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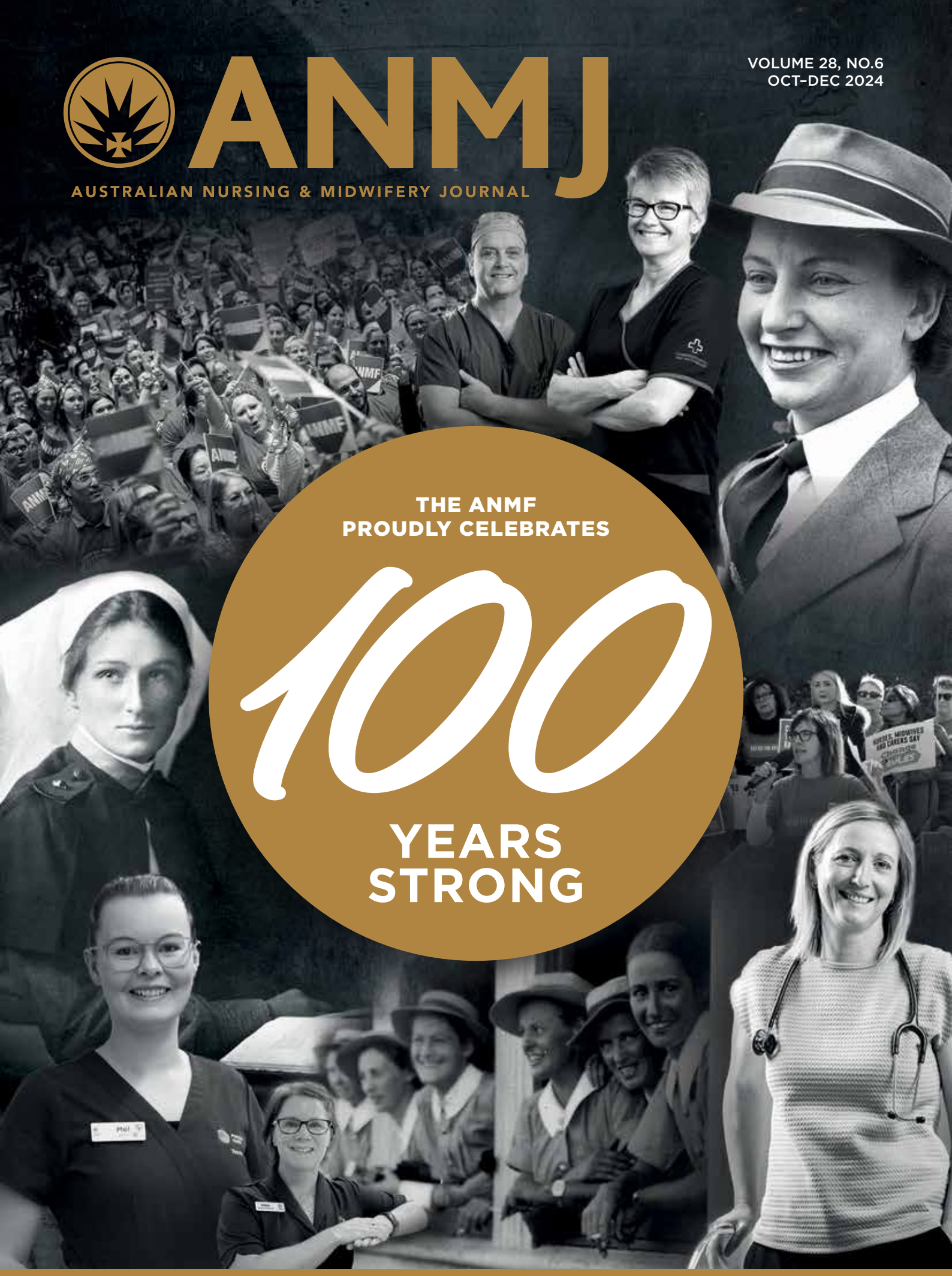

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Annie Butler

ANMF Federal Secretary

Congratulations to all ANMF members, past and present for reaching this remarkable milestone – 100 years old, 100 years strong! Welcome to this special edition of the *ANMJ*, where we proudly celebrate the Australian Nursing and Midwifery Federation's century of collective strength, dedication, and determination.

Over the years, our union has grown to become the largest in the country, now boasting a membership of 326,785 strong. Together, we've made transformative strides that have improved working conditions for nurses and midwives while enhancing the care provided to all Australians across the country.

Our accomplishments span decades – from establishing nursing and midwifery schools in the 1920s to the transition into university education during the 1970s and early 80s. We've fought for and won nurse-to-patient ratios, penalty rates, and better pay and conditions. We have been instrumental in lobbying for and supporting national registration and the establishment of the Australian Nursing Council (ANC) in the late 1980s and early 90s; and later the establishment of the National Registration and Accreditation Scheme (NRAS), Ahpra and the Nursing and Midwifery Board of Australia (NMBA). Since Nurse Practitioners were first recognised, the ANMF has played a leading role in advocating for expanded scopes of practice and advancing the role. More recently, we have focused on improving the scope of practice for all nurses, midwives, and nurse practitioners, while also achieving significant progress in securing fair wages for aged care workers and better conditions in aged care facilities, including mandated care minutes.

This year we also launched the Nurse Midwife Health Program Australia (NMHPA), to provide free, confidential, and independent support for nurses, midwives, and students facing psychological health issues.

This issue of the *ANMJ* highlights many of the significant achievements of the ANMF, showcasing the tireless advocacy and innovation that has shaped not only our professions but also the quality of care we are now able to provide the community. None of this would have been possible without the collective strength of our members, standing united for better outcomes.

To mark this incredible journey, we've also produced a special documentary reflecting on our past and present accomplishments. Many of you have already seen a teaser for the documentary on social media or at delegate conferences, and I've been moved by your supportive feedback and also your reflections on what our union means to you. It's clear that this documentary resonates with the shared passion and commitment that drives us all.

We are excited to announce that the full documentary will be launched through a virtual premiere on 23 October. It promises to be a celebration of everything that makes the ANMF extraordinary, and we hope you'll join us for this landmark event.

Watch out for notifications on ANMF's social media and on our website for details.

While this centennial year has been a moment to reflect on our progress, it is also a time to look forward to the work still ahead.

Inspired by our previous achievements and the legacy of those that came before us, we continue the important work on numerous priorities. These include advancing workforce reforms, including making certain we have a national nursing workforce strategy that tackles recruitment and retention issues, working with the Federal Government on strengthening Medicare, ensuring nurses and midwives work to their full scope of practice, promoting equitable access to healthcare for all Australians no matter their circumstances, and advocating for gender equity.

Here's to 100 years of strength, unity, and progress – and to many more years of making a difference together.

Thank you for being part of this incredible journey.

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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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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

Wounds Australia unveils plan to solve Australia's hidden wound epidemic

Wounds Australia has released a '5 Point Plan' it believes can solve Australia's chronic wound epidemic, which affects an estimated 450,000 people and costs $6.6 billion to annual health and aged care budgets.

The proposed solution outlines:

1. Extend free wound care to people at high risk of chronic wounds
2. Establish an ongoing National Wound Prevention Campaign
3. Expert wound support in primary and aged care
4. Wound care education for primary and aged care
5. World-leading Australian wound care research

Leading burns surgeon, Professor Fiona Wood, explained at a recent Press Club address that if left untreated, chronic wounds could cause crippling pain, isolation, and lead to significant issues like sepsis.

According to Wounds Australia, the nation can solve its chronic wounds crisis by investing in evidence-based prevention, assessment, treatment and education. But unless prioritised through urgent reforms, chronic wounds will continue to "burden the physical and emotional health of our country".

The lasting impact of women's pain revealed

A landmark Inquiry into women's pain has revealed the significant impact pain conditions like endometriosis, pelvic pain and migraines are having on the lives of Victorian women and girls.

The results from the survey of more than 13,000 women, girls, carers, families and healthcare workers highlighted the negative experiences that many had when seeking care. Women and girls shared experiences of sexism and misogyny, feeling ignored or dismissed by clinicians who attributed their pain to psychological and personality factors, as well as culturally unsafe care. They reported cases of delayed diagnosis, the high cost of care and the impact of pain on quality of life, relationships with family and friends, and their careers.

Nurses made up the majority of healthcare workers who participated, observing that lack of knowledge about women's health of clinicians was the biggest barrier to care for many of their patients.

About 40% of women who participated in the survey were from regional and rural Victoria, who highlighted the importance of being able to access the right care closer to home.

The stories and experiences shared by Victorian women and girls will form the development of recommendations to improve the way women's healthcare is delivered in Victoria. For more information about the Victorian Government's Inquiry into Women's Pain, visit: **health.vic.gov.au/inquiry-into-womens-pain**

WAGING WAR ON 'SUPERBUGS' IN AGED CARE

There's an urgent need for more careful antibiotic management to protect older people living in residential aged care from the dangerous spread of antibiotic-resistant bacteria or 'superbugs', researchers from Flinders University and the South Australian Health and Medical Research Institute (SAHMRI) have warned.

A new study, published in the *Journal of Infection*, explored the link between the widespread use of antibiotics in residential aged care and the resulting antibiotic- resistant bacteria in the gut that can be passed on to other residents.

"Commonly used tablet antibiotics in the elderly increase many types of resistance bacteria carried in the gut and these so called 'superbugs' can increase resistance to other important life-saving antibiotic drugs," says lead author and PhD student, Sophie Miller.

"High rates of antibiotic prescriptions in aged care settings are likely to be contributing to the proliferation of these bugs, which can lead to longer hospital stays, higher medical costs and increased mortality.

"This trend not only compromises the effectiveness of antibiotic treatment but also poses a significant risk of treatment failures in an already vulnerable community."

Researchers analysed stool samples collected from 164 residents from five long-term aged care facilities in South Australia to learn more about the genes carried by their gut bacteria that lead to antibiotic resistance.

Alarmingly, research revealed nearly all participants carried these resistant genes without displaying any symptoms, raising significant concerns for this particularly vulnerable demographic.

Low carb/high fat diets for weight loss boost risk of type 2 diabetes

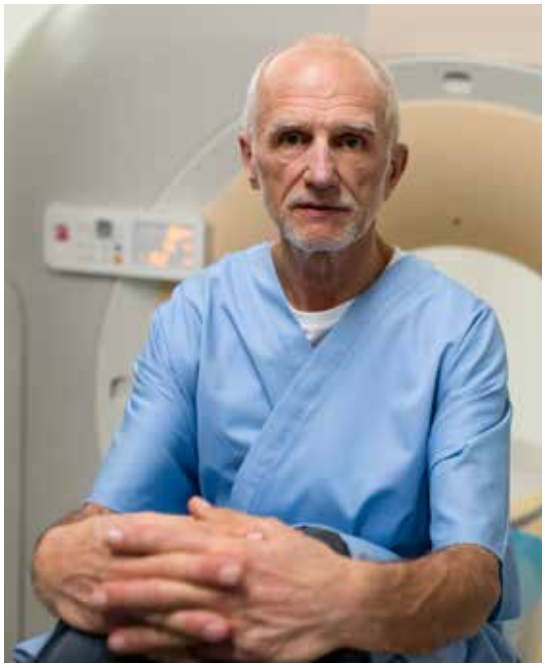
A new study suggests that low-carb, high-fat diets, popular for weight loss, may increase the risk of type 2 diabetes by 20%.

Researchers from Monash University and RMIT University conducted a 17-year study involving nearly 40,000 participants from the Melbourne Collaborative Cohort Study (MCCS). Participants, aged 40-69, were recruited between 1990 and 1994, with their health reviewed in subsequent years.

The researchers developed a Low Carbohydrate Score (LCD), which measured the percentage of energy from carbohydrates, fats, and protein. They found that individuals whose diet included only 38% carbohydrates had a 20% higher risk of developing type 2 diabetes compared to those consuming 55% carbohydrates. This increased risk was linked to higher obesity rates.

Professor de Courten, a lead researcher, noted that while high-carb diets with refined sugars can promote weight gain and insulin resistance, this study is the first to analyse the long-term effects of low-carb diets on diabetes risk using Australian data. The study suggests that low-carb diets may increase diabetes risk through higher fat intake and reduced fibre consumption.

Researchers recommend a balanced diet with minimally processed carbohydrates rich in fibre, healthy fats (like mono- and polyunsaturated fats), and protein from sources such as fish, seafood, white meat, and legumes, similar to a Mediterranean diet. This approach may help reduce the risk of type 2 diabetes in the long term.



Men's cancer risk to rise 84% by 2050

A new study predicts an 84% increase in men's cancer rates globally by 2050, with Australia leading in cancer incidence.

Conducted by Charles Sturt University's Rural Health Research Institute, the study analysed 30 cancer types and their mortality-to-incidence ratios (MIRs) across 185 countries.

Dr Kedir Ahmed, co-author and epidemiologist, revealed that Australia has the highest cancer incidence globally, with 514.3 cases per 100,000 people. However, Australia's MIR is among the lowest, indicating fewer cancer-related deaths compared to other countries.

Globally, cancer cases are expected to rise from 10.3 million in 2022 to 19 million by 2050, with cancer-related deaths projected to increase from 5.4 million to 10.5 million. Lung cancer is likely to remain the leading cause of both cases and deaths.

The study emphasises the need to strengthen health infrastructure, improve workforce quality and access, foster national and international collaborations, and promote universal health coverage to reduce cancer risks and fatalities.

The research, titled "Burden of 30 cancers among men: Global statistics in 2022 and projections for 2050 using population-based estimates," was published in the international journal *Cancer*.

Lori-Anne Sharp

Federal Assistant Secretary

What a time to be an ANMF member as we celebrate our proud 100-year history

From humble beginnings of some 700 members over a century ago, we now mark a national membership of over 326,000, making us the largest union in the country.

This year is especially important as we reflect on ANMF's proud history and all it has achieved over the past 100 years to improve the working lives of its members.

You will read a lot about these collective achievements in this issue's feature and online in the coming months as we formally mark the occasion in October. This includes the release of a short documentary commemorating the century, aptly titled **100 years strong**.

As we celebrate this important milestone, I have reflected on what a great privilege it is to be one of many ANMF leaders during this time and express gratitude to the thousands of ANMF members and delegates who are the primary reason why the ANMF continues to go from strength to strength.

It is a delight to look back and reflect on how far we have come. From some of the early campaigns that fought for improved wages and safe working conditions to speaking out on social justice issues such as marriage equality and supporting First Nations justice. With each campaign, with each gain, we lift the benchmark and pass the baton to the next generation for further advances to be achieved.

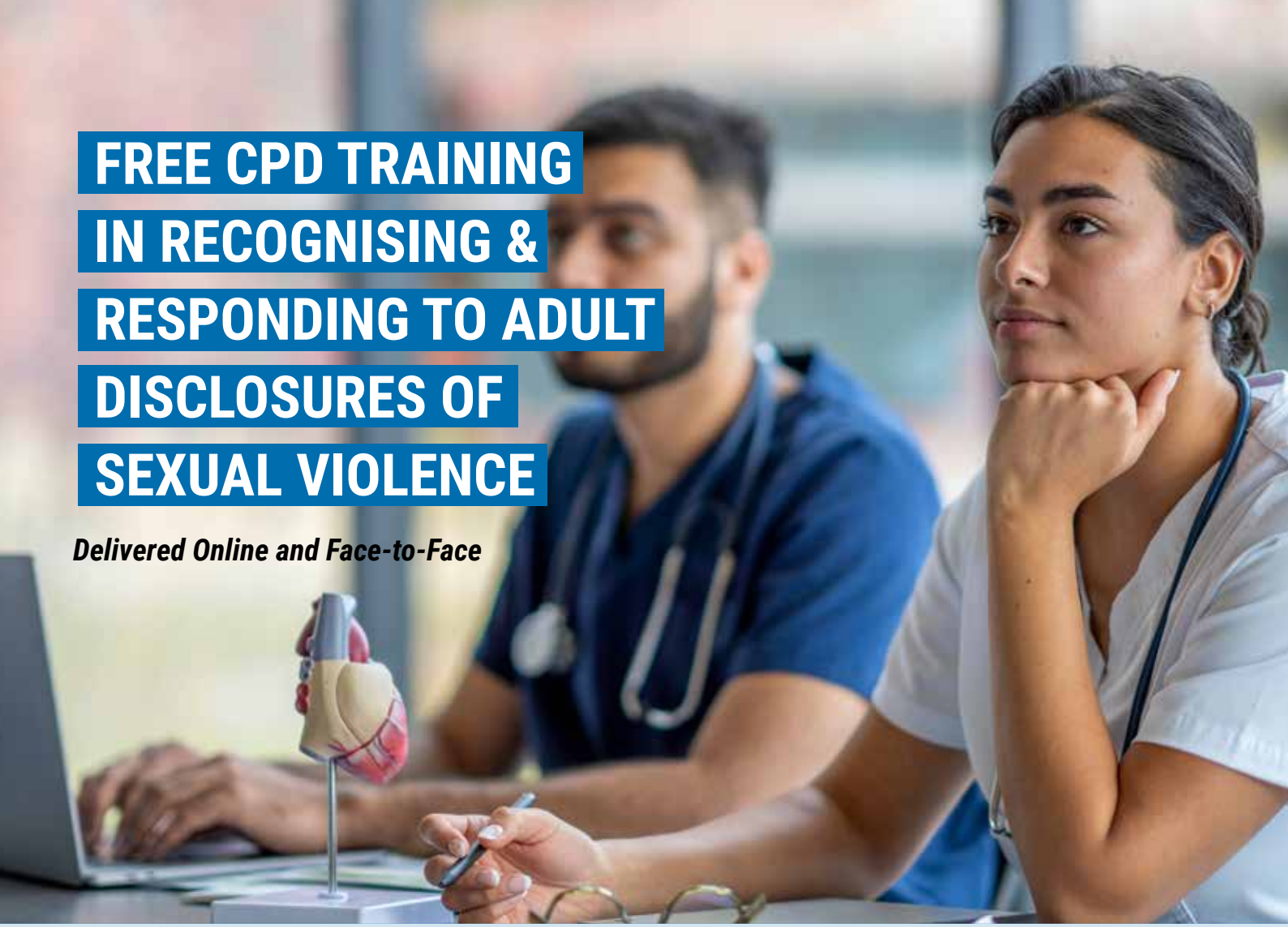
During my time as an ANMF member, job delegate, Branch Councillor, and now as a federal elected official, I have witnessed the incredible power and generosity of our members and leaders. Their willingness to share knowledge, provide unwavering support, and, when needed, demonstrate the perfect balance of resolve and tenacity is remarkable.

