Services, Aboriginal Medical Services, homelessness settings, mental health services and point-of-care testing sites. Through outreach visits and flexible service delivery models, patients are screened, diagnosed, scripted, and treated in a safe, convenient, and cost-effective manner without them having to attend the 'standard' healthcare system.

Case example: Frank, a 53-year-old man, tested positive for hepatitis C at the Drug and Alcohol Service in Kempsey in November 2022. He had previously been successfully treated but was found to be re-infected. Frank was referred for remote consultation and his treatment was dispensed with his daily methadone to support adherence. He was educated regarding harm minimisation and

respectively encouraged his injecting partners to attend for testing. Frank achieved a cure in February 2023.

There are currently 22 nurse referrers participating in the program. Increased nursing participation could enable more people living with hepatitis C to access timely treatment in their preferred setting. For more information, see ashm.org.au/hcv/nsw-hepatitis-c-remote-prescribing-program or email NSWLinkages@ashm.org.au. Free online learning can be accessed at ashm.org.au/learning-hub.

References

1. Muller K, Hasan M. Treating chronic hepatitis C in general practice. *AJGP* Vol. 50, No. 10, October 2021.
2. Burnet Institute and Kirby Institute. Australia's progress towards hepatitis C elimination: annual report 2022. Melbourne: Burnet Institute; 2022.

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Mental health education via connection – exploring the role of tertiary education providers in supporting the mental health workforce

By Latitia Kernaghan, Lucinda Derrick and Elyce Green

The health workforce is experiencing ongoing and increasing demands for mental health services across Australia.

Reflecting this, there has been significant government attention on this area of health, particularly concerning services and workforce.¹⁻³

Education providers have an important role to play in supporting the mental health workforce – including those who will work exclusively in this area and others who work in more general roles that have contact with people experiencing mental ill-health. What remains uncertain is how education providers can best support the current and future health workforce to work with community members across diverse mental health needs. The Mental Health and Suicide Prevention Parliamentary White Paper (2021)⁴ called on the Australian Rural Health Education Network to consider ways to utilise their position as a conduit between university and industry partners in delivering hybrid mental health hubs for their respective footprints. This article details the approach of one University Department of Rural Health (UDRH) to explore its role in mental health education, including an approach to implementing a Mental Health Educational Enhancement Hub.

Three Rivers Department of Rural Health is a UDRH in central west and southern New South Wales. In 2021, we commenced



Lucy Derrick (L) and Latitia Kernaghan.

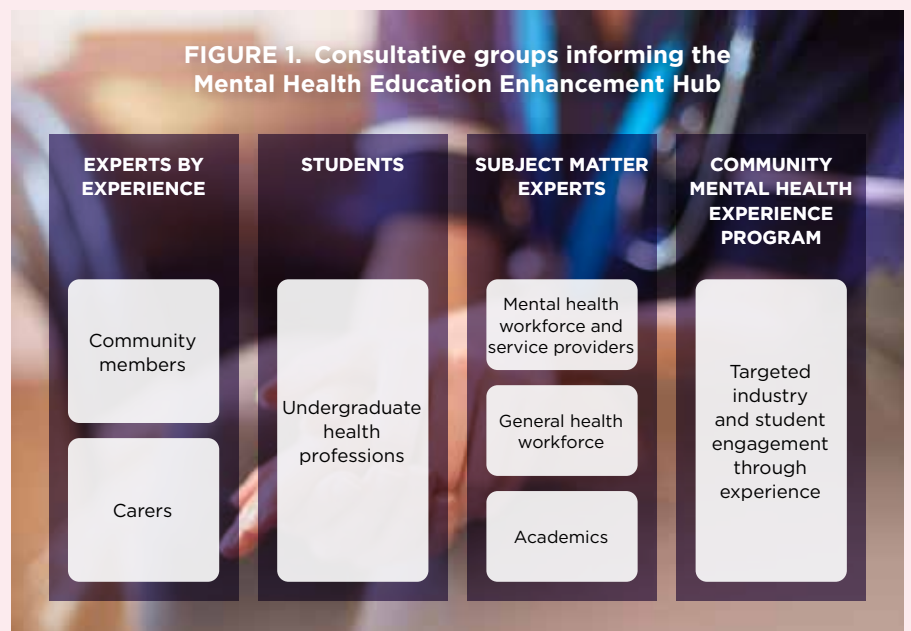
consultations with community and industry partners to explore how a tertiary education provider could influence the recruitment and retention of the mental health workforce and support all health professionals in working with people experiencing mental health concerns. Our aim was to uncover and examine student and industry needs alongside academic and curriculum needs in conjunction with the supervisory needs of students whilst on a mental health placement. A local advisory group comprising of two Primary Health Networks and Local Health Districts, with a shared interest in student learning and the future health workforce, was developed as a starting point. Additional insights have been gained from targeted consultation from a rural university student committee, student paramedics, nurses, social workers, academics, subject matter experts in nursing, psychology, social work, occupational therapy, and work-integrated learning educators from a regional university. Initial data was collated from these consultations to create a draft idea for a virtual Mental Health Education Enhancement Hub.

