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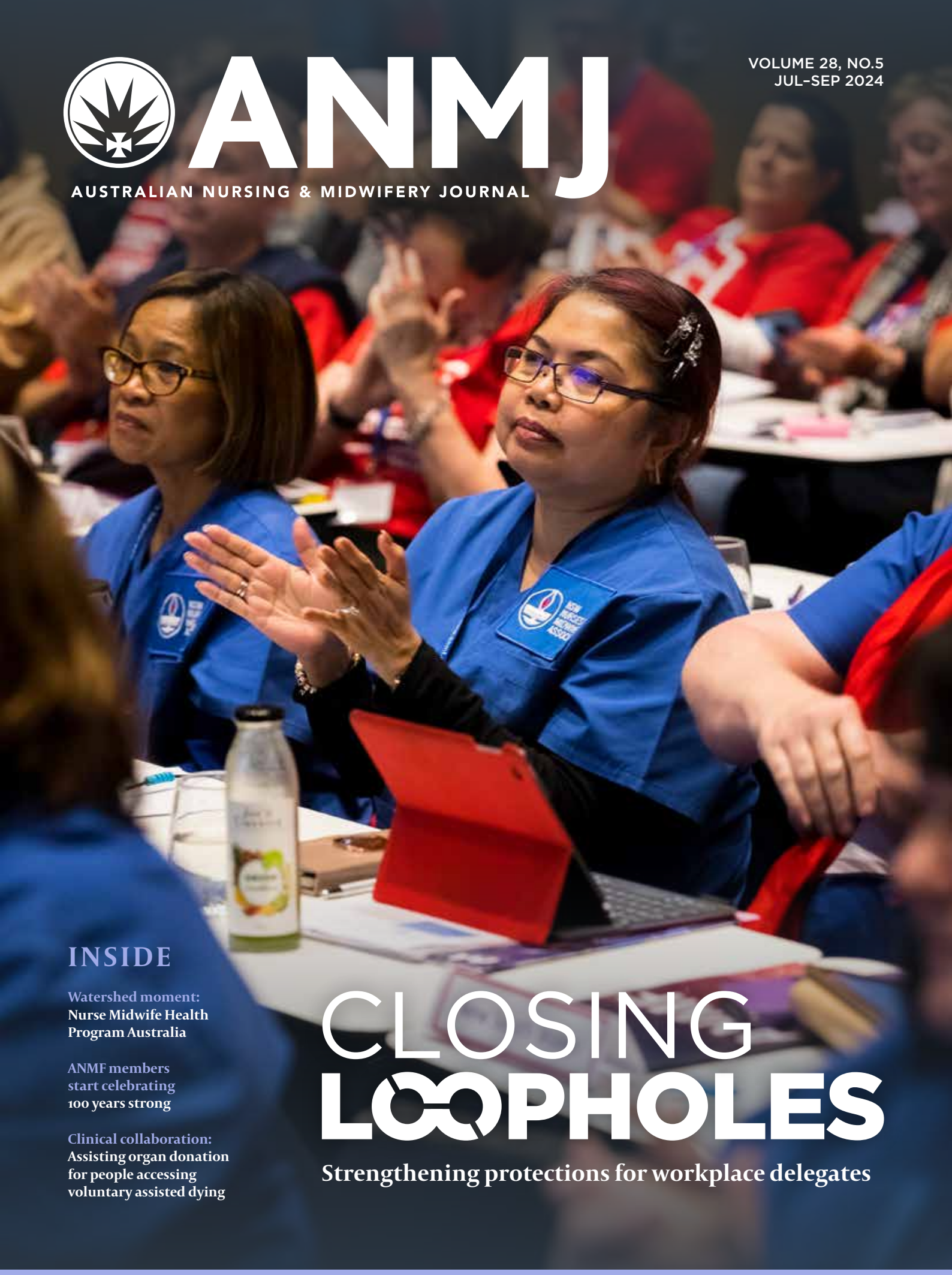

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Strengthening protections for workplace delegates

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Annie Butler

ANMF Federal Secretary

The Australian Nursing and Midwifery Federation (ANMF) has recently welcomed a number of government initiatives that promise much-needed relief and support to students and the nursing and midwifery community.

The Albanese Government's new support payments for student nurses and midwives, along with the *Health Legislation Amendment (Removal of Requirement for Collaborative Arrangement) Bill 2024*, mark significant strides forward. These changes not only acknowledge the critical roles nurses and midwives play but also begin to dismantle long-standing barriers that have hindered their full potential. However, while we celebrate these wins, there is still much work to be done.

To clarify, support payments for student nurses and midwives, known as 'Commonwealth Prac Payments,' will allow eligible nursing and midwifery students to receive $319.50 a week during their mandatory clinical placements. This financial support is a lifeline for students who often juggle their studies with part-time work, only to see their income diminish during placement periods. These payments will help alleviate the financial strain from costs like travel, childcare, uniforms, and other necessities. By easing these burdens, the payments will help retain students and also encourage more to enter the profession, addressing critical workforce shortages.

The recent passage of the *Health Legislation Amendment (Removal of Requirement for Collaborative Arrangement) Bill 2024* is another significant victory. This legislation removes the outdated requirement for nurse practitioners (NPs) and endorsed midwives to have a collaborative arrangement with a medical practitioner to prescribe medicines under the PBS and provide services under Medicare. This reform empowers nurses and midwives to utilise their full skill-set and training, providing better access to care without unnecessary bureaucratic hurdles.

By allowing nurses and midwives to operate at their full scope, we can reduce the pressure on general practitioners and emergency departments, improving the overall efficiency and responsiveness of the healthcare system and ultimately enhance patient care. The success of nurse-led clinics in the ACT and Tasmania stands as a testament to the potential of these reforms.

Despite these advances, we must acknowledge the ongoing challenges that hinder nurses and midwives from working to their full scope. The recently released *Scope of Practice Review Issues Paper Two* identifies four key challenges: poor recognition of skills, inadequate preparation for primary care, restrictive legislation, and funding/payment arrangements that limit professional practice. These barriers not only restrict the potential of our healthcare workforce but also impede access to optimal care for consumers.

The ANMF, along with other peak nursing and midwifery organisations, views the *Scope of Practice Review* as a pivotal opportunity to drive further reforms. The review calls for a holistic approach to healthcare delivery, one that fully utilises the expertise of all health professionals. The evidence is clear: when nurses and midwives can work to their full scope, patient outcomes improve, and the health system becomes more resilient and sustainable.

To truly future-proof Australia's health and aged care systems, the government must commit to bold, evidence-based reforms. This includes removing remaining legislative and financial barriers, fostering modern models of health delivery, and ensuring that health policy aligns with the best available evidence.

As highlighted by the Australian Primary Health Care Nurses Association 2023 Workforce Survey, many nurses are not working to their full scope, and this underutilisation contributes to workforce attrition. Addressing these issues is crucial for both retaining current staff and attracting new talent to the profession.

While the recent budget and legislative changes are promising first steps, they are just the beginning. The ANMF and its members will continue to advocate for comprehensive reforms that empower nurses and midwives to provide the highest quality of care. The journey towards a more efficient, equitable, and effective healthcare system is ongoing, and with continued support and bold action, we can ensure that all Australians receive the care they need, when they need it.

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Moving state.

Transfer your ANMF membership

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

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FOCUS

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

@ANMJAUSTRALIA

Fostering collaboration and innovation in nursing leadership in the South Pacific

As the *ANMJ* goes to print, nurse leaders from across the South Pacific are debating key issues facing the professions.

The South Pacific Nurses Forum (SPNF), held every two years, took place on 4–7 June at Port Moresby, Papua New Guinea.

The purpose of the SPNF is for nursing professionals from across the region to convene, collaborate, and deliberate on the pressing issues that shape the profession and influence healthcare outcomes.

The ANMF's long-time affiliation with the SPNF provides a valuable opportunity to develop the nursing and midwifery professions in smaller neighbouring countries that often face barriers like workforce shortages and fewer training opportunities.

The meeting is the group's 21st Forum which first began in 1982 after a group of nurses from the region connected at the 1980 International Council of Nurses (ICN) conference in Los Angeles.

Australian representatives at the Forum included ANMF's Federal Assistant Secretary Lori-Anne Sharp and CEO of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Ali Drummond.

The *ANMJ* crew were also delighted that some of the delegates at the Forum were lucky enough to receive a copy of the *ANMJ* (pictured). We hope they enjoyed it!

HEART HEALTH YARNING TOOL FOR SHARED DECISION-MAKING

A new shared decision-making resource is available to help health professionals discuss cardiovascular risk with Aboriginal and Torres Strait Islander peoples in a culturally safe and meaningful way.

The *Heart Health Yarning Tool* is designed to help health professionals and consumers make informed choices once cardiovascular risk has been assessed using the new Australian guidelines. The tool was informed by yarning sessions with community.

"Having a way of talking through the options and choices, using a tool that has been designed with community members, means that health professionals can make decisions with their patients instead of for them," said qualitative researcher Dr Shannon McKinn, who interviewed clinicians during development of the tool.

The tool provides different options depending on where an individual is at in the decision-making process. A short video explains how to use the *Heart Health Yarning Tool* in practice.

"We know that holistic, culturally safe care is critical to reducing cardiovascular risk. This tool supports clinicians to do that really well," said senior project officer and National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP) chairperson Mr David Follent.

The *Heart Health Yarning Tool* is freely available online **heartyarningtool.com/**

The Sydney team behind the shared decision-making project (L to R): Shannon McKinn and Carissa Bonner, Sydney Health Literacy and David Follent, NAATSIHWP and Agency for Clinical Innovation (ACI)

What do Australians die from?

Coronary heart disease is the most common *underlying* cause of death in Australians, responsible for one in 10 deaths.

This figure rises to one in five if all health information included on medical death certificates are included, according to a new Australian Institute of Health and Welfare (AIHW) report.

What do Australians die from? highlights the most common causes involved in the 191,000 registered deaths in Australia in 2022. It uses all health conditions recorded on the death certificate contributing to a person's death, highlighting the interplay of multiple diseases and the role played by each. The report shows that four in five deaths involved more than one cause and almost one-quarter of deaths had five or more causes recorded.

"Traditionally, statistics about how people die are based primarily on the initiating or 'underlying' cause of death, but death certificates also contain other information that can be useful in understanding why a death occurred," AIHW spokesperson Michelle Gourley said.

For example, while the *underlying* cause of death might be coronary heart disease, the death certificate might also record an acute myocardial infarction that led directly to death.

The most common conditions *contributing* included hypertension (8%), diabetes (7%) and CHD (6%). Substance use disorders such as alcohol (2.0%), tobacco (1.3%) and other drugs (1.6%) were more common *contributory* conditions for males, while dementia (7%) and musculoskeletal conditions such as osteoporosis (1.9%) and osteoarthritis (1.5%) were more common *contributory* conditions for females.

The most common *direct* causes of death (those that ultimately end a person's life) were lower respiratory infections (8%), cardiac/respiratory arrest (7%) and sepsis (6%).

New powers for nurse practitioners and endorsed midwives to provide quality care

The Australian Nursing and Midwifery Federation (ANMF) has commended MPs and Senators for supporting new legislation which finally removes outdated barriers which have prevented highly trained nurse practitioners (NPs) and midwives from working to their full scope.

The Health Legislation Amendment (Removal of Requirement for Collaborative Arrangement) Bill 2024 passed the Parliament in May, after being earlier introduced in March by Assistant Minister for Health and Aged Care, Ged Kearney.

The landmark legislation removes barriers that have prevented NPs and endorsed midwives from prescribing medicines under the PBS (Pharmaceutical Benefits Scheme) and providing services under Medicare because of the requirement for a 'collaborative arrangement' with a medical practitioner.

"This is a critical workforce reform, which will empower nurses and midwives to utilise their full skillset, training and experience, for the benefit of those needing care and support in the community," ANMF Federal Secretary, Annie Butler, said.

"Removing old barriers like these are long overdue and means nurses and midwives will now be able to provide people across the community with better access to safe, quality care, without the need to visit a GP surgery or wait in a strained hospital ED. This has been the case in the ACT and Tasmania, where nurse-led clinics have been successful and very popular in the community."

Government commits to 'Prac Payment' to support nursing and midwifery students during placements

Student nurses and midwives will be paid $319.50 per week while undertaking their mandatory clinical placements following a new federal government 2024-25 budget measure to address rising 'placement poverty'.

The $427.4 million 'Prac Payment', set to benefit around 68,000 higher education students and over 5,000 VET students each year, will be means tested and available from 1 July 2025 and be in addition to any income support a student may also receive.

The Australian Nursing and Midwifery Federation (ANMF), which has long advocated for paid support for students during clinical placements, commended the government's pledge, saying it would finally recognise the financial and social pressures student nurses and midwives face while typically completing a minimum of 800 hours in practical training.

In its 2024-25 budget submission, the ANMF called on the federal government to fund payments for nursing and midwifery students undertaking placements as part of their courses, including meals, travel, and accommodation allowances.

"This new payment will help alleviate these costs and better support students who need to complete their clinical placements before starting their career," ANMF Federal Secretary Annie Butler said.

"Alleviating financial burdens will also encourage more students into the nursing and midwifery workforce – supporting them through their, often, challenging courses."

ANMJ highlighted the issue earlier this year. Final-year midwifery student Erin Pereira estimated it has cost her about $9,000 each year in out-of-pocket expenses to complete clinical placement hours as part of her Griffith University Bachelor of Midwifery.

"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," said Erin.

Introducing the Nurse Midwife Health Program Australia

The highly anticipated Nurse Midwife Health Program Australia was launched in Canberra recently, marking a significant milestone for Australian nurses, midwives and students grappling with sensitive psychological health issues.

The Australian government, recognising that nurses and midwives are suffering from fatigue, stress and burnout, which places both the Australian and global nursing and midwifery workforce in jeopardy, has committed to $25.2 million over five years to implement and support for the program.

The Australian Nursing and Midwifery Federation, who has lobbied for the service for many years, was responsible for rolling out the framework in consultation with the Australian and state and territory governments, key service providers and nursing and midwifery peaks.

The program was founded on principles of inclusivity, equity, and clinical accountability, offering a safe haven for nurses, midwives and students to confront their struggles without fear of judgement or stigma.

Implementation Director Heather Pickard said at the launch the service is delivered by experienced nurses and midwives for nurses and midwives, aiming to provide early intervention and foster a culture of help-seeking within the profession.

Ms Pickard said that nursing and midwifery are rewarding vocations, but come with their own set of challenges working in demanding workplace environments.

"High workloads, long hours and emotional stressors can put nurses and midwives at greater risk of mental health issues, such as anxiety, depression and burnout," she said.

"At the extreme, such risks can result in significant harms, including drug and alcohol misuse and other diversionary behaviours, such as gambling.

"We know from research, feedback and experience that stigma can hold nurses, midwives and students back from reaching out for assistance, which is why this new service offers a nonjudgemental, safe space for them to deal with their sensitive challenges.

"In our professions we're often not wired or used to putting our own needs or self-care first, so it's important to reinforce that if we have concerns and aren't feeling right that help is at hand."

KEY FEATURES:

- **National, confidential, and free:** The program offers national coverage and provides confidential and free support to nurses and midwives across Australia.
- **Comprehensive health support:** It addresses a range of health needs including drug and alcohol issues, stress, burnout, mental health concerns, occupational violence, chronic injury and illness, and domestic and family violence.
- **Safe and confidential service:** Nurses and midwives can expect a safe, confidential, and nonjudgemental space to confront their struggles without fear of stigma.
- **Continuous support:** Unlimited sessions, culturally appropriate care, goal setting, and check-ins ensure continuous support tailored to individual needs.
- **Flexible delivery:** The service is available via telehealth or face-to-face consultations, Monday to Friday from 9 am to 5 pm.

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You are not alone.
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L–R: Lori-Anne Sharp, ANMF Federal Assistant Secreatry; Sally Anne Jones, ANMF Federal President and Annie Butler, ANMF Federal Secretary. Photo: Sharon Hickey

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CLOSING LOOPHOLES

Strengthening protections for workplace delegates

The Australian government has enacted the *Closing Loopholes* laws, which will be implemented in stages from December 2023 to August 2025. A key aspect of this legislation is the introduction of delegates' rights within the modern award system, seen as a transformative step for workplaces to enhance protections for union delegates. NATALIE DRAGON reports on this significant development.

"There's the broad view that [this new legislation] will allow delegates to operate in the open rather than covertly in the shadows," says Australian Nursing and Midwifery Federation (ANMF) Federal Industrial Officer Paul Yiallouros.

While previously some protection for union activity existed under the Fair Work Act, none explicitly protected the rights of delegates or established what those rights are, Mr Yiallouros explained.

"This legislation is designed to protect delegates from adverse actions from employers be it punishment, or other forms of adverse action, demotions, and refusal to promote."

Yet despite acknowledging the protection of the legislation, in reality there will still be hostile workplaces, Mr Yiallouros says. However, the legislation will change the dynamics how workplace relations occur.

Monica, a long-time ANMF Tasmanian Branch member and job representative, welcomes the further protections. "If you know that there's protections, I think people may find their voice and speak up for what they believe is the right thing to do. "

Workplace delegates at the ANMF Biennial National Conference 17–18 October 2019, Melbourne. Photographer: Chris Hopkins.

Monica says this is important as it empowers nurses and midwives to address issues even when people are afraid to talk to their managers.

Monica, who has been an ANMF Tas Branch member since 1981, explains she became a job representative when a workplace grievance about workloads and safety issues led to her and her colleagues seeking help from the union. "I became involved . . . , and from there, I was approached to become a rep." Monica then joined the Branch Council.

Ultimately the value of the role of the job delegate extends beyond the workplace, says Monica.

"Because we understand that it's about our communities, what we do and who we stand for.

"You do this voluntarily. It's not a paid job. You do it because it matters and you're passionate about it and you care about your work standards. You care about your colleagues, and you care about your patients and care about your profession as well.