These qualities are fundamental to building and sustaining a strong union. Much of our work is rooted in deeply held values, which, in many ways, mirror those of the nursing and midwifery profession. A commitment to improving the lives of the less fortunate, advocating for the voiceless, and upholding principles of fairness, honesty, and courage are at the heart of everything we do, come instantly to mind.

Many of the ANMF's achievements have been hard-fought by members who may not immediately reap the benefits during their own careers. I fondly recall one member, 36 weeks pregnant with her fourth child, tirelessly walking the halls of federal Parliament to lobby for improved superannuation, aiming to prevent women from retiring in poverty. Thanks to efforts like hers and many others, we now have a major victory—superannuation will be paid on the Commonwealth parental leave scheme starting from 1 July 2025. This success will benefit not only future generations of nurses and midwives but society as a whole.

Happy 100th Birthday to all ANMF members, stand proud and take strength in knowing you are part of the largest union in the country. May we continue to be the largest and respected union 100 years from now. I am in no doubt that the ANMF will continue to grow and advance, because when we maintain a strong united voice and a membership that is motivated by improving the lives of others and not personal gain, everyone benefits.

ANMF Federal Council members at the August 2024 meeting celebrating ANMF's 100-year anniversary. Photo: Christopher Hopkins



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Sustainability in health champion

Targeting unnecessary use of medical consumables

By Nancy Leong

Designing material waste out of our clinical workflow improves efficiency while reducing the environmental and financial cost of healthcare without compromising patient outcomes.

This case study demonstrates how our knowledge on the ward can target unnecessary use of medical consumables and advocating how an apparent small change can lead to a big impact.

Working as Nurse Manager on the postnatal ward at the Royal Women's Hospital, Melbourne, I have noticed with dismay the box that collected unused caps that get discarded every time that a sterile teat is attached to a milk bottle for feeding a newborn baby. The box became full quickly and while these caps are recyclable, the waste hierarchy goal is to avoid waste in the first place.

When our Sustainability group representative, Dr Ying Gu came for a visit, I raised my concern that this cap already came with the feeding bottle but was unnecessarily supplied with the separately packaged sterile teat.

An important aspect of designing waste out of our clinical workflow is to involve all stakeholders in the process. Firstly, we involved our Clinical Midwife Lactation Consultants within the Lactation and Breastfeeding Services to confirm that removing this unnecessary cap did not have any unexpected clinical impact such as the assembly of the feeding bottle. Next, we contacted the supplier and asked if the sterile teat could be supplied without the cap.

This revealed a surprise when we found the teat was available without the cap and could be purchased through Healthshare Victoria, the state's procurement entity, at a lower cost. We approached our Procurement department with a proposal to change to the teat-only item. With the endorsement from Lactation and Breastfeeding Services, we were able to obtain agreement from each department's Unit Manager to the change.

Lastly, the Procurement department were able to update the item codes for ordering by removing the 'teat with cap' item from the hospital catalogue. By actively involving all members of the healthcare team in the process, organisations can effectively implement change and have the support of the whole team in the long term.

It is truly remarkable to see the power of spreading a simple message and witnessing how impactful it can be. It has been eighteen months since we removed this extra cap from the teats supplied to our postnatal wards. By examining our purchase data, we estimate that 42,625 plastic caps have been diverted from manufacturer and landfill and saved our hospital $5,000.

It is our hope that by sharing information of this initiative, that we can spread the reach of this seemingly simple change to your postnatal unit. By spreading the word about avoiding waste in healthcare, we can create a ripple effect that resonates with others and inspire individual action that collectively can deliver the triple bottom line of financial sustainability while caring for people and planet.

AUTHOR

Nancy Leong is Associate Unit Manager/ Blue Maternity Services, The Royal Women's Hospital, Victoria

Tips and hints

In the pursuit of a greener and more sustainable workplace, nurses and midwives are key innovators in finding practical ways to reduce waste, conserve resources, and enhance environmental practices within their healthcare settings.

Over the past year many of you have shared with the *ANMJ* your tips and hints to foster a culture of sustainability in your workplaces. In this issue Melbourne Health's sustainability Officer Monika Page shares her insights into sustainable practices.

PRACTICAL TIPS FOR A GREENER HEALTHCARE WORKPLACE

With the demands of a busy day, sustainability and waste reduction often take a backseat. However, Melbourne Health's Sustainability Manager Monika Page, believes that with a simple shift in mindset, healthcare professionals can make a significant impact.

Speaking at the recent ANMF (Vic Branch) Health and Environmental Sustainability Conference, Monika emphasised that creating meaningful change doesn't always require starting from scratch. She shared practical examples of how nurses at Melbourne Health are embracing sustainability in their daily routines - lessons that can be applied across various healthcare settings.

Many of these initiatives were initially unknown to Monika. She explained that while numerous sustainability projects were already in progress at Melbourne Health, tracking all the advancements proved difficult. In response, she partnered with the University of Melbourne to launch a sustainability competition, now in its second year. The competition attracted 25 entries, showcasing significant cost savings and reductions in CO_2 emissions, while also bringing to light previously unrecognised initiatives.

Monika highlighted several of the entries, many of which are adaptable to a wide range of settings.

A SUSTAINABILITY BOARD

Monika recommends that a board ensures sustainability information is easily accessible to all staff by displaying it in a central, visible location and incorporating it into huddles and ward meetings. Providing regular updates on ongoing initiatives boosts staff engagement, raises awareness, and encourages participation in sustainability efforts. This strategy not only keeps everyone informed but also creates a replicable model for other wards.

"This is a really simple one, but a really great one. It's a really easy thing to replicate, and it works really, really well," Monika said.

CHOOSING WISELY – SAFELY REDUCING UNNECESSARY TESTS

One of the entries focused on reducing low-value care by cutting down on unnecessary COAG tests, CTKUBs, blood gas tests, and cannula use.

"This saved seven tonnes of emissions each year and $340,000," Monika said.

Monika suggested that the sustainability initiatives also benefited patients. "If you don't need a cannula, having one can be quite uncomfortable – trust me, I've had them."

She pointed out that the same applies to unnecessary tests, as avoiding them not only reduces waste but also improves the patient experience.

THROWAWAY TOURNIQUETS

The service's Pathology initiative originated when the NUM discovered that the unit was discarding 90,000 single-use yellow tourniquets each year at a cost of $205,000 and eight tonnes of waste.

In response, the NUM, Pathology leadership, collections team, procurement, infection prevention, and suppliers collaborated to find a reusable solution, ultimately settling on a reusable silicone tourniquet that can be used 10,000 times.

"It took him a year and four prototypes, but they're launching it next month," Monika shared.

Monika remarked that what started as a small initiative in Pathology has now gained traction. "It's being implemented across Royal Melbourne, with interest growing at Northern Health, Western Health, the Victorian Comprehensive Cancer Centre (VCCC), and the Royal Children's Hospital. Between these four organisations, this shift will prevent 400,000 tourniquets from being discarded annually."

DISPOSABLE FACE SHIELDS

The Emergency Department trialled replacing disposable face shields with reusable glasses, which proved to be successful. Now, the ED provides a pair of glasses to all new staff as part of their orientation, and glasses are available to all staff. In the past 12 months, the unit has provided 1,600 pairs of glasses.

"This is keeping a quarter of a million face shields out of landfill each year," Monika said.

Other initiatives Monika shared included replacing printed patient brochures with QR codes and using paper bags instead of plastic for patient belongings on the wards.

On top of the competition entries, Monika also suggests simple energy-saving tips:

WATER

"Talk to your engineering department about raising the chilled water temperature by two degrees during winter. It's such a small adjustment that no one will notice, but it can significantly reduce emissions and save money."

DISPOSABLE GLOVES

Monika said the health service conducted a preliminary survey across three wards, which revealed that gloves were frequently worn unnecessarily. She explained that 89% of staff reported wearing gloves to change uncontaminated bed linen, 82% used them to reposition patients, 72% to prepare antibiotics for IV injection, 70% to assist patients walking around the ward, 35% to administer oral medications, and 26% during routine observations. Based on these findings, changes were implemented regarding glove use.

"Gloves end up in the rubbish and landfill, and it's such a waste to use them when it's not necessary," Monika emphasised.

Other initiatives include researching the feasibility of using reusable sterile gowns.

"We've been exploring this for a while – we're now going to trial it in theatres," Monika said.

EXPIRING STOCK

Monika also recommends utilising expiring stock from the state stockpile, much of which would otherwise end up in landfill. She noted that Melbourne Health's procurement team sourced all of their gloves for 2024 and 2025 from the stockpile, resulting in a $600,000 saving.

"While the items will eventually be disposed of, at least they'll be used. Currently, the procurement team are also evaluating sterilised rapid isolation gowns, overshoes, and theatre caps from the stockpile for future procurement."

"We're also looking at a company that now makes reusable 'bluies'. To give you an idea, in theatres alone, we use 30,000 a year that go straight to the bin. So, we're trying to shift as much as we can to reusable options, just because it's better for the environment."

Monika explained that many sustainable practice changes have been driven by audits, surveys, and business cases that highlight both environmental benefits and significant financial savings.

She also encourages all nurses and midwives to share and implement their ideas to improve sustainability in the workplace.

"If any of you have an idea, don't think, 'Oh, I'm just a nurse, I can't do that.' You can - just push," Monika said. "You can make a difference, a really big difference. It can really take off."

Sustainability tips or questions

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

Ask a question or share your sustainable at work and at home tips with the *ANMJ* so nurses and midwives nation-wide can do their bit to save the planet.

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

James Lloyd

ANMF Federal Vice President

The ANMF leadership is in good hands

This is my last article for the *ANMJ*, as I am standing down as ANMF Federal Vice President.

Usually in my articles I write about something I am passionate about, such as critical thinking, vicarious trauma, or burnout amongst people in our professions. But today I want to tell you about the ANMF Federal Executive/Council, how they work in your best interests, and how I sometimes sit in awe of those members around the meeting table. The ANMF is in good hands, and this assurance stems from the collective efforts and empathetic leadership that have become the hallmark of our organisation.

One of the most commendable aspects of the Federal Executive/Council is their deep connection with the realities of the workplace. Unlike many leadership bodies that operate in isolation, the federal senior leadership, state secretaries and presidents are actively engaged with employees at all levels. I'm sure we all have examples in our workplace of managers who have lost touch with the realities of being a bedside nurse or midwife. ANMF leadership does not suffer from this. Over the last four years that I sat in meetings, the one thing that has struck me the most is just how connected the senior leadership is with the bedside nurse and midwife. I've seen secretaries experience grief and empathy over a member's adversity. They understand the challenges and triumphs that define our work.

This connection is not just symbolic; it translates into policies and decisions that are grounded in the actual needs and aspirations of you, the member. They are in touch and have not forgotten their nursing or midwifery roots.

But empathy is more than a buzzword; it is the cornerstone of effective leadership. The ANMF Executive/Council exemplify this through their actions and decisions. Around the meeting table, they listen actively, and engage sincerely with everyone else in the room. This collective empathetic approach at our meetings makes everyone feel valued and heard, leading to a collective bond that is steadfast. They have not forgotten what makes a nurse or midwife: empathy, teamwork, self-sacrifice, and having each other's backs. Members of the Federal Executive/Council are not motivated by self-interest, they have carried that core feature of nurses and midwives – altruism.

Unionism and the power of the collective are integral to our organisation's success. The ANMF Executive/Council recognises that true strength lies in unity. By fostering a collaborative environment, they have harnessed the collective power of nurses and midwives to drive innovation and achieve common goals. This collective approach ensures that every voice is heard and that decisions reflect the diverse perspectives within the organisation.

The ANMF is the largest union in Australia, and we are one of the few unions that have consistent membership growth. In part this is due to the collective leadership at state and federal level. This is also due to the basic tenants of nursing and midwifery – we advocate for those who cannot care for themselves or need assistance to overcome challenges. Our primary commitment is to the patient. We give ourselves to the care and assistance of those groups, showing compassion and respect for the inherent dignity, worth, and uniqueness of every patient. We are an ideological force that drives change.

Annie, Sally, Lori-Anne and the of the rest of the Federal Executive/Council live and breathe one thing: they are there for you and the people you care for. Your concerns are reflected in our broad agenda and discussion at the federal level.

Their empathy, connection to workplace realities, unwavering support, and commitment to unionism have created a strong foundation for the future. The power of the collective, guided by empathetic leadership, ensures the ANMF is well-equipped to navigate the challenges ahead and to seize new opportunities.

Your union is strong, with leadership that is compassionate, focused on its members and the needs of the profession. Our collective voice drives change in healthcare that ultimately changes the lives of the most important aspect of our professions – the human beings we care for.

Rest assured, our ANMF is in good hands.

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The feasibility and acceptability of Libre Flash™ glucose monitoring in persons with insulin-requiring unstable diabetes and complex needs

By Emma Bevelander, Wendy Radcliffe, Rebecca Howard, Kim Brock, Helen Easterby and Dr Kylie McLachlan

FIGURE 1: Libre sensor and reader showing glucose reading, daily graph and trend arrow.[15]

Members of the Libre research project team. Photo: St Vincent's Hospital Melbourne

Self-blood glucose monitoring (SBGM), commonly done via finger pricks, is an essential part of self-care for people with Type 1 Diabetes Mellitus (T1DM).

It is also important for people with Type 2 Diabetes Mellitus (T2DM) who:

- are using insulin or other medications that carry a risk of hypoglycaemia (eg. sulfonylureas);
- are using other medications that act on glucose levels (eg. corticosteroids);
- have another short or long term illness that may act on glucose levels; and
- have had a change to their diabetes treatment.[1]

Clients commonly report finger pricks to be painful, inconvenient and "pointless".[2] Even if done regularly, these tests only provide a single point in time measurement, with no means of visualising range or trend in blood glucose levels (BGLs). Alternatively, the current gold-standard Glycated Haemoglobin test (HbA1c) provides the average glucose levels over the preceding three months, without actionable information about glycaemic excursions, particularly hypoglycaemia and hyperglycaemia. Glucose variability is also linked to micro and macro-vascular complications,[3] morbidity, early mortality and high rates of avoidable hospitalisations, with 1 million hospitalisations in 2014-15 being associated with diabetes, and 10% of all Australian hospitalisations being diabetes related.[4]

Without accurate and regular BGL readings, doctors and Diabetes Nurse Educators (DNE) face difficulty in safely and effectively titrating insulin doses to stabilise diabetes and reduce complications.

OVERVIEW OF THE ISSUE

Technological advances in continuous glucose monitoring (CGM) can address this information gap. The American Diabetes Association states that adults on multiple daily injections or basal insulin should be offered intermittent scanned continuous glucose monitoring, if they or a carer can safely use it.[5]

CGM helps identify variability in glucose related to food intake, physical activity, or insulin administration, facilitating self-modification of lifestyle and diabetes management behaviours.[6] One such CGM is the Libre Flash™ Glucose Monitoring (LFGM). Two large randomised controlled trials (RCTs) of the Libre Flash™ prior to commencement of this study showed increased glucose testing frequency, improved quality of life and treatment satisfaction, with statistically significant reductions in hypoglycaemia for both T1DM and T2DM clients.[7,8]

Whilst a recent meta-analysis showed that CGM was significantly superior to SBGM in terms of glycaemic control for type 2 diabetes, factors such as age, comorbidities and frailty were not included in the analysis.[9]

One study in older populations (>65 years) showed CGM was well- accepted and allowed participants to make therapeutic decisions to reduce glucose variability.[10]

Whilst CGM demonstrates significant potential to support diabetes management, the cost of devices has to date been prohibitive for people.[11] It is well established that people from lower socioeconomic groups are more likely to experience higher rates of illness and disability[12] including being 1.9 times more likely to have diabetes.[13]

In addition, presence of complex medical and/or psychosocial issues impact on the ability to complete diabetes self-management tasks and can reduce health outcomes for people with diabetes, yet these clients are often excluded from clinical trials.

In Victoria, Australia, multidisciplinary services (such as Complex Care Services, CCS) offer community-based assessment, education and care coordination for clients with diabetes who are at high risk of hospital re-presentations. These clients often have complex psychosocial needs, including tenuous housing, frailty, cultural/linguistic diversity, disability, mental health issues, substance use, low health literacy, socioeconomic disadvantage, cognitive impairment or social isolation.