Alongside these consultations, a partnership was formed with a local community mental health organisation to develop, implement and evaluate a student placement model focused on mental health skill development for undergraduate health students. The Community Mental Health Experience Program involves social work, nursing, and paramedicine students supervised by community mental health professionals while they work with community members with lived experience

of mental health and connect with outreach and in-reach organisations involved in delivering holistic mental health services. This program has contributed additional insights into the theory-practice gap in mental health, identified ongoing student apprehension in selecting and attending a mental health placement, and shown opportunities to bolster their experience. Despite increased mental health awareness in the community, students enrolled in undergraduate health courses (namely nursing and paramedicine) are looking for more support to understand, prepare and thrive when working with someone experiencing mental ill-health. In addition, a detectable gap was revealed in the nexus between university student requirements, industry expectations and the inherent needs of the people seeking support for their mental health. Preliminary evaluation of the Community Mental Health Experience Program after 158 placement weeks for 38 students (ethics approval: H23588) showed an increase from 78 to 89% in confidence working with people who have a lived experience of mental illness and a 68 to 84% increase in confidence delivering information about mental health to consumers. The evaluation of this program has informed the body of content that will be accessible to students via the creation of the Mental Health Educational Enhancement Hub. **See Figure 1 below.**

The Mental Health Educational Enhancement Hub is planned to launch in early 2024. The Hub represents a commitment towards building authentic learning environments that impact student connection with the mental health field

FIGURE 1. Consultative groups informing the Mental Health Education Enhancement Hub



of study and support the health workforce across the diversity of mental health practice. To remain flexible to an interprofessional audience, accessible to both on and off-campus students, and responsive to future content development, a digital platform was selected for the Hub. The Hub aims to be collaborative and responsive to health workforce needs while maintaining connection with community members who are experts by experience and can inform the educational direction of mental health content. Toward this endeavour, we welcome feedback or comments, which can be directed to

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References

1. ACIL ALLEN. Mental Health Workforce – Educational Institutes Review [Internet]. Report to Commonwealth Department of Health; 2020 [cited 2023 Dec 11]. Available from: health.gov.au/sites/default/files/2023-01/mental-health-workforce-educational-institutes-review-final-report_o.pdf
2. Department of Health and Aged Care. National Mental Health Workforce Strategy 2022-2032 [Internet]. Canberra (AU): Australian Government; 2023 [cited 2023 Dec 11]. Available from: health.gov.au/resources/publications/national-mental-health-workforce-strategy-2022-2032?language=en
3. Institute for Social Science Research. National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries [Internet]. The University of Queensland; 2020 [cited 2023 Dec 11]. Available from: health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_o.pdf
4. House of Representatives Select Committee on Mental Health and Suicide Prevention. Mental Health and Suicide Prevention - Final Report [Internet]. Canberra (AU): Parliament of the Commonwealth of Australia; 2021 [cited 11 Dec 2023]. Available from: parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024705/toc_pdf/MentalHealthandSuicidePrevention-FinalReport.pdf;fileType=application%2Fpdf



Chronic diseases leading cause of death for people over 45

Leading causes of death vary substantially at different ages, according to new analysis released by the Australian Institute of Health and Welfare (AIHW).