"And I think this is what makes us different to some other unions is that we have these core values, and we have this sense of what is humanely right, even outside the workplace. We speak up for our colleagues overseas in conflict zones- we speak up on behalf of marginalised people- we know the change in the environment affects health. We speak up."

Victorian public sector registered nurse Elise became a job representative after her colleagues recognised her as a strong voice and sought her out for support.

"There's often questions on most of my shifts. They range from 'I forgot how many breaks I can have' or 'I don't think I'm getting paid correctly' or 'how about we do something in our next EBA about this'."

Workplace delegates at the ANMF Biennial National Conference 17–18 October 2019, Melbourne. Photographer: Chris Hopkins.

Monica addresses media at a Tasmanian rally

Monica with ANMF Federal Vice President James Lloyd

She says many of the issues that colleagues come to her for advice on, don't require escalation.

"For the majority of the issues, I can give advice directly or I have a communication with my manager in order to fix the issues that colleagues have come to me with. It saves a lot of time, it saves a lot of resources, and it also helps members directly at the time of their concern."

Elise says the training she received empowered and educated her to handle these matters effectively.

ANMF Federal Assistant Secretary Lori-Anne Sharp, who testified at the Closing the Loopholes Senate Inquiry, also emphasises the importance of delegates like Monica and Elise and for the need to protect them.

Ms Sharp stresses that delegates are the lifeblood of the movement, explaining that they are workers selected by their colleagues to represent them in their respective workplaces.

"They are the connecting thread between their colleagues, their employers and the industrial associations [members of unions].

"They are leaders in their workplace, recognised and endorsed by their colleagues for their ability to solve problems diplomatically and represent their best interests.

"It could be as simple as pay, superannuation, meal breaks, unsafe workloads or not having enough breaks between shifts. The whole community benefits when the voices of workers are heard through their workplace representatives," she says.

Ms Sharp believes the new legislative changes ensure that delegates are empowered and perform the role effectively.

"The legislation formalises the rights of delegates, it provides protection for those people, and it allows people to put their hands up to be delegates because it helps normalise it."

WHAT IS THE NEW LEGISLATION AND HOW DOES IT PROTECT DELEGATES?

The legislation sets out three obligations for employers and how they conduct themselves specifically in their dealings with delegates. Paul Yiallouros explains.

Employers cannot unreasonably fail or refuse to deal with the workplace delegate.

> "Basically, they [employers] can't without good reason, ignore [delegates]. Previously there was nothing to compel employers to deal with the delegate who came to an employer with an issue they wanted dealt with."

Employers cannot knowingly or recklessly make a false or misleading representation.

> "In other words, they can't lie to delegates, fob them off or placate them with mistruths. Employers who get caught out by that have contravened the Fair Work Act."

An employer cannot unreasonably hinder, obstruct or prevent the exercise of the rights of the workplace delegate under the Fair Work Act or a fair work instrument (such as an award or enterprise agreement).

> "A delegate has a right to do four things under the Act and the employer can't get in the way of that."

SO, WHAT ARE THE 'FOUR THINGS' THAT DELEGATES CAN DO UNDER THE ACT?

1 Represent the industrial interests of union members.

They can be the representative, they can advocate on their behalf in relation to industrial interests, including in disputes with the employer.

2 Communicate with members and potential members in relation to their industrial interests.

If there's a problem in the workplace and the delegate is the go-to person, there is a right for that delegate to be approached and have that conversation and vice versa for the delegate to approach people and talk to them about workplace issues.

"It seems absurd that you'd have a system which didn't permit a delegate to approach a member or a potential member to have a conversation with them about their workplace rights, but the Act previously hasn't said that you could do that," Mr Yiallouros says.

However, he adds it remains unclear whether these conversations can happen during work hours or only outside of work hours.

"We [the union] say a delegate is a delegate at all times, be it inside or outside of work. They should be able to have a conversation and also be able to communicate with people in other ways. That means being able to distribute flyers, put information on notice boards, send emails and texts to workers about their industrial interests, including their right to join a union and participate in legitimate union activities. All these things should be able to be communicated. There should be a natural flow of information between union delegates, union members and potential members."

3 A delegate has reasonable access to the workplace and workplace facilities.

When it comes to representing industrial interests, union delegates should be able to use the workplace to conduct their role. Use of facilities might be an appropriate meeting room, or the delegate has materials they want to distribute, use of the work email or the work photocopier.

"People are more effectively represented when there's someone in the workplace making those conversations happen, making sure that people are up to date on what is the progress on enterprise bargaining or if we've got a dispute currently afoot," says Mr Yiallouros.

4 The delegate is entitled to reasonable access to paid time during normal working hours to participate in training, for the role of delegate. (Item only applies to employers who are not a small business (fewer than 15 employees)).

Where there is no enterprise agreements that specifically provide for delegate training, there is now an automatic right under the Fair Work Act to participate in training and at times when delegates would usually be paid.

"This is really important," Mr Yiallouros says. "Delegates are not natural experts in industrial relations (IR) and workplace relations. They're usually chosen by their colleagues because they display some leadership attributes and often have basic or sometimes quite sophisticated diplomatic skills in dealing with employers. And most nurses and midwives are very good at identifying people who have these attributes and they're the people who naturally become delegates and leaders in their own workplace. But that doesn't mean they're experts in IR.

"They need access to training to know how to be a delegate. How do you approach a new employee to invite them to be a member of the union? How do you respond to an employer who tries to do something that's in breach of an enterprise agreement? If someone comes to you with a bullying complaint, how do you handle that? Access to training means that they will be able to do that more readily or at least they'll have the skills and tools to be able to solve those problems," he says.

ARE THERE LIMITATIONS TO THE LEGISLATION?

The wording in the legislation uses "reasonable" which means how far these protections go is still to be tested.

"Everything except representing industrial interest has the word reasonable before it. So, reasonable communication, reasonable access to the workplace and workplace facilities, reasonable access to paid time to undertake training," says Mr Yiallouros.

"So, whilst all of this is really good and positive, a lot of it is tempered by the reasonableness of the circumstances about what the delegate wants in terms of exercising their rights. So much of this is about scale and degree.

"There's a Fair Work process [to set out the wording of those rights], but also over time, as case law develops and there may be disputes to resolve ambiguous questions [about how far those rights extend]".

Unsurprisingly, some employers are seeking to narrow the operation of the provisions.

For example, some employers argue that industrial interests should be clearly and narrowly defined to mean participation in bargaining, involvement in disciplinary processes, industrial disputes and dealing with staff grievances.

Unions say there should be an ability to advocate broadly about a whole range of issues and they should be considered an industrial right. For example, attending hearings, Inquiries, commissions, lobbying politicians and the like.

"We're in this interim of what's being worked out in the Fair Work Commission in trying to bed down in the various modern awards, including the nurses award, what a delegate can do," says Mr Yiallouros. "Once we have the modern award clause settled, it may be clearer about what delegates can and can't do.

"Similarly, once enterprise agreements have to include these clauses, it may be the case that they have to include or at least provide a minimum. So, this is going to evolve over time."

James Lloyd

ANMF Federal Vice President

Undergraduates and poverty placement

The financial hardship experienced by student nurses and midwives in Australia during mandatory clinical placements has become desperate.

These placements, integral to their training, require student nurses and midwives to work unpaid for hundreds of hours, accruing significant personal expenses without compensation. Recognising the unsustainable nature of this burden, the Australian federal government has recently announced initiatives to alleviate this financial burden, aiming to support student nurses and midwives financially while on mandatory clinical placement, and ensure a robust future workforce.

Australian nursing students are required to complete a minimum of 800 hours of clinical placements to meet their undergraduate degree requirements and qualify for Ahpra registration. These placements are conducted in a variety of healthcare settings, including hospitals, aged care facilities, and community health centres, in both urban and rural settings. These clinical, practical placements are invaluable, providing hands-on learning and real-world experience. But these compulsory placements, can come at a high financial cost for some nursing and midwifery students.

When on placement, expenses often include travel, accommodation (especially in rural areas), and daily living costs. On placement, students receive no remuneration for the work they undertake, and importantly, they are missing the opportunity to hold part-time work due to the demanding nature of their study and placement.

Nurses and midwives trained via an apprenticeship-based system in the past. We were paid during our training. The wages were low, but it was a guaranteed income that helped nurses and midwives complete their 1-3 years of training. Times have changed and the move to a more professional model of training (university/TAFE) has seen us gain much needed vocational merit. However, our undergraduate nurses and midwives have lost that 'training wage' as monetary support.

The financial implications of unpaid placements and the inability to earn income can have other effects on student wellbeing. The pressure of financial stress can lead to mental health issues, such as anxiety and depression, and affects academic performance. Importantly, it also impacts the demographic makeup of the nursing profession, as individuals from lower socioeconomic backgrounds may be discouraged from entering the field due to the financial/economic barriers.

At the 2023 ANMF Biennial National Conference, the Victorian Branch brought forward a resolution requesting the ANMF Federal Office lobby for paid stipends while undergraduate nurses and midwives were on clinical placement. This resolution was passed unanimously.

In response to the poverty placement issues our members were voicing, the ANMF, in its 2024-25 budget submission, called on the federal government to fund payments for nursing and midwifery students undertaking placements. The Australian federal government responded by making funding announcements aimed at supporting student nurses and midwives. Recognising the dual role these placements play in education and workforce sustenance, the government has proposed a model that includes stipends for student nurses and midwives during their clinical placements. This payment is means-tested and will be available from 1 July 2025. This funding is intended to assist in covering basic living expenses and travel, reducing the financial strain on students. The ANMF has long advocated for financial support to ensure equitable access to nursing education and to sustain the inflow of new nurses into the healthcare system.

By alleviating some of the financial burden, this announcement by the federal government will help increase accessibility to our professions to those from diverse backgrounds, enhancing socioeconomic and cultural diversity within the field. Reducing the financial stress of undergraduate nurses and midwives is likely to increase mental health and wellbeing, leading to improved academic and clinical performance. Further, this financial support may also decrease the dropout rates for undergraduates and help to alleviate present and upcoming nursing shortages.

The issue of work placement poverty among student nurses and midwives in Australia is a multifaceted problem. For the nursing and midwifery profession, this financial assistance for undergraduates is, in my view, a game changer. Although not perfect, it goes a long way towards relieving the financial burden on undergraduates during clinical placement.

These changes are not only for the wellbeing of the nurses themselves but also for the overall health of the Australian population, which relies heavily on the dedication and expertise of its nursing and midwifery workforce.

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References: 1. ABRYSVO Approved Product Information. **2.** Australian Government Department of Health and Aged Care. Therapeutic Goods Administration (TGA). ABRYSVO (Pfizer Australia Pty Ltd). Public Summary, 20/03/2024.

Pfizer

‘Why would you do this to us?’: Northern Territory nurses and midwives rally against Middle Arm Industrial Precinct

By Robert Fedele

In April, Northern Territory (NT) nurses and midwives, flanked by healthcare colleagues, stood on the steps of NT Parliament to voice their opposition to the contentious Middle Arm Industrial Precinct and its potential health and climate impacts.

A Senate Inquiry is currently scrutinising the development, particularly the federal government’s $1.5 billion funding commitment, and most importantly, the associated health and climate impacts that extraction of natural gas and oil through fracking in the Beetaloo Basin, and subsequent processing at Middle Arm’s proposed petrochemical hub, could trigger.

In its submission, the ANMF NT Branch highlighted “extreme concerns” regarding health and climate consequences.

“In the short term, we know that the particulate matter and noxious chemicals emitted from the proposed Middle Arm will cause increased respiratory illness and cancers in those living within a 5km radius from the plant,” the submission stated.

Cath Hatcher, ANMF NT Branch Secretary addressing the media outside the Senate Inquiry

"Being just 2.5km from Palmerston, the population there will be subject to an unacceptably high risk of hospitalisation in an already over-burdened system.

"This year alone, there have been seven episodes over 53 days during which the Royal Darwin Hospital was under a "code yellow", an emergency response due to insufficient staffing and no beds and needing to meet these demands. These are patently unsafe working conditions for all staff, that exacerbates our staffing shortages as people burn out and choose to work elsewhere, or in another profession."

ANMF (NT Branch) Secretary Cath Hatcher, giving evidence at the Inquiry, argued the likelihood of increased health issues caused by the Middle Arm project would have a disproportionate impact on First Nations peoples, who make up 31% of the NT's population and occupy 80% of its health system with chronic issues like renal disease and rheumatic heart disease.

"Why are they going to use the Darwin-Palmerston region as a guinea pig, because that's what we are going to be," Ms Hatcher told Senators.

"The air quality is already poor. If it's going to get worse people aren't going to stay."

Louise Brown, a recently retired nurse with decades of experience working across Darwin and the Top End, echoes the ANMF's call to stop the precinct from going ahead.

In her submission to the Inquiry, Louise questioned the ethical motivations behind both tiers of government partnering with the gas industry and, effectively, exposing the community to toxic outputs that will inevitably see a surge in the rates of premature births, childhood and adult cancers, and respiratory, cardiac, and other chronic diseases – "How is that fair, ethical or condoned by our governments?" she said.

"The air quality is already poor. If it's going to get worse people aren't going to stay."

"I feel very strongly that the plans that the government has to expand the gas industry will be catastrophic for the climate and health of our community," Louise told the *ANMJ*.

"As a nurse, you go into nursing because it's a caring profession, and we have a duty to protect and care for our clients. This [advocacy] is an expansion of that – it doesn't stop just because you retire. I feel a very strong obligation to my community. I'm a mother and a grandmother and I want my family and everyone's family to have a good, healthy life."

Joining the chorus of concern, emergency and flight nurse Olivia Conan-Davies urged the Inquiry to consider the added strain on the health system from increased air pollution and illnesses.

"The Territory's healthcare system is not coping with this burden of disease," she said.

"People are waiting unacceptably long in Emergency waiting rooms and staff are burning out under the constant pressure. I believe this is because as nurses we are being put in the uncomfortable position of being unable to provide adequate healthcare to our increasing and critically unwell patient load."

With the health system already "busting at the seams", Ms Hatcher said it was important for the ANMF (NT Branch) to take a stand.

"I felt privileged to be able to be up there with my nursing and medical colleagues [giving evidence], sharing the concerns of the nursing and midwifery workforce. It's already under strain and it will only get worse if a petrochemical hub is built."

The Branch remains staunchly opposed to the development and is calling on the government to redirect $1.5 billion in taxpayer funds to more pressing local issues like healthcare, education, and housing.

"The evidence is clear, building this facility in Middle Arm is the wrong decision for the people of the Greater Palmerston/Darwin Region of the NT," the Branch's submission declared.

"If you lived in the Palmerston/Darwin region of the NT, would you put yourself and your family, at risk? So why would you do this to us?"

As the Senate Inquiry nears its conclusion, with a final report due on 13 August, the ANMF (NT Branch) plans to continue fighting the project by raising awareness of its potential public health risks.

Ms Hatcher admits that had you asked her 20 years ago if the ANMF should be political on issues such as Middle Arm, she'd have, matter-of-factly, said no. As times have changed, engaging in politics has become imperative to advance the nursing and midwifery professions and improve community health and wellbeing, she says.

"I think you're on the back foot if you're not up there and in that political space. You're really not doing the whole federation, particularly in the territory, and all of the other states across Australia, justice."

Sustainability in health champion

How a nurse and horticultural therapist is changing the landscape at Austin Health, Victoria

By Robert Fedele

Steven Wells wears many hats – nurse, horticultural therapist, and Gardens & Grounds Coordinator at Austin Health in Victoria.

Two decades ago, he embarked on a path that saw him lucky enough to combine his two passions within the organisation. While these days his Grounds Coordinator role takes up most of his time, he still works clinically one day a fortnight at the Royal Talbot Rehabilitation Centre's Acquired Brain Injury (ABI) Unit, and for one day per week, provides horticultural therapy for patients, using gardening activities like planting and watering to improve people's physical and mental health.

"The drive has been twofold," he tells the *ANMJ*.

"One, it's about creating therapeutic spaces and impacting the therapeutic environment of a healthcare facility. There's a lot of conversations around how we use our internal spaces but not a lot gets talked about the external spaces [like gardens] and what they can achieve.

"For me, within that, at the end of the day, it's all about linking back to our core business, which is patient care."

In his bid to create picturesque garden spaces that provide therapeutic environments for patients, staff, and visitors, Steven is always acutely mindful of overarching sustainability considerations.

"It's doing it in a way that is manageable, sustainable, maintainable, and looking at it from a resource point of view, both the environmental resource of watering but also then the physical resource of people managing the spaces," he explains.

Take garden waste, for example, where Austin Health partners with the local council to ensure it gets reused.

"Sustainability is about an end-to-end context," says Steven.

"If we've got things coming in, what does it mean for it for its lifespan that we have it for.

"There's no point in us creating something that is beyond our capacity to look after. I'm looking at it in the context of how we can sustain this long-term, with the goal of making it look as good as it can be for long-term sustainability."

As Austin Health's leading green thumb, Steven has steered numerous garden projects over the years, which are largely supported through philanthropic donations.

This includes the Royal Talbot Rehabilitation Centre's idyllic gardens that sprouted wings nearly 20 years ago.

"It is still growing and thriving and achieving the goals that we set out, with it being a garden that we don't irrigate; it survives on natural rainfall."

For more recent projects, Steven is similarly fixed on appropriate plant selection to meet needs, not only from an aesthetic point of view, but also lower maintenance requirements.

Perhaps most rewardingly, Steven combines both his nursing and gardening skills to run a Horticultural Therapy program for patients, enabling them to get their hands dirty and work on their physical, therapeutic, and social rehabilitation goals, including transitioning back into the community post-discharge.

"Some of their goals might be overtly physical, but in some instances, also emotional, psychological, or relate to building confidence and self-esteem during their time," says Steven.

"The focus is around connecting plant and garden spaces with people to help achieve outcomes and improve their recovery."

After dedicating his career to nursing and horticulture, Steven hopes that awareness of the importance of environmental sustainability in healthcare continues to grow, and that nurses and midwives keep using their voice to advocate for change to protect the health and wellbeing of generations to come.