These factors impact on their diabetes self-management. Studies of CGM feasibility and effectiveness to date have not explicitly considered people with complex psychosocial needs. Demonstration of feasibility and effectiveness for people with multi-faceted needs may improve access to these devices and reduce preventable diabetes related harm.

PURPOSE AND AIMS

The purpose of this study was to explore whether a CGM device could be utilised by people with complex needs, to improve their blood glucose control.

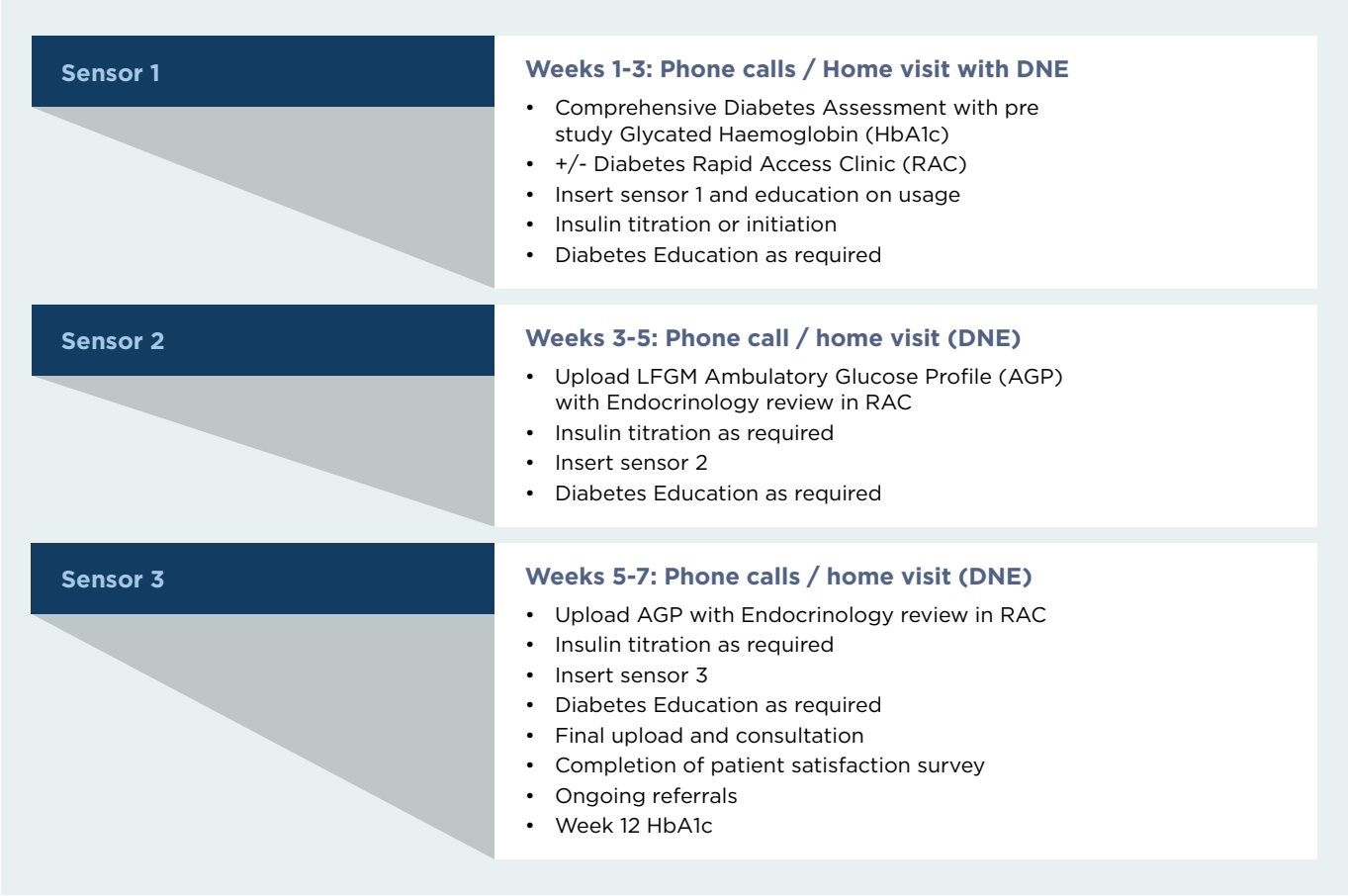
AIMS

1. To establish the utilisation of the device (scans per day).
2. To describe the BGL time in range.
3. To compare pre and post study HbA1c.
4. To establish the resources required to facilitate successful CGM use.
5. To establish acceptability of the device to consumers.

SETTING

A tertiary teaching hospital, St Vincent's Hospital in Melbourne (SVHM), which provides multi-disciplinary CCS, primarily through DNEs in the hospital and community for clients at high risk of hospital re-presentations.

FIGURE 2: Study procedures following recruitment.



METHOD

A six-week observational study of Libre Flash™ device provision to participants with complex needs, with supportive care coordination and DNE.

ABOUT THE LIBRE FLASH™ DEVICE

A small, disc-shaped sensor is inserted into subcutaneous tissue of the posterior upper arm and measures glucose levels in interstitial fluid rather than capillary blood (as with finger prick testing). Sensors last 14 days and a Libre Flash™ reader is waved over the sensor to download the last eight hours of glucose history, providing a detailed graphical trace, trend arrows and time within a target range eg. 4-8mmol/L (Figure 1). The reader can store up to 90 days of use and data is uploaded to the LibreView website to generate a report with detailed data analyses, trends and patterns.[14]

PARTICIPANTS

Inclusion criteria:

- People with unstable T1DM or T2DM requiring insulin.
- People with complex psychosocial needs that limit their ability to self-manage their diabetes.
- People living within 20km of SVHM.

Exclusion criteria

- People with known hypersensitivity to medical grade adhesives.

Participants were recruited from existing CCS clients as well as newly referred clients with unstable diabetes and complex needs. The LFGM system was selected as it provides accessible real time data, does not require calibration or a compatible smartphone and can be used as a self-blood glucose and ketone meter.

PROCEDURES

Participants were reviewed by the CCS DNEs at least weekly for sensor insertion, education, insulin titration, ongoing assessment, and device support. **(Figure 2)**

MEASURES

LFGM device reports provided data on the frequency and timing of device scans and Time in Range (TIR), defined as 3.9-10.0 mmol/L. HbA1c values pre (within 12 weeks prior to study commencement for 92% of participants) and post (between weeks 12 and 20 for 82% of participants) study were obtained. Acceptability to consumers was measured with a simple questionnaire using a 5-point Likert scale, Yes/No and qualitative response options.

DATA ANALYSIS

Descriptive analyses including mean and standard deviation were utilised to measure change in number of scans and TIR. Comparison of pre and post HbA1c was conducted using t-tests and changes in TIR over the study were assessed with ANOVA.

RESULTS

Thirty-eight participants were recruited to the study. Mean age was 64.8 years (SD 15.5, range 24–89) and 27 (71%) were male. Most clients had T2DM (33 participants, 87%), five participants had T1DM (13%). (Note: recruitment of participants of T1DM ceased early in the study due to the introduction of subsidised Libre 2 devices.) The frequency of

psychosocial issues is shown in **Table 1**. Most participants had multiple issues (with a median four issues per person (IQR 2, 4.5)).

The number of device scans remained stable over the three fortnight periods with mean scans per fortnight 64.8 (SD 44.8) in the first fortnight, 68 (SD 48) in the second fortnight and 64.2 (SD 47.4) in the final fortnight. In addition, the number of participants who scanned at regular intervals over the day was captured to determine whether participants were using the device over the 24-hour period as recommended. Figure 3 shows that most participants met this minimum requirement, and this was sustained over the length of the study. However visual analysis of Figure 2 also shows less consistent use in the evening.

TIR was assessed for each fortnight (see **Table 2**). No statistically significant differences were observed over the three timepoints ($p>0.05$).

Comparison of pre and post study HbA1c values demonstrated a decrease from pre- ($M = 10.3$, $SD = 2.1$) to post- study ($M = 9.2$, $SD = 1.5$). A paired samples t-test ($n = 82$) indicated that the mean reduction in HbA1c scores of 1.1% ($SD = 1.6$, 95% CI [0.5,1.7]) was statistically significant, $t(31) = 3.99$, $p < .001$.

While the study protocol required a minimum of nine contacts, the median number of contacts related to use of the LFGM was 12 (IQR 10,13). Twenty participants had 12 or more contacts, with seven of these having 14 or more contacts. Additional contacts were made when staff perceived that the participant/carer had difficulty understanding or using the LFGM. 45.3 % (n=207) of contacts were face to face, 48.8% (n=223) were telephone and 5.9% (n=27) were other modes (telehealth or email).

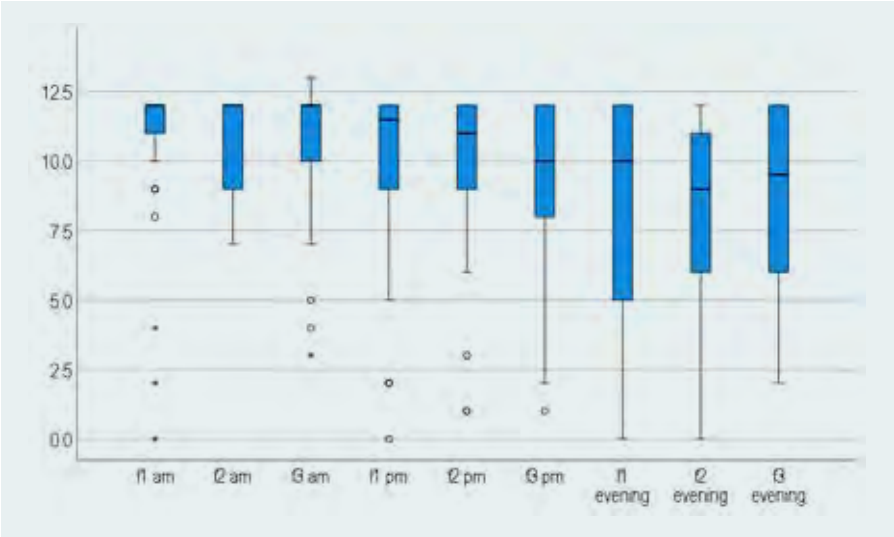
The response rate to the qualitative questionnaire was 79% (n=30 responses), with ease of use reported as "very easy" by 24 participants (80%) or "mostly easy" by six participants (20%). Twenty-nine participants (97%) reported they would like to continue using the device. Eight participants (27%) expressed concerns regarding cost, twenty-nine participants (97%) agreed the device improved their BGL management and 25 participants (66%) agreed the device helped them better understand their diabetes. All participants would recommend the device to others.

DISCUSSION

This study demonstrated that people with diabetes and complex psychosocial needs, were able and willing to utilise CGM.

A high level of acceptability was demonstrated by continued use of the

FIGURE 3: Use of the device over the 24-hour period. Number of days per fortnight (maximum 12-13) that at least one scan was taken in the time slots of morning, afternoon, and evening.



BOXPLOT: the black bar is the median, the box indicates the 25th and 75th percentiles, the 'whiskers' indicate 10th and 90th percentiles, the circles are outlier values; f1 fortnight one, f2 fortnight 2, f3 fortnight 3.

TABLE 1: Psychosocial issues

Psychosocial issues	Percentage of participants
Complex medical history**	97.40%
Disability (vision, mobility and/or dexterity)	65.80%
Social issues (economic or housing concerns)	55.30%
Non-English-speaking background with reduced English literacy	36.80%
Cognitive impairment	34.20%
Reduced engagement	31.60%
Mental Health concerns	31.60%
Carer dependency	28.90%
Drug and/or alcohol dependence	7.90%

**Complex medical history defined as having diabetes with either an associated complication and/or another chronic disease

TABLE 2: TIR by fortnight

Time in range	Fortnight 1	Fortnight 2	Fortnight 3
Average	47.69%	44.74%	48.43%
SD	25.19%	21.81%	20.41%
Range	0 – 91%	1 – 92%	0 – 92%

LFGM over the trial and by the number of scans per day. Participants' perceptions of using the LFGM were positive and included improved understanding of the management of their diabetes. The mean number of scans per day, 5.6, exceeded the necessary threshold of required minimum scanning and was sustained over the six weeks.

The study demonstrated that morning glucose testing patterns were more consistent than later in the day. Early assessment of participants' pattern of testing after introduction of the device may be useful to promote testing later in the day. Contributing factors to reduced scanning later in the day may include increased demands as the day progresses, limited availability of carers, cognitive or physical fatigue, or avoidance of perceived negative glucose levels (health anxiety).

TIR guidelines for glycaemic control for people with T1DM or T2DM and older/high risk people recommend spending at least 70% of the time within target glucose range (3.9–10.0 mmol/L).[16]

TIR was below the guideline, which remained consistent over the length of the study. As data is not available about TIR prior to the introduction of the LFGM, the effect of the device on TIR is not known. However, individually, a visual representation of glucose data was useful for both clinician and client. With real-time data trends, clients and carers have more data to inform adjustments to diabetes medications and self-management behaviours. Overnight glucose data is useful in cases where hypoglycaemia or significant glucose excursions are suspected due to evening food choices, alcohol intake, and physical activity with mismatched medication regimen. Clinician review of the fortnightly report enables targeting areas of concern with clients and informs decision making and education.

The finding of a statistically significant HbA1c reduction is a promising outcome, suggesting that more optimum diabetes control may be achievable in these vulnerable groups using LFGMs. Future research should investigate the efficacy of these devices for complex cases in terms of both HbA1c and TIR to minimise microvascular and macrovascular complications.[3]

The study protocol outlined nine contacts with participants. When clinicians observed difficulty understanding, using the device, or responding appropriately to BGL readings, participants received additional contacts. A similar finding of increased need for clinician support for implementation of CGM was demonstrated in a pilot study in Indigenous Australians.[11]

For people with lower health literacy, swapping from an embedded practise to something new may require additional, tailored, support above standard practice for successful implementation.

LIMITATIONS

This study has a relatively small sample size. It also lacks baseline values for frequency of blood glucose testing and TIR prior to study. Future studies in this population with larger sample sizes should include acquisition of comprehensive baseline data. A further limitation is the lack of data regarding participant response to suboptimal BGLs.

CONCLUSION

The Libre Flash™ Device was found to be highly feasible and acceptable to consumers with complex needs. However, to optimise use of this technology with a complex cohort, additional support may be required to use the device successfully.

The blood glucose data generated enabled participants and clinicians to make comprehensive and timely decisions to improve safety and glycaemic control, as demonstrated by statistically significant reductions in HbA1c.

Future research should assess the economic impact of subsidising such devices on reduction in preventable hospital utilisation and health burden, through better diabetes control.

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100 YEARS STRONG

THE ANMF CELEBRATES A CENTURY OF ACHIEVEMENT

As the Australian Nursing and Midwifery Federation (ANMF) turns 100 this year, we have much to celebrate. With a collective force of more than 326,000 members, the union has grown from strength to strength, achieving significant milestones that have improved the conditions of nurses, midwives, and the health and welfare of our patients. None of this would have been possible without the determination of our members to make a difference for our professions and the community.

In honour of this milestone, the *ANMJ* reflects on ANMF's many accomplishments over the decades. *Kathryn Anderson*, *Robert Fedele*, and *Natalie Dragon* report.

Nurse and Midwife Health Program Australia Launch – 30 April 2024
From L to R NMHPA Board member Pip Carew, ANMF Federal President Sally-Anne Jones, ANMF Federal Assistant Secretary Lori-Anne Sharp, NMHPA Director Heather Pickard, ANMF Federal Secretary Annie Butler, ANMF ACT Branch Secretary Carlyn Fidow, NMHPA Deputy Director Mark Aitken

Nurse Midwife Health Program Australia: A health service for us

The ANMF lobbied the federal government for many years before a service to support the health needs of nurses, midwives and students of the professions came to fruition this year.

The Nurse Midwife Health Program Australia (NMHPA) which officially launched on 30 April 2024, is the result of a 2022 election commitment by Anthony Albanese after years of advocacy by the ANMF.

Federal ANMF sought a commitment from the then opposition leader to support a national extension of the Victorian program and Anthony Albanese promised to implement such a program if elected.

On 15 November 2022, the Albanese Government announced a $25.2 million investment to establish and run the new national program recognising the toll the COVID-19 pandemic had taken on the professions.

Led by the ANMF, in consultation with Federal, state and territory governments, key service providers and nursing peaks, the project kicked off on 23 January 2023 with the service officially launched on 30 April 2024.

NMHPA is a free, confidential, peer delivered and independent service for nurses and midwives, as well as nursing and midwifery students, experiencing any sensitive psychological health issues. It is modelled on the Nursing and Midwifery Health Program Victoria (NMHPV) which was set up in 2007 to offer Victorian nurses, midwives and students free, confidential, and independent peer-led delivered support.

NMHPA's peer support, counselling and case model approach uses a framework that incorporates prevention, support, and intervention, working towards health restoration.

The service enables early intervention to address sensitive health issues faced by the nursing and midwifery workforce, NMHPA CEO Heather Pickard said.

"Nursing and midwifery are very rewarding professions. But we recognise that the professions are also demanding and stressful, with nurses and midwives facing higher vulnerability and potential exposure to psychological health risks.