The *AIHW Deaths snapshot* presents the latest data on deaths in Australia including information on age at death, trends over time, causes of death and life expectancy.

It shows that chronic diseases—such as heart disease, dementia, cancers and chronic obstructive pulmonary disease—feature much more prominently among people aged 45 and over, and external causes, such as transport accidents and suicide, are the leading causes of death among people aged 1–44.

“Coronary heart disease was the most common underlying cause of death in Australia for people aged 45 and over, followed by stroke, cancers, dementia and Alzheimer disease and respiratory conditions in 2011,” said AIHW spokesperson Louise York.

Transport accidents were the leading cause of death for people aged 1–24 and suicide was the leading cause among people aged 25–44. Among infants, maternal, perinatal and congenital conditions were responsible for the most deaths (76%).

The snapshot shows there were 147,098 deaths registered in Australia in 2012. There has been a long and continuing decline in death rates in Australia, falling by 70% for males and 75% for females since 1907.

Most of the 147,098 deaths occurred among people aged 75 or over (66%). More women died when they were aged 75 and over (74%) than men (59%).

“In general, women outlived men: the average age at death for men was 78.6, compared with 84.6 for women,” Ms York said.

Australia has one of the highest life expectancies of any country in the world. Among OECD countries in 2011, Australia was ranked 6th for male life expectancy at birth and 7th for female life expectancy at birth.

Deaths in children aged 0–4 have dropped substantially over the past century; in 1907, deaths in this age group accounted for 26% of all deaths compared to 1% in 2012.

“This may be due to improved hygiene, sanitation and neonatal healthcare, increased community awareness of risk factors for child death—such as accidents—and the reduction of vaccine-preventable diseases through universal immunisation programs,” Ms York said.

Men's health literacy, lifestyle risk and engagement in preventive care

By Ruth Mursa, Elizabeth Halcomb, Christopher Patterson and Gemma McErlean

Chronic conditions, or non-communicable diseases, are major health concerns of global significance, resulting in ill health, disability and premature death.¹

Living with a chronic condition impacts the individual's quality of life and has social and economic ramifications, including high health system costs.¹ Chronic conditions affect almost half of all Australians,² with 52% of females and 48% of males living with at least one chronic condition.³

Mental health, back problems, arthritis, asthma, and diabetes are the most common chronic conditions experienced by males in Australia,¹ with 75% of males living with overweight or obesity.⁴ Modifiable lifestyle risk factors such as smoking, an unhealthy diet, increased intake of alcohol, physical inactivity and being overweight/obese heighten the risk of developing a chronic condition.¹

As part of a doctoral project by Ruth Mursa at the University of Wollongong, an online survey of 431 men from the NSW Rural Fire Service was undertaken to explore their health literacy, lifestyle risk, and engagement in preventive care. Findings suggest that the majority of participants were overweight/obese (77.9%), although their doctor has told fewer that they are overweight/obese (29.9%). Less than half of the

participants met daily fruit (11.1%) and vegetable (52.7%) consumption guidelines. Those with a regular General Practitioner/General practice were significantly more likely to have engaged in preventive and screening activities, except dental checks.

Health literacy was measured using the 44-item Health Literacy Questionnaire (HLQ).⁵ Participants scored lowest related to 'Appraisal of health information' (Mean 2.81) and 'Navigating the healthcare system' (Mean 3.74). However, the highest scores were obtained in the 'Feeling understood and supported by healthcare professionals' (Mean 3.08) and 'Reading and understanding health information enough to know what to do' (Mean 4.10) subscales. Health literacy levels were significantly related to age, income and urban/rural location.

Interview data is being explored to further understand men's engagement with general practice for preventive care. Our findings have identified the ongoing need for the healthcare team within general practice to openly communicate lifestyle risk factors to their patients, including the practical translation of such factors to guideline recommendations,⁶ working towards reducing the impact of chronic conditions.