"Healthcare facilities are significant consumers of resources, materials, and products. I think it's our duty to make sure we look at how we can address that impact," he says.

"[Environmental sustainability] should be one of the key pillars in a healthcare organisation, including promoting sustainability and facilitating sustainable practices."

Efficient energy practices:

Water and food conservation tips

TURN OFF TAP WHILE BRUSHING TEETH

Save up to six litres of water per minute.

FIX LEAKY TAPS

Prevents significant water wastage. Leaks can waste up to 60 litres per week.

REDUCE SHOWER TIME

Limiting time spent in power showers. Power showers can use up to 17 litres per minute.

CHOOSE LOCAL

Opt for locally sourced food whenever possible. Reduce greenhouse gas emissions associated with long-distance transportation to grocery stores

GO MEAT FREE

Incorporate meat free days into your diet, especially avoiding beef. Beef production contributes significantly to water usage and emits potent greenhouse gases like methane.

EMBRACE HOME GARDENING

Grow herbs, fruits, and vegetables at home to reduce reliance on store-bought produce.

MINIMISE EMISSIONS FROM TRANSPORTATION AND REFRIGERATION.

Even without a backyard, cultivate items like scallions, celery, and herbs on your windowsill.

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

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

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

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

Leaders map future of health across Asia and the Pacific at World Health Summit in Melbourne

By Robert Fedele

"By working together across disciplines and sectors we can foster more resilient and equitable systems for health that truly leave no one behind," declared Sandro Demaio, CEO of VicHealth, at the 2024 World Health Summit Regional Meeting in Melbourne in April.

Global leaders came together to discuss the key challenges and opportunities facing health across Asia and the Pacific, with an emphasis on building collaborations to co-create pathways forward that can deliver better health outcomes for all.

Chairing the opening session, Shaping the future of health across Asia and the Pacific, Dr Demaio said the 2024 Summit, the first held in Melbourne, arrived at a critical juncture for global health amid pressing challenges including widening health inequities, escalating geopolitical tensions, climate driven-health crises, and the ongoing impacts of preventable diseases.

Making meaningful action requires confronting the stark reality of widening health inequity, especially among marginalised communities, listening to diverse perspectives, and working together to promote health and wellbeing, said Dr Demaio.

"The health of one community, of one region, is inextricably linked to the health of all. As such, we must reaffirm our commitment to multilateralism, cooperation, and diplomacy as essential tools for promoting health and wellbeing at the global scale."

Guest speaker Dr Saia Ma'u Piukala, the World Health Organization's (WHO) Regional Director for the Western Pacific, said as the world grapples with multiple crises, from conflicts to the post-pandemic period, there are two types of healthcare systems – one for the rich, and one for the poor.

"Two out of every five people living in the Western Pacific still can't get essential health services and that is a staggering 782 million out of the 1.9 billion people in the region that are struggling to find the basic care they need," he highlighted.

"These are the problems of today, but if we can't find a way to get them right, they will also be our failures of tomorrow."

To sustain good health in the face of mounting challenges, Dr Piukala, who holds nearly 30 years' experience as a politician, public health leader and surgeon, agreed that solidarity was one of the key solutions but stressed it could only be possible through mutual respect and trust, including adapting to local solutions.

"Our priorities are clear," he said.

"Promote an integrated approach to health system development, which uses primary healthcare to achieve universal health coverage. That is how we will address the leading causes of disease and the inequities."

Action on climate change and building on the lessons of the pandemic before the next one arrives are among other leading challenges, he said, saying that improving equitable access to healthcare over coming years demands listening and engaging with diverse communities.

Fellow speaker Dr Lucas de Toca, Australia's Ambassador for Global Health, told delegates health systems everywhere are working under constrained budgets as the world emerges from the pandemic.

Dr de Toca said Australia's position as a high-income country well-connected to the world meant it was well-placed to lead shared challenges facing Asia and the Pacific. He said his role is focused on ensuring that global health systems focus on equity, and that Pacific and Southeast Asian perspectives are strongly represented so that the diverse and complex health challenges the regions face are addressed.

Professor Adeeba Kamarulzaman, CEO of Monash University Malaysia, highlighted the complexities, socioeconomic differences, and emerging health challenges of the Southeast Asian region, home to almost 700 million people, a hundred ethnic groups, and more than a thousand languages and dialects.

According to Professor Kamarulzaman, the rapidly ageing region faces a large non-communicable disease burden, with cardiovascular diseases, chronic respiratory diseases, diabetes, and cancer, the top killers, claiming about 8.5 million lives each year.

She listed antimicrobial resistance, which doesn't often get talked about, along with climate change, and rising mental health issues, as other key health challenges.

"Many countries in the region fall into either emerging economies or [are] doing very well," she said.

"I think there is a huge opportunity, particularly for countries who are shaping their health system, who are shaping digital health, to not be settled with some of the legacy systems and to really design health, and also rebuild health systems, after the Covid pandemic, that is patient-centred, that integrates infectious diseases and non-communicable diseases, all the way from prevention, diagnosis, treatment and care."

Renowned Professor Ilona Kickbusch, Founding Director, Global Health Center, Graduate Institute of International and Development Studies, Geneva, and Co-chair, Council of the World Health Summit, listed trust, in governments, institutions, and people within communities, as a vitally important factor, as evidenced by the COVID-19 pandemic, in achieving global health objectives. The challenge now is to build resilient communities based on trust, and, importantly, to view distrust as a public health risk.

"As public health professionals, I think we need to strengthen that public health perspective on trust and to start seeing low public trust as a risk factor," Professor Kickbusch explained.

"And that risk factor of low public trust is linked to the social determinants of health. It is linked to the lack of fairness. And democracies must consider how to address that because a democracy cannot function with an increasingly divided community and if we are not listening to those, that through their distrust, are actually expressing to us that their needs are not being met."

Dr Saia Ma'u Piukala,World Health Summit. Photo: Monash University

Dr Sandro Demaio, World Health Summit. Photo: Monash University

The nursing experience of delivering virtual care during COVID-19: A qualitative study

By Jessica-Rose Tait, Casandra Dearing and Greg Fairbrother

The COVID-19 pandemic has brought about many challenges to the healthcare system.

For example, the pandemic forced and accelerated the implementation of virtual technology to provide adequate clinical care to patients whilst at home. However, the experience of nurses who provided assessment and management of COVID-19 patients using virtual technology during the COVID-19 pandemic has not been widely researched.

THE STUDY

Aim: To describe the experience of nurses who were using virtual healthcare technologies to provide clinical care to patients impacted by the COVID-19 pandemic.

Method: A qualitative descriptive study was conducted among 15 nurses who transitioned to delivering virtual clinical care to patients impacted by the COVID-19 pandemic. Interviewees were working in intensive care, medical, surgical and community nursing settings prior to joining the virtual care team. Interviews were transcribed and thematically analysed.

Results: Three primary themes descriptive of the nurses' experience were identified. These related to barriers and enablers regarding the process of transitioning to virtual care in the context of a pandemic. The themes were: 'Commencing', 'Transition and support' and 'Patient care and processes'.

'Commencing' was impacted by urgency and information deficits regarding the nature of the role. 'Transition and support' were advantaged/disadvantaged by the education and the strength of information/communication technology (ICT) service back up. 'Patient care and processes' were advantaged by capacity to provide patient-centred care and the presence of strong leadership and team culture but were disadvantaged by long call lists and workflow issues.

Conclusion: It is possible to implement virtual clinical care during a pandemic despite the challenges. The key enablers of role transition related to maintaining the capacity to provide patient-centred care and the presence of a flexible approach to team management. Key factors which mediated enablement positively or negatively related to the availability of education and the perceived efficiency of digital processes.

INTRODUCTION

Access to healthcare during the COVID-19 pandemic was limited in some areas due to rapid viral spread. Facilities were prompted to look at alternative ways of delivering care. Key among these was virtual care.[1,2,3] The activity of a virtual care hospital[4] was described by Hutchings et al (2021) which found that most of the patient contacts comprised of video consultations. It was noted that health services implementing virtual healthcare should anticipate challenges associated with rapid staff deployments and provide adequate support to resolve these.

The virtual care delivery model uses phone and video-based conferencing technology to provide remote consultation and monitoring. Telehealth-based models (often reliant on a phone connection) have been at play for some years, particularly in specialty specific and rural/remote contexts. Telehealth nursing has been defined as a method of remote nursing care delivery driven by goals of improving care access and system efficiency.[5]

The contemporary expansion of virtual care technology has brought about change to the way nursing care is delivered. Assessment, diagnosis, monitoring and health information delivery occurs remotely. It has been claimed that telehealth nursing has helped reduce strain on the healthcare system by assisting patients to avoid unnecessary emergency department visits, and by instilling confidence in patients to self-care at home.[5]

A 2017 overview of systematic reviews reported significant improvements in time spent in patient care and the number of patients able to be seen per day under telehealth models, and that the quality of the nurse-patient relationship was unaffected.[6] Such positive findings have not always been advanced. A 2014 systematic review reported that nurses' preconceived ideas about telehealth may impact their relationships with patients and their clinical autonomy.[7] Adequacy of learning support has been raised as a predictor of acceptance. An examination of the response to the COVID-19 pandemic within New York City hospitals reported a significant telehealth-related learning curve for staff and claimed that current training programs did not provide enough support.[8] Ten years earlier, Edirippulige (2010) found that the main barrier for nurse usage of telehealth was lack of systematic training.[9] Multiple authors have recently identified the importance of training[10,11,12] and a recent scoping review identified digital literacy as a factor responsive to education, and key to progress in virtual care system development.[13]

Efforts to help nurses transition into using virtual technology have been described through the use of simple reliable technology with support resources.[7] Utility, security and cost-competitiveness have also been emphasised,[12] as have an adaptive and flexible working environment[8] with linkage to electronic medical record (eMR) systems.[14]

It is widely agreed that virtual care is an important component of any pandemic response.[15,16]

To sustain effective use of this technology, the nursing experience of transitioning into virtual care roles needs to be understood. Borek emphasised the strains experienced by staff in managing high virtual care workloads and called for further exploration of the nurse experience of the pandemic virtual care role.[1] This qualitative study among nurses who were either current employees or rapidly deployed to work in a Sydney-based virtual care service targeting COVID-19, seeks to describe nurse experience regarding delivering virtual care.

METHOD

Design

A qualitative descriptive study which employed a case study design[17] was employed to describe participants' experience of transition to and delivery of virtual care. The approach taken to interview design emphasised the practical realities of the nurse experience, with an emphasis on enablers and disablers of positive experience.

Setting

In early 2020, a Virtual Hospital was implemented in a large Sydney metropolitan health district, as the COVID-19 pandemic escalated. The service was comprised of a Virtual Care Centre (VCC) and a community nursing service.

Some 100 to 120 registered nurses (RNs) staffed the VCC during the peak Delta wave period in 2021. Virtual care involved wearable devices, remote monitoring and providing 24/7 phone access to clinical support.[14]

Patients who were monitored by VCC nurses were either living at home or staying in district-supported accommodation.

VCC nurses called positive patients and their contacts to establish a risk level. Ongoing contact was then established. At the time, people were required to isolate if they tested positive or had a positive contact. Newly arrived travellers to Sydney were required to isolate and were managed by the VCC if they had health issues.

Sample characteristics

Study participants were RNs who commenced their employment with the virtual hospital during the study period. Most had no prior virtual care experience. Some had been deployed during the Alpha outbreak in March 2020 and chose to stay, while others had no experience, having been deployed during the Delta outbreak. In most cases, re-deployed participants came to the service from inpatient acute care service units. From among the 15 consenting RN participants, three were novices, seven were mid-career, and five were in senior specialist or consultant roles.

Data collection

The choice for in-person or virtual interview was made by the participant and based on convenience. Interviews were 30 to 60 minutes and conducted during the Delta outbreak. The interviewer was not known to the participants. Incentives were not offered. The interviewer received in-house training in interviewing skills. The interview schedule was piloted prior to study commencement with minor modifications made following this process. The interview content sought a narrative from the participant regarding their transition into the role. Further questions related to support and role enablers and disablers. Once data saturation was agreed to have occurred, the study was ceased, and a final thematic analysis was brought together by the team.

Data analysis

Interviews were de-identified and transcribed verbatim by a professional agency as they were completed, and transcripts read and re-read by the researchers. A pragmatic stance was made in relation to the thematic coding process.[17] Data was organised initially into concept areas using an open coding approach. Themes were then identified from each of the broadly defined concept areas. To ensure rigour, three coders (authors) were used. Authors coded and analysed independently and came together on multiple occasions to check interpretations.

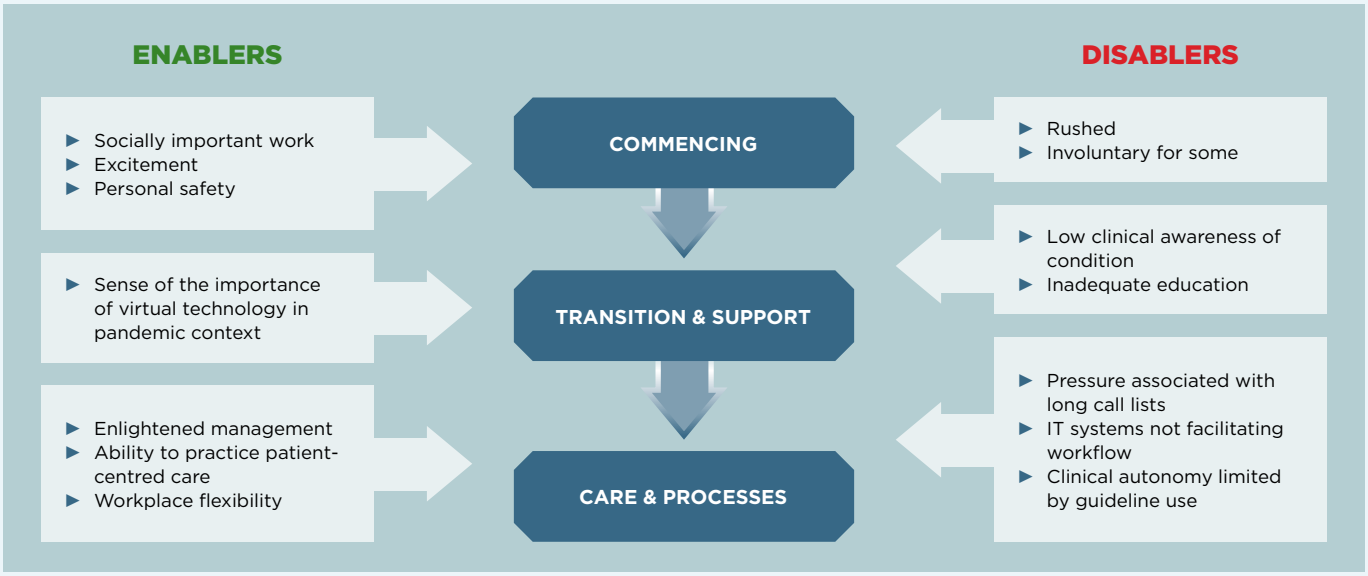
Ethics

The study was approved by the Sydney Local Health District Research Ethics Committee.

FINDINGS

Fifteen interviews were conducted in-person and virtually among volunteering nurses who responded to an invitation and were working with the VCC team between September 2021 and February 2022. The mean interview length was 40 minutes. Three primary themes descriptive of nurse experience were identified. These identified barriers and enablers in relation to transitioning into virtual care in the pandemic context: 'Commencing', 'Transition and support' and 'Patient care and processes'. Figure 1 provides an illustration of thematic findings regarding the enabler/disabler split.

FIGURE 1: Enablers and disablers of nurse experience



COMMENCING

Nurse experience of transitioning was shaped by circumstances surrounding deployment and commencement.

Due to the evolving nature of the Delta outbreak, some clinical services were shut down and nurses were deployed to essential areas with little warning or choice.

'24 hours, I was told in the afternoon that I had to report to virtual the next day at eight o'clock. Yes, so it was bit like ooh' **(Nurse 6)**

Nurse consultants and specialists were asked to take on RN roles.

Participants described a range of emotional responses when told that they were being redeployed. Feelings of being rushed or compelled to be redeployed may have affected transitioning and may have been a barrier to full role immersion during adaption.

"I got a phone call saying due to the surging COVID numbers, priorities had shifted, and I had to be sent to Virtual to help … because they were too overwhelmed with the workload here. So, it was rushed. That's how I arrived here…." **(Nurse 8)**

While some nurses expressed unhappiness with their redeployment, others were positive.

"I was asked to come over here, and I just thought it was a great opportunity, because I was helping the community … also, it was good then to pull out of the ED [Emergency Department], where there was a risk of contracting COVID and bringing it home to my pregnant wife." **(Nurse 11)**

Some participants applied for a role at the virtual hospital or volunteered, being motivated to move into a different area that incorporated new technology. These nurses had often researched the available roles and sensed that the virtual hospital was potentially a part of the future of nursing.

"I was looking at having a break from Intensive Care for a little bit. That's when I found the virtual hospital… I was interested and I applied because I wanted to be part of something." **(Nurse 14)**

Some participants who applied perceived the VCC as a place of safety during a dangerous time.

"It made me nervous and a bit anxious. But also, another side of me was quite relieved, because it was a lot of unknown about COVID at that time, and so I knew that by coming into Virtual I was going to be quite safe and wasn't going to be exposed to patients so much." **(Nurse 12)**

TRANSITION AND SUPPORT

Participant-perceived limitations in relation to transition and support were evident. A commonly perceived barrier to delivering virtual care related to education.

"It was 100% a baptism of fire if that's what you mean. On my first day I can remember I had the educator give me two hours of here's your templates, open zoom, I didn't even watch her make a call. I literally had to call, it was that busy, you didn't have time to learn, you learned on the job." **(Nurse 11)**

Participants sometimes related feeling unaware of COVID-19 impacts and expected outcomes. This affected confidence regarding providing patient education.