"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.

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

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

"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," Ms Pickard said.

The five-year investment to deliver the NMHPA is being rolled out in stages, starting with national telehealth consultations, and working towards establishing four hubs and regional offices that will offer face to face and telehealth services.

"The new National Nurse and Midwife Health Program will provide much-needed health and wellbeing support for frontline nurses and midwives across the country," said ANMF Federal Secretary Annie Butler.

nursemidwifehpa.org.au
Ph: 1800 001 060

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

Strength in numbers: 100 years of improving the working lives of nurses and midwives

ANF Vic Branch Rally, Nov 1992. Photo by Pamela Kleeman

The working lives of nurses and midwives have undergone significant transformation over the past 100 years.

In 1938, a typical staff nurse in Victoria earned just two pounds, four shillings, and four pence, for a 50-hour work week, caring for 10 patients during the day and 15 at night. These early nurses' responsibilities extended far beyond nursing at the bedside and medication administration to domestic tasks such as mopping floors, doing laundry, and assisting in meal preparation.

Undeniably, the evolution of nursing into the professional field we know today was achieved through decades of collective action from the ANMF and its members. We fought tirelessly for improvements to better wages and conditions, including the introduction of penalty rates and landmark staffing ratios.

Penalty rates, for instance, were introduced around the country through the 1950s and 60s as part of broader reforms to compensate workers, including nurses, for working outside standard hours, such as nights, weekends, and public holidays. Looking back, under the 1977 Victorian Nurses' Award, nurses whose shifts ended between 6pm and 8am or started between 6pm and 6.30am received an additional $2.66 per shift.

The 1970s marked a turning point in the working lives of nurses and midwives, as industrial action became more prominent and calls for change intensified.

The 1986 Victorian nurses' strike remains one of the most significant moments in Australian nursing history, made possible after the Royal Australian Nursing Federation (RANF), now ANMF (Vic Branch), voted in 1984 to remove the no-strike clause from its rules.

The 50-day strike rallied against cuts to health, low wages, high patient loads and attempts to downgrade nurses into lower qualifications.

Unprecedented in scale and duration, the industrial action, which involved a wave of walkouts and 24-hour picket lines, gained widespread public support, leading to an improved package offer from the then Cain Government, delivering wage rises, the return of qualification allowances and a new career structure.

ANF Tas Branch – Nurses worth every cent of 8% campaign 1990s

More broadly, the victory underscored the power of collective action in securing fair working conditions for nurses and ensuring quality healthcare for patients.

The 1980s, of course, also saw nursing education transition to the tertiary sector, starting with NSW in 1985 and soon followed by other states and territories. This shift coincided with another landmark campaign for professional rates of pay and full professional status.

The 1970s marked a turning point in the working lives of nurses and midwives, as industrial action became more prominent and calls for change intensified.

In 1989, the NSW Nurses' Association successfully argued before the NSW Industrial Relations Commission for 'Professional Rates' for public hospital nurses, stating that nurses trained and educated under the new tertiary system should be classified as 'professional' employees just like other health disciplines. The determination closely followed a similar claim by the RANF in the Victorian Commission.

These cases paved the way for greater uniformity in professional rates of pay and federal award structures nationally. By 1990, entry level nurses were paid the same as equivalent professional scientific officers in hospitals for the first time.

More recently, the ANMF has played a leading role in securing nurse-to-patient ratios across the nation to ensure enough nurses are employed to safely deliver care to patients. Pioneered by Victoria in 2000, they are now being adopted across the country.

The ANMF has also successfully championed historic Work Value cases before the Fair Work Commission over the past couple of years, achieving pay increases for aged care workers by demonstrating that their work has been significantly undervalued due to historical gender-based reasons.

Picket outside Qld Health 2000


Picket outside Qld Health


ANMF Vic Branch statewide meeting

QNMU Ratios rally

Nurse and midwife to patient ratios: Saving Lives 2000-2024

For more than two decades nurses and midwives have stood with the ANMF in fighting for and achieving minimum staffing ratios that assist in maintaining patient safety, contribute to better patient outcomes and create safer workplaces for nurses and midwives.

In 2000 Victoria became the first state in Australia to introduce nurse-to-patient ratios, and the first place in the world to have mandated ratios. After the decimation of the nursing workforce under the conservative Kennett government in the 1990s, the ANF (now known as ANMF) Victorian Branch launched its 1:4 ratios campaign for one nurse for four patients in a hospital ward during a day shift.

The ANF Vic Branch successfully convinced Fair Work Australia that ratios were necessary to bring back nurses who had left the profession in droves. Ratios were introduced through the nurses and midwives' enterprise agreement setting minimum staffing levels in certain publicly funded health facilities.

But having gained ratios, the union and the state's nurses and midwives spent the next decade campaigning to keep them. Following the Liberal Baillieu government's brazen attempt to roll back nurse to patient ratios and plans to replace RNs with healthcare assistants in hospitals, nurses and midwives became even more determined to see ratios enshrined in law.

Their campaigning convinced Daniel Andrews to make the historic commitment to legislate nurse- and midwife-to-patient ratios should he win office at the 2014 state election.

In October 2015, the Andrews Government made history with the passing of the Safe Patient Care Act 2015 making Victoria the second jurisdiction in the world to legislate nurse- and midwife-to-patient ratios.

In October 2015, the Andrews Government made history with the passing of the Safe Patient Care Act 2015 making Victoria the second jurisdiction in the world to legislate nurse- and midwife-to-patient ratios.

Shortly after, Queensland nurses and midwives with the Queensland Nurses and Midwives' Union (QNMU, ANMF Queensland) launched their campaign for staffing ratios. The Saving Lives campaign for an evidence-based, cost-effective way to improve the safety and quality of healthcare in Queensland won the hearts of both the public and government.

On 1 July 2016, legislation establishing nurse to patient ratios in 27 prescribed public facilities across the state made Queensland the fourth government in the world to make nurse-to-patient ratios law.

In 2019, QNMU undertook collaborative research with the University of Pennsylvania, United States, which showed that 'ratios work'.[1] It demonstrated that ratios had positive effects on nurse staffing and patient outcomes, including reduced mortality, readmissions, and length of stay.

Queensland midwives and the QNMU launched its Count the Babies campaign in 2020. Under legislation passed in March 2024, both mothers and babies are counted in midwifery ratios. Commencing later this year, a 1:6 midwife-to-patient ratio will be implemented at public maternity wards.

Four historic statewide strikes in NSW in 2022 resulted in a taskforce set up in April 2023 to pursue the introduction of ratios in the public health system. In 2024 for the first time, NSW will have minimum and enforceable shift-by-shift ratios in specific clinical areas in public hospitals – a major milestone in the NSWNMA's longstanding fight for reform.

A 2020 Labor election commitment saw nurse to patient ratios delivered across general medical/surgical wards, acute aged care, and mental health from February 2022 in the ACT. The expansion of nurse- and midwife-to patient ratios this year will make Canberra the second jurisdiction in Australia to include babies as part of staffing ratios.

The Western Australian government committed to phase in nurse-to-patient ratios with a trial at Royal Children's Hospital in 2022. More recently, the government announced ratios will start in two public hospitals in August 2024 as part of a wider rollout across the state.

The ANMF SA Branch is currently working with the state government on legislating nurse- and midwife-to-patient ratios with a staged implementation expected to start by March 2026.

Reference

1. Research by Linda Aiken (U Penn) et al: Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *The Lancet*, 11 May 2021.

QNMU (ANMF Qld Branch) fight for ratios

ANF Vic ratios rally, 2010

NSWNMA (ANMF NSW Branch) ratios rally

ANMF Vic ratios rally, 2010

Transitioning nursing education into higher education

The transfer of nursing education to the higher education system was one of the most significant milestones in the history of nursing in Australia.

Australian Nursing Federation (ANF), now the Australian Nursing and Midwifery Federation (ANMF), has played a pivotal role in the evolution of nursing and midwifery education in Australia. Its involvement spans decades of advocacy, policy development, and active engagement with governments and educational institutions to ensure that nurses and midwives receive the best possible education to meet the demands of an evolving healthcare system.

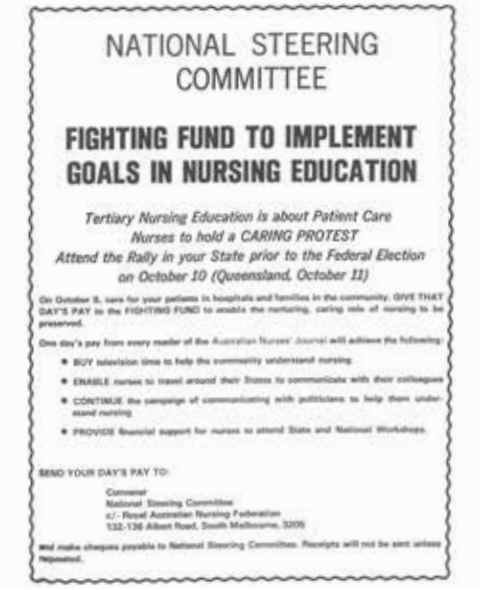
From its early days, the ANF was involved in advocating for the professionalisation of nursing and midwifery. As healthcare began to modernise in the early 20th century, the ANF recognised the need for standardised and formalised education. It lobbied for the establishment of training programs that would equip nurses with the skills and knowledge necessary to provide safe and effective care.

One of the ANF's most significant contributions to nursing education came during the 1970s and 1980s when it strongly advocated for the transfer of nursing education from hospital-based training to university programs.

The union recognised that the increasing complexity of healthcare required nurses to be more broadly educated, with a deeper understanding of theory, research, and leadership. The ANF was a vocal supporter of the recommendations of the 1978 Sax Report, which called for nursing to move into the tertiary education sector.

The ANF's leadership pressure on policymakers helped facilitate the move toward university-based education, culminating in the establishment of Diploma followed by Bachelor of Nursing programs and master's degrees. This shift fundamentally transformed nursing education in Australia, elevating it to a university standard and aligning it with other health professions. The transition also ensured that nurses had greater career development opportunities and more pathways into specialised roles.

The transfer to the university sector was a staged process with different states and territories moving at different times. The entire transfer was not completed until the end of 1993.



NATIONAL STEERING COMMITTEE

FIGHTING FUND TO IMPLEMENT GOALS IN NURSING EDUCATION

Tertiary Nursing Education is about Patient Care
Nurses to hold a CARING PROTEST
Attend the Rally in your State prior to the Federal Election
on October 10 (Queensland, October 11)

On October 9, care for your patients in hospitals and families in the community. GIVE THAT DAY'S PAY to the FIGHTING FUND to enable the nurturing, caring role of nursing to be preserved.

One day's pay from every reader of the Australian Nurses' Journal will achieve the following:

- BUY television time to help the community understand nursing
- ENABLE nurses to travel around their States to communicate with their colleagues
- CONTINUE the campaign of communicating with politicians to help them understand nursing
- PROVIDE financial support for nurses to attend State and National Workshops.

SEND YOUR DAY'S PAY TO:

Convenor
National Steering Committee
c/- Royal Australian Nursing Federation
132-136 Albert Road, South Melbourne, 3205

and make cheques payable to National Steering Committee. Receipts will not be sent unless requested.

Fighting fund to implement Goals in Nursing Education, 1977. From Nightingale to Now – Nurse Education in Australia

THE ADVERTISER, Friday, June 7, 1974 — NEWS

SA to have first tertiary course for nurses

By Education Writer CHRIS MILNE

The first full-scale academic course for nurses in Australia will begin at Sturt College of Advanced Education next year.

It will be the first time training has been based in an educational institution instead of a hospital.

The course will be run in collaboration with the Flinders Medical Centre.

No nurses will be trained at the centre's hospital, but it will be used for clinical training for the Sturt CAE nursing students.

The three-year course has been approved by the SA Board of Advanced Education and will receive Commonwealth finance from the Commission of Advanced Education.

The SA Hospitals Department will provide 100 scholarships for next year's initial intake; the scholarships will include eight weeks paid work in hospitals.

Students will need to complete fifth-year secondary school "satisfactorily" — but not necessarily matriculate — to take the course.

The director of Sturt CAE (Dr. G. W. Speedy) said yesterday the diploma course was aimed at raising the level of nurse training.

"Under traditional hospital training, the trainee is divided between being a working nurse and a student, often at the expense of study," he said.

"With the expanded concept of the nurse's role as a member of a medical team, a more concentrated, sophisticated approach to nurse education is needed."

Nurses were called on to make important decisions, to handle complicated tasks and intricate equipment and communication was an important aspect of their work, he said.

The theoretical work in this training could be carried out better away from the pressures of normal hospital work.

"However," he said, "we do not want to make nurse training academic and removed from the clinical situation.

"Theory and practice will be highly integrated and the amount of practical work will increase substantially as the student progresses through the course."

Much of the clinic experience would be gained at the Flinders Medical Centre, where the hospital was due to begin operating in 1976, but students would work in a variety of medical institutions and fields during their course, he said.

"We want to prepare nurses for any community health work, not just hospitals," Dr. Sheedy said.

As well as young girls, the college hoped to attract mature-age students and men into the course, he said.

It was also proposing post-diploma courses in nursing administration, ward management and public health.

The planned annual intake would be 120 students, although the first intake might be a little lower.

The college was seeking a senior lecturer to take charge of the course and would advertise in Australia, Britain and the US.

Several nursing educators would be appointed, and the course would draw on Sturt CAE's existing staff in the sciences and on Flinders Medical Centre staff.

Dr. Speedy said both the Royal Adelaide and Queen Elizabeth Hospitals had been represented on the joint planning committee.

The Nurses Registration Board, which would need to recognise the qualifications of the graduate students before they could be employed, had been kept informed about the planning of the course.

Sturt CAE is planning to hold a week of open days from July 15 for potential nursing students.

ABOVE Sturt College of Advanced Education (Sturt College), Bedford Park, the precursor institution of Flinders University was the first tertiary institution in South Australia, and the third in Australia, to offer a three-year Diploma of Applied Science program. (photo and clipping curtesy of Flinders University South Australia)

LEFT Nursing class of 1981 from the new course at Sturt CAE, which became Flinders University

Rally to promote nursing education 1980 in Adelaide – with RANF SA Branch president Joan Durdin holding loudspeaker

Mary Patten the ANF Federal Secretary, at the time of the transition reported to the *Australian Nursing Journal* that it was absolutely the right thing to do. "I have no doubt about that. It was a very difficult battle because there were so many people against it."

The ANF also played a key role in the evolution of midwifery education.

Recognising the distinct but complementary nature of nursing and midwifery, the ANF pushed for midwifery education programs that acknowledged the unique skills and knowledge midwives require. The federation worked closely with midwifery groups to ensure that education pathways were tailored to the needs of midwives while also advocating for midwifery to be recognised as a stand-alone profession within the broader health system.

With the establishment of the National Registration and Accreditation Scheme (NRAS) in 2010, the ANF continued its active involvement in shaping nursing and midwifery education. The Federation supported the move towards national registration, which standardised educational requirements and ensured consistent accreditation processes across the country. This was crucial in raising the overall standard of nursing and midwifery education, ensuring that all graduates, regardless of their state or territory, met the same high standards for practice.

One of the ANF's most significant contributions to nursing education came during the 1970s and 1980s when it strongly advocated for the transfer of nursing education from hospital-based training to university programs.

Nursing and midwifery visionaries who were instrumental in the drive to transfer hospital training to the higher education sector Back Row: Dr Rosemary Bryant AO, Carol Gaston AM, Christine Cornwell, Front Row: Pamela J Spry AM, Dr Joan Durdin

ANMF champions universal health coverage and high-quality aged care

The ANMF continues to be a powerful advocate for universal health coverage (UHC) in Australia, underlining the pivotal role nurses and midwives can play in ensuring all people have access to the healthcare services they need, when and where they need them, without financial hardship.

The ANMF has consistently supported and campaigned to protect Medicare to ensure universal health coverage. In recent years the ANMF has partaken in the Strengthening Medicare Taskforce committee, advocating for reforms, including funding nurses and midwives to work to their full capacity to ensure the community has optimal access to healthcare.

For example, the expansion of nurse-led and midwife-led clinics, such as free Walk-in Centres (WiC), are improving access and health outcomes and filling critical gaps in the health system. In these clinics, nurses and midwives lead care across a range of services including health assessments and treatment, chronic disease management, and mental health support.

"There's a lot of incredibly skilled and intelligent nurses working across all areas of healthcare, and I believe this nurse-led model of care gives us the opportunity to utilise our skills and work to our full scope. We work autonomously and we're cost-effective," advanced practice nurse Kirsten Madsen, who works at a WiC in the ACT, told the *ANMJ*.

Another significant area of ANMF advocacy is the union's ongoing fight to improve the quality of aged care for Australia's elderly population.

Australia's aged care crisis can be traced back to the then Howard Government's Aged Care Act 1997, which removed the funding mechanism to ensure a certain percentage of Commonwealth funding was directed towards nurse staffing and the delivery of nursing care. It left providers with the power to employ fewer qualified nurses and carers to meet the needs of residents. Aged care nurses left the sector, workloads were untenable for those that remained, wages in the sector were 30% lower than for the public hospital sector, and the quality of aged care deteriorated.

After years of countless Inquiries and reports that did not lead to any concrete action, the ANMF in 2017 launched its campaign, Ratios for Aged Care: Make Them Law Now, calling on politicians to fix the longstanding crisis by introducing mandated staffing ratios in every nursing home.