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References

1. Australian Institute of Health and Welfare. Chronic conditions and multimorbidity Canberra: AIHW; 2023 [Available from: aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity.
2. Australian Bureau of Statistics. Health Conditions Prevalence 2020-21 [Available from: abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/2020-21.
3. Fetherston H, Craike M. Australia's Gender Health Tracker Technical Appendix. Australian Health Policy Collaboration: Mitchell Institute Victoria University 2020 [Available from: vu.edu.au/sites/default/files/australias-gender-health-tracker-2020.pdf.
4. Australian Institute of Health and Welfare. The health of Australia's males. Canberra: AIHW; 2023.
5. Osborne RH, Batterham RW, Elsworth GR, Hawkins M, Buchbinder R. The grounded psychometric development and initial validation of the Health Literacy Questionnaire (HLQ). *BMC Public Health*. 2013;13(1):658-.
6. The Royal Australian College of General Practitioners. Smoking, nutrition, alcohol, physical activity (SNAP): a population health guide to behavioural risk factors in general practice. 2nd ed. Melbourne: The Royal Australian College of General Practitioners; 2015.



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James Bonnamy

MNurs, GradCertHlth ProfEd, BN(Hons), BNurs, is a Clinical Nurse Specialist, Research Fellow and Teaching Associate at Monash University. He is one of many young-onset colorectal cancer survivors navigating cancer as a chronic disease.

Changing landscape of cancer

For many people, a cancer diagnosis feels like a death sentence. That is undoubtedly how I felt when I was diagnosed with young-onset colorectal cancer.

But, the landscape of cancer is changing, and for many people, cancer is now a chronic disease analogous to HIV/AIDS, multiple sclerosis, chronic obstructive pulmonary disease and chronic kidney disease.¹

With improved screening, detection and precision medicine, the number of cancer survivors is growing exponentially. It is estimated that there will be 1.9 million Australians with a history of cancer in 2040; that is, one in 18 people will have received a cancer diagnosis in their lifetime.²

Cancer survivorship encompasses life after a cancer diagnosis and extends beyond the completion of active treatment. Most cancer survivors share the common belief that their lives will forever be different after cancer.³ Reaching the milestone of being cancer-free five years after the initial diagnosis is a profound experience. This milestone brings a sense of relief and newfound hope as the risk of cancer recurrence diminishes substantially.⁴ Still, some cancer cells can remain in your body after active treatment and may one day return.

Many factors influence the use of the word 'cure' in cancer care, including a balance of optimism, realism, medico-legal concerns, and even superstition.⁵ Accordingly, oncologists hesitate to tell patients they are 'cured'. Instead, they say that there is 'no evidence of disease'; in that sense, you are living with a chronic disease.⁴ The World Health Organization⁶ now recognises cancer as a chronic disease. Defining cancer as a chronic disease is not simply a change in linguistic definition. Rather, it represents a shift in how we approach cancer care and survivorship. Cancer as a chronic disease is not shared ubiquitously, however, with some authors cautioning that only certain types of cancer can be viewed in terms of a chronic disease.⁷

In November 2023, I celebrated the five-year cancer-free survival milestone. Irrespective of the various arguments for or against viewing cancer as a chronic disease, a cancer diagnosis is life-changing, and I can see that it shares many similarities with other chronic diseases, requiring prevention and surveillance for recurrence, intervention for the consequences of the disease and its treatment as well as mental health support to adjust to the realities of living with a disease that requires long-term attention and resilience.⁸

SO, WHAT DOES CANCER AS A CHRONIC DISEASE ACTUALLY LOOK LIKE?