"It's a new condition; everyone was pretty much overwhelmed by the nature of the disease and everything so despite whether it was face to face or virtual care, first embracing the condition was a bit of a challenge. But as we got to understand it more, the epidemiology of the condition, how it can be treated and how to help, it got a bit easier". **(Nurse 15)**

Some participants reported a lack of clarity in terms of role definition as they transitioned. However, by and large there was a tacit view that the role was likely to evolve over time.

"I think overall the transition has been pretty good. I think that I just maybe needed a few more days in order to take everything in. I felt like things were quite rushed but understandably. At the time that I had started my orientation, we had over 2,000 patients enrolled under the COVID cohort and so I think that it did need to be rushed in that sense." **(Nurse 4)**

Unsurprisingly, participants who had volunteered or applied for their role reported a more positive transition experience than those who were redeployed at short notice. These staff members often had previous experience in delivering virtual care.

PATIENT CARE AND PROCESSES

Participants related the importance of being able to provide patient-centred care while being in a new virtual environment.

"It was a bit of an adjustment really because initially coming from a ward environment I was concerned with trying to get my head around how exactly I'll be able to provide good care for people distantly. It was a bit of an unknown step, but once I was there, slowly but surely things started to build." **(Nurse 1)**

For some participants, a felt pressure to complete call lists and assess patients

quickly was discussed as a limiter of their ability to provide the level of patient-centredness they wished for. Varying degrees of comfort were expressed with regards staying on the line to discuss not just COVID-19 but the patient's social and other issues that might be causing problems.

"It can be a little stressful. But what I've learned about COVID-19 you have to be calm because the patients are getting their energy from you." **(Nurse 9)**

Some participants found the day-to-day process of patient care to be repetitive at times with many different platforms needing to be accessed at once.

"There's a lot of different programs that you're using when you're providing virtual care that you need to learn how to use all at the same time when you start. There's quite a few platforms that you're using all at the same time, and so just learning all of those from scratch was a bit of a challenge". **(Nurse 12)**

Some participants felt that virtual care could result in them losing hands-on clinical skills.

"I do feel that one of the big concerns about staying in virtual care for long is that you'll lose your clinical skills. Or some of your knowledge." **(Nurse 4)**

Some participants felt that they were unable to use their clinical judgement enough, due to reliance on guidelines and risk stratification tools.

"And sort of not being able, being in strict guidelines, strict protocols, you couldn't use any of your clinical skills that you had…. that was a little bit frustrating, not being able to utilise your clinical experience, because you just had to follow the protocols." **(Nurse 6)**

Despite the challenges experienced, a stand-out feature of participant talk was the support and guidance the management team provided.

"It's quite demoralising to be treated in such a rushed way … but in saying that, once we got to Virtual, the managers there have been so wonderful, just amazing. Like [xxx] has been more than accommodating with rosters and that, to try and keep us happy. And she constantly reassures. Having that support has been really good. Yes, just the acknowledgement I guess." **(Nurse 6)**

"I look at my team and then we would look back at each other. We're doing something really good here. We've got to keep going. And we're looking after ourselves. I think that's one major support for me, even though it's busy, my team is here. Especially a specific manager [xxx], she's the guiding light all the time." **(Nurse 9)**

DISCUSSION

The study results support an increasingly established view [4,12] that it is possible to rapidly implement community based virtual care during a pandemic. Virtual care service development teams have been reported to demonstrate resilience in the face of a pandemic.[18]

Participants in the current study were a mix of volunteer/applicant nurses and involuntarily re-deployed nurses. Whilst there were indications of greater transition-related difficulties among re-deployed nurses, both groups were clearly required to 'hit the ground running' and both groups reported ultimately coping with the new role.

Figure 1 outlined factors which impacted positively and negatively on nurse experiences. In terms of intrinsic motivators to become involved or accept involvement, the perceived social importance of being involved and feelings of activation around this were found to be enabling. Factors which negatively impacted experience were often extrinsic to the nurse, and were education, support or information related.

Two key extrinsic factors relevant to organising and managing care delivery identified by Shaw et al were found to be linked to role coping success: the quality of team management and team culture, and the participants' felt capacity to provide patient-centred care.[18] A recent patient experience study of Covid virtual care services found that patients reported mainly positive experiences.[19]

In a recent qualitative exploration of digital technology competence among nurses, ability to provide person-centred care was found to be in successful uptake of virtual technology.[20] Issues relating to maintaining patient-centred relationships associated with transition to virtual care during the pandemic have been recently reported in discrete specialties,[21] though widespread negative impacts have not been advanced.[22,23]

The findings in the present study regarding the importance of virtual care team management are consistent with other recent reports.[4,24]

The need for prioritisation of formalised, ongoing education was expressed by many participants in this study. Education and preparation have recently been identified[10,25] as key to successful implementation with digital literacy, a key education-sensitive challenge area.[14] Policies and guidelines are important allies to high quality ongoing clinical education, particularly in the context of a pandemic.[26] The study findings highlighted the need for these to be as live as possible, particularly given the guideline-based restraints that some participants reported as impinging their clinical autonomy, and that there are challenges associated with actioning complex clinical assessment virtually.[25] The findings highlight the need for integrated practice and collegial support mechanisms. The importance of accounting for cultural diversity among patient groups when developing supports has also been raised.[27]

Digital system-related processes were discussed by many in the sample as a key success factor impacting workload management. Systems which required repetitive inputs were flagged as a barrier to role satisfaction. Process simplicity has been raised as a key success factor in telehealth implementation since the early 2010s.[3,7,14,25]

Supportive informatics solutions which are simple and interconnected with other systems, eg. eMR, are needed. These should be integrated with educational and guideline material.[3] Acceptability and affordability should also be factored into such efforts.[13]

The social context of working as a pandemic-specific healthcare provider was highlighted by some in the study sample as important as they transitioned and ultimately established themselves in their virtual care roles. The socio-cultural factors associated with nurses' felt social responsibilities has yet to be explored in this emerging literature.

CONCLUSION

The findings of this study have demonstrated that the nurses' experience of delivering virtual care can vary depending on either being a current or an involuntarily deployed nurse of the caring/treating organisation. Despite this, involuntary deployment of nurses to virtual care services in a pandemic environment can be successfully achieved. Key factors enabling role uptake and satisfaction relate to the capacity of the nurse to provide patient-centred care and the quality of the team management at play in the nursing shift environment. The need for comprehensive initial and ongoing education was strongly voiced by study participants, as was the need for digital systems which facilitated workflow and minimised repetition.

Authors

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Kristen Wischer

ANMF Senior Federal Industrial Officer

Gender assumptions and the value of work

The recent Fair Work Commission aged care work value decision confirmed that the work of aged care sector employees and nurses has been undervalued on the basis of gender assumptions.[1]

The decision sets out a fascinating history of how and why gender-based assumptions about the value of women's work has permeated Australia's industrial relations system since its inception in the early 20th century. A brief look at what those assumptions were, helps us to understand why achieving gender equality in wage setting is so important.

The 1907 Harvester decision is the starting point in the role of industrial tribunals setting minimum wages. Justice Higgins looked at what was required to meet 'the normal needs of the average employee' being a married man with three children.

This approach was confirmed in the 1912 Fruit Pickers decision. In that case a dispute arose about the rates to be set for fruit pickers, work predominantly performed by men, and fruit packing, which was done by women and girls. Justice Higgins observed that for fruit pickers, it was not just about the value of the work. As the work was performed by men, the wage rate must be enough for the man to support his wife and children, whereas for fruit packers, it would be exceptional for a female worker to have such an obligation. This justified setting lower rates for fruit packers, because a woman only needed her wages to cover her own food, shelter, and clothing.

This concept was made more evident in the 1921 Archer decision, which observes 'it is not fair to force employers to pay for all that a girl may fancy as being necessary human requirements.'

These early decisions reflected social policy- it is desirable for men to go out to work but not for women to be dragged from their homes to work. Wage setting principles were intended to ensure that employers would not employ women to undercut male wages. Work suited to men- such as blacksmithing, had a higher starting rate, as women were unlikely to do the work and therefore posed no competition for the work. For work more suited to women, such as millinery or fruit packing, requiring nimble fingers and dexterity, wage rates were set approximately 25% less than the rates for male dominated work, as there would be few men who would compete for such work.

The award system recognises additional skills through increased wage rates. This too, has long been subject to gender assumptions. For instance, during WWII, women entered more male dominated trades, such as metal trades. A 1945 Inquiry into Female Minimum Rates, noted, however, that women did metal work that they were adept at due to their nimble fingers, but which did not require the skill and experience of a tradesman.

The post war period resulted in some improvement to female wages. Nevertheless, wage setting tribunals remained concerned that increasing women's wages, even for work of comparable skill to that done by men, would depress the relative living standard of men and their dependent families. One tribunal noted 'the share of men workers in the fruits of production will need to be reduced if women are to participate therein on an equal footing'. Furthermore, increasing the basic female wage would 'put an intolerable strain on the economy'.

Greater shifts in wage setting occurred in the 1960s and 70s, with the introduction of the concept of equal pay for equal work. The 1969 Equal Pay Case set out principles for wage setting, that said if work is done under the same award at the same classification by men and women, then the rate should be the same. This, however, did not address the problem of work done in female dominated industries, such as nursing.

In the following decades, work value assessments were intended to address this problem, by comparing work performed in female dominated industries with work done in male dominated industries. Such assessments, however, were only to deal with wage setting anomalies, and the problem of identifying comparable work was not resolved. The perception that skills exercised in female dominated work were not as valuable, meant historical undervaluation, for nurses in particular, was never properly remedied. All of these factors carried through in the setting of Modern Award rates in 2009.

The 2024 decision and ANMF applications to vary the Nurses Award will see the end of over a century of undervaluation of women's work.

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Mihirika Pincha Baduge

Breaking Barriers: Advancing women nurses in healthcare leadership

In Australia, women make up the majority of the nursing profession, yet they are under-represented in healthcare leadership. ROBERT FEDELE talks with researcher Mihirika Pincha Baduge about efforts to break down barriers.

The glaring under-representation of women nurses in healthcare leadership is currently being explored by Victorian critical care registered nurse and PhD candidate Mihirika Pincha Baduge, as part of Monash University's broader Advancing Women in Healthcare Leadership (AWHL) initiative to address the issue.

"I am looking at factors and organisational-level interventions to advancing women nurses into healthcare leadership positions," she says.

"Improving women's leadership capabilities through skill development alone won't be enough unless we also tackle the organisational structure and culture to ensure women are provided with the essential support and opportunities they need to flourish."

ADVANCING WOMEN IN HEALTHCARE LEADERSHIP

AWHL is a Monash University-led national research, implementation, and impact initiative, funded by two National Health and Medical Research Council (NHMRC) partnership grants and partner contributions.

It is seeking evidence-based solutions to drive systemic organisational changes that create and enable equal opportunities for women in healthcare leadership.

Gender equity in healthcare leadership can have wider benefits, it suggests, including improved quality of care, and building a more empowered workforce, with reduced attrition.

"We believe organisational and policy-level interventions are needed to improve gender equity and enable women nurses' advancement in healthcare leadership," Ms Pincha Baduge says.

BARRIERS TO ADVANCING WOMEN NURSES IN HEALTHCARE LEADERSHIP

Ms Pincha Baduge's research has identified numerous barriers hindering women nurses' progress into leadership roles.

In her 2023 systematic review, which included 32 studies from across the globe involving registered nurses, nurse academics, executives, and leaders, factors included:

- Social and cultural expectations and perceptions of nursing as a feminised profession.
- Gender bias and expectations of men as leaders, women as nurturers.
- Hierarchal leadership structures: medicine dominating with more power in senior leadership.
- Lack of women nurse role models in leadership.
- Lack of formal and informal leadership training.
- Inadequate orientation to leadership roles.
- Limited part-time options for leadership positions.
- Part-time nurses overlooked and perceived as less committed.

"From the findings, it is clear that the prevailing belief that caregiving is a feminine occupation, and the societal expectations of women's subordinate position, are both significant obstacles preventing women nurses from advancing in healthcare leadership," Ms Pincha Baduge explains.

"Men were viewed as credible leaders, and this perception has created traditional gender biases for women nurses. Additionally, the lack of recognition and respect for nurses further discourages women from pursuing leadership roles. Once they are in leadership, lack of organisational support, such as giving them minimal orientation to roles, and limited opportunities for leadership training, is a prevalent issue."

ORGANISATIONAL STRATEGIES TO ADVANCING WOMEN NURSES IN HEALTHCARE LEADERSHIP

To counteract these barriers, Ms Pincha Baduge's research is aiming to develop evidence-based organisational interventions.

Her 2023 paper undertook a systematic review focusing on organisational strategies that specifically advance women nurses in healthcare leadership roles.

Key organisational-level strategies uncovered included:

- Investing in leadership development programs.
- Policies that recognise the career leadership potential of nurses.
- Opportunities for mentoring and networking.
- Leadership training.
- Career planning opportunities aimed at mid-career nurses' personal and professional development.
- Targeted recruitment processes for increasing gender diversity in leadership roles.

"Our findings suggest that optimising women nurses' leadership attainment needs to shift focus from individual strategies to systemic level and organisational strategies and using tailored evidence-based approaches," Ms Pincha Baduge says.

INTERSECTIONALITY

Meanwhile, Ms Pincha Baduge's research hopes to also address additional barriers faced by women nurses from racial and ethnic minorities, including migrants, in advancing to leadership positions.

She migrated to Australia from Sri Lanka in 2012 and says global literature shows that women nurses from racial and ethnic minority groups face greater challenges compared to other nurses when striving to land leadership roles.

"Recent research indicates that women from racial and ethnic minorities (REM) including migrant backgrounds are experiencing instances of discrimination by colleagues, supervisors, as well as patients and their families within workplaces," Ms Pincha Baduge says.

"These experiences have been described as both frustrating and demotivating, contributing to a reluctance to pursue career advancement opportunities. Additionally, studies suggest that having a foreign accent may serve as an additional obstacle to progressing in one's career. These women often report feeling invisible in their workplaces, experiencing being disregarded, unheard, and facing persistent challenges to the recognition and validation of their skills and qualifications."

NEXT STEPS

The research project, which is still in its early stages, is tapping into stakeholder engagement so that evidence-based interventions effectively address industry needs.

"It centres around the implementation science, emphasising collaborative efforts rather than working in silos," she says.

"Nursing stakeholders actively contribute their insights and direction to guide the project's progression. Engaging these stakeholders presents a valuable opportunity to pinpoint existing industry gaps and co-design, co-produce, and implement evidence-based strategies at the organisational level."

Looking ahead, Ms Pincha Baduge believes that initiatives like hers can help change the status quo when it comes to healthcare leadership.

"I think having more part-time leadership roles with job sharing will enable more women to progress into leadership positions," she says.

Her advice for women nurses aspiring to advance into leadership roles?

"Trust yourself. Trust your capabilities. Find new opportunities. Negotiate. Be assertive. If you don't communicate your expectations and experiences, others won't know them. Therefore, strive to be a great communicator."

Nurses outside Sydney Hospital

100 Years Strong: The Australian Nursing and Midwifery Federation Celebrates

The Australian Nursing and Midwifery Federation (ANMF) proudly marks its 100th year, celebrating a century of remarkable achievements and the strength of its members. Their story is one of purpose and passion, people and power. It's a story of fighting for workers and their rights, and of protecting and promoting their members, our professions, and our communities. As we reflect on the past century, we honour the resilience and dedication that have defined the ANMF's journey.

For the past century, the ANMF has been a steadfast advocate for the rights and wellbeing of nurses, midwives, and the communities they serve. From striving for fair wages and better working conditions to promoting safer healthcare practices and improved patient care, the ANMF has been a catalyst for positive change.

In tribute to the ANMF, the *ANMJ* is gearing up to celebrate with a series of special articles that will highlight some of the incredible ANMF victories, from its early days to the present. We'll also be active on our social media channels, encouraging you to share your stories with the hashtag *#OurStoryIsYourStory.*

Among the celebratory activities, a short documentary showcasing the ANMF's collective strength and milestone wins is set to premiere in October. To coincide with this event, the *ANMJ* will release a centennial keepsake edition. This special edition will spotlight the ANMF, nurses, and midwives as a united, powerful collective that has been central to shaping the union's successes and driving significant advancements in their professions.

The power of nurse and midwife collective. NSWNMA members fighting for ratios and better conditions

Throughout its history, the ANMF has shown remarkable resilience and adaptability in the face of challenges. Looking ahead, the ANMF remains dedicated to advancing the nursing and midwifery professions. As we honour the achievements of the past 100 years, we also look forward with enthusiasm. The future holds limitless opportunities, and with the ongoing commitment and passion of nurses, midwives, carers, and the ANMF, the outlook for healthcare in Australia is promising.

Happy 100th anniversary, ANMF!

FOUNDATIONS OF THE ANMF

The Australasian Trained Nurses' Association, with branches in New South Wales, Queensland, South Australia,

(go to page 30 for the rest of the story)

Remembering Evelyn Augusta Conyers

A pioneering ANF leader and a force in Australian nursing (1870-1944)

Many of the original members of the ANF were visionary leaders and activists for nurses and women, far ahead of their time. They laid the foundation for the ANMF's achievements today.

Evelyn Augusta Conyers, an attendee of the Australian Nursing Federation's inaugural 1924 meeting, was one of them. Evelyn, a trailblazer in Australian nursing and instrumental in professional nursing organisations, became the vice president of the Federation the following year.

Evelyn was also the founder of the (Royal) Victorian Trained Nurses' Association in 1901. Additionally, she served as a director of the Victorian Trained Nurses' Club Ltd, and a trustee of the Edith Cavell Trust Fund. She also served on the board of management of Fairfield Infectious Diseases Hospital.

Born on 1 March 1870 in Invercargill, New Zealand, Evelyn was the daughter of engineer William Conyers and his wife, Fanny. She received a private education and attended girls' high schools in Invercargill and Dunedin.

