ANMJ

AUSTRALIAN NURSING & MIDWIFERY JOURNAL

VOLUME 28, NO.7
JAN–MAR 2025

ANMF *PRIORITIES* 2025

A PUBLICATION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

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Annie Butler

ANMF Federal Secretary

As we step into a new year, I want to take a moment to reflect on the incredible work we've achieved together and share how we plan to continue building on this momentum. The Australian Nursing and Midwifery Federation (ANMF) remains steadfast in its commitment to improving the lives of nurses, midwives, care workers, and communities across the country.

Looking back, 2024 was a landmark year for the ANMF. Together, we celebrated a century of advocacy, solidarity, and progress, culminating in the powerful documentary that captured the union's transformative journey (now available on the ANMF website). Beyond this milestone celebration, we achieved significant advancements in our key areas of advocacy.

In aged care we saw significant reforms including historic wage increases for care workers marking a long-overdue acknowledgment of their dedication and professionalism. Alongside these gains, new regulations mandating registered nurses to be on-site 24/7 and the introduction of mandated care minutes for residents have begun to reshape aged care standards.

Over the past two years, the ANMF and the union movement have secured landmark reforms, including the *Closing Loopholes* and *Secure Jobs, Better Pay* Acts. These introduced vital protections such as the right to disconnect and improved conditions for casual and 'employee-like' workers. Meanwhile, the ANMF's Aged Care work value case resulted in significant wage increases for aged care nurses and assistants in nursing (AINs). In 2025, we aim to build on this progress with a second work value case to raise minimum wage rates for all award covered registered nurses (RNs), midwives, enrolled nurses (ENs), and AINs outside the aged care sector.

The ANMF has also been working with the federal government and other nursing and midwifery organisations to ensure nurses and midwives can work to their full scope of practice, particularly in primary health services.

While there is still progress to be made, reforms such as the removal of collaborative arrangements for nurse practitioners and endorsed midwives represent steps in the right direction. Additionally, the federal government's *Unleashing the Potential of our Health Workforce – Scope of Practice Review* has made several recommendations that could significantly improve accessibility for health consumers.

The ANMF has welcomed proposals for nurse practitioners, remote area nurses, and endorsed midwives to make direct referrals to medical specialists.

Many of the review's recommendations align with the ANMF's position on introducing innovative, multidisciplinary, nurse- and midwife-led models of care. The ANMF is now urging the government to fund these transformative models to improve healthcare access across the country.

Achieving gender equity remains central to the ANMF's mission, reflecting the predominantly female composition of our workforce. While progress has been made – such as reducing the gender pay gap to 11.5% and achieving record-high women's workforce participation at 63.2% – systemic challenges persist. Key wins include legislating gender equality in the *Fair Work* Act, banning pay secrecy clauses, expanding paid parental leave to 26 weeks by 2026, and introducing superannuation on paid parental leave from 2025. Despite these advancements, the ANMF continues to advocate for policies addressing lifetime earning inequalities for women, including promoting workplace flexibility, leadership opportunities, and equity across all sectors.

These victories are a testament to the strength of our collective voice and the unwavering dedication of our members. But as always, there is more work to be done.

In 2025, we will build on these achievements and push for further reforms. We will renew our focus and call on all members to continue standing together. Whether you're on the front lines of care, leading advocacy efforts, or supporting your colleagues, your voice is invaluable.

Together, we have made nursing and midwifery stronger and safer. Together, we can meet the challenges ahead and create the future we want for ourselves and the communities we serve.

For more on our priorities, see this issue's feature article.

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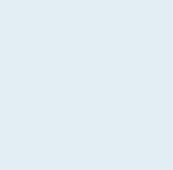

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Printing: IVE Group
Distribution: D&D Mailing Services

The *Australian Nursing & Midwifery Journal* is delivered free quarterly to members of ANMF Branches other than New South Wales, Queensland, Western Australia and ACT. Subscription rates are available via *ANMJ*admin@anmf.org.au. Nurses and midwives who wish to join the ANMF should contact their state or territory branch. The statements or opinions expressed in the journal reflect the view of the authors and do not represent the official policy of the Australian Nursing & Midwifery Federation unless this is so stated. Although all accepted advertising material is expected to conform to the ANMF's ethical standards, such acceptance does not imply endorsement. All rights reserved. Material in the Australian Nursing & Midwifery Journal is copyright and may be reprinted only by arrangement with the *Australian Nursing & Midwifery Journal*

Note: *ANMJ* is indexed in the cumulative index to nursing and allied health literature and the international nursing index
ISSN 2202-7114
Online: ISSN 2207-1512

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.