Following my cancer diagnosis, I was also diagnosed with familial adenomatous polyposis (FAP) syndrome, a genetic condition characterised by cancer of the colon and rectum. FAP also predisposes

me to extracolonic cancers, which means I must undergo lifelong whole-body surveillance to detect metachronous cancers due to faulty tumour suppression genes. The distress leading up to, during and after ongoing surveillance scans has earned the infamous title 'scanxiety' because it has clinically meaningful outcomes.⁹ Uncertainty is inherent in cancer because prognosis, treatment options and effectiveness are all uncertain, highlighting the need for comprehensive care approaches. Unfortunately, though, your mental health is often overlooked. Insomnia quickly took hold during chemotherapy. It started with waking up during the night. Then it progressed to trouble falling asleep and eventually being awake all night. Young people will often endure physical and mental health symptoms associated with cancer treatments to stay as independent as possible;¹⁰ I know that I was not explicit about the severity of my insomnia because I wanted to divert attention from the physical impact of my treatment. Still, five years later, insomnia continues, especially near the time of surveillance scans and colonoscopies.

Cancer is a group of diseases that can be caused by and contribute to changes in multiple body systems, either from cancer alone or from cancer treatments. I have polycystic kidney disease, and prior to commencing cancer treatment, I had normal kidney function. A combination of chemotherapy, repeated episodes of dehydration during treatment and when undertaking colonoscopy preparation, and contrast-induced acute kidney injury have resulted in a rapid decline in kidney function. I have now started on disease-modifying medications and must see my nephrologist monthly to monitor my declining kidney function. Polypharmacy in those with cancer involves treating long-term comorbidities and contributes to the 'financial toxicity' or harm that occurs from cancer as a chronic disease.¹¹ While the risk of cancer recurrence is lower now that I have reached the five-year disease-free milestone, the discussion has turned to eventual kidney failure and renal replacement therapies.

Absurdly, some of the investigations and treatments involved in achieving a 'cure' can increase the risk of secondary cancers and death. Just before my high anterior resection, I learned of studies demonstrating the potentially overlapping processes underlying the development of cancer and the therapeutic pathways of various anaesthetic agents, which could affect postoperative outcomes.¹² Can you imagine the feeling of the oxygen mask being placed on your face, knowing that the very surgery you are about to undergo to remove your cancer could contribute to its recurrence? On top of that, each time I read and sign the PET scan consent form, glaring back at me is the familiar warning that the radioisotopes used in PET scans can cause cancer.¹³ Finally, exposure to the medications prescribed to assist with cancer-induced insomnia increases overall cancer risk, making every pill difficult to swallow.¹⁴

Reduced fertility is a common long-term effect of cancer treatment. Infertility is a major concern for young people, especially if, like me, they are childless



at the time of diagnosis. I underwent fertility preservation before chemotherapy, but this does not guarantee unaffected children in the future because, despite having received a clinical diagnosis of FAP, a genetic cause has not been confirmed, and it is possible that I have a yet unidentified genetic mutation which could be passed to future children. There is an ongoing cost for sperm cryopreservation every six months and a deadline by which it must be used. Future genetic testing will come at a considerable expense, and I must weigh this cost against the possible benefits of identifying yet unknown genetic mutations that may cause FAP in future children.

Everyone's experience of cancer as a chronic disease will be different. I have only offered a few insights into cancer as a chronic disease. Cancer survivorship can mean living with a chronic and complex condition that continues to impact on quality of life many years after diagnosis. There are as yet no international guidelines for the support of patients living with cancer as a chronic disease.¹⁵ The aim ahead is to define cancer as a chronic disease better and involve those diagnosed with cancer to devise interventions to improve quality of life because, as can be seen by my case, five-year survival (and beyond) is possible.