In her early 20s, Evelyn moved to Victoria, Australia, where she trained as a nurse. She earned her certificate at the Children's Hospital in 1894 and completed her training at Melbourne Hospital in 1896. By 1901, she became the matron of a private hospital in Melbourne. In 1904, she was appointed the first matron of the Queen's Memorial Infectious Diseases Hospital at Fairfield. Around 1907, Evelyn and Sister Jessie MacBeth co-founded Lancewood, a private hospital in Kew, Victoria.

Evelyn's military career began in 1903 when she joined the Australian Army Nursing Service as a sister. In October 1914, she joined the Australian Imperial Force (AIF) as a senior sister at the 1st Australian General Hospital. Her first deployment was to Cairo, assisting at the Egyptian Army Hospital, Abbassia. By July 1915, she was back with the 1st Australian General Hospital at Heliopolis and quickly rose to the position of acting matron of the 3rd Australian Auxiliary Hospital.

In December 1915, during a reorganisation, Evelyn was appointed matron-in-chief of the Australian Army Nursing Service, overseeing all Australian Army nurses except those in India and Salonica, Greece.

In 1916, she moved to AIF headquarters in London, where her exceptional negotiation skills helped ease tensions between nurses and medical officers and reduced rivalry between Australian and British nursing services. She worked closely with Maud McCarthy, matron-in-chief of the British Expeditionary Force, visiting casualty clearing stations and auxiliary hospitals on the Western Front.

Evelyn took a brief absence in Australia from November 1917 to January 1918 before finally returning in December 1918 to continue her work at Lancewood Hospital. Her AIF appointment ended in March 1920, but she remained active in the military. Throughout her career, Evelyn received numerous honours including the Order of the Royal Red Cross (1st Class), the OBE, the CBE, and the Florence Nightingale Medal.

Evelyn Conyers passed away on 6 September 1944 at Epworth Private Hospital in Richmond, Victoria. She was buried with full military honours in Kew Cemetery, leaving behind a legacy of significant contributions to the nursing profession in Australia.[3,4]

At sea. c. 1919. Five Australian nursing sisters on board troopship Orvieto returning to Australia after overseas service. Matron Evelyn Conyers, Matron In Chief (overseas), Australian Army Nursing Service, AIF Centre

1986 – The first nurse and midwife strike in Victoria over downgrading of pay and conditions. The 50 day strike ended in a $30 million package for the professions including a pay rise, qualification recognition and a new career structure

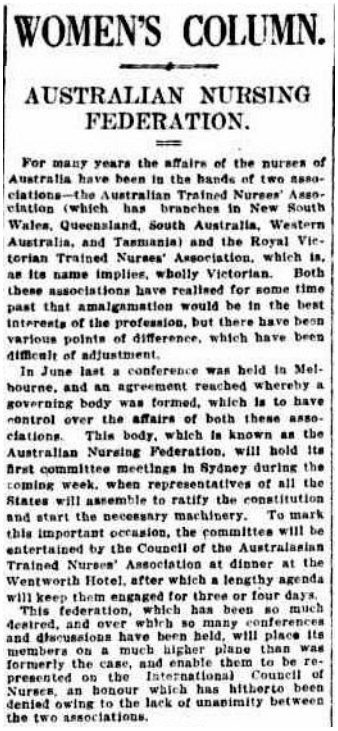
Western Australia, and Tasmania, and the Royal Victorian Trained Nurses' Association, which operated solely in Victoria, merged to benefit the profession in 1924.

Both associations had long recognised the advantages of a merger, but various differences posed challenges. However, by June of the previous year, a conference held in Melbourne led to an agreement to form a governing body to oversee the affairs of both associations. This new entity was known then as the Australian Nursing Federation with Evelyn Paget Evans appointed as its first Secretary. A position she held to 1950.[1]

In the leadup to ANF's first meeting, the Sydney Morning Hearld reported in its Women's column of the historical event. The article read: *For many years the affairs of the nurses of Australia have been in the hands of two associations – the Australasian Trained Nurses' Association (which has branches in New South Wales, Queensland, South Australia, Western Australia, and Tasmania) and the Royal Victorian Trained Nurses' Association, which is, as its name implies, wholly Victorian. Both these associations have realised for some time past that amalgamation would be in the best interests of the profession, but there have been various points of difference, which have been difficult of adjustment.*

In June last a conference was held in Melbourne, and an agreement reached whereby a governing body was formed, which is to have control over the affairs of both these associations. This body, which is known as the Australian Nursing Federation, will hold its first committee meetings in Sydney during the coming week, when representatives of all the States will assemble to ratify the constitution and start the necessary machinery. To mark this important occasion, the committee will be entertained by the Council of the Australasian Trained Nurses' Association at dinner at the Wentworth Hotel, after which a lengthy agenda will keep them engaged for three or four days.

This federation, which has been so much desired, and over which so many conferences and discussions have been held, will place its members on a much higher plane than was formerly the case, and enable them to be represented on the International Council of Nurses, an honour which has hitherto been denied owing to the lack of unanimity between the two associations.[2]



WOMEN'S COLUMN.

AUSTRALIAN NURSING FEDERATION.

For many years the affairs of the nurses of Australia have been in the hands of two associations—the Australian Trained Nurses' Association (which has branches in New South Wales, Queensland, South Australia, Western Australia, and Tasmania) and the Royal Victorian Trained Nurses' Association, which is, as its name implies, wholly Victorian. Both these associations have realised for some time past that amalgamation would be in the best interests of the profession, but there have been various points of difference, which have been difficult of adjustment.

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The crisis of gendered occupational violence and aggression

The global crisis of gender-based violence is inseparable from occupational violence and aggression (OVA) experienced by the healthcare workforce.

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As most of the healthcare workforce are nurses, midwives, and care workers, the majority of whom are women, there are undeniable gender-based patterns inherent in both linked phenomena. Women face greater risks of violence and aggression in the wider community, with female healthcare workers also facing higher risks of OVA at work.

OVA is characterised by abuse, threats, and assault at work. It can include aggressive and threatening gestures, verbal abuse, intimidating behaviour, and physical and sexual assault and can be catastrophic for those who experience it in the workplace and beyond.

Estimates suggest that almost three quarters of nurses have experienced some kind of OVA in the past year, with close to a quarter experiencing OVA on a weekly or daily basis.[1]

Most experience nonphysical violence such as verbal abuse or threats (67%) while physical violence accounts for an estimated 36% of OVA, with around 40% attributed to bullying and 25% for sexual harassment.[2] The most frequent perpetrators of OVA, particularly that which includes physical violence, are male patients, visitors, or parents of paediatric patients.[3]

Beyond the acute physical and/or psychosocial harm caused by OVA, healthcare staff experiences of violence and/or aggression can lead to many negative outcomes including poor mental health such as post-traumatic stress disorder and depression, burnout and absenteeism, sleep disturbances, and impaired jobs performance including poorer quality of clinical care.[4,5] It is likely, however, that reported rates of OVA substantially underestimate the real extent and severity of OVA due to barriers in reporting. Barriers to reporting include shame and fear of further violence.[6] One major challenge is that reporting and support systems seldom go far enough, with many nurses and midwives having little trust that substantial action will follow a report to employers. Alarmingly, OVA is so prevalent that to many it has simply become an expected, if unfortunate, part of the job.[7]

OVA estimates do not capture women's experiences of violence outside of work. One in three women has experienced physical or sexual violence since the age of 15 by someone known to them, and one woman is murdered by a current or former partner every week. This means that nurses, midwives, and carer workers are very likely to experience OVA at work, care for patients and clients who have experienced violence at home or in the community, and potentially be victim-survivors themselves.

Like gender-based violence, preventing OVA is complex and challenging and it must be achieved. In terms of OVA, many interventions have been implemented, however, the increasing prevalence of violence and aggression highlights that genuine and sustained action is urgently required. Without preventing OVA and supporting women in the health workforce, the broader and linked issue of gender-based violence cannot be addressed. This is because the healthcare workforce is itself critical to fighting gender-based violence despite the fact that many members are at risk or victim-survivors themselves. Key strategies include advocacy, supporting survivors, identifying and responding to warning signs, educating children and young people, and building more evidence and knowledge. Further, as the perpetrators of gender-based violence and OVA are most frequently men, men must call out this scourge whenever they can and proactively prevent and combat it. Education and investment are needed to raise public awareness of the issues and push governments to provide support in the form of funding, policy, legislation, and real-world reforms including addressing embedded socioeconomic inequities to protect women and girls from gender-based violence and OVA.

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A big heart

By Denise Cummins and Kristine Louis

This article discusses reflections from staff and family (who consented and contributed to this article); and provides an insight into clinical collaboration to assist a person accessing voluntary assisted dying (VAD) to become an organ donor.

The NSW Voluntary Assisted Dying (VAD) Act (2022) allows an eligible adult to access medical help to end their life. The person must fulfil eligibility criteria and be in the late stages of an advanced disease, illness, or medical condition.[1]

Depending on the medical diagnosis some people who plan to access VAD may also be eligible to be an organ donor. If the person raises this issue, appropriate health professionals can discuss the options with them.

Six weeks after VAD became available in NSW, our service received a request to simultaneously facilitate VAD and organ donation. Our patient was a 45-year-old man who was deteriorating from a non-metastasised cancer and who had chosen to access VAD. He enquired about donating his organs as he wanted to be able to help others and leave a legacy for life. His wife was very supportive of this wish. The VAD Coordinator liaised with other health professionals to achieve this request.

A description of collaboration and the process can be described in Figure 1.

The oncologist requested feasibility testing and once organ donation eligibility was confirmed, the patient chose to have the VAD substance administered two working days later.

All clinical teams involved (eg. VAD, oncology, organ transplant, operating theatres, ward staff, nursing executive as well as NSW Organ and Tissue Donation Service) attended many meetings over the course of the next two days to work together to provide a seamless journey for him and his family. Throughout the process the VAD coordinator monitored his health and updated the family.

On his chosen day, whilst laying in an anaesthetic bay, with his wife in attendance, he said a final goodbye, listening to a favourite song as the VAD substance was administered. In the room next door, a team of theatre staff waited respectfully in silence. Once deceased he was transferred immediately into the operating theatre for only the second organ retrieval in Australia post VAD, successfully donating several organs including the first heart.

REFLECTIONS FROM THOSE INVOLVED

This was a new experience for everyone involved and each person had their own personal reflections:

Family member: "Some people need help at the end, they become exhausted and may need someone to advocate for them, to support their wishes and to make sure their voice is heard. We were fortunate to have the support of the VAD team to achieve my husband's wishes to donate his organs which was so important to him. By talking to other health professionals, they got the ball rolling and then it just all happened quickly which was what my husband wanted."

VAD coordinator: "This was all new to us and we had a short timeframe to arrange things. But everyone stepped up to help us to achieve the best outcome for them. We learnt a lot and developed key contacts for the future. As VAD can be polarising it was wonderful from a personal perspective that everyone really wanted to do their best for this family."

Nurse Manager Perioperative Services: "It was a great collaboration of the multidisciplinary team to ensure the patient's needs and wishes were met. This was a new scenario for theatre staff, so although it was a bit challenging at first, working together we planned care with a common goal to provide the best service we could for this family."

Donation specialist nurse: "Usually discussions regarding organ donation are with the family as the person is usually unconscious or intubated in ICU. I found it a little confronting at first talking to the person directly, however it was comforting to me knowing that I was giving him all the information so he knew exactly what would be happening. I was completely blown away by the family and him as they pushed hard to have this case looked in to and their overwhelming desire to help others."

VAD doctor: "It went so well for our patient, the whole process was seamless, this is how health should be!"

NEXT STEPS TO DEVELOP CLINICAL PRACTICE

Currently there is guidance and policies regarding organ donation on the NSW MoH website and NSW Organ and Donation Service. Updates are being developed in relation to VAD, including first person consent to advise clinicians and families. Locally, we have established professional partnerships and working groups to develop a policy and guideline for future VAD organ donation which will be distributed across the area health.

Finally, everyone involved will never forget their role in this very special person's desire to help others.

Acknowledgement: We would like to acknowledge clinical and executive staff of Concord Hospital, Sydney NSW for support and especially Kelly Lewis and Paul Hogan donation specialist nurses for expert knowledge and Janice Chew, Nurse Manager Perioperative Services.

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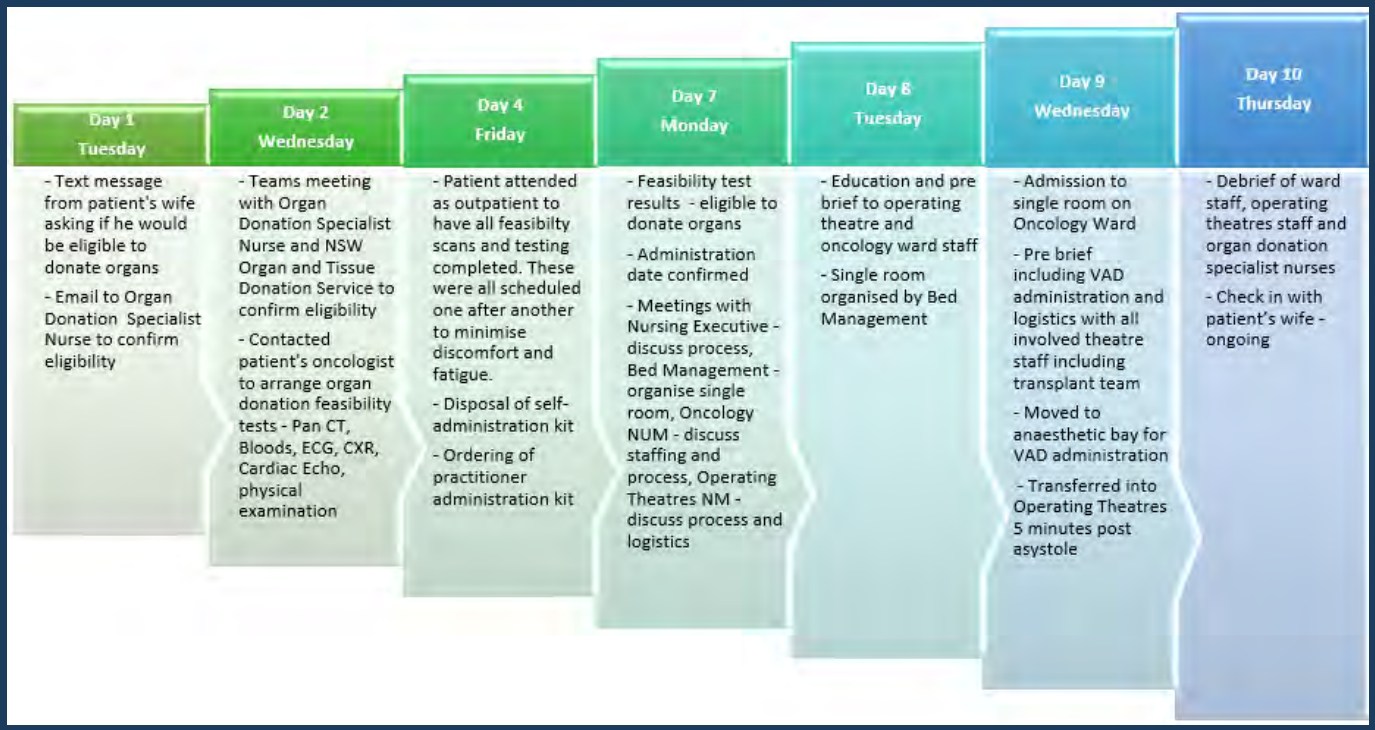
FIGURE 1: Description of the process and collaboration
COLLABORATIVE CARE – ORGAN DONATION



Jasmine Kirk

Federal Professional Officer

National midwifery update

"I didn't know there was a midwife at the ANMF."

At a national conference in 2023, I was excited to run into a midwifery professor I had learned from during my Bachelor of Midwifery. We talked about my journey since my graduate year, and when I mentioned that I had been working for the union she said, "I didn't know there was a midwife at the ANMF."

The Australian Nursing Federation changed our name in 2013 to the Australian Nursing and Midwifery Federation to acknowledge the valuable skills and knowledge of midwife members. Most state and territory branches employ at least one professional officer with a midwifery background who is responsible for the midwifery portfolio. The Federal Office of the ANMF currently employs two professional officers registered as midwives.

Every month, these professional officers come together to discuss issues facing midwives around the country. The network celebrates wins from each Branch and learns from one another's experience to agitate for better working conditions for midwives across the country. We contribute to national policy submissions on issues related to midwives and collaborate to appropriately represent our midwife members.

The ANMF is represented on the NMBA's Midwifery Futures Project's Expert Advisory Group and Working Advisory Group. In these groups, the ANMF has been advocating for workforce retention strategies such as midwifery-led models of care and public hospital ratios which are separate to nursing ratios and count the babies. In addition, the ANMF has advocated for block funding for maternity care and midwifery positions of leadership across all levels of government. The final report from the Midwifery Futures Project is expected by the end of 2024.

Midwives currently do not have access to upload to the My Health Record, though registered nurses do. The ANMF is in conversation with the Australian Digital Health Agency (ADHA) about increasing access for midwives to allow them to upload to the My Health Record. The ANMF has also produced a webinar specifically targeted to midwives with the help of the ADHA, which is available at: **anmf.org.au/digital-health**.

The valuable, woman-centred continuity of care experiences required of student midwives mean that midwifery students pay approximately $7,000 more per year than nursing students to complete their studies.[1]

The ANMF has welcomed the Government's recent announcement of the 'prac payment,' which is an excellent first step towards financially supporting midwifery students while they learn to support women.

The ANMF has also worked to create Nurse Midwife Health Program Australia (NMHPA), a 24/7 national support service for nurses and midwives. The program provides confidential, evidence-based advice and referral to promote health for midwives, nurses, and students. Midwives within the ANMF have provided feedback about midwifery-specific issues to assist NMHPA. These include PTSD (Post Traumatic Stress Disorder) and vicarious trauma, low clinical supervision, coping with the demands of on-call work, and physical or moral injuries midwives can incur in the course of their work. Having these midwifery issues raised means NMHPA can better target their materials to the specific problems midwives in Australia face.