ANMJ is printed on A2 Gloss Finesse, PEFC accredited paper. The journal is also wrapped in post-consumer recycled (PCR) plastic.

Correction: The middle photo on page 23 of the October–December 2024 issue (Vol. 18, No. 6) was incorrectly captioned. It should have read: ANMF Vic Branch picket.

We apologise for the oversight.

PCR – Post Consumer Recycled

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

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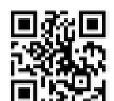

Aged care resources for Forgotten Australians

New resources to help aged care clinicians in the delivery of trauma aware services for Forgotten Australians are now available.

There are 500,000 Forgotten Australians and Care Leavers who as children, were placed into institutional and out-of-home care in Australia in the last century. The idea of requiring care as they age can be deeply retraumatising as their experiences as children in care were often traumatic.

The Helping Hand resources give practical information about the questions they can ask and what to expect in aged care. People who identify as Forgotten Australians or Care Leavers co-designed the training and resources.

The freely available resources and training benefit educators, managers, and senior clinicians in aged care into the delivery of trauma aware services.

helpinghand.org.au

Life expectancy rates lower due to COVID fallout

Life expectancy in Australia has fallen slightly for the second straight year.

A boy born today is expected to live to 81.1 years and a girl to 85.1 years, according to the Australian Bureau of Statistics (ABS) data.

The years 2021-2023 saw the highest number of COVID-19 deaths with 15,982 in Australia, which was up by 4,100 from 2020-2022. As a result, life expectancy has fallen by 0.1 years for men and 0.2 years for women over this period.

Australians still have a higher life expectancy than many comparable countries, like New Zealand, the United Kingdom, the United States of America, and Canada.

The Australian Capital Territory had the highest male life expectancy of 81.7 years, followed by Western Australia (81.6 years) and Victoria (81.5 years).

The Australian Capital Territory and Western Australia had the highest female life expectancy (85.7 years), followed by Victoria (85.4 years) and New South Wales (85.2 years).

‘RIGHT TO DISCONNECT’ NEW WORD OF THE YEAR

The new Right to Disconnect law has scored a nod in the Macquarie Dictionary’s 2024 Word of the Year, re-affirming the importance of helping Australians to improve their work-life balance.

The Macquarie Dictionary committee awarded ‘Right to Disconnect’ an honorary mention in their list of this year’s top new words to enter the dictionary.

The Right to Disconnect: noun a law which grants employees the right to not work or be contacted about work during non-work hours.

‘The lines between work and our private lives have become blurred, especially with the growth in working from home during and after COVID. Making the right to disconnect a federal legal reality was a recognition of this,’ noted the committee.

Other honourable mentions included: rawdogging (undertaking a long-haul flight with no electronic entertainment or reading material), brainrot (low quality content viewed for extended periods, especially on social media) and social battery (your energy reserve for engaging in social interactions).

macquariedictionary.com.au/woty-2024/

Health spending in Australia returns to pre-pandemic levels

Australia's health spending has returned to pre-pandemic levels, with a total expenditure of $252.5 billion spent on health goods and services in 2022–23, or $9,597 per person.

Recently released reports from the Australian Institute of Health and Welfare (AIHW) provided a snapshot of the nation's health spending and the sources of funding for goods and services.

A decrease in government spending during 2022-23 was largely associated with reduced spending related to the COVID-19 pandemic, such as vaccines and personal protective equipment.

Primary healthcare spending fell by 8.2% to $83.3 billion, indicating a reduction in pandemic-related public health spending such as on the vaccine rollout, rapid antigen tests and PPE. Hospital expenditure rose 4.7% to $107.1 billion, driven by increased hospitalisations and patient admissions post pandemic.