References

1. Pituskin E. Cancer as a new chronic disease: Oncology nursing in the 21st Century. *Canadian Oncology Nursing Journal*, 2022;32(1), 87-92. ncbi.nlm.nih.gov/pmc/articles/PMC8849169/pdf/conj-32-1-87.pdf
2. Cancer Council. *Australians living with and beyond cancer in 2040*. 2018. cancer.org.au/assets/pdf/australians-living-with-and-beyond-cancer-in-2040
3. Australian Cancer Survivorship Centre. *Life after treatment*. 2023. petermac.org/patients-and-carers/support-and-wellbeing/life-after-treatment
4. National Cancer Institute. *Understanding cancer prognosis*. 2019. cancer.gov/about-cancer/diagnosis-staging/prognosis
5. Miller K, Abraham JH, Rhodes L, & Roberts R. Use of the Word "Cure" in Oncology. *Journal of Oncology Practice*, 2013;9(4), e136-e140. doi.org/10.1200/jop.2012.000806
6. World Health Organization. *Noncommunicable diseases*. 2022. who.int/westernpacific/health-topics/noncommunicable-diseases
7. Bernell S, & Howard SW. Use Your Words Carefully: What Is a Chronic Disease? [Opinion]. *Frontiers in Public Health*, 2016; 4. doi.org/10.3389/fpubh.2016.00159
8. Phillips JL, & Currow DC. Cancer as a chronic disease. *Collegian*, 2010;17(2), 47-50. doi.org/10.1016/j.collegn.2010.04.007
9. Derry-Vick HM, Heathcote LC, Glesby N, Stribling J, Luebke M, Epstein AS, & Prigerson HG. Scanzxiety among Adults with Cancer: A Scoping Review to Guide Research and Interventions. *Cancers*, 2023;15(5), 1381. mdpi.com/2072-6694/15/5/1381
10. AlZaabi A, AlHarrasi A, AlMusalimi A, AlMahiyari N, Al Hinai K, Aladawi H, et al. Early onset colorectal cancer: Challenges across the cancer care continuum. *Annals of Medicine and Surgery*. 2022;82.
11. Hussaini SMQ, Gupta A, & Dusetzina SB. Financial Toxicity of Cancer Treatment. *JAMA Oncology* 2022;8(5), 788-788. doi.org/10.1001/jamaoncol.2021.7987
12. Alam A, Rampes S, Patel S, Hana Z, & Ma D. Anesthetics or anesthetic techniques and cancer surgical outcomes: a possible link. *Korean J Anesthesiol*, 2021;74(3), 191-203. doi.org/10.4097/kja.20679
13. Kessara A, Buyukcizmeci N, & Gedik GK. Cancer risk estimation for patients undergoing whole-body PET/CT scans. *Radiation Protection Dosimetry*, 2023;199(6), 509-518. doi.org/10.1093/rpd/ncado40
14. Iqbal U, Nguyen P-A, Syed-Abdul S, Yang H-C, Huang C-W, Jian W-S, Hsu M-H, Yen Y, & Li Y-C. Is Long-term Use of Benzodiazepine a Risk for Cancer? *Medicine*, 2015;94(6), e483. doi.org/10.1097/md.0000000000000483
15. Pizzoli SFM, Renzi C, Arnaboldi P, Russell-Edu W, & Pravettoni G. From life-threatening to chronic disease: Is this the case of cancers? A systematic review. *Cogent Psychology*, 2019;6(1), 1577593. doi.org/10.1080/23311908.2019.1577593

Challenge to healthcare providers prevention and management hypertension in Thailand

By Pataporn Bawornthip, Apinya Koontalay, Andrea Driscoll and Anastasia Hutchinson

Hypertension, as a major cause of premature death, is a rapidly increasing healthcare challenge in Southeast Asia.¹

The 2019 Thai guidelines on the treatment of hypertension defined hypertension as a systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg, similar to the 2016 National Heart Foundation of Australia.² In Thailand, the mortality and morbidity rate in hypertension is increasing; previous surveys in Chiang Mai province, Thailand, show that the prevalence of hypertension is 60.95% and 57.06% uncontrolled blood pressure.³

Social, cultural, and economic factors in Southeast Asian countries such as Thailand are key modifiable risk factors for hypertension in these communities, with food cost and affordability essential barriers to reaching healthy diets.⁴ In addition, many Asian dishes commonly have high sodium levels as they include traditionally fermented foods such as salted fish and condiments that are high in salt and the unrestricted addition of other salt to previously prepared meals.⁵