This year, the Government also announced $50 million in scholarships for nurse practitioners and endorsed midwives. Scheduled medicines endorsement is the way of the future for our midwifery workforce, and these scholarships will help to make endorsement financially viable for midwives. While only a small percentage of the midwifery workforce is currently endorsed, affordable pathways to endorsement will remove barriers to the additional qualification required. Midwives will be involved in every step of the process to ensure that as more endorsed midwives join the workforce, they are renumerated appropriately for their skill and education level.

As a midwife and member, how can you get involved in the midwifery-related work of the ANMF?

Midwives can become local branch members, promoting active membership participation, and facilitating two-way communication between ANMF members and officials. Midwives can be valuable union organisers and delegates, ensuring that midwifery-led care models and local midwifery-specific priorities are adequately addressed in enterprise bargaining agreements.

To hear more about any of these initiatives, or have your voice heard as a midwife to inform the broader work of the ANMF, please contact your state or territory Branch.

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Stronger minds brighter futures: Promoting engagement and inclusiveness through mental health awareness workshops for migrant adults in Victoria

By Bindu Joseph, Robeena Emmanuel and Michael Olasoji

Mental health remains an area of concern in Australia with one in four Australian adults experiencing mental illness.

L-R Mrs Robeena Emmanuel and Dr Bindu Joseph

Australia has a robust mental health system, and the population accessing services is influenced by several factors. Australia is a multicultural nation with 30% of people born overseas.[1] Mental illness is highly prevalent among migrants and there is at times delay in seeking help among this population.[1,2]

The interplay of culture, language, practices, stigma, and understanding put forth unique challenges in accessing mental health services for populations with Culturally and Linguistically Diverse (CALD) backgrounds. Addressing the unique mental healthcare needs of these communities is paramount to creating inclusive and timely mental healthcare. This article aims to discuss a community outreach Mental Health Awareness Program for CALD adults initiated by Federation University academics with the support of an Academic Seed Grant by the Collaborative Evaluation and Research Centre (CERC).

This program is codesigned by mental health academics and members of various CALD communities. The overall objective of this program was community engagement and capacity building. This community outreach program adopted a multifaceted approach including workshops, discussions, and sharing online resources. The focus of the three-hour workshop is to improve awareness about common mental health disorders, discussions on stigma and misconceptions, post-migration stress, and its impact.

Additional focus is also on second-generation migrants, adolescent brains and behaviours, challenges specific to second-generation migrants, and access to mental health services. Phase one of this program is currently in progress and the focus is on Indian migrants. Indian–born population is the second largest migrant community in Australia.[4] Approximately 300 adults are expected to complete this program. Three community workshops were completed with other sessions booked for the coming months. Advertisements and implementation of this program were through collaborations with the CALD community organisations, religious institutions, and leaders from CALD communities.

Preliminary evaluation of this project confirms promising outcomes and impacts. We have completed pre- and post-workshop surveys and post-program evaluations. Furthermore, the post-survey highlighted the improvement in knowledge and awareness of mental health, mental illness, help-seeking behaviours, and insights into stigma related to mental illness.

The highlights of evaluations are:

"The best mental health awareness session",

"I am a healthcare worker, and it improved my knowledge",

"I wish more people had this chance",

"I felt you were talking for me",

"I am experiencing this",

"Can you do more sessions".

In summary, this program so far has resulted in promising outcomes. Reflecting on this journey, we have come across a few challenges. This includes language diversity, the stigma associated with the terminologies (mental health and mental illness) and ensuring sustainable community engagement. Future programs will aim to focus on different CALD communities, assess the long-term impacts of expanding community partnerships, and reach minority subgroups within CALD communities.

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Our Dreaming Legacy (2013-2023): Pushing our mob forward on the bush tracks of higher education success

By Lynne Stuart and Aunty Leone Smith

To achieve greater educational success amongst Aboriginal and Torres Straight Islander students, a specific mentoring model was used.

MODEL OVERVIEW

This model 'Capture and Keep', is an Indigenised nursing and midwifery student support and mentoring model in use at the University of the Sunshine Coast (UniSC). This discipline specific model was developed to support Indigenous nursing and midwifery students to succeed in their university programs.

'Capture and Keep' provides Indigenous nursing and midwifery students with comprehensive cultural, social, and academic support to enable them to successfully navigate both their university studies and clinical placements.[1] The model also supports the transition of Indigenous graduates into the workforce, in the form of Queensland Health identified graduate positions within UniSC's geographic footprint. This support extends to linking students with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) for advocacy and support at a national level. The aim of the 'Capture and Keep' model highlights the importance for Schools of Nursing and Midwifery to employ Indigenous nursing and midwifery academics on staff.[2]

Indigenous nursing and midwifery academics are positioned well culturally and academically to lead work supporting Indigenous nursing and midwifery students that will build a workforce equipped to 'Close the Gap'.[2]

MILESTONES

In 2013, Stuart joined UniSC and started informally mentoring and supporting 13 Indigenous students enrolled in nursing and midwifery programs. Her experience in this area originated from her extensive work at the University of Southern Queensland (UniSQ) where she implemented 'Helping Hands', a similar model to 'Capture and Keep'.[3,4] Stuart was able to draw on her own personal journey from undertaking a nursing undergraduate program in 2001 to completing her PhD in 2017. The 'Capture and Keep' model operating at UniSC from 2013 continues to be advertised to Indigenous nursing and midwifery students in line with course teaching timetables in Semester 1, 2024.

From 2013–2016, UniSC Indigenous nursing and midwifery student numbers had grown from 13 to 37, and to manage this growth Stuart applied to Health Workforce Australia (HWA) for funding to establish an Academic Mentoring position. Smith commenced in this new position, which now operates under UniSC Indigenous services.

By 2018, student numbers had again increased, and graduates were entering the workforce. Smith established a strong working partnership with Queensland Health's Sunshine Coast Hospital and Health Service (SCHHS), and in May 2023 a new 'Nursing and Midwifery Graduate Program Cultural Recruitment Position Statement' was approved through their Practice Development Team. From 2019 to 2023, through this Queensland Health cultural support program, Smith successfully guided 23 UniSC Indigenous nursing and midwifery graduates into SCHHS's Identified graduate positions. In 2023, additional partnerships have been established with the Metro North Hospital and Health Service (MNHHS) and the Wide Bay/Fraser Coast Health Service graduate programs, both within UniSC's geographic footprint.

IMPACT AND OUTCOMES

Since the formal commencement of the 'Capture and Keep' model at UniSC in 2016, Indigenous nursing and midwifery student enrolments have increased from 37 to 114 in 2022 across several nursing and midwifery degrees (Figure 1). By Semester 1, 2023 enrolments have again increased to 125, with 121 nursing students and four midwifery students (Table 1). The first UniSC Indigenous Nursing Doctor of Philosophy graduate was Stuart in 2017. A highlight in 2023 was a second Indigenous Nursing Doctor of Philosophy candidate commencing PhD studies. Another highlight in 2023 was a UniSC Indigenous nursing graduand receiving a commendation for academic excellence and then chosen to deliver the nursing valedictory speech on behalf of her fellow graduands. These student highpoints at UniSC demonstrate the development of Indigenous nursing and midwifery leadership within the student body. In 2020, Stuart and Smith were awardees of the UniSC Vice-Chancellor and President's Diversity and Inclusion Award for the success of 'Capture and Keep'.

Enrolment numbers continue to increase as demonstrated in Table 1 for Semester 1, 2023.

The Indigenous nursing and midwifery student success rate has increased by 16.6% from 76.9% in 2013 to 93.5% in 2022. Additionally, student attrition rates have decreased from 41.7% in 2013 to 23.1% in 2021. By the end of Semester 1, 2023, a total of 83 Indigenous nursing and midwifery students have graduated. This represents 2% of the total UniSC nursing and midwifery graduate cohort from 2013 to Semester 1, 2023 (Table 2).

CONCLUDING THOUGHTS

Through implementing the 'Capture and Keep' model at UniSC, we continue our 'Dreaming with Care' cycle to push our mob

Lynne Stuart & Aunty Leone Smith

FIGURE 1: Aboriginal and Torres Strait Islander student enrolments Nursing and Midwifery degrees at UniSC from 2016 to 2022

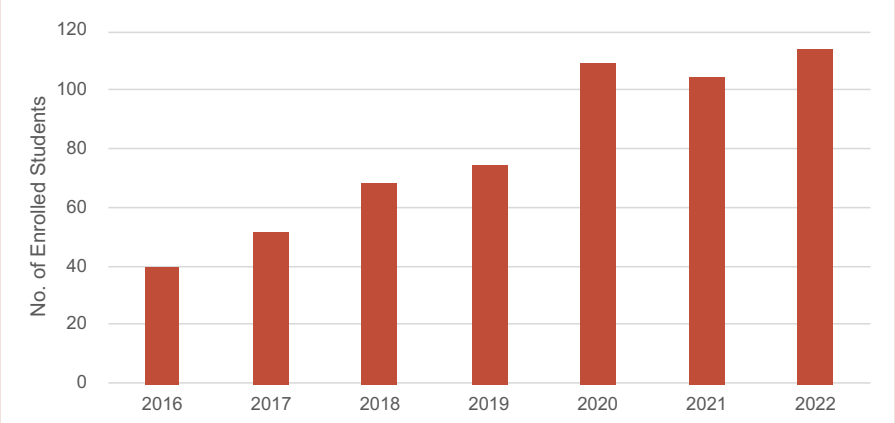

TABLE 1: Aboriginal and Torres Strait Islander Bachelor of Nursing Science/Midwifery Semester 1, 2023

Campus	Degree	Commencing	1st Year	2nd Year	3rd Year	Total
Sunshine Coast	Nursing Midwifery	19 2	7	15 1	6 1	**47** **4**
Fraser Coast	Nursing	5	5	5	5	**20**
Gympie	Nursing	3	0	3	1	**7**
Caboolture	Nursing	6	5	4	4	**19**
Moreton Bay	Nursing	9	6	10	3	**28**
TOTAL		**44**	**23**	**38**	**20**	**125**

TABLE 2: Aboriginal and Torres Strait Islander Nursing and Midwifery Completions 2013-2023

Year	Ba Nursing Science	Ba Midwifery	Ba Nursing Science/ Ba Midwifery	Postgraduate Nursing Science	Doctor of Philosophy	Total (% of cohort)
2013				1		**1 (0.7%)**
2014	2			1		**3 (1.8%)**
2015	3					**3 (1.4%)**
2016	4					**4 (1.6%)**
2017	2		1		1	**4 (1.2%)**
2018	7		1			**8 (2.3%)**
2019	11	1		2		**14 (3.0%)**
2020	13					**13 (1.9%)**
2021	12	2	1			**15 (2.2%)**
2022	13					**13 (1.9%)**
2023*	3	1		1		**5 (2.4%)**
Total (% of cohort)	**70 (1.8%)**	**4 (3.3%)**	**3 (2.5%)**	**5 (2.9%)**	**1 (5.9%)**	**83 (2.0%)**

*** Semester 1 only in 2023**

forward on the bush tracks of success. In Semester 1, 2024 at UniSC we have record numbers of 'Deadly' Indigenous nursing and midwifery student enrolments and graduates. Enrolments have increased to 128 with 123 nursing students and five midwifery students. Additionally, successful graduate completion numbers have reached 92 with 85 nursing graduates and seven midwifery graduates. This UniSC success of recruiting, retaining, and graduating Indigenous nursing and midwifery students qualified for 'Closing the Gap'… is our 'Dreaming Legacy'.

***Note**: For this case study, 'Indigenous nurses and midwives' refers to the Aboriginal and Torres Strait Islander nurses and midwives of Australia.*

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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.

Aged care residents' rights: The new Aged Care Act

Significant changes are expected in the aged care landscape in the not too distant future.

Following the 2021 Royal Commission into Aged Care, a scathing report made aged care conditions public, leading to a demand for improved protections for our most vulnerable population. Legislative changes, developed in conjunction with stakeholders are set to provide new, and purportedly more robust protections for aged care residents. These changes will not only ensure clear standards and rights for residents, but also enshrine civil and criminal penalties for aged care staff and directors where the standards are breached.

Existing aged care protections have been criticised as being piecemeal and difficult to navigate. From the Aged Care Quality and Safety Commissions' Serious Incident Response Scheme, Star Ratings for aged care homes and accreditation audit processes, to protections in tort law, there is no doubt that the system is difficult to understand and navigate – particularly for aged care residents.

As a result of the complexity, it is often families and carers who take the reigns to hold aged care services accountable. The management of Covid–19 in aged care settings is an example of this, where there are currently two class actions on foot against Australian aged care providers. At the heart of both of these class actions are allegations that the aged care services failed to prevent the spread of Covid–19 by not complying with reasonable standards of care, resulting in resident deaths and subsequent psychological harm to their families.

It might seem that class actions can sufficiently address situations where standards of practice are breached, however, class actions can take years, are expensive and will do little to assist the residents that lived through Covid–19 lockdowns – and even less to help those that didn't.

Without rehashing the moral, ethical and legal issues of Covid–19, these issues serve to highlight the vulnerabilities of aged care residents in a regulatory system that is predominantly reactive rather than proactive. In addition, it highlights the practical challenges that aged care residents experience in accessing and participating in systems that affect them. Many have long argued for a rights-based approach to protecting the interests of aged care residents (Bennet et al, 2022). Currently, residents are often blocked from upholding their personal rights whether by the involvement of substituted decision makers, perceived issues of consent or the practical challenge of access to legal services resulting from technological inequities.

Whilst class actions are intended to promote the pursuit of legal claims for breaches of duty of care by people who otherwise might not be able to do so (whether through financial or technological challenges for example), there remains a heavy reliance on others, often care givers, to pursue that avenue. Additionally, aged care residents' ability to actively participate in protecting their own rights is further compounded by the lack of an international convention on the rights of the older person and the absence of consistent anti-discrimination laws across the Australian states. Even where aged care residents are able to access torts law for rectifying wrongs, the outcomes may take years to reach and ultimately result in less than desirable immediate outcomes, with little evidence to suggest that litigation improves the quality of aged care.

Choice, control, and autonomy feature heavily in aged care residents' perspectives of quality care (Cleland et al, 2021). These themes are largely reflected in the new Act, which appears to facilitate a shift from protection to empowerment for aged care residents. Replacing the existing Aged Care Act and the *Aged Care Quality and Safety Commission Act 2018*, the aim of the new Aged Care Act is to "create a simplified, rights based legislative framework, comprised of a single piece of primary legislation. . .that focuses on the needs of older people" (Australian Government Department of Health and Aged Care, 2023).

This aim may be achieved though the significant changes to the regulatory system, such as the new complaints commissioner, tasked to focus on a person-centred complaints process, and the newly shared governance by both the Secretary of the Department (System Governor) and the Aged Care Quality and Safety Commissioner (Commissioner) both with expanded regulatory powers.

Invariably, existing frameworks for the protection of aged care residents have failed at the implementation stage, where systems have been found to be simply too hard for residents and carers to navigate and penalties are too hard for regulators to impose. The new Aged Care Act is set to come into effect from 1 July 2024. Although the delay between the report release and recommendations being implemented has been criticised, the legislative changes will no doubt be welcomed by residents and carers, however we will watch for the impact on residents' rights with bated breath.

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Nurses, midwives, and substance use

By Melise Ammit and Nick Miles

Nurses and midwives, like the general population, use alcohol and other drugs. However, they may face unique challenges related to substance use within their professional context due to the standards and codes inherent in being a registered practitioner.

Nursing and midwifery are demanding professions carrying high levels of public and professional expectation. High job stress coupled with physical and emotionally burdensome work can result in use of substances such as alcohol, sedatives, stimulants, opioids, and nicotine as coping mechanisms.

Evidence on the incidence of substance use among nurses and midwives is scarce in Australia. However, the American Nurses Association posits that up to 10% of the nursing workforce may be dependent on alcohol or other drugs,[1] in line with global statistics for the community at large.

An Australian online study by Searby and colleagues found that 36.9% of the 1,300 nurse respondents reported consuming alcohol at risky levels – a much higher rate when compared to previous studies.[2]

A recent study from the United States found that 40% of nurses who were disciplined for substance abuse used prescription medication to control chronic pain conditions and 42.5% of them used substances for emotional problems. A study of undergraduate nursing students by the same author found that 10% reported non-medical prescribed stimulant use and 50% screened positive for alcohol and other drugs.[3]

Furthermore, certain specialties, such as anaesthesiology are associated with increased risk for abuse of and dependency on certain classes of drugs such as opioids, and potent benzodiazepines.[4] Midwives also work in environments where they have access to controlled substances and are exposed to stressful work environments. A study by Pezaro et al. (2020) found that a link exists between substance use and long working hours, work-related psychological distress, and avoidant coping behaviour in midwifery populations.[5]

Nurses are usually the problem solvers in patient care settings, and they can have difficulty asking for, and accepting, help. This is one of the reasons nurses can sometimes have trouble accepting they have substance use issues in the first place. Nurses are more likely to diagnose and self-medicate due to familiarity with, and access to, medications. Yet, despite this familiarity, nurses may be unaware of the risk of dependence and fail to recognise symptoms until their use has become problematic.

Nurses with substance use disorders (SUD) have been described as hardworking, conscientious, and devious. They may exhibit some behaviours such as preferring night duty or weekend shifts when there is minimal oversight by colleagues or management, having higher frequency of narcotics dispensing, lack of witnesses to discarding unused medications, and seeking opportunities to be alone when accessing the medication safe. Evidence of hangovers or smelling of alcohol in the morning may be indicators of harmful alcohol use.[6]

The public places their trust in registered health practitioners. However, SUDs can lead to significant compromise in patient care due to impaired judgement, lower reaction times, increased errors, patient neglect, and diversion of medications for personal use.