Of the $172.3 billion in health spending that could be directly attributed to disease and injury in 2022–23, cancer was the highest-cost disease group at $18.9 billion, followed by cardiovascular diseases ($16.2 billion) and musculoskeletal disorders ($15.9 billion).

Chronic conditions made up almost half (48%) of disease-related spending, totalling $82 billion. The most expensive chronic conditions were osteoarthritis ($4.9 billion) and back pain ($3.9 billion). However, injuries from falls were the most expensive of the disease conditions with expenditure of $5.1 billion in 2022–23.

Superannuation legislated as workplace right

Unions have welcomed legislation to safeguard Australian workers' super and wages in retirement.

The objective of Superannuation law confirms that superannuation is a workplace right, preserved until retirement. Future governments will have to demonstrate to the Australian people how they are safeguarding and advancing Australians' retirement incomes and not undermining the core pillars of super.

It will help to safeguard the retirements of Australians for generations to come, said Australian Council of Trade Unions Assistant Secretary, Joseph Mitchell.

"Workers know super is a key workplace right and is for your retirement, the legislated objective of super confirms and solidifies the Australian community's understanding that super should be preserved, equitable and sustainable."

Biggest increase in registered practitioners in four years

The number of registered health practitioners in Australia has exceeded 900,000 for the first time, Ahpra's 2023/24 annual report has revealed.

At 30 June this year, there were 920,535 registered health practitioners in Australia, a 4.9% increase on the previous year. This means there are now 3.4 registered health practitioners for every 100 Australians.

Ahpra says it is continuing to work hard to get more international practitioners registered faster and safely by implementing changes in response to the Kruk review. Improvements to its registration processes have almost halved the time to finalise international applications, cutting the previous 60-day average to just 33 days.

Meanwhile, maintaining a balance between access to needed healthcare and the risk posed by some emerging models of care is another of its key priorities amid the rise of telehealth, online prescribing and direct-to-consumer health services.

The annual report shows notifications about practitioners increased 14.2% over the past financial year, with 19,522 notifications received nationally by Ahpra and co-regulatory agencies. Of those, Ahpra managed 11,200, an increase of 15.4%. Concerns about the standard of clinical care provided by practitioners accounted for 34.7% of all notifications received by Ahpra.

HISTORIC MOMENT: Former and current federal secretaries unite for ANMF's 100-year celebration

For the first time, five former Federal Secretaries joined current leaders Annie Butler and Lori-Anne Sharp at the official launch of the Australian Nursing and Midwifery Federation's (ANMF) 100-year documentary in Sydney late last year.

The event was a momentous gathering of ANMF members, officials, politicians, and leaders from peak nursing and midwifery bodies across the country. Emotions ran high as tears of joy, pride, camaraderie, and nostalgia filled the room. Attendees reflected on the union's incredible achievements over the past century.

The documentary celebrated the ANMF's pivotal role in key milestones, including the transition of nursing and midwifery education to universities, the establishment of national registration, and landmark industrial campaigns such as securing nurse-to-patient ratios.

Assistant Minister for Health and Aged Care, and former Federal Secretary, Ged Kearney, praised the ANMF's impact, saying, "It's made us stand straighter with our shoulders back. So very proud."

Victorian nurse practitioner Leanne Boase shared her heartfelt response to the screening: "It brought back so many memories. This is our history, our heritage. It makes me so proud of what we've achieved."

Minister Kearney emphasised the union's ongoing influence: "We're the biggest union in the country, a force for change, good, and progress."

Federal Secretary Annie Butler reflected on both the legacy and future of the ANMF, stating, "Marking 100 years is also a time to look forward. Our priorities include advancing workforce reforms, strengthening Medicare for equitable healthcare access, achieving full scope of practice for nurses and midwives, and advocating for gender pay equity."

"We've achieved so much over 100 years," Ms Butler concluded. "Where we are now, 100 years strong, I think our founders would be proud."

ANMF VIC Branch Assistant Secretary Madeline Harradence

NT Yvonne Falck and SA Nanette Lawson

ANMF Federal Secretary Annie Butler, with former Federal Secretaries Ged Kearney (current Federal Assistant Minister for Health and Aged Care), Lee Thomas, Jill Iliffe and Marilyn Beaumont.