Amid the mass national campaign, the ANMF also played an important part in the landmark Aged Care Royal Commission, which concluded in 2021, that led to the incoming Albanese Government introducing historic legislated aged care staffing ratios, including a registered nurse on site 24/7.

As of this October, aged care providers will have to ensure that each resident receives an average of 215 minutes of care daily, including 44 minutes from a registered nurse.

On top of this, the ANMF's seminal Work Value cases before the Fair Work Commission (FWC) have resulted in significant wage increases for aged care workers, recognising the critical importance of their roles.

In November 2022, the ANMF won an initial increase of 15% to award rates for RNs, ENs and AINs working in aged care. On 15 March 2024 final increases were decided, ranging from a total of 20.9% to 28.5% (inclusive of the 15% increase) for direct care workers under the Aged Care Award and between 17.9% and 23% for AINs under the Nurses Award (inclusive of the 15% increase). The final wage decision for RNs and ENs in aged care is still being determined.

As the full implementation of aged care reforms continues, the ANMF will carry on its lobbying efforts to hold providers and the government accountable to ensure that nursing home residents receive the care they need and deserve. Right to now, the ANMF is calling for EN care minutes be specified in aged care legislation, in addition to RN and care worker minutes. This will ensure a safe number of nurses, and the right skills mix, is delivering care to older people.

Amid the mass national campaign, the ANMF also played an important part in the landmark Aged Care Royal Commission, which concluded in 2021, that led to the incoming Albanese Government introducing historic legislated aged care staffing ratios, including a registered nurse on site 24/7.

ANMF Federal Secretary Annie Butler speaking at an Aged Care rally in Melbourne, 2018

NSWNMA (ANMF NSW Branch) Save Medicare march

NSWNMA (ANMF NSW Branch) Medicare rally 2014

ANMF ACT Branch Lead Organiser (now branch secretary) Carlyn Fidow and ANMF ACT Industrial Officer Michael Quincy O'Neill

ANMF Vic Branch members supporting healthcare

NSWNMA (ANMF NSW Branch) Aged Care members in Canberra, 2022

ANMF VIC Branch Members at an Aged Care Productivity Commission rally Melbourne, 2011

The Power of Persistence: How the ANMF's advocacy laid the foundation for NPs in Australia

The nurse practitioner (NP) role originated in the United States in the mid-1960s to address gaps in healthcare. But it took 35 years later, on 12 December 2000, for Jane O'Connell (emergency) and Sue Denison (rural and remote health) to become Australia's first authorised NPs.

Requiring Master's level education, NPs possess the expertise and authority to diagnose and treat a wide range of acute and chronic health conditions across all ages. Working across diverse settings, their goals include improving access to healthcare, especially for at-risk populations, and providing cost-effective care.

While there are 2,860 endorsed NPs in Australia today, the role developed slowly, hampered by legislative barriers and outside resistance, including the AMA (Australian Medical Association), who at one early stage labelled it "third-world medicine".

Australia's NP movement traces back to 1990, when a nurse at the New South Wales Nurses' Association's (NSWNMA) annual conference quizzed the then state Health Minister on whether he backed the role.

That probing question sparked a series of developments, including the formation of committees, pilot projects, and research efforts.

Jane O'Connell, Australia's first NP, transitioned from her role as a clinical nurse specialist at Royal North Shore Hospital's Emergency Department to participate in one of the first NP pilot programs.

"ED nurse practitioners saw the fast-track type patients and the kind of walking wounded, if you like, so that we could free up the waiting room and get people moving through. As the role evolved, we moved into doing initial assessments on anyone who came through the door, and then suggesting treatment pathways for them," she told the *ANMJ*.

By 1998, the NP role was legislated through the NSW Nurses Amendment (Nurse Practitioners) Act. NP trials began in the ACT in December 1999, with models including wound care, sexual health, mental health liaison and military, demonstrating that NPs could safely and effectively manage a range of health issues.

Throughout the 90s, and the years to come, the ANF promoted and advocated for the role's vital place in Australia's healthcare system.

This included, alongside ACNP (Australian College of Nurse Practitioners), informing advisory groups that shaped historic legislation in 2010 enabling access to the MBS (Medicare Benefits Schedule) and PBS (Pharmaceutical Benefit Scheme) for nurse practitioners and eligible midwives.

Notwithstanding the progress, the expansion of NPs in Australia has continued to face barriers, including lack of broader acceptance and recognition, patient access, and limitations on scope of practice.

Committed to making sure NPs grow in numbers and are recognised for their vital contributions to the healthcare system, the ANMF continues to lead lobbying at a national level. Most recently, this helped achieve a 30% increase to the MBS rebate for NP item numbers, and removal of outdated collaborative arrangements required with doctors.

"This outdated requirement [collaborative arrangements] has needlessly constrained services and prevented people from accessing quality healthcare when they need it and where they need it," ANMF Federal Secretary Annie Butler said.

"This has been particularly acute in rural and regional, and other underserved communities, where it is becoming harder and harder to see a doctor.

"Removing these unnecessary restrictions, which are completely out of step with international best practice, will allow highly trained NPs to utilise their full set of skills and experience to provide best quality care in the community for people when and where they need it."

NP Chris Helms. Photo Rohan Thomson

NP Lesley Salem, left, Australia's first Aboriginal Nurse Practitioner

Nurse Stephanie Lee was at the frontline of the COVID response

On the frontline: ANMF helps steer Australia through emergencies and natural disasters

Over the years, the ANMF has played a crucial role in shaping the healthcare response during emergencies, from natural disasters to the recent COVID-19 pandemic.

The union has provided staunch support for nurses, midwives, and carers on the frontlines, as well as those directly impacted by crises.

The devastating 2019-2020 Australian summer bushfires were a clear example of this. The fires swept through vast regions, destroying homes, killing wildlife, and leaving communities in despair. With nurses and midwives being among the frontline workers leading relief efforts, ANMF members and branches across the country offered support such as members volunteering their services, supporting colleagues in affected areas, while branches offered financial and industrial assistance to those in need.

It is widely acknowledged that the frequency and severity of natural disasters, linked to climate change are putting increased pressure on health and aged care facilities. These sectors must be equipped to manage climate-related health impacts, which are stretching already overburdened systems. Nurses, midwives, and carers are particularly affected in both their work and personal lives as they care for individuals impacted by climate change.

Moreover, health and aged care facilities are also significant contributors to climate change, consuming vast amounts of energy and water and producing substantial waste.

Consequently, the ANMF has been actively campaigning for sustainability and leads efforts to implement greener practices in healthcare settings. The ANMF is a member of the Climate and Health Alliance (CAHA), that works to educate the sector on climate change, promote sustainability, and communicate the health impacts to governments and the broader community.

The COVID-19 pandemic, which posed unprecedented challenges to healthcare systems worldwide, with Australia no exception.

From the outset, the ANMF played a pivotal role in lobbying for the necessary resources and protections for nurses and midwives, including adequate and appropriate personal protective equipment (PPE), sufficient staffing to deal with the influx of COVID-19 patients, and proper infection control training, especially in vulnerable sectors like aged care.

Efforts also included pushing for widespread vaccination, recognising its critical role in controlling the virus.

Throughout the pandemic, nurses, midwives and carers demonstrated unwavering courage and dedication to ensure the country's health system stayed afloat, despite the uncertainty and personal risk involved.

Tasmanian ICU nurse Stephanie Lee, for example, cared for COVID-19 patients inside a negative pressure room, enduring long hours in full PPE.

"The longest stretch I did in full PPE was three hours and it definitely takes a toll on you. You're breathing becomes laboured and you aren't able to touch your face to readjust your mask or goggles. By the end of my shift, I had indents all over my face," she said at the time.

"I'm not scared that I'll contract COVID-19. I'm just worried that I would potentially pass it on to someone else who is more vulnerable in the community, or in the hospital."

ANMF Vic Branch Sustainability Officer Ros Morgan

Supporting the beginning of CATSINaM

The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) began as an idea and question 'Why are there so few Aboriginal and Torres Strait Islander nurses?'

In 1995, Wiradjuri woman, registered nurse and academic Dr Sally Goold OAM had completed a Masters' Degree investigating the reasons for continuing low numbers of Aboriginal and Torres Strait Islander nurses, which she attributed to persistent racism and the lack of student support. The low numbers of Aboriginal and Torres Strait Islander nurses spurred her on to change the system.

Establishing a national organisation of Aboriginal and Torres Strait Islander nurses and bringing those nurses together for a national forum was identified as the first step in developing strategies to encourage Aboriginal and Torres Strait Islander peoples in nursing.

The Australian Nursing Federation (ANF) was actively involved in locating and making contact with Aboriginal and Torres Strait Islander nurses across the country. A grant from the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to the ANF provided for the first national meeting of 28 Aboriginal and Torres Strait Islander nurses in August 1997.

Held in Sydney, the three-day meeting developed a series of recommendations for strategies and initiatives to advance the recruitment of Aboriginal and Torres Strait Islander peoples into nursing.

CATSIN was founded in 1997 to formally represent Aboriginal and Torres Strait Islander nurses and midwives. In 1998, CATSIN was incorporated and until July 2012, led by founding Executive Director, Dr Sally Goold OAM.

"It's a wonderful organisation and I'm so proud to have been involved in its inception," said Dr Goold.

Founding Executive Director Dr Sally Goold OAM

CATSIN promotes, supports and advocates for Aboriginal and Torres Strait Islander nurses and midwives in numerous ways, including collaborating with government and universities on nursing and midwifery workforce planning and curriculum, and targeted support, assistance and cultural safety education for university students and practising nurses and midwives.

More than two decades on, CATSINaM, as it is now known, has grown to over 3,000 members and is an active member of the National Aboriginal and Torres Strait Islander Coalition of Peaks as well as the Nursing and Midwifery Strategic Reference Group, a group that advises the Department of Health and Aged Care and the Commonwealth Chief Nursing and Midwifery Officer. It has helped boost the Aboriginal and Torres Strait Islander nursing and midwifery workforce into the thousands and is considered a prominent peak body with an influential voice.

Aboriginal and Torres Strait Islander nurses and midwives continue to draw on the strength and wisdom of the organisation's founders to face current challenges, said former CATSINaM CEO Professor Roianne West.

"Strong Indigenous leadership has helped us navigate some of the profession's most challenging times – through COVID, bushfires, floods, and Black Lives Matter" said Professor West.

Attracting and retaining Indigenous nurses, midwives and university students remains a key issue for CATSINaM, as it was for its founding members.

Current CATSINaM CEO, Dr Ali Drummond, emphasises that "increasing the Aboriginal and Torres Strait Islander nursing and midwifery workforce is not a feel-good or diversity or assimilation project. Our greater presence in the nursing and midwifery workforce is primarily about nation-building. We have a relational duty to our families and communities to work tirelessly, like our founding members, towards improving the quality and safety of nursing, midwifery and subsequently healthcare for Aboriginal and Torres Strait Islander peoples."

"It's a wonderful organisation and I'm so proud to have been involved in its inception," said Dr Goold.

TOP Eldership workshop

ABOVE CATSINaM CEO, Dr Ali Drummond

LEFT CATSIN forum delegates, 1997 Founding members

CATSINaM LTD

CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES

UNITY AND STRENGTH THROUGH CARING

Manual handling and no lift

Safe manual handling and no lift policies had their origins with the union back in the late 1980s and early 1990s.

The movement towards 'no lift' policies were driven by nurses and midwives on the ground with increasing awareness of occupational health and safety issues. These policies aim to improve both patient and staff safety by minimising the need for nurses to manually lift patients.

After nearly two decades working as a nurse and midwife, ANF Victorian Branch member Elizabeth Langford sustained a back injury at work in the late 1980s which led to the end of her nursing career. She joined the ANF's Injured Nurses Support Group and began researching back injuries among nurses in Victoria.

Langford discovered that nurses had the highest injury rate in the female workforce in Victoria and the majority were back injuries from manual handling - these accounted for about 84% of injuries amongst nurses with those injured aged in their 40s.

Langford began work on what would become the *Buried but not dead* report published in 1997. The report helped inform the ANF Victorian Branch's initial 'no lifting' policy, which was launched in April 1998.

ABC media coverage gave the issue traction and governments started to pay attention. This led to the ANF Victorian Nurses Back Injury Prevention Project (VNBIPP) with funding by the state government to help healthcare organisations implement back injury prevention programs based on the Branch's 'no lifting' policy.

ANMF Tas Branch, Say no to unsafe transfers rally

Various mechanical aids and devices, such as hoists, slide sheets, and lifting machines were introduced to assist in patient handling, ensuring patients were moved safely while also protecting staff from injury.

The project resulted in a substantial reduction in back injuries, and the government acknowledged the program had been an outstanding success. So much so that Elizabeth Langford received an Order of Australia in 2003, which she donated to the ANMF Victorian Branch.

When the VNBIPP was initiated in 1998, nurses accounted for more than 54% of compensation claims by health industry workers. In 2004, evaluation of the project found:

- a 24% reduction in the rate of standard back injury claims by nurses in Victorian public health services; and
- a 41% reduction in working days lost due to back injuries.

Ahead of the 10th anniversary of the 'no lifting' policy in Victoria, WorkSafe Victoria data showed that overall compensation injuries to Victorian nurses, recorded a 15% drop since 2001.

Today, 'no lifting' policies are widely accepted not only throughout Victoria but other states and territories. The adoption of 'no lift' policies has significantly improved workplace safety in the healthcare sector, leading to a reduction in injury rates and promoting a safer working environment for nurses and midwives.

Reference

Buried but not dead: a survey of occupational illness and injury incurred by nurses in the Victorian health service industry. ANF (Vic Branch) Injured Nurses Support Group; Elizabeth Langford. 1997.


No Lift Policy

The role of regulation in nursing and midwifery in Australia: A legacy of excellence and advocacy

In Australia's healthcare system, regulating and accrediting nursing and midwifery are vital for maintaining high standards and ensuring public safety.

The ANMF's contributions to nursing and midwifery regulation in Australia reflect its commitment to excellence and safety. From advocating for professional recognition to shaping national standards, the ANMF has been a significant force in Australian healthcare. Through its ongoing collaboration with the NMBA, ANMAC and Ahpra, the ANMF ensures that nurses and midwives are prepared to deliver safe, competent, and compassionate care across the nation.

HISTORICAL FOUNDATIONS

The regulation of nursing in Australia began in the early 20th century. South Australia led the charge in 1920 by making nursing a registered profession, followed by Western Australia in 1922, and New South Wales and Victoria in 1924. These milestones established a foundation for a regulated profession that emphasised high standards and education.

Midwifery regulation in Australia also has a distinct history. The Midwives Act of 1901 in Tasmania was the earliest formal regulation, with other states establishing registration by 1926. However, regulation remained state-specific, creating a complex landscape of varying standards until national registration.

THE ANMF'S ADVOCACY FOR NATIONAL REGISTRATION

The ANMF has been instrumental in pushing for national registration and workforce data collection. In October 1989, the ANMF (then ANF) Federal Council passed a resolution supporting these initiatives. The Australian Nursing Council Inc. (ANCI), established in 1992, collected national workforce data, coordinated registration boards, and assessed overseas-trained nurses. Although the ANCI struggled with data collection, its establishment paved the way for the NMBA, ANMAC's and the NRAS's success in 2010.

THE EMERGENCE OF ANMAC

By the late 1970s, it became clear that a dedicated body was needed to oversee nursing and midwifery education. This led to the creation of the Australian Nursing Council Inc. (ANCI) in 1992 and later, when the national scheme was introduced in 2010, the establishment of the Australian Nursing and Midwifery Accreditation Council (ANMAC). ANMAC's role is pivotal: it ensures that all entry-to-practice education programs for nurses and midwives meet rigorous national standards. ANMAC also assesses qualifications of internationally trained nurses and midwives seeking to practice in Australia under the Skills Migration Program. The ANMF has been an active supporter of ANMAC and is represented on the Board of Directors, contributing advice and recommendations to the Nursing and Midwifery Board of Australia (NMBA).

THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME (NRAS)

A significant advancement came on 1 July 2010, with the launch of the National Registration and Accreditation Scheme (NRAS), governed by the *Health Practitioner Regulation National Law Act 2009*. NRAS marked a major shift towards a unified approach to health practitioner regulation. Under NRAS, all Health Practitioner National Boards, including the NMBA, focus on public protection. The Australian Health Practitioner Regulation Agency (Ahpra) collaborates with the National Boards to implement the scheme, managing agreements on fees, budgets, and services.

The NRAS has streamlined many processes, including creating a single piece of national legislation, allowing nurses and midwives to practice across all states and territories, and providing a consistent registration renewal period and national workforce dataset.

THE ESTABLISHMENT OF THE NMBA

The Nursing and Midwifery Board of Australia was established to set policy and professional standards for the professions. In partnership with Ahpra, the Board regulates Australian nurses, midwives, and nursing and midwifery students. Its responsibilities include approving accreditation standards and courses leading to registration or endorsement, managing the registration process, developing standards, codes, and guidelines, and handling notifications.

ANMF'S COMMITMENT TO NATIONAL ACCREDITATION

The ANMF's stance on accreditation is clear: national standards are essential for public safety and high-quality practice. The ANMF believes that the determination and maintenance of these standards should be managed by the nursing and midwifery professions to ensure integrity. Additionally, both registration and accreditation processes should be funded by registration fees, without cross-subsiding other disciplines.