To safeguard public trust, the national law mandates that health practitioners report specific incidents to the Australian Health Practitioner Regulatory Agency (Ahpra) and the National Boards of nursing and midwifery. These incidents fall into four categories: intoxication while practicing, impairment, practice outside professional standards, and sexual misconduct.[7]

Changes were made to the mandatory notification requirements in 2020 with the aim to encourage practitioners with problematic substance use to seek professional advice without fearing repercussions or triggering a mandatory notification unless there is a substantial risk of harm to the public.

Being honest about drug use is uncommon, especially with nurses who have a lot to lose if they are 'found out'. Usually, the problem has been going on for a while, and great efforts have been made to conceal it. Nurses may have ill-informed, erroneous beliefs about mandatory reporting criteria. Likewise, nurses may harbour anxious fantasies that a notification will spell the end of their career. They may be fearful for their livelihoods and reputation.

Ahpra's response to notifications involves assessing the situation, seeking the practitioner's response, and determining appropriate action. Understanding this regulatory process is important for nurses and midwives as it ensures both a public

and practitioner safety focus rather than a disciplinary, punitive one.

Nurses can fail to extend compassion and understanding to one another and can view their colleagues with SUD as having flawed characters. This can exacerbate feelings of shame and disappointment in both themselves and those that trust them, contributing to the denial of substance use or the need for treatment.[8]

Early identification and tailored interventions are crucial to address the specific needs of nurses with problematic substance use. American nurse and author Rachel Shuster describes her personal experience of board-mandated treatment for opioid dependency in the US and credits the program with 'saving her career'.[9] She calls for strategies such as implementing policies in education to encourage early detection and treatment for nurses with substance use issues. Education about regulatory processes and procedures can diminish the shame, secrecy and fear experienced by nurses and midwives who use substances.

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ANMF supports Go Gentle Australia's push to make telehealth available to Australians accessing Voluntary Assisted Dying (VAD)

Voluntary Assisted Dying (VAD) is now legal across most parts of Australia for terminally ill people. Despite the advancements, health professionals remain banned from discussing VAD via telehealth, leading to disruptions and delays in care, and putting those who are unable to travel for face-to-face consultations at a disadvantage.

The significant barrier is the result of a 2005 amendment to the *Commonwealth Criminal Code Act 1995*, which made it an offence to use a 'carriage service' to publish or distribute material that counsels or incites a person to suicide. It has meant that health professionals cannot use any electronic communications – including telehealth, phone, email, text – to discuss the VAD process. If they do, they risk criminal charges and a $300,000 fine.

Despite widespread efforts to clarify the technicality, a federal court ruling last December confirmed that conversations about VAD must not occur via telehealth, email, or telephone. While nearly all state VAD laws explicitly differentiate VAD from suicide, and leading suicide prevention organisations echo the same view, the federal ruling ultimately takes precedence.

At the time, advocacy organisation Go Gentle Australia labelled the decision a "retrograde" step and "blow to terminally ill people everywhere" but especially for those living in rural and regional areas who cannot access in-person appointments with clinicians.

Since the decision, Go Gentle Australia has continued to lobby federal politicians to take action to ensure telehealth becomes available for terminally ill Australians accessing VAD.

Now, the ANMF has joined other national peak health organisations, to call on the government to urgently amend the Commonwealth Criminal Code to allow electronic communications, including telehealth, to be used by health professionals when needed to support VAD care.

The ANMF Federal Executive agrees with Go Gentle that: "Electronic communication is essential for high-quality and safe healthcare. However, the Criminal Code's restriction on how health professionals communicate about voluntary assisted dying (VAD) is causing disruptions and delays in care provision and limiting health professionals' ability to do their jobs.

"It should be for health professionals and their patients to decide if electronic communications are an appropriate alternative to in-person care, not politicians."

The current restriction is having far-reaching impacts as blurred boundaries mean nurses working in the field face the risk of prosecution while simply attempting to provide care and support.

"Everything we do is impacted by the Criminal Code," one care navigator told the *ANMJ*.

"When people want to find out more about VAD or get access to it, we are the people that they'll call in the first instance. So, we're the most vulnerable to just [*sic*] the general public, or anyone, phoning us, and [by that I mean] we're immediately breaching the criminal code.

"The moment we ring a doctor, email a doctor, email a patient because we need some information; absolutely every single thing that we do every day we know that we're breaching the Criminal Code, and that's just by doing our job."

Go Gentle's CEO, Dr Linda Swan (pictured), said the challenge is that the Criminal Code amendment was written almost two decades ago, long before the introduction of VAD in Australia, and is clearly outdated.

"Tragically, we're in this bizarre situation where there is an old Commonwealth law that is significantly, and I would say unintentionally, impacting on the delivery of a health service for dying Australians," Dr Swan said. "In-person appointments are always preferred by clinicians, but requiring them for every part of the VAD process is unreasonable".

Go Gentle will continue to lobby federal politicians for urgent reform.

Dr Swan said that organisations like the ANMF, and its more than 325,000 members, would help elevate the message so that Australians who need it can access VAD services.

The important issue will be discussed at the second annual Trans-Tasman Voluntary Assisted Dying Conference in Brisbane in October.
gogentleaustralia.org.au/vadcon24

If you have experienced disruptions and delays in VAD care caused by the ban on electronic communications, including telehealth, please contact Go Gentle Australia **contact@gogentleaustralia.org.au** or **0426 283 865**

Go Gentle Australia

AGED CARE

Aged Care IPC Community of Practice

By Carrie Spinks

Infection prevention and control (IPC) was not considered a high priority in aged care prior to the COVID-19 pandemic.

The high rates of mortality and morbidity (residents and staff) associated with COVID-19, as well as the release of the Royal Commission into Aged Care Quality and Safety Final Report[1] recommending the need for enhanced IPC in aged care, brought change.

During the pandemic, the aged care industry was faced with the sudden demand to implement high level IPC measures not previously implemented. The industry struggled for many reasons, most notably the lack of change preparedness, knowledge and understanding of IPC practices and their implementation. To assist with change, the Aged Care Quality and Safety Commission introduced the role of the IPC Lead (inclusive of education requirements), into every residential aged care facility, as a condition of accreditation.[2]

To improve IPC practices in aged care, staff training and education has been at the forefront of government and provider strategies, however factors besides knowledge/competence impact IPC practice in the aged care setting. Social influences, motivation, change readiness, reinforcement capacity and environment and setting context, have all impacted IPC implementation over recent years.[3] For successful IPC implementation, these factors all need to be addressed alongside the provision of education and training. This requires a more collaborative and peer supported approach, such as a 'community of practice'.

The definition of a 'community of practice' includes "the collaboration of a group of people who share a common concern, a set of problems, or an interest in a topic and who come together to fulfill both individual and group goals".[4] Considering this concept, the establishment of an aged care IPC community of practice would provide the capacity to address social, setting context, and educational factors needed to enhance IPC in aged care.

Though the role of the IPC Lead remains new and evolving, with varying scopes of practice across the nation, challenges have been met. The foundations of IPC can be taught and tailoring them to the aged care context through discussions with peers in interpreting teachings, guidelines and IPC practices have proven invaluable.[5] Conversations around up-to-date and credible IPC information, relevant to mandates and recommendations in the sector have guided those new to aged care IPC. The need for ongoing support, guidance and reassurance for the Leads is very real.

The Australasian College of Infection Prevention and Control (ACIPC) recognises the need for a community of practice amongst aged care IPC Leads, nurse consultants/specialists, public health nurses and others managing or assisting with IPC implementation in the sector. The College has established an aged care IPC community of practice through the provision of free bi-monthly interactive webinars, via an online platform, steered by ACIPC IPC Consultant. Each webinar has a topic focus, provision of education, guideline review and open

floor discussion. The end goal being to strengthen IPC knowledge across the sector and devise sustainable solutions.

For further information on the ACIPC Aged Care Community of Practice webinars visit: **acipc.org.au/about/aged-care-ipc-community-of-practice/**

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Cognitive Stimulation Therapy in Australia

By Robyn Lewis

Cognitive Stimulation Therapy (CST) is a short-term, evidence-based psycho-social intervention for people with mild to moderate dementia developed in the United Kingdom (UK).

CST is widely delivered through the National Health Service in the UK, recommended by the National Institute for Health and Care Excellence to promote cognition, independence and wellbeing and is the only non-pharmacological therapy endorsed by the UK government. CST is delivered in 38 countries including Australia.

CST is a structured program that is delivered over 14 sessions in small groups in person, online (virtual CST) or with individuals (individual CST) by trained professionals or family carers. Following the initial CST program, a follow-up maintenance CST program can be delivered to participants. CST is suitable for residential care, day care, medical and community settings.

Each CST session involves a theme and uses materials and hands-on activities to reinforce thinking, learning and involvement. Group identity is strengthened with a group name and song chosen by participants and orientation to time, place and events are guided through reminiscence and discussion led by facilitators. Group activities are tailored to the interests and needs of participants. A Cochrane Review published in 2023 found that CST resulted in short-term cognitive benefits for people with mild to moderate dementia and improvements in communication and social interaction.[1]

In 2022, an independent Australian CST Working Group was established for CST practitioners, researchers and for people interested in CST. The Australian CST Working Group meets bi-monthly via a video platform and aims to provide a point of contact, support, and identity for people in a wide range of Australian settings delivering or interested to deliver CST.

To increase awareness of CST and increase the number of facilitators in Australia, a CST facilitator training was held in Melbourne in 2023 by master trainers from New Zealand. An Australian Master Trainer was identified in 2023 and CST facilitator training will be conducted in-person on an annual basis to increase the number of CST facilitators in Australia. The next CST facilitator training will be held in Sydney on 7 September 2024. Online CST facilitator training can also be accessed from the International CST Centre.[2]

Information about the work of the Australian CST Working Group and contact details for the Coordinator and Master Trainer are available from the CST International Centre.[3]

Author

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(Robyn Lewis): CST Facilitator Training 2023 (Melbourne). CST facilitator trainees (names unknown) under the supervision of Associate Professor Gary Cheung, academic old age psychiatrist at the University of Auckland and Health New Zealand

(Robyn Lewis): CST Facilitator Training 2023 (Melbourne). CST facilitator trainees (names unknown) under the supervision of Dr Kathy Peri, Gerontology academic and Nurse specialist at the University of Auckland and Director, Dementia Learning Centre, Alzheimer's NZ.

Ageing: Loneliness of older Australian men diagnosed and treated for prostate cancer

By Peter 'Kevin' O'Shaughnessy and Michelle King-Okoye

BACKGROUND

Prostate cancer (PCa) is the most diagnosed cancer among older men in Australia.[1]

Whilst it has a high prevalence, older Australian men are more likely to die with PCa rather than from PCa due to improvements in treatment and nursing care.[2-4]

The increased survival rates are 96% at five years, enabling more men to live longer following a PCa diagnosis.[4] Adverse outcomes associated with PCa treatment including sexual dysfunction, faecal and urinary incontinence often lead to prolonged physical and psychological distress.[5,6] These adverse events are reported to impact mens' self-esteem and relationships leading to potential social disconnect and decreased engagement with healthcare.[6-8]

SOCIAL ISOLATION AND LONELINESS

Living with PCa diagnosis and/or following treatment men are not only distressing on a physiological and emotional level; this distress can lead to feelings of vulnerability and social isolation.[9-11]

Moreover, as men grapple with these challenges, they may be less inclined to seek support or discuss their concerns openly, further exacerbating feelings of loneliness and isolation. Furthermore, the COVID-19 pandemic with its social distancing measures potentially fractured existing friendships and social circles.[12,13]

Social isolation and loneliness disproportionately affect older adults, with men being particularly susceptible across all age groups.[14] Factors such as retirement, mobility limitations, illness, and the loss of a spouse or friends contribute to the erosion of social connections among older men.[15,16] Research has shown that the PCa diagnosis and treatment adds a strain to relationships with some men distancing themselves from their wives/partners in order to cope.[16-18] Unlike women, men often have smaller social networks and may be less adept at seeking out and maintaining social connections.[17-19] However, interventions aimed at fostering social connections for older men have the potential to mitigate the adverse effects of social isolation and loneliness on mental and physical health outcomes.

ROLE OF NURSES

Nurses are trusted by PCa survivors and involved at every stage of their cancer journey.[9,20] Nurses play a vital role in addressing the psycho-social and emotional aspects of PCa treatment men experience on their cancer journey.[9,20-22] Nurses can also support men with PCa through a complex decision-making process. However, there is a need to build knowledge and capacity for nurses delivering care to at-risk prostate cancer survivors including CALD, LGBTQI, rural and remote populations.[8,9,23]

By providing unbiased, easily understood information and counsel, nurses could empower men to make informed decisions about their treatment options and are positioned to assess the potential impact on their social connections and quality of life.[8,9,20-23] Additionally, nurses can facilitate discussions about coping strategies, support networks, and community resources to help men navigate the challenges of PCa treatment, its side effects and mitigate feelings of social isolation and loneliness.

In conclusion, addressing the emotional implications of PCa treatment, including its impact on social isolation and loneliness among older Australian men, is essential for promoting holistic care and wellbeing. Building nurses knowledge of the emotional challenges PCa survivors face, and implementing innovative interventions and evidence-based practices, nurses can assist older men work towards fostering meaningful social connections and reduce the adverse effects of social isolation and loneliness.

Authors

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Dr Peter 'Kevin' O'Shaughnessy PhD, BN, BHSc (hons), RN, CN, Lecturer, UniSA Clinical and Health Sciences Academic Unit. Dr Peter 'Kevin' O'Shaughnessy has experience researching the supportive care needs of men with prostate cancer, their partners and families at various stages of men's prostate cancer journey. Kevin continues to explore the role loneliness and isolation play in the lives of cancer survivors.

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Placing mum in Residential Aged Care – thoughts of a nurse/daughter

By Lorna Moxham

This article is offered as a personal reflection on my lived experience of placing my nonagenarian mother into residential aged care.

Of course, my personal lived experience is also inextricably intertwined with me being a nurse of 44 years.

As much as I try, these two "personas" cannot be separated, and both are apparent every time I visit mum.

Mum lived with me for 23 years, in a separate space, but in the latter years required ongoing and continuous daily care. However, during a period of insistent and heavy rain her space got flooded and my space was not designed for her. She went into respite care.

The first residential facility was 90 minutes from me – I could not get anything closer no matter how hard I tried. Potential permanent local providers could not talk about her because she was in a facility "out of area", and the providers of the facility she was in, could not help as her home address was "out of their area". Bureaucratic boundary madness.

The first facility was very old, I do wonder how it got through accreditation based on the physical environment. Mum's tiny room could only fit one chair, a single bed and a tiny one-door wardrobe. Long, noisy and cold lino covered corridors with only two shared bathrooms, a single lift to the dining room (that was continuously broken), most staff changed regularly – apparently agency.

The food was really good (cooked on site by a European cook), most staff were really pleasant. No activities per se – most involved turning on the very large TV in the dining and sitting area.

Then a miracle happened – yes that's how it felt. A local provider had a bed, we transferred mum to be near us, and care was now permanent. Nine months had passed.

Mum felt she had moved into what she said was a "5 star hotel". She has a large private room, WITH carpet, WITH an ensuite, WITH a kitchenette (she now had a fridge), WITH a double wardrobe, WITH a wall mounted remote controlled TV, WITH storage space. There was also enough room for us to get her an electronic rising chair, buy her a bookcase and a display cabinet for her photos. She was SO happy and we were and still are – SO grateful.

Fast forward 12 months. Mum has declined physically and cognitively although still very much able to have a conversation and would pass a mental status exam (MSE). The staff work very hard and provide the best care they can. Many are nursing students and people brought in from overseas to look after our older family members.

Weekends are a challenge for the organisation, much of the staff are agency which fills the roster but of course this poses challenges as to not knowing the residents or their routines. Mum likes things done a certain way – and expects the staff to know what that is. It can be frustrating for her and the staff member.

Daily care needs are met but just as important is the many activities that mum gets involved in. Activities are often held in the lounge room and done as a large group and include name that tune, country etc. crosswords, exercise groups, singing, and craft.

The facility goes out of its way to have a roster of volunteers who take those residents who want to go out in the bus, pull weeds from the lovely garden area, and bring in dogs to pat.

There is always a choice of food on the menu, tea/coffee/hot chocolate/milkshakes are on offer regularly, usually accompanied by a scone with jam or cream or a Tim Tam. A wee dram of Port at night is not uncommon and helps mum relax into her comfortable bed.

As a daughter I am grateful and pleased with her care. She is safe, clean, well fed and entertained. As a nurse I am also grateful and pleased with her care, but I do notice 'other' things. The shortage of staff, many of whom come from an agency. Untrained nurses distributing medication – yes from a Webster pack – but are they aware they are administering? I get phone calls ALL the time about everything. Your mum has stubbed her toe, your mum said no to washing her hair today, your mum has a spot on her leg. Not major things and I appreciate being told but the extent of 'reporting' must be onerous for the staff.

The nurse in me notices a 'crinkle' on a sheet that could result in a pressure area, or the call buzzer just out of reach, the lemonade bottle that remains full as it's too hard to open and mum doesn't want to disturb the busy staff, or the flat tyres on the wheelchairs (who has time to pump these up). The nurse in me also notices all the 'doing' – the tasks that are done quickly, efficiently and effectively. Mum though, wants someone to sit with her, talk to her, look through her photo albums.

Staff just do not have time for that kind of interaction, and it's that level of engagement that is desired. I walk right past the nurse's station, in fact mum's room is right opposite. The nurse in me notices that it is empty, the staff are always on the floor and when they are in the nurse's station, they are writing up notes. They don't congregate there to chat – and nor should they.

Ultimately, my mum is happy – she says so. We often chat about how aged care is portrayed on TV and all the terrible media that surrounds a complex, difficult job. Mum and I are not at all saying that bad things haven't and don't happen – but what we do know though, is that many people get great care from dedicated people who are often not acknowledged as much as they should be. Mum talks about being totally looked after and having her needs met.

Staff in residential aged care do work that many people just do not want to do, providing person-centred care to people in their own home (the facility), their pay rate in not at the top of the pile, they have challenging residents who have challenging families.