Many Southeast Asian people participate in insufficient physical activity. This is influenced by rapid urbanisation and employment conditions, with as many as 14.7% of the population employed in low-paid jobs that require extended working hours, so they have limited time to incorporate exercise into their daily routine.⁶

Thai cultural values play an important role in preventing hypertension.⁷ Folkways, such as local dietary and traditional alcohol consumption, are also a disincentive for Thai people to participate in lifestyle modification.⁷

Lifestyle modifications are recommended as the key first-line interventions to manage raised blood pressure and hypertension, including dietary modification to decrease salt intake, decrease intake of sweetened, high-salt and alcoholic beverages, smoking cessation, regular physical activity and exercise, and weight reduction.⁸

A systematic narrative review of the effectiveness of interventions to manage prehypertension and hypertension in Southeast Asia showed that dietary interventions



included the Dietary Approaches to Stop Hypertension (DASH) Diet, sodium restriction, and increasing food literacy decreased systolic blood pressure 7 to 11 mmHg, exercise interventions decreased systolic blood pressure between 4 and 16 mmHg, combined diet and exercise decreased systolic blood pressure 9 to 17 mmHg, and health education resulted in reductions in systolic blood pressure between 9 and 16 mmHg.⁹ Thai health policy encourages healthcare providers to use technology for people with hypertension, such as mobile applications (Facebook, LINE) to provide health education and appointments and the Internet of things to develop innovative healthcare for attending and monitoring older people living alone in their homes.¹⁰

In the Thai healthcare system, primary healthcare nurses play a leading role in health promotion in community settings. The demonstrated effectiveness of non-pharmacological interventions highlights an important opportunity for nurses to evaluate the effectiveness of nurse-led programs to increase the uptake of these lifestyle changes in Southeast Asian communities.

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References

- World Health Organization [Internet]. Geneva. Hypertension; 2023 [cited 2023 Jan 16]. Available from: [who.int/news-room/fact-sheets/detail/hypertension](https://www.who.int/news-room/fact-sheets/detail/hypertension)
- Thai Hypertension Society. 2019 Thai guidelines on the treatment of hypertension. Bangkok: *Trick Think*; 2019.
- Bawornthip P, Aungwattana S, Sripetchwandee N. The relationship between personal factors, health literacy, and health behaviors among uncontrolled hypertensive patients in Muang districts Chiang Mai province. *Nursing Journal CMU*. 2023; 50(1):284-299.
- Gaupholm J, Papadopoulos A, Asif A, Dodd W, Little M. The influence of food environments on dietary behaviour and nutrition in Southeast Asia: A systematic scoping review. *Nutrition and Health*. 2023;29(2):231-53.
- Amarra MS, Khor GL. Sodium Consumption in Southeast Asia: An Updated Review of Intake Levels and Dietary Sources in Six Countries. In: Bendich A, Deckerbaum RJ, editors. *Preventive Nutrition: The comprehensive guide for health professionals*. Cham: Springer International Publishing; 2015. p. 765-92.
- World Health Organization [Internet]. Geneva. Status report on 'physical activity and health in the South-East Asia Region; 2018 [cited 2023 Jan 16]. Available from: [file:///C:/Users/HP/Downloads/9789290226697-eng%20\(1\).pdf](file:///C:/Users/HP/Downloads/9789290226697-eng%20(1).pdf)
- Chukumnird S, Boonyasopun U, Sirisom K. Factors influencing adherence to preventive behaviours among Thais with hypertension: a literature review. *Walailak Journal*. 2019; 16(8): 509-521.
- Unger T, Borghi C, Charchar F, Khan NA, Poulter NR, Prabhakaran D, et al. 2020 International Society of Hypertension Global Hypertension Practice guidelines. *Hypertension*. 2020; 75(6): 1334-57.
- Bawornthip P, Hutchinson A, Driscoll A. Evidence for non-pharmacological interventions to manage prehypertension and hypertension in community settings in Southeast Asia: a narrative review. In: Oh EG, editors. Proceedings of the 2023 Yonsei International Nursing Conference Person-centered, Technology-driven health care innovation toward health equity; 2023 Oct 5-7; Seoul, Republic of Korea. Seoul: Double-you Plan; 2023. P.322.
- Bawornthip P, Pienrakkarn K. Community nurse roles in using health care technology for patients with hypertension in Thailand 4.0. *Journal of Nurses Association of Thailand Northern Office*. 2019; 25(1): 14-22.