If you enjoyed reading this feature, watch our documentary on celebrating ANMF's first 100 years.

Available from 23 October

Paul Yiallouros
Federal Industrial Officer

Workers win 'Right to Disconnect' under the *Fair Work Act 2009* (Cth)

Earlier this year, the Federal Parliament passed laws to create a new workplace right: the right to disconnect.

The change came about because lawmakers recognised that technological developments, such as laptops and mobile phones, which allow many employees to work remotely, also allow the workplace to encroach into people's lives outside of work. This phenomenon was turbocharged during the height of the COVID-19 pandemic, when workers across the country were directed to work from home using their digital devices, sometimes for months on end.

Employers have increasingly expected their workers to be contactable at all hours to respond to calls, emails, and sometimes return to work. While this is nothing new for nurses, midwives and carers, the legislation acknowledges the psychosocial hazards posed to worker wellbeing by not placing fair boundaries between work and personal time.

This is a massive win for union members, particularly in the health and aged care sectors, where the need to recover and recharge between shifts has never been more important.

These laws will only apply to workers covered by the *Fair Work Act 2009* (Cth). For ANMF members, this will broadly include:

- all employees in the ACT, the NT and Victoria; and
- in all other jurisdictions, all employees in the private sector.

The right to disconnect laws offer a new way to push back against bosses who do not respect their workers' downtime. The law does not forbid an employer from attempting to contact a worker, but instead outlines when it might be reasonable for that worker to not respond. The following will likely be considered:

- the reason for the employer attempting contact;
- how the contact is made and whether it is disruptive to the worker;
- whether the worker is getting paid extra to be contactable;
- the nature of the worker's job and whether they are a senior employee; and
- the worker's personal circumstances, such as family or other caring responsibilities.

It is easy to imagine how this could play out in the workplace:

Christine is a registered midwife in a private hospital. When she gets more than one consecutive day off, she likes to go camping in the outback, often to areas without phone reception. Christine's manager is not aware that Christine has gone camping and messages her to see if she can come in to work to cover unplanned sick leave. The text message is not seen by Christine until she gets back from her trip. In this situation, it was probably reasonable for Christine to have refused contact from her manager.

Vanessa is an emergency department registered nurse at a public hospital. Vanessa has a day where she is not working but is being paid an allowance to remain on-call and be prepared to be recalled to work if necessary. Vanessa notices her manager is trying to call her, presumably to ask her to come in to work. Vanessa decides to ignore the call until the next morning. In this situation, it was probably unreasonable for Vanessa to ignore the call from her manager.

Nick is a personal care worker in an aged care facility. On weekdays, his shift ends at 3pm so he can go pick up his kids from school. One day at 4pm, Nick's manager is preparing the upcoming rosters for the Christmas and new year period and wants to know whether Nick will be applying for leave. Nick ignores the call because he is busy with his children. His manager wants to get the roster sorted that afternoon so repeatedly calls Nick and leaves some angry voice messages. This is not the first time the manager has called Nick after he has left for the day to discuss something non-urgent. In this situation, it was probably reasonable for Nick to have ignored the calls.

Frida is a nurse coordinator at a private health clinic and is provided with a laptop to monitor emails out of hours. Frida works full-time and is not paid any additional amount for this work, but her salary is intended to cover additional responsibility. In this situation, Frida could reasonably refuse to respond where email demand is excessive, or timeframes are unreasonable.

As these scenarios illustrate, circumstances where an employee can reasonably disconnect from work will vary. The ANMF recommends starting conversations about how the right will work in practice at your workplace and contacting your ANMF branch with any questions or concerns about the new right to disconnect.

Julianne Bryce

Senior Federal Professional Officer

Decades of advocacy for NPs

In the late 80s, early in my grad year, I recall telling my mum I was puzzled that the most experienced nurses were the furthest from the bedside.

Pathways to promotion led away from clinical practice to management and education roles. The 90s saw the introduction of Clinical Nurse Specialists and Clinical Nurse Consultants, followed in 2001 by the first Nurse Practitioner (NP).

The NP role in Australia developed slowly. Planning began in the early 90s but advancement was hindered by legislative barriers and opposition from medical colleagues. Once established, momentum built, as advanced practice registered nurses acquired the necessary qualifications and experience for endorsement.

Now, in 2024, there are 2,860 endorsed NPs in Australia.[1]

Although frustrating, slowly and steadily building momentum for NPs allowed us to learn from international experiences and to develop our own robust framework. Our regulated title, master's degree qualification, national standards, and accreditation process are highly regarded and coveted globally.

We laid the groundwork, built the framework, consistently and persistently promoted and advocated for the role, despite the negativity and criticism from other professions and sometimes even our own.

In 2009, the efforts of Federal Health Minister, Nicola Roxon were instrumental in overcoming barriers to affordable, safe, high-quality healthcare. She was interested in the role of nurses and midwives, and particularly the role of NPs. In May that year, the Labor federal government introduced historic health reform enabling access to the MBS and PBS for nurses and midwives. The resultant *Health Legislation Amendment (Nurse Practitioners and Midwives) Act 2010* provided the legal framework for those receiving care from NPs and eligible midwives to access MBS and PBS funding.

The then ANF, alongside the Australian College of Nurse Practitioners, played a pivotal role in the advisory groups that shaped this legislation. Despite being outnumbered by medical colleagues, we navigated tough negotiations on MBS rebate amounts and PBS medicine access. While we gained access to more PBS medicines than we thought we would, restrictions remained, mostly under 'shared care' and 'continuing therapy only' arrangements, which continue to limit NP practice and impact the provision of care.

In the past decade we have been part of the research team that developed the NMBA *Nurse Practitioner Standards for Practice*; participated in the review of the NMBA *Endorsement as a nurse practitioner registration standard*; provided expert advice on the ANMAC *Nurse Practitioner Accreditation Standards*; participated in the MBS Review Taskforce consultation; provided expert advice as a member of the Taskforce's Nurse Practitioner Reference Group; reviewed NP scholarship applications; commissioned and participated in NP research; and made hundreds of submissions to consultations on health policy and reform highlighting the importance of growing the NP workforce. Although much of our feedback was initially overlooked, in more recent times, thanks to the efforts of Assistant Minister for Health and Aged Care, Ged Kearney, we have had success with several recommendations previously made to the MBS Review Taskforce. Most significantly, the 30% increase to the MBS rebate for NP item numbers from 1 July 2024 and the removal of collaborative arrangements taking effect 1 November 2024.

Our journey has been marked by both frustrations and successes. The bonds formed through collective efforts in these battles remain strong. Our shared experiences and support for one another have been crucial in overcoming challenges.

There is still significant work ahead to ensure NPs receive the recognition and place in our healthcare system they have worked hard for and deserve. The ANMF continues to lead this work because acknowledging and supporting NPs is advancing the whole of the profession. All nurses need to get behind NPs and the work they do.

Our aim is a universal understanding of the NP role, much greater NP numbers, widespread employment in all contexts of practice, appropriate funding for NP services wherever they're delivered, and acceptance, trust and respect from our health practitioner colleagues. For our part, we will continue our lobbying, advocacy, research and policy efforts, and promote NPs through submissions, publications, and collaboration with other nursing organisations.

We have been persistent and most recently heard. The ANMF is committed to ensuring the vital contributions of NPs are widely recognised and valued. We will continue to make sure that everyone knows about NPs, works with NPs, and wonders what we ever did without them.

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Beyond judgement: A nursing perspective on obesity, medications, and the path to health

By Amanda Wilson

Recently, while waiting at a pharmacy, I witnessed an interaction that has stayed with me.

A young man, around 30 years old, stood at the counter, visibly uncomfortable. He was breathless and sweating slightly, despite the cool, air-conditioned environment – signs of the physical and maybe emotional burden he was carrying. The pharmacist, with a firm tone, informed him that he was not eligible for the drug his doctor had prescribed: Ozempic.

"But my doctor said I should use it," the man said, clearly confused.

"Do you have diabetes?" the pharmacist asked, loudly enough for everyone to hear.

"No," the man replied.

"Then you can't have this drug. It's for people with diabetes, not for those who just want to lose weight." The man turned away, embarrassed and defeated, while the pharmacist appeared satisfied, as if she had won a small victory.

As a nurse, this scene deeply unsettled me – not just because of the pharmacist's strict adherence to her medication protocol while ignoring patient confidentiality, but because of the underlying message it sent. The pharmacist seemed to believe that healthcare decisions could be based on moral judgements rather than medical needs. The young man did not need to be turned away with a sense of shame; he needed understanding and support in finding a path to better health.

Obesity is a significant health issue, contributing significantly to (ironically) diabetes, heart disease, and certain cancers. The conversation about managing it should never be about who 'deserves' treatment. It should focus on finding the most effective interventions to help people achieve better health and ensuring these interventions are accessible to everyone, regardless of their financial situation or the complexities of their health status.

In this instance, the doctor had already prescribed Ozempic, indicating that a medical professional had determined it was appropriate for the patient's needs. The pharmacist's decision not to fill the prescription – whether due to limited stock or a perceived moral obligation – left the patient feeling as though they were in the wrong, when they were simply following their doctor's advice. This situation highlights a concerning trend where patients are judged or denied care based on non-medical factors, leading to unnecessary shame and confusion.

Ozempic (semaglutide), initially developed to treat diabetes, is a promising tool for weight management. Like any medication, it has side effects, including possibly serious ones such as depression and suicidal thoughts. This risk underscores the complexity of using pharmaceuticals to manage obesity and the need for a holistic approach that includes psychological support and careful monitoring. But this pharmacist's reaction was not about these risks – it was about the perceived misuse of a resource, reflecting an underlying bias in our society that judges those struggling with obesity as less deserving of care.

This bias is pervasive, often manifesting in subtle ways that discourage people from seeking the help they need. As healthcare professionals, our role is to challenge these biases and advocate for all patients, regardless of their size or the complexity of their health challenges. It is crucial that we shift the focus from rationing resources to ensuring that effective, comprehensive care – including medications like semaglutide – is accessible to everyone who could benefit, supported by education, lifestyle changes, and ongoing healthcare guidance.

This pharmacist missed an opportunity to provide care that was compassionate and person-centred. Rather than focusing on denying access, what if we had systems in place where effective interventions like semaglutide were freely available to everyone who could benefit, with proper safeguards to monitor and mitigate potential side effects? What if the conversation shifted from rationing resources to ensuring everyone had the support they need to lead healthier lives?

As nurses, we strive to advocate for our patients' wellbeing in all its forms. This means pushing for a healthcare system where interventions, whether pharmaceutical or otherwise, are accessible to everyone who needs them, and where the underlying biases that shape who we believe 'deserves' care are actively challenged. It is not about judgement; it is about ensuring that every individual has the tools and support necessary to achieve better health. Our focus should always be on care, compassion, and creating a society where effective treatments are within reach for all, free from bias and stigma.

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A review of the health-law landscape over the last 50 years

As the ANMF celebrates its 100TH anniversary, so does the concept of health justice.

Thought to have emerged in the literature around the late 19th century, the health justice movement only really started to take shape in the 1990s as the World Health Organization (WHO) highlighted the importance of social determinants of health and introduced the concept of health equity.[1]

The term is now used to include "both a community-led movement for power building and transformational change and a community-oriented framework for health law scholarship".[2(P636)] On this dual centenary, it is only fitting to look back at what have been some of the key moments in health and law.

Some might be surprised to know that Australia's federal anti-discrimination law was only passed in 1975. Described by Prime Minister Gough Whitlam as a "historic measure [for] entrench[ing] new attitudes of tolerance and understanding in the hearts and minds of the people". Despite this historic move, over 20% of Indigenous Australians report continuing to experience racism in the healthcare system, inequity in accessing healthcare and have an avoidable mortality rate more than three times higher than the non-Indigenous population.

Nothing has better showcased the inequities in health and the role the rule of law plays in health like COVID-19 did. Access, or lack thereof, to vaccines and a patchwork pandemic response, amongst other issues, led to amendments to the *International Health Regulations 2005* as countries were added to the list of States Parties and lessons learned about global pandemic responses were enshrined in law. Although not binding, the amendments made in 2022 provide for the Director-General of WHO to issue a 'pandemic emergency' global alert, designed to facilitate a consistent, coordinated global response to future pandemics. Undoubtedly, one benefit to have come from the pandemic was the sudden increase in technological advances in healthcare delivery, such as Telehealth.

Whilst digital technologies are being hailed as game changers in increasing access to care, its critics remain concerned about the lack of security of patient data, bringing back into question if there is a need for a tort of privacy in Australia.

Other significant milestones in the health justice landscape have included the passing of the *Unemployment and Sickness Benefits Act 1944* (NO. 10, 1944) creating the first Australian welfare system, the first time the term 'Australian citizen' was used in Australian legislation with the enactment of the *Nationality and Citizenship Act 1948 (Cth)*, and the legislative introduction of Medicare with the *Human Services (Medicare) Act 1973 (Cth)*. Arguably one of the most epochal events of the last 100 years was the passage of the *Native Title Act 1993 (Cth)*, likely the most important step forward in addressing systemic disadvantage since the end of the White Australia Policy in 1966. Further significant legislative changes had followed for Indigenous Australians, with the *Commonwealth Electoral Act 1962 (Cth)* allowing Indigenous people to vote for the first time. This was quickly followed by the referendum of 1967 which successfully removed the discriminatory words against Indigenous Australians from s51 (xxvi). The introduction of the *Sex Discrimination Act 1984 (Cth)*, voluntary assisted dying legislation and a suite of tobacco laws are likely to have similarly wide-reaching effects on Australians' health into the future.

From the discovery of penicillin, the founding of the United Nations and the definition of the Australian flag, the last 100 years have been significant for Australia. During that time, nurses have been instrumental advocates for health justice. Providing a forum for nurses to learn from each other and show strength in numbers, the ANMF and others have played a role in promoting health justice through putting issues such as gender inequity, family violence, and voluntary assisted dying in the spotlight. One can only imagine what is to come in the next 100 years.

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Improving care for older Australians: Reducing transfers from nursing homes

The increasing complexity of care required by Australia's ageing population places significant strain on healthcare systems. The high rate of transfers of nursing home residents to emergency departments (EDs) is especially concerning.

Transfers can compromise the health and wellbeing of vulnerable older adults and place burden on healthcare systems. The distinction between 'necessary' and 'unnecessary' transfers is complex and unclear. While some transfers are warranted due to acute medical emergencies or deteriorating conditions, many transfers could be avoided with appropriate on-site care and support.

Unnecessary transfers carry significant risks for residents. Hospital environments can be overwhelming and disorienting for older people, increasing their vulnerability to falls, infections, and delirium. These settings often involve invasive procedures and medications that may not be required for conditions that could be managed on site. Determining whether a transfer is necessary requires careful assessment. A resident's underlying health conditions, symptom severity, availability of resources and staff expertise within the nursing home must be considered. Decision-making is also often influenced by the preferences of the resident or their family.

Numerous factors contribute to avoidable transfers. Insufficient staffing and skill mix within nursing homes hinder timely and effective care. Many nursing homes struggle to provide sufficient on-site clinical expertise making it challenging to identify and manage complex conditions. Ineffective communication between nursing homes and EDs can also lead to unnecessary transfers.

While preventing unnecessary transfers is essential, it is equally important to ensure that residents with genuine medical emergencies receive timely, appropriate care. This requires ongoing evaluation of care practices, staff training, and the availability of resources within nursing homes. To minimise unnecessary transfers, adequate staffing levels and skill mixes with registered and enrolled nurses, allied health professionals, and potentially medical practitioners must be available onsite. Early intervention and effective management of chronic conditions can also reduce need for emergency care. Strong partnerships and communication channels with external healthcare providers can also facilitate interventions without resorting to ED transfers. Here, the implementation of nurse practitioner-led care models and in-reach care has also shown promise in enhancing care coordination and reducing the need for transfers.

Quality improvement initiatives are essential for driving continuous improvement. Implementing evidence-based interventions to prevent common conditions leading to transfers, such as falls, constipation, UTIs, and pressure injuries, can significantly reduce the need for hospitalisations. Utilising virtual care and telehealth can also facilitate access to specialised care. The implementation of electronic health records streamlines information sharing and reduces the risk of errors. Empowering residents and their families is also vital. Encouraging advance care planning allows residents to express their care preferences which can help avoid unwanted transfers. Providing education about the benefits of care in place can also help dispel misconceptions and improve confidence. Involving families in decision-making can foster trust and ensure that concerns are addressed.

Ultimately, the goal is to provide high-quality, person-centred care within nursing homes whenever possible. By reducing unnecessary transfers, quality of life for residents can be improved and pressure on the healthcare system alleviated. Reducing unnecessary transfers requires a comprehensive approach that addresses numerous factors. By investing in the nursing home workforce, enhancing clinical expertise, improving communication, empowering residents and families, and implementing quality improvement initiatives, we can better support the needs of older Australians and more effectively support access, health, and wellbeing of the wider community.