Vic Hannah Sellers and Terry Swanson

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ANMF *PRIORITIES* 2025

The Australian Nursing and Midwifery Federation (ANMF) is focused on driving meaningful change in 2025 to ensure better conditions for nurses, midwives, carers, students; and to meet the health and aged care needs of the community.

Recognising the critical milestones we have already achieved like wage increases and mandated care minutes, we know progress is possible.

The ANMF's vision is to prioritise reforms that support recruitment and retention, empower nurses and midwives to work to their full scope of practice to ensure accessible and affordable healthcare, and deliver improved outcomes for women.

Robert Fedele and Natalie Dragon report.

ACCESSIBLE AND AFFORDABLE HEALTHCARE

While we celebrated the 40th anniversary of Medicare in 2024 commemorating the advent of universal healthcare in this country, there are many Australians for who accessible and affordable healthcare remains out of reach.

Cost-of-living pressures, service availability, rising out-of-pocket costs, and reduced bulkbilling GPs are hurdles to accessible healthcare for many coming into 2025.

According to the Australian Bureau of Statistics, three in 10 Australians delayed or did not go to their GP, when they needed to, during the 2022-23 financial year. Twice as many Australians delayed or deferred seeing a GP because of cost in 2022-23, with 7% of people doing so, compared to 3.5% in 2021-22.

Historically nurses, midwives and other disciplines have been locked out of providing the full scope of primary health services as autonomous practitioners. Australian communities feel the result of this constraint due to a shortage of independent primary healthcare providers.

The federal government's *Unleashing the Potential of our Health Workforce – scope of practice review*, has made several recommendations that will improve accessibility for health consumers. The ANMF has welcomed several key reforms including allowing nurse practitioners, remote area nurses and endorsed midwives, to make direct referrals for a wider range of procedures and services with MBS rebates.

The ANMF also supports the recommendation for a new 'bundled' payment for maternity services, including midwifery continuity of care models, traditional midwife plus medically led models, or GP shared care models.

The proposed payment model would enable the maternity care team to work to their full scope when they practice across different parts of the healthcare system, which currently operates under separate funding arrangements, and hence reduce inefficiencies caused by current MBS arrangements.

The government has introduced several new Medicare rebates to better support nurses and midwives to provide the care Australians need. Working in primary care is now more viable for nurse practitioners. The 30% increase in the MBS rebate has already impacted bulk billing rates, particularly for more vulnerable or disadvantaged people, improving access to primary healthcare.

Photo: Christopher Hopkins

"Nurses and midwives, who comprise the majority of the healthcare workforce, have the capacity, expertise, and education to vastly improve health equity and access for people living in all areas of Australia," said ANMF Federal Secretary Annie Butler.

Similarly, the removal of collaborative arrangements for nurse practitioners and endorsed midwives will improve access to services for those accessing their care, particularly in rural, regional and remote areas where access to GP services is limited. This provides equitable choice and access to PBS and MBS funded care where there are significant gaps in health access and outcomes.

"Many of the recommendations align with the ANMF's draft policies and submissions for the introduction of innovative multidisciplined and nurse-and-midwife-led models of care. We now look forward to working with the Albanese Government, other nursing and midwifery peak organisations and key stakeholders to deliver these reforms in 2025," said Ms Butler.

WINS

- Removal of collaborative arrangements for nurse practitioners and endorsed midwives
- Scope of practice recommendations that support nurses and midwives working to scope of practice with funding models to support this
- New Medicare rebates for nurse practitioners
- New Medicare services for endorsed midwives pre- and post-natal

ASKS

- Realise the full value of using nurses and midwives
- Enable modern models of health delivery
- Embed evidence-based workforce decisions in Australia's health system
- Fund nurse-led and midwifery-led models of care

GENDER EQUITY: CENTRAL TO THE WORK OF UNIONS

With a predominantly female membership, achieving gender equity is central to the work of the ANMF. While there has been an unprecedented focus by the current federal government towards gender equity, progress is not linear.

We have seen substantive wins for women overall this past year. The gender pay gap has dropped to 11.5% (from 13.3% in 2023) and women's workforce participation has risen to a record high of 63.2%.