Experiences of the elderly with chronic illnesses through COVID-19 lockdowns

By Reza Navidinejad, Amanda Kimpton, Leanne Sheeran and Linda K Jones

There is a national and worldwide shortage of research on the effects of lockdown on individuals with various chronic diseases.¹

The healthcare system was only one area profoundly affected by the sudden global spread of the COVID-19 outbreak. The restrictions that were imposed on the healthcare system had the most impact on vulnerable populations, such as the elderly and those living with chronic health conditions. The demographic shift towards an ageing population has significant implications for healthcare services.

In 2020, 11.1% of the population in the catchment area of the North-Western Melbourne Primary Health Network were aged at least 65.

This figure is projected to increase up to 12.2% by 2030.² Elderly individuals have an increased likelihood of

developing chronic illnesses, necessitating consistent access to healthcare services to monitor and manage their conditions.³

To gain a deeper understanding of this vulnerable population group, a RMIT University PhD research project is focusing on the lived experiences of elderly individuals with chronic diseases, particularly during the COVID-19 lockdowns in Western Melbourne communities. This study will be undertaken by a series of semi-structured interviews to find out what older people with long-term illnesses went through during the pandemic restrictions. This study will highlight the 'adequacy and deficiency' of the existing healthcare system from the participant's point of view. In addition to strengthening healthcare services, the findings will be utilised to better prepare the health system for similar occurrences in the future.

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References

1. Boulin M, Cransac-Miet A, Maynadié M, Volot F, Creuzot-Garcher C, Eicher J-C, et al. COVID-19 Lockdown in Patients with Chronic Diseases: A Cross-Sectional Study. *Int J Environ Res Public Health*. 2022; 19(7): 3957. Available from: doi.org/10.3390/ijerph19073957
2. North Western Melbourne Primary Health Network. Older adults and aged care; 2023 [Internet] Available from: nwmpnhn.org.au/our-work/priority-populations/older-adults-and-aged-care/.
3. Foo KM, Sundram M, Legido-Quigley H. Facilitators and barriers of managing patients with multiple chronic conditions in the community: a qualitative study. *BMC Public Health*. 2020;20(1):273. Available from: doi.org/10.1186/s12889-020-8375-8



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, Blueberry & Yoghurt Loaf

This is a quick, simple, one-bowl-bake. It produces a light, lovely cake that is perfect for morning or afternoon teas.

Prep time 15 mins **Cook time** 1 hr

Portions 8-10

INGREDIENTS

150 g unsalted butter, melted

200 g caster sugar

2 eggs

150 g (½ cup) Greek-style yoghurt

Zest and juice from 1 medium lemon

225 g (1 ½ cup) self-raising flour*

150 g fresh or frozen** blueberries

* for added protein, substitute ½ cup of the flour with almond meal.

** if using frozen, toss blueberries in a tablespoon of flour as this will stop them from sinking to the bottom.



Food styling and photo by Erika Budiman © pixelsandpaper.studio

METHOD

1. Preheat oven to 160°C.
2. Place butter, sugar, eggs, yoghurt, lemon zest and juice in a bowl and whisk to combine.
3. Add flour and whisk until well combined. Don't worry if the mixture looks curdled.
4. Fold through the blueberries and spoon into a loaf tin lined with baking paper.
5. Smooth the top and bake for 1 hour to 1 hour and 10 minutes or until cooked when tested with a skewer.
6. Allow to cool before transferring to a wire rack.



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, Lucy, on making Maggie's Lemon Myrtle Melting Moments published last issue. We hope you enjoy your \$50 Maggie Beer voucher.

"These biscuits were a hit in the tea room! I should have made more." Lucy says.



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