MENTAL HEALTH AND ALCOHOL & OTHER DRUGS

Students and consumers benefit from learning about suicide together

By Taylor Yousiph, Christopher Patterson and Lorna Moxham

Suicide education for nurses is critical amidst the current impact that suicide has on a global, national, and individual level. In Australia, there are 3,000 people per year who die by suicide, with seven million Australians bereaved by suicide.[1,2]

Involving people with lived experience of suicide in research, policy formation, program production, and education around suicide, offers profound understanding and impactful solutions that can save lives.[3]

The involvement of lived experience knowledge in these domains aims to overturn the history of marginalisation and epistemic injustice experienced by people living with suicidality. Sharing of lived experience knowledge in an educational context can be seen as an action towards social justice, striving to transform knowledge and practices related to suicide prevention. This is specifically important for nursing education.

Nurses play a vital role in providing compassionate and trauma-informed care that is free of stigma. One avenue to promote these practices to accelerate widespread impact is through lived experience education. Understanding the experiences of people with lived experience of suicide in the education of nursing students is the focus of my doctoral project, with the knowledge that the involvement of lived experience educators in mental health nursing education can positively affect wellbeing and humanise people living with mental health conditions for future nurses.[4]

So far, educating pre-registration nursing students about suicide has made people with lived experience feel that they are making a difference. Educating about suicide care is helping future nurses of Australia be more empathetic, understanding, and compassionate towards one in six Australians who have had serious thoughts of suicide at some point in their life.[1] Participants feel their involvement in pre-registration nursing education is changing stigmatising attitudes, challenging negative stereotypes, and helping nursing students feel more comfortable talking about suicide. Many want to turn their negative help-seeking experiences into positive ones for people seeking suicide care, and it starts with direct engagement with the future of the health workforce.

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Enhancing respite care for consumers with mental illness through qualified nursing staff

By Zahra Almoaber and Lorna Moxham

Respite care services are an essential support system for maintaining the wellbeing of both carers and consumers, particularly those managing mental illness.

The employment of qualified nurses with strong communication skills is crucial to enhancing the quality of care and optimising the use of these services.

Experienced nurses bring a wealth of expertise, ensuring that the medical and personal needs of consumers with mental illness are met with a high standard of care. Their professional training enables them to effectively manage complex mental health conditions, administer medications, and respond to crises. This level of care not only enhances the safety and comfort of individuals but also significantly improves the overall experience for both carers and care recipients.

Strong communication skills are not just essential for nurses in their interactions with consumers and carers; they are the cornerstone of a collaborative and reassuring environment.

Effective communication allows nurses to understand the specific needs and concerns of those they care for, build trust, and provide emotional support. It also ensures that accurate information is shared with carers, creating a collaborative and reassuring environment.

For carers, knowing that their loved ones are in the hands of nurses who communicate well provides peace of mind, reducing stress and allowing them to take much-needed breaks without worrying about the quality of care being provided.

This assurance can lead to more frequent and consistent use of respite care services, which is essential for the long-term health and wellbeing of carers.

The presence of skilled nurses with strong communication abilities is not just crucial for consumers, particularly those dealing with mental illness, but it also significantly impacts their emotional wellbeing.

Their involvement guarantees a superior level of tailored and expert care, leading to an enhancement in the mental and emotional wellbeing of the recipients. Establishing positive connections with empathetic and communicative nurses can increase the comfort level of consumers with respite care, making them more inclined to utilise these services on a regular basis.

Additionally, having qualified nurses on staff can help attract more families to respite care services. When they see the presence of qualified nurses, families are more likely to trust that their loved ones with mental illness are in capable and caring hands. This trust is crucial for increasing the utilisation rates of respite care services, as carers are more likely to seek respite when they are confident in the quality of care provided.

To increase service effectiveness, respite care facilities need to not just prioritise but urgently focus on the recruitment and retention of qualified nurses with strong communication skills. This can be achieved through offering competitive salaries, providing continuous professional development opportunities, and fostering a supportive work environment.

By investing in skilled nursing staff, respite care services can improve the quality of care, enhance the experiences of both carers and care recipients, and become a more attractive option for families, leading to increased overall service utilisation.

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Addressing the challenges of recruiting and retaining mental health nurses

By Louise Alexander, Lauren McTier and Nikki Phillips

Nurses make up much of the healthcare workforce, and despite this there continues to be a shortage of nurses globally.[1]

By 2025 the projected shortfall of nurses in Australia is expected to exceed 85,000[2] and this deficit will impact the mental health sector the hardest where workforce shortages are expected to reach 42% by 2030.[3] It is well understood that it is difficult to garner student interest in undergraduate mental health nursing (MHN), and recruitment and retention of MHNs remains a challenge.[3,4] This projected shortfall will result in additional strain on our already vulnerable mental health system with flow on effects to consumers, carers and supporters.

The findings of the recent Royal Commission into Mental Health in Victoria[5] called for significant system reform and overhaul. System reform is complex and requires a collaborative effort between government, health services, consumer groups and education providers. Importantly, many of the current recommendations called for changes that require implementation at an educational level. Not long after the recommendations from the Commission, Deakin University began engaging key stakeholders to design and develop a new suite of postgraduate MHN degrees.

What resulted during the consultations included identification and mapping of MHN skills, shortfalls and needs. Consultation with consumers and carers was also undertaken to codesign units that facilitate collaboration, service user buy-in and are representative of their unique needs. As a result of this stakeholder engagement, the School of Nursing and Midwifery at Deakin University has developed a contemporary, dynamic, and person-centred curricula that provides the knowledge and skills necessary to implement quality service provision necessary to deliver recovery-oriented care in a mental health setting.

We need a mental health system that is not just surviving but is *thriving*. We need a system where nurses can enact positive change, influence policy and be leaders. It is crucial that MHNs have the skills and knowledge to advocate for both consumers and provide quality evidence-based care. MHNs must be competent *and* confident in their clinical skills and compassionate, sensitive, and passionate about supporting people living with mental illness. To achieve this, we need nurses to engage in postgraduate education that is dynamic, responsive, contemporary, and practical. Deakin's suite of MHN degrees have been developed by educational experts in consultation with industry experts, consumers, carers, and supporters.

Figure 1: Study an online Master of Mental Health Nursing at Deakin University

Mental health nurses utilise advanced therapeutic communication skills to undertake complex mental health assessments

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Transforming Alcohol and Other Drug use education through co-design

By Mark Goodhew, Megan Moses and Jo River

Alcohol and Other Drug (AOD) use is a significant public health issue in Australia and worldwide.

In 2021, around 275 million people used substances, an increase of 22% since 2010.[1] Substance use can lead to significant harm, with an estimated 11.8 million deaths annually[2] attributed mainly to opioid-related deaths.[3] Substance use is also associated with hospitalisation from harms such as overdose, liver-related disease, injury and mental distress.[4] As the largest workforce, nurses are well-positioned to help reduce the harms associated with substance use.[5] However, they are often ill-prepared, as they receive little AOD education[6] and can hold stigmatising views of people who use substances that reflect broader community stereotypes,[7] causing people who use substances to avoid health services or discharge themselves from treatment prematurely.[8]

We report here on a phased co-design project to improve AOD education for nurses. There has been a recent turn towards co-designed education as a means of improving the attitudes and caregiving of health professionals.[9] It is an approach where people with lived experience partner in designing education, research and/or service development.[10] Research indicates that education co-designed with people from marginalised populations better prepares nurses to provide inclusive, collaborative and person-centred care.[11,12]

Co-designed AOD education that includes the input of people who use substances will enable nurses to provide evidence-based clinical care that reflects the actual needs of people with lived experience.

Considering this, in 2019, we embarked on a phased co-design project to improve AOD education for nurses and other healthcare clinicians. In the first phase, people with lived experience of AOD and health service use, clinical nurses, and academics partnered to co-design, co-deliver and co-evaluate an undergraduate nursing AOD subject.[13]

Delivered in 2021 and 2022, the evaluation indicated that the co-designed education supported trainee nurses to understand and appreciate the impact of stigma on people who use substances and how to recognise and undertake inclusive, collaborative, harm-reduction and trauma-informed care.[14] In the second phase, we co-designed AOD education modules for nurses in clinical practice, as well as other AOD clinicians, and evaluated the co-design process. Table 1 outlines the three co-designed modules, and the findings are being drafted for publication. In phase three, we will co-deliver and co-evaluate the co-designed clinical education across four health districts to determine the impact on clinicians' attitudes towards people who use substances and their motivation to work collaboratively and in a harm reduction model.

Given the turn towards co-design, co-designed AOD education will likely become the new norm for the design and delivery of training to nurses and other health clinicians, potentially impacting care provision and health outcomes for people who use substances. Notably, co-designed education could support nurses and other clinicians to provide more humanistic, collaborative and person-centred care that better reflects the needs of people who use substances and shift the current status quo in health services.

TABLE 1: Co-designed AOD Education Program's Modules

MODULE 1	MODULE 2	MODULE 3
AOD and service use from a lived experience perspective, including: • The origins and impacts of stigma and discrimination • Inclusive language for AOD service provision • The relationship between AOD use, complex trauma and the social determinants of health	Best-practice approaches to the care of people who use AOD, which include: • Building a therapeutic alliance with people who use AOD • Trauma-informed care and practice • Harm reduction principles and practice	Collaborative, therapeutic and person-centred AOD assessments and care planning, including: • Strengths-based care planning • Goal setting, prioritisation and review for clinical skills that promote help-seeking and harm-reduction

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Whose recovery: Yours or mine?

By Rinlita Chatwiriyaphong, Rebecca Bosworth, Grant Kinghorn and Lorna Moxham

Nurses working in hospital settings are very familiar with the dominant medical model, which focuses heavily on diagnosis, pharmacology, and treatment for people living with mental illness.

This traditional approach to care has previously paid less attention to individual needs. Using the medical paradigm in mental health practice may make sense for helping to address clinical symptoms and biomedical treatment, including pharmacology and electroconvulsive therapy (ECT).[1,2] However, a biomedical approach contributes to seeing consumers primarily through the lens of their diagnoses, rather than viewing them as whole persons with unique experiences.[3] The biomedical approach positions the clinician as the expert. Possessing expertise through learned mental health knowledge though, does not mean that clinicians are an expert in the consumer's journey, which is highly individual and personal. This raises the question: whose recovery is it- yours or mine?

In Australia, the recovery-oriented approach has been a national framework for mental health professionals and services in delivering care that supports an individual's recovery.[4] This shift in perspective regards and values mental health consumers as 'experts' in their own experience and recovery journey, resulting in staff moving away from the traditional 'expert' role. In this regard, a systematic review,[5] explored the experiences of healthcare professionals regarding recovery-oriented care in mental health inpatient units. Outcomes showed that developing a safe and hopeful space for consumers was reported as an important part of recovery-oriented practice within acute care environments. The necessity of creating a safe space, was inclusive of both physical and emotional safety. Helping people feel safe can be achieved through therapeutic relationships that involve interacting with consumers as whole people, not just as diagnoses, and by using both verbal and non-verbal communication to build trust and rapport. Verbal expressions of hope and optimism are crucial to support mental health recovery for consumers. The change in focus, therefore, to a more person-centred and recovery-oriented approach necessitates considering whose recovery it is anyway – the consumer's or the nurse?

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Is it acceptable for nurses to cry with patients and their families?

By Brent Hayward

Nurses frequently support patients and their families when they are crying. It is often just considered 'part of the job'. But is it acceptable for nurses to cry with patients and their families?

A memorable occasion in my professional life exposed the reality of this. I became tearful with a parent when she began crying following the death of her child. I was aware of my welling tears, but I could not disengage with her at this critical time in our engagement. So, I adjusted my spectacles and wiped the tears away while we continued talking about this significant change in her life.

While the emotional expression of nurses is often reported positively in the media,[1] we know little about the experience of mental health nurses crying. A systematic narrative review was conducted which identified 17 records,[2] including three from Australia.

The mental health nurses in these studies interpreted their crying differently, however crying and not crying served similar personal functions for their emotional management and relationships with patients.

Crying while practicing mental health nursing does occur, but few nurses openly acknowledge it, perhaps contributing to its lack of discussion in the literature or elsewhere. The literature identified in this review is startlingly limited when we consider the nature of mental health nursing, which includes promoting wellbeing and ameliorating emotional distress.

The review has identified two opportunities for mental health nursing education. The first is to deliberately address nurse crying in the context of the nurse-patient relationship so that novice mental health nurses can prepare themselves for situations where they may cry. The second is the inclusion of psychotherapeutic competencies in postgraduate mental health nursing education as the scope of mental health nursing expands beyond serious mental illness.[3] This will ensure that mental health nurses are prepared to deliver therapeutic supports to people with a wide range of needs, and mental health nurses can effectively reflect on and manage their own crying.

Importantly, nurses of all specialisations should not worry if they cry with a patient or their family member. Crying means that you are congruent with your feelings and are authentic. We can't be any other way in our therapeutic relationships with patients and their families.

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Supporting mental health nursing workforce recruitment: Considerations for undergraduate nursing curriculum

By Eileen Petrie, Paul Cooper, Nicole Snaith, Raymond Tini, H Dafney and K Tori

The challenges created, in part, by the movement towards community-based mental health services across Australia in the late 1990s[1] and the underinvestment in workforce projections, coupled with outdated services, have resulted in increasing demand on an already ailing sector of the healthcare system.[2]

Compounding the situation there is a critical shortage of mental health clinicians, especially nurses, to address the growing need for mental healthcare services for consumers, families/caregivers.[3] The lack of sufficient mental health services translates into extended wait times, diminished access to care, and exacerbation of broader social issues, and is even more dire in geographically rural communities where services are less available than in urban areas. The scarcity of mental health professionals has resulted in marked disparities in quality healthcare access.[4]

While there are many factors associated with the high turnover of the mental health workforce research demonstrates that elevated burnout, stress, job dissatisfaction, an ageing demographic, and retirement of the current workforce also contribute significantly to anticipated staffing shortages.[5,6] The experience, skills, and capabilities of the current mental health professional workforce will not be easily replaced, potentially to the detriment of the provision of high-quality mental healthcare for consumers.

The shortages of the mental health nursing workforce will also adversely affect the professional socialisation and mentoring of future mental health graduates. Effectively, there may be a causal relationship to the decreased professional mentoring opportunities for the neophyte mental health graduate's professional development and consolidation of skills and knowledge[7] if there simply are not enough mental health clinicians.

Exacerbating the situation further it is mooted that there is a perceived decreased mental health focus, both for theoretical and clinical placement opportunities, in contemporary pre-registration degrees. Not only does it seem that clinical placements have been removed from some undergraduate curriculums upon undertaking an environmental scan of mental health offerings in pre-registration nursing courses, but it would also appear that the theoretical component may not be as robust as in previous curricula. Although it is recommended that experiential learning should provide authentic learning as a key factor in the nursing student's formation of knowledge[8] this is seen as ensuring a 'fit for purpose' curriculum[9] it would appear mental health content is being eroded from undergraduate curriculum. Although integrating mental health education into nursing programs equips future nurses with the necessary skills and knowledge and addresses the urgent need for a competent and sustainable mental health workforce, it would seem the emphasis is on the acute care competencies rather than teaching the fundamentals of mental health nursing. A comprehensive approach, encompassing all the theoretical and clinical experiences in mental health nursing, not only enhances patient outcomes and strengthens mental healthcare delivery across diverse healthcare settings, but encourages new graduates into the specialty field of mental health. Contemporary education approaches must be central to building a sustainable mental health workforce.[10] As such a closer look at what is contained in undergraduate nursing curricula from a national mental health perspective is not only warranted but timely.

(The authors are currently researching the core mental health components embedded in undergraduate curricula, nationally, and have completed an environment desktop scan soon to be published)

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Co-creating safety plans with people experiencing suicide-related distress

By Monika Ferguson, Heather McIntyre, Kate Rhodes and Nicholas Procter

Suicide is the leading cause of death for Australians aged 15-49 years.[1] It has profound and long-lasting impacts for individuals and communities.

Many people who die by suicide have contact with a health service prior to their death, suggesting nurses and midwives are often at the forefront of care for people experiencing suicide-related distress.

Nurses and midwives have skills in compassionate, person-centred care[2] to engage in suicide prevention strategies. One strategy gaining popularity is safety planning. Originally used in the US, to assist veterans presenting to health services in suicide-related distress,[3] safety planning involves the co-creation of a personalised list of coping strategies that a person can use when they notice signs of suicidal thoughts. It has six components:

1. recognising warning signs;
2. identifying and employing internal coping strategies;
3. social supports for distraction;
4. identifying trusted family or friends who can help;
5. contacting details of specific mental health services; and
6. reducing lethal means.[3]

Safety planning is very flexible and can be used by any health professional, in collaboration with the person and ideally their loved one/s. It can be done in person or virtually; in hard copy, or using the Beyond Now app,[4] to keep and share a digital copy. It can be created immediately in one conversation, so that people have strategies in place while waiting for formal support. Ideally though, it forms the basis of ongoing conversations, along with other therapeutic supports. Various guides exist for personalising safety planning for specific groups, such as young people,[5] and those in the perinatal period.[6]

Our team from the Mental Health and Suicide Prevention Research and Education Group, at the University of South Australia, has been building a body of work related to safety planning. We have conducted systematic reviews of international evidence to understand the impact and experiences of safety planning. In our first review,[7] we found quantitative evidence that safety planning is associated with improvements in reducing suicidal ideation, depression, and hopelessness, while increasing treatment attendance, plus fewer hospitalisations. We are now working on a qualitative systematic review, to understand peoples' lived experiences with safety planning.