As a registered nurse and daughter – thank you to each and every person who works in residential aged care – I think you are all heroes.

Author

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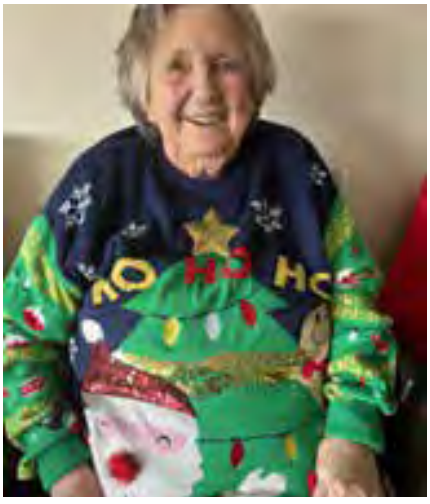

Empathy development for nursing older Australians, introducing Agnes Jenkins

By Claire Webber, Robyn Harvey, Skye Cluse, Heidi Rose, Michelle King-Okoye, Peter 'Kevin' O'Shaughnessy and Michelle Kelly

This article describes a simulation teaching activity created by a nursing team within the Clinical and Health Sciences academic unit at the University of South Australia (UniSA).

The aim was to provide a blended learning experience in managing age-related health issues, refine critical thinking and communication skills, and developing empathy for older people. The undergraduate nursing program at UniSA incorporates both experiential learning and aged care placements within first year, for over 650 students.

BACKGROUND

Nursing students generally do not perceive aged care as a popular career path compared to acute nursing, due to stigma, complexity of client need, and the perceived nursing roles.[1-3]

Australia's ageing population leads to complexity of healthcare issues, and consequently a need for skilled empathetic nurses.[2,3]

Depth of field innovation surfaces assumptions about older people, illustrated through real case studies and builds empathy and understanding of patients' life experiences, contributions to society and greater awareness of patient-centred care.[4] Recent studies have identified the importance of preparing nursing students for the first clinical experience, often in aged care settings, using a simulation learning activity.[1,5] Photo elicitation and facilitated discussions develop increasingly positive opinions about older people.

DESCRIPTION OF THE SIMULATED CLINICAL SCENARIOS

UniSA provides case-based simulations aimed to develop students' clinical skills and competencies to ensure provision of safe care during clinical placements. This is achieved via blended delivery of realistic simulated scenarios both online and in face-to face workshops.[6] The intent is for students to engage in hands-on practice in an authentic environment, mirroring real-life situations.

SIMULATED WORKSHOP

Agnes Jenkins is one of the resident scenarios within the simulated residential care facility. Students learn to assess Agnes's activities of daily living, and perform risk assessments, to develop and implement person-centred plans of care. Agnes's high-fidelity capabilities – such as chest rise and fall, blinking, and palpable pulses – enable students to undertake comprehensive assessments, which are customised to meet students' relevant learning needs.

For an authentic student experience, modified charts and patient documentation are provided. Utilising modified dispensing aids with simulated medications, reflects real life medication administration, developing student knowledge of safe, context specific medication administration practice.

Above: Agnes Jenkins (credit: UniSA HHHS collection)

Right: Clinical Nurse Educator supporting a UniSA student to provide care to Agnes (reproduced with permission)

ONLINE DELIVERY OF CURRICULUM

Online resources via the LearnOnline (learning management) platform, promote continued inquiry-based learning. Story telling via the provision of in-depth information regarding backstories, family life and social histories are provided. This information bridges the gap between theoretical and practical learning, allowing solid preparation and seamless transition into aged care clinical placements.

DEMONSTRATION OF KNOWLEDGE AND SKILLS

Utilising an objective structured clinical examination (OSCE) within the simulated environment, provides an opportunity to assess student skill acquisition in a safe and controlled environment.[7] Both strengths and weaknesses of students' clinical performance are identified, allowing for encouragement of further skill development or refinement, through educator feedback.[8]

DISCUSSION

Learning through simulation offers numerous benefits for nursing students. It provides a dedicated space and time for students to develop and refine their clinical skills, critical thinking abilities, safe medication administration, communication techniques, and fosters compassion, essential for delivering patient-centred care to older Australians.[9-12]

A detailed back story explaining the early lives and the life journeys of the resident scenarios facilitates awareness, insight and empathy for older people.[13,14]

CONCLUSION/FUTURE DIRECTIONS

Piloting this initiative with other simulated scenarios of older Australians, incorporating elements of complex emotional care; for example, cancer and end of life care scenarios, is planned. We believe these foci to be a valued investment in developing the 'personal touch' aligning with key recommendations from the recent Australian Royal Commission into Aged Care Quality and Safety.[15]

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Developing digital health capability in residential aged care facilities: Lessons for successful implementation of the Royal Commission into Aged Care Quality and Safety Report Recommendation 68

By Jennifer Rennie, William Baker and Carey Mather

Recommendation 68 of the Royal Commission into Aged Care Quality and Safety Report[1] outlined implementation of digital technology and My Health Record into residential aged care facilities (RACFs).

Progress on implementation of Recommendations[2] focus on My Health Record (MHR) and several funded projects to support registration of MHR and electronic medication charts.[2] Further projects are planned to enable implementation of digital technology into RACFs, however, specific information is yet to be released. While progress has been made to support implementation of MHR at a systems level, this report highlights lack of funding to support the RACF workforce to become digitally capable as outlined by the National Nursing and Midwifery Digital Health Capability Framework (Figure 1)[3] and enable leadership by nurses for successful implementation of digital technology into RACFs.

An Australian study about nurses' perceptions about using mobile digital devices in an RACF provides direction about how to successfully implement digital technology into RACF staff workflows[4]. Findings suggest that any change management process involving nurses' clinical practice should be considered to gain an understanding of both the benefits and risks of using digital technology such as mobile digital devices in RACFs. The introduction of digital technology requires an understanding of RACF clinical workflow, an adequate wireless (Wi-Fi) network system, along with the ability to incorporate nurses' own perceptions and experiences to facilitate necessary changes to ensure safe and appropriate use of digital technology to provide quality healthcare[4].

The study also emphasised the need for ongoing education and training to support all levels of learning for nurses that is inclusive and tailored to their specific requirements. Nurses identified many changes in working with a mobile digital device, including the negativity of increased alarms, which affected resident wellbeing. Nurses experienced unreliability of mobile digital devices due to constant Wi-Fi dropout. Unintended consequences were revealed as nurses developed workarounds to ensure effective communication. One safeguard was to carry another model telephone, hence two devices, to guarantee nurses would be able to call for assistance in case of emergency, due to the mistrust of Wi-Fi connection.

Systems failures, although external to the operations of the mobile digital device, impacted perceived usefulness and integrated use of mobile digital devices in delivery of healthcare. Weakness was not a result of the functionality of the mobile digital device but the network system and lack of education for end users. The prolonged failure of the Wi-Fi network, without a quick resolution caused much angst amongst nurses, resulting in a general belief amongst the RACF nursing team that the mobile digital device was faulty and inadequate.

Incorporating mobile digital device technology training at beginning of installation, prior to going live and provision of educational preparation to suit the nurses may have resolved many of the issues. Training tailored to the working environment encourages greater adoption of technology and smoother implementation[5]. Actively seeking feedback and adapting change to reflect safe and supportive care for nurses is essential for successful change management. The ability to learn from past failures and success, to help create a plan for future healthcare technology to advance nursing practice is invaluable for developing digital health technology capability of the aged care nursing profession[6].

For Recommendation 68[1] to be successfully implemented requires nurses to lead change management within RACFs, ensure adequate systems infrastructure, organisational clinical governance, and timely individual professional development opportunities prior to implementation of digital technology into workplaces. The National Nursing and Midwifery Digital Health Capability Framework[3] provides direction that will enable RACF nurses to model safe, effective, and appropriate healthcare to the next generation of health professionals. Nurses need to grasp this opportunity to lead the implementation of digital technology in RACFs for the benefit of residents. Advocating for enabling digital capability has the potential to transform nursing practice and contribute to delivery of contemporary 21ST century healthcare in RACFs.

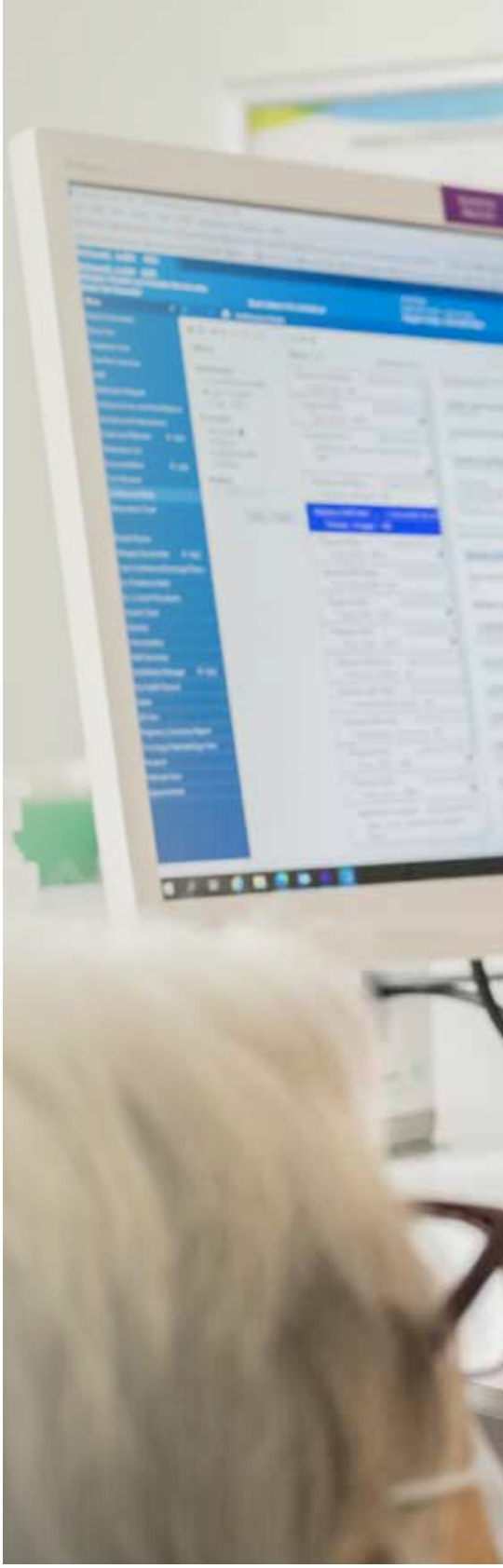
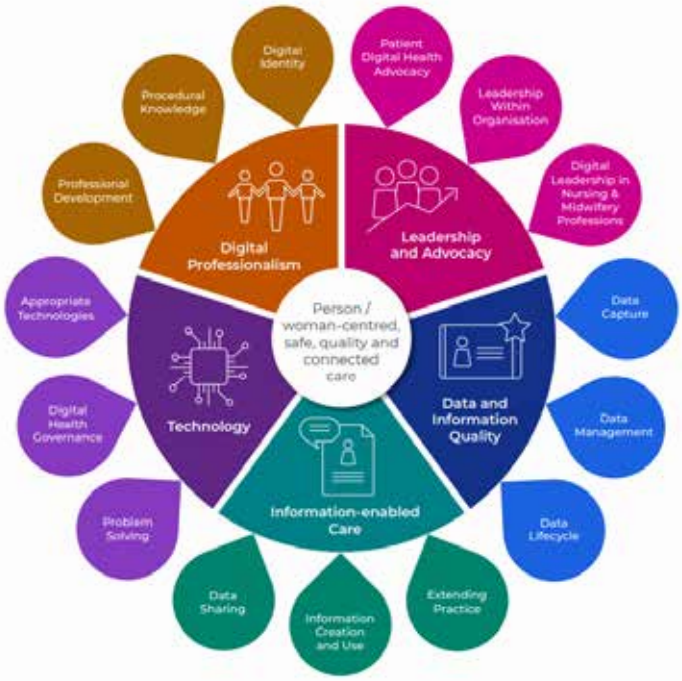


FIGURE 1: National nursing and Midwifery Digital Health Capability Framework[3]



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Welcome to Healthy Eating

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

Pumpkin, ginger and date scones

Perfectly spiced, easy to make, moist and delicious

Prep time 20 mins **Cook time** 15-20 mins **Portions** 12

INGREDIENTS

180g butternut pumpkin, peeled and roughly cut into 1 inch pieces
1½ tsp olive oil
2 tbsp verjuice
425g self raising flour
2 tsp ground ginger
2 tsp baking powder
2 tsp sea salt flakes
½ tsp freshly grated nutmeg
70g pitted dates, chopped into 5mm pieces
180g sour cream
2 free range eggs
60ml ginger beer
60ml buttermilk
Extra flour to dust

METHOD

1. Preheat a fan-forced oven to 230°c and line an oven tray with parchment paper.
2. Spread the peeled and chopped pumpkin over two of the prepared trays, drizzle with olive oil and cook for 30 minutes. Pour over the verjuice and cook for a further 5–10 minutes or until tender. Remove from the oven, allow to cool before mashing; you want to use about 110g of the mash.
3. Reduce the oven temperature to 220°c.
4. Sieve together the flour, ginger, baking powder, salt and nutmeg, stir in the chopped dates.

Food styling and photo by Erika Budiman © pixelsandpaper.studio

5. In a separate bowl whisk together the sour cream, eggs, mashed pumpkin, ginger beer and buttermilk.
6. Make a well in the centre of the flour and use a large metal spoon to fold in the wet mix – just bring it together, don't over mix it.
7. Turn out onto a floured surface and gently bring together. Press the dough to approximately 3cm thickness. Flour your 5.5cm round cutter and cut rounds as close together as possible. Divide the scones onto the lined trays leaving 1cm gap between each scone.
8. Lightly dust with flour and place into the oven
9. Cook for 15–18 minutes or until golden and cooked through. Remove from the oven and cool slightly on a rack. Serve warm with butter.

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 Amy, on making Maggie's, Lemon, blueberry and yoghurt loaf, published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"This recipe was easy enough for my toddler to help with and would be perfect for work or school lunch boxes. Delicious." says Amy.

Nurse & Midwife Support

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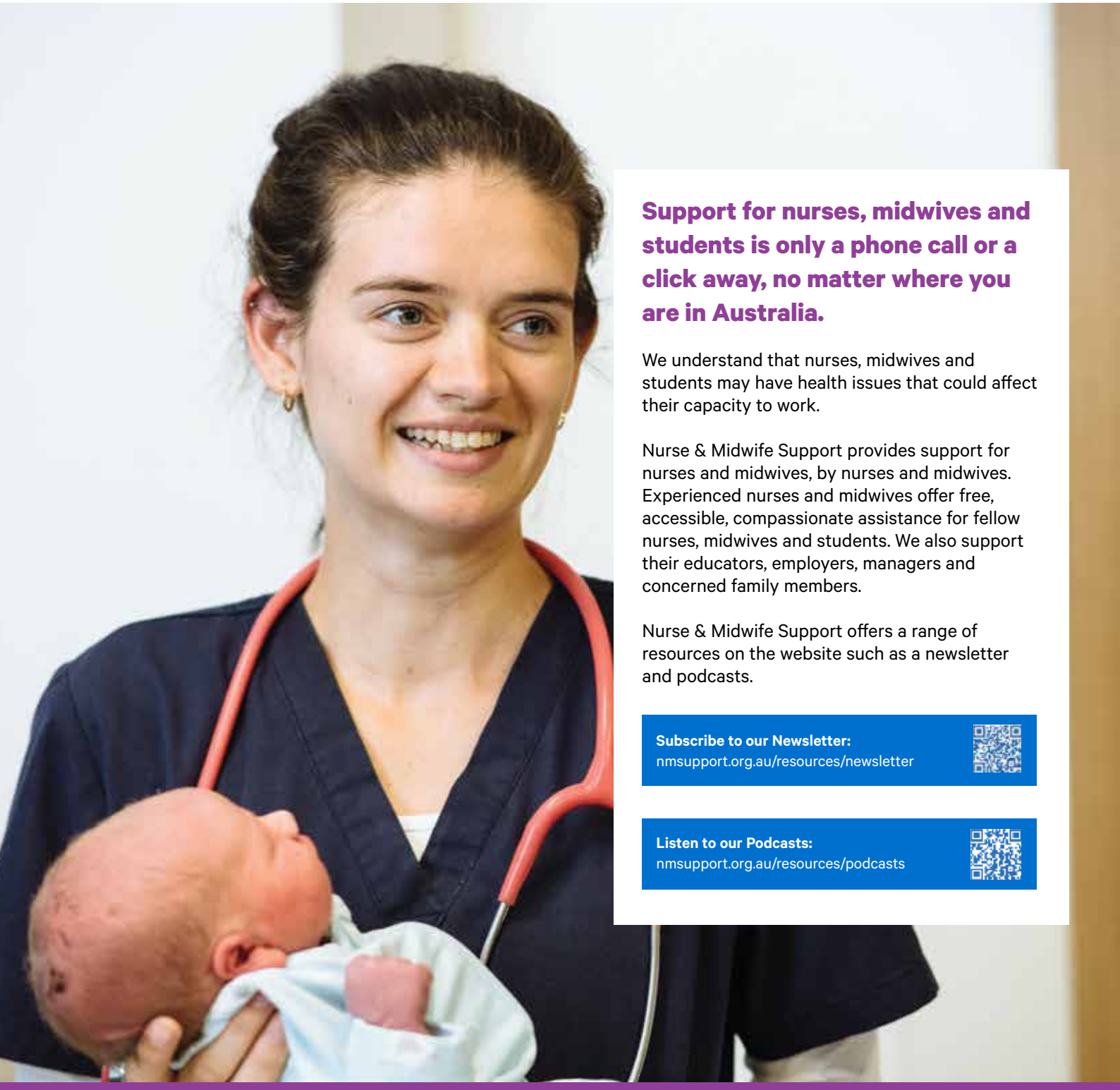

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