We also conducted a national, qualitative study to understand how staff/volunteers who care for people of refugee and asylum seeker background use safety planning. We found that safety plans enabled a 'collaborative activity involving equal contribution from the worker and the client with both acknowledging that the client is the expert in their own life'.[8] More recently, we have a project underway with emergency department nurses and medical officers, where we have delivered safety planning training and are evaluating its impact at two South Australian hospitals.

So far, our research is telling us that many people are using safety planning, and that nurses and midwives are well-equipped to support people with this suicide prevention strategy. We encourage them to learn more about it and see if it is useful in their areas of practice.

SUPPORTS

If you or someone you know needs help, these 24/7 services are available:

Lifeline: 13 11 14
Suicide Call Back Service: 1300 659 467
13YARN: 13 92 76

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Enhancing mental healthcare in Emergency Departments: The role of technology

By Ngoni Jeranyama, Paul Cooper and Raymond Tini

Clinicians working in the fast-paced environments of Emergency Departments (EDs) face significant challenges in providing comprehensive nursing care for consumers presenting with mental health and substance use disorders. The high volume of mental health (MH) consumers, combined with limited resources, often leads to gaps in mental health support. However, integrating technology such as virtual reality (VR) and AI-powered chatbots, as evidenced by their successful use in other areas of healthcare, can significantly enhance support for individuals with these conditions, improving outcomes and experiences of services.

The use of VR technology has emerged as a powerful tool in mental healthcare, offering immersive experiences that can help modulate symptoms of anxiety, PTSD, and other mental health conditions. VR provides patients with controlled, calming environments that can reduce stress and agitation while the consumer is still waiting for medical review and subsequent review by ED psychiatric teams. Research has demonstrated VR's effectiveness in clinical settings, showing significant reductions in anxiety and improvement in patient comfort.[1] While VR is not yet widely used in EDs, its potential for sensory modulation could help stabilise patients before further assessment and treatment. Incorporating VR in emergency departments could create a more therapeutic environment, helping with the de-escalation of individuals experiencing acute mental health crises.

For instance, in psychiatric settings, VR has been used to help patients with anxiety disorders by exposing them to virtual environments where they can practice coping strategies in a controlled and safe manner. This technology could be adapted for use in EDs to provide immediate calming effects for patients experiencing severe anxiety or agitation, potentially reducing the need for sedative medications.

AI-powered chatbots represent another innovative solution that has shown promise in enhancing mental healthcare. These chatbots can engage with patients through text or voice interactions, providing immediate support and gathering critical information about their mental state. Studies have shown that chatbots like Woebot, which deliver cognitive-behavioural therapy (CBT) techniques, can effectively reduce symptoms of depression and anxiety.[2] While not yet commonplace in EDs, chatbots could be used for initial mental health screenings, helping to triage patients and prioritise those in need of urgent care.

In other healthcare settings, chatbots have been successfully used to provide psychological support and monitor patient symptoms in real-time. Implementing chatbots in the ED could streamline the triage process, allowing for quicker and more informed decision-making. Chatbots can also offer real-time support, providing coping strategies and calming techniques to individuals experiencing acute distress while they wait for further evaluation.

IMPROVING ACCESS AND CONTINUITY OF CARE

The integration of VR and chatbots not only enhances immediate care in the ED but also improves access and continuity of care. These technologies can bridge the gap between initial emergency treatment and ongoing mental health support. For example, patients introduced to chatbot applications during their ED visit can continue using these tools after discharge for ongoing support and monitoring. This continuity ensures that patients have ready access to services and receive consistent care, which can prevent ED representations or inpatient admissions due to mental health crises.

Though we have not yet implemented these technologies in our ED, literature from other areas of mental and physical healthcare suggests significant potential benefits. For example, in community mental health services, the use of VR and chatbots has improved patient engagement and adherence to treatment plans, highlighting their value in enhancing overall care delivery.[3,4]

CONCLUSION

The use of technology, such as virtual reality and AI-powered chatbots, represents a significant advancement in the delivery of mental healthcare in emergency departments. Although we have not yet implemented these technologies, their successful use in other areas of healthcare demonstrates their potential to enhance immediate support for patients and improve overall access and continuity of care. As technology continues to evolve, its integration into mental health services will become increasingly important, offering innovative solutions to the challenges faced by healthcare providers in the ED. Utilising these innovations has the potential to provide better support for MH consumers and improve overall health outcomes.

The authors are currently conducting a systematic review on the use of VR and chatbots in mental healthcare, which will soon be published.

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Developmental screening tools in adolescent period in relation to mental health and Alcohol and Other Drug (AOD) use

By Annabel Axford and Paul Cooper

Adolescents between 10 and 19 years of age, are at a pivotal stage of health development marked by curiosity, experimentation, self-discovery; this period of development is often when many young individuals have their initial experiences with alcohol and other drugs (AOD).[1-3]

The connection between AOD use and adolescent mental health is complex and associated with the distinct vulnerabilities and difficulties; half of all lifetime lifelong mental health conditions beginning during this age group.[3,4] For some adolescents, AOD use can serve as a method of self-exploration, or a way to assert their independence as they formulate their own identity and to seeking social acceptance with peer influences and pressures. However, these behaviours come with inherent risks.[5,6]

The relationship between AOD use and mental health is bidirectional and associated with vulnerabilities and/or internalising or externalising behaviours. This is further complicated by the impact of adverse childhood experiences (ACE) and the presence of complex developmental trauma.[5,7-9]

Adolescents who have experienced ACE and/or trauma may be more likely to use substances as a coping mechanism, potentially leading to a pattern of harmful use.[3,10]

Equally, adolescents with mental health conditions may in turn use AOD as a form of self-medication as a self-soothing strategy or escapism, which can further complicate their mental health status, to manage their vulnerabilities or trauma.[3,11] ACE and trauma increase the risk of mental health conditions developing and substance use can exacerbate existing mental health issues or trigger the onset of conditions such as post-traumatic stress disorder (PTSD) anxiety, depression or psychosis. This can lead to a vicious cycle, where AOD use worsens mental health symptoms, which in turn increases substance use and/or addiction.[4,10-12]

A 'therapeutic use of self' approach is an essential part of adolescent mental health work, as it is important to have a sense of awareness of one's own wellness to be able to connect with others in a therapeutic relationship.[13,14] Therapeutic relationships can impact the quality of the healthcare; therefore, it is important nurses adopt a holistic and trauma-informed care approach that considers developmental issues and mental health when caring for an adolescent.[3,15-17] When adolescent substance use becomes problematic, the nurse should use validated developmental screening and assessment tools to assist with engagement, selecting the most appropriate mental health and AOD care and interventions necessary for the adolescent; these can include psychoeducation and/or counselling referral and follow ups.[5,18-22] These age-appropriate tools can assist nurses to understand the complexities experienced by an adolescent to better support them in navigating this critical period in their lives (see Appendix).

APPENDIX

The table opposite lists some commonly used developmental mental health and AOD tools that nurses can consider within the adolescent period. It's important to remember that these tools are not in isolation and should be used as part of a comprehensive assessment and require clinical nursing and organisation judgement and decision-making processes as part of choice and use in any clinical setting.[15]

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Available on request

Tool	Description	Components	Recommend Age
Mental Health Tools			
HEEADSSS[23, 24]	A psychosocial assessment that is to initiate dialogue with adolescents about their health concerns and relationships including AOD use and risk-taking behaviours.	Includes probing open-ended questions focused on empowering adolescents to contribute to the creation of suitable strategies that prevent harmful actions both presently and into the future.	Between 12-25 years
HEADS-ED[25–27]	Two rapid psychosocial assessment mental health screening tools for Emergency Department use based on infant, children, adolescents and youth. Please note that the HEADS-ED is a screening tool and is not intended to replace clinical judgement.	Each of these tools include seven domains, incorporated into the acronym HEADS-ED with score of 0, 1, or 2 and is assigned for each psychosocial variable to obtain a total score.	HEADS-ED Under Six (birth to 6 years) HEADS-ED Over Six (6 to 21 years)
Preferred Alcohol and Other Drug (AOD) Tools			
CRAFFT 2.1[28–32]	A developmental and behavioural screening tool for adolescents for AOD misuse. *Note: It is recommended to complete the CRAFFT Screening Tool before proceeding to other tools.	Consists of a series of curious six open ended questions.	Between 12-17 years
CRAFFT 2.1+N[33]	A developmental and behavioural screening tool for adolescents for AOD misuse (related to tobacco and nicotine use).	Consists of a series of curious six open ended questions with +N version which contains additional questions about tobacco and nicotine use.	Between 12-17 years
Alcohol, Smoking and Substance Involvement Screening Test – Young People (ASSIST-Y)[29,35–39]	The ASSIST-Y was initially developed by the International World Health Organization to detect and manage substance use and related problems in primary and general medical care settings. The modified developmental versions of the ASSIST tool specifically designed for young people aged 10-14 and 15-17 years. *Note: It is recommended to complete the CRAFFT Screening Tool before proceeding to ASSIST-Y.	Consists of a series of single frequency question for types of substances, present and past usage of substances and relationship of substance use to detect and manage substance use and related problems in adolescents.	Version one: Between 10-14 years Version two: Between 15-17 years.
Drug Abuse Screening Test for Adolescents (DAST-A)[28,29,40–42]	Modified version to the DAST-10 developmental screening tool for assessing adolescent drug use and related problems. It provides a comprehensive overview of drug-related behaviours, experiences, and issues by exploring various substances, usage patterns, consequences and personal perceptions. *Note: It is recommended to complete the CRAFFT Screening Tool before proceeding to DAST-A.	Consists of a 28-item questionnaire and provides a structured format for screening and evaluating substance abuse among adolescents.	Adults and older youth (18-25 years)
Additional Alcohol and Other Drug (AOD) Tools			
Substance and Choices Scale (SACS-ABC)[43–45]	A developmental screening and assessment tool that aids in identifying adolescents who may be at risk of AOD issues and a guide for suitable interventions by providing guidance for brief interventions, additional treatment, and potential referral pathway.	Consists of a series 12 AOD type questions and 10 questions on thoughts and behaviours.	Between 13-18 years
Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD) and Screening to Brief Intervention (S2BI)[46,47,48]	Developmental screening tools for tobacco, alcohol and other drug use, identify risky substance use by adolescent and utilised to transition from the screening process to a brief intervention.	Consists of a series of single frequency questions for past year's use of the three substances most used by adolescents i.e. tobacco, alcohol and marijuana.	Between 12-17 years
Alcohol Use Disorders Identification Test (AUDIT)[29,42,49, 50]	A screening tool to assess alcohol consumption, drinking behaviours, and alcohol-related problems. It is more effective when used with adolescents and young adults. *Note: Due to the prevalence of substance use among adolescent and young people, it is more beneficial to initially conduct a broader screening for substance use i.e., CRAFFT Screening Tool, rather than focusing solely on alcohol use.	Consists of 10-item focus questions to assess alcohol consumption, drinking behaviours and alcohol-related problems. *Note: Alcohol Use Disorders Identification Test-Concise (AUDIT-C) is a modified version which includes three screening questions for risky drinkers or active alcohol use disorders (including alcohol abuse or dependence).	Older adolescents and people aged 18 years and over.

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.

Mushroom and lentil sausage rolls

Prep time 30 mins **Cook time** 30 mins **Portions** 24

INGREDIENTS

FILLING
25ml extra virgin olive oil
1 onion (130g), chopped
2 garlic cloves, minced
1/2 tbsp (2g) fresh thyme leaves
15g butter
150g mushroom, cut into 6
1 (80g) carrot, grated
20g flat leaf parsley chopped
90g cooked brown lentils
80g rolled oats
¼ cup (20g) bread crumbs or ground almonds
80g Persian fetta
1 egg
Sea salt flakes
Ground black pepper

2 sheets butter puff pastry
1 egg yolk, splash of milk
Sesame seeds (optional)
Tomato chutney to serve

METHOD

1. Pre-heat a fan-forced oven to 220°c
2. Line 2 oven trays with parchment paper.
3. Place a medium saucepan over medium heat, add olive oil and chopped onion, cook for five minutes
4. Add garlic, thyme, some salt and butter, cook for a further three minutes until the onion is translucent and soft.
5. Increase the heat to high, add chopped mushrooms and cook until soft, reduce the heat to medium low, stir occasionally until all the liquid is evaporated.
6. Remove from the heat and place the mix into food processor, along with remaining filling ingredients. Pulse gently until the mix is brought together, retaining some texture, check the seasoning.
7. Place sheets of puff pastry onto a lightly floured surface and cut each in half, so you have four pieces in total.
8. Brush each top and bottom edge of the pastry with egg yolk and milk mix.
9. Place a quarter of the mushroom and lentil mix in a long even line. Using pressure, roll the puff pastry around the filling, finishing so the yolk brushed edge is on the bottom of the roll.
10. Place on the prepared trays and repeat with the remaining sheets.
11. Brush tops with egg yolk and milk mix (and sesame seeds if using).
12. Place into preheated oven and bake for 20 minutes until lovely and golden, reduce the heat to 190c and cook for a further 10 minutes.
13. Transfer to a cooling rack, cut and serve with chutney.

Food styling + photo by Erika Budiman © pixelsandpaper.studio

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

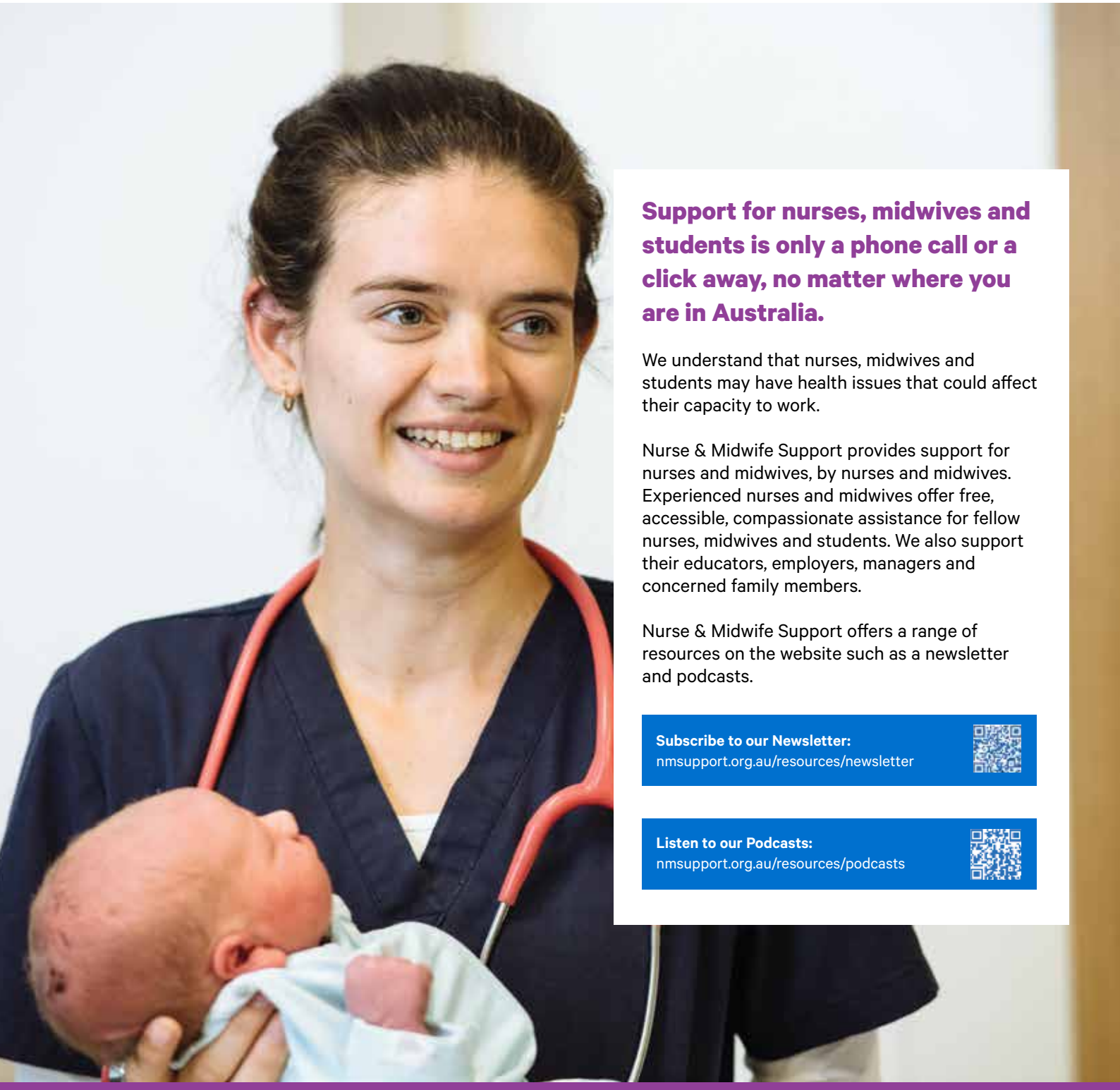
Send a photo of you and your creation from this issue, and in a sentence, let us know what you liked about It. If we pick your entry, we'll publish it in the next *ANMJ* and reward you with a $50 Maggie Beer voucher. Send your entry to: **healthyeating@anmf.org.au**

Nicely done Michelle, on making Maggie's Pumpkin, ginger and date scones, published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"Maggie Beer's Pumpkin, ginger and date scones are light, fluffy, and with hidden goodness that tastes superb and feeds a family! says Michelle.

Nurse & Midwife Support

Your health matters



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