Progress has been made in making gender equality an objective of the Fair Work Act, banning pay secrecy clauses, legislating for the Workplace Gender Equality Agency (WGEA) to publish gender pay gaps of employers with 100 or more workers, introducing a new positive duty on employers to prevent workplace sexual harassment and discrimination and increasing wages for aged care workers, a sector that is highly feminised and historically undervalued.

Recognition of women's health needs has come to the fore. The National Women's Health Advisory Council established in 2022 is addressing stark differences in health outcome for women and girls. A Senate Inquiry examining issues related to menopause and perimenopause has recommended the federal government consider introducing paid gender-inclusive reproductive leave in the National Employment Standards (NES) and modern awards to help people manage symptoms and a range of impacts. Queensland public sector nurses and midwives are now able to access 10 days paid reproductive leave, the state setting the bar for the rest of the country.

The ANMF and the superannuation industry welcomed the announcement this year for 12% superannuation to be paid on government-funded paid parental leave from 1 July 2025. In March, new laws were passed to expand the Paid Parental Leave (PPL) scheme to 26 weeks by 2026. These are significant wins: Australian women currently retire with an average of 25% less superannuation than men. Despite increased workforce participation, women are more likely to be engaged in part-time and casual work contributing to the stark gender pay gap in their retirement savings.

Gender equity is also about workplace policies. We know that flexible working arrangements are critical to support gender equality and women's leadership in the workplace.

The ANMF will continue to advocate for a national policy to address the diminished earning capacity throughout a woman's lifetime. Until this is achieved, inequalities between men and women will remain. We all benefit from having a society where women are equal, and able to fulfil their potential.

WINS

- Two weeks extra paid parental leave
- Superannuation on government-funded paid parental leave
- Banned pay secrecy contracts
- Stronger protections from discrimination and sexual harassment
- Right to flexible work for parents
- Family domestic violence leave

ASKS

- Gender pay equity and addressing gender-based undervaluation and gender pay gaps
- Reproductive health and wellbeing leave
- Models of secure employment, roster justice, and security and predictability of hours
- Strong flexible working arrangements with a right to revert to previous hours after a period of reduced hours
- Measures to address gender-based violence, including family and domestic violence, sexual harassment, discrimination and bullying
- Measures to assist workers returning to work from parental leave (such as paid lactation breaks and facilities)
- Women's health reform

WORK VALUE 2: THE NURSES' AND MIDWIVES' CASE

In the past two years, the ANMF and union movement have won the biggest changes to workers' rights and conditions seen in generations.

Industrial relations reforms, achieved through Closing Loopholes and the Secure Jobs Better Pay Act, helped deliver new right to disconnect laws, better protections for union delegates, and new minimum standards and protections for 'employee-like workers' and casuals, just to name a few. Meanwhile, the ANMF's landmark Aged Care Work Value Case at the Fair Work Commission (FWC) secured significant wage increases for nurses and AINs working across the sector.

Winning pay rises for aged care workers was just the beginning. In 2025, the ANMF will shift focus to its second Work Value Case, which seeks to vary the *Nurses Award 2020* to lift the minimum award wage rates for all RNs, midwives, ENs, and AINs who work in other settings.

The application impacts nurses, midwives and AINs working across a range of settings in the health system including primary healthcare. Like the aged care case, the ANMF's application seeks to address:

- the impact of historic, gender-based undervaluation of work
- recognise changes to the nature of work performed
- value the skill and responsibility required to do the work
- and identify and recognise skills that have previously been ignored and, therefore, not properly valued.

If successful, the minimum rates of pay for all classifications and pay points of RNs, ENs, student ENs, nurse practitioners and occupational health nurses in the relevant settings would increase by about 35.8%. The minimum rate of pay for an RN level 1, pay point 1, would move to $1,472.60 per week.

ANMF Federal Secretary Annie Butler says that while the nature of nurses, midwives and AINs' work, level of skill and responsibility involved in doing the work, and conditions have changed significantly over the past decades, wages have not kept up.

"The current rates of pay for employees working under the *Nurses Award* fail to properly value the full spectrum of skills required by nurses, midwives, and AINs," Ms Butler said.

"Much like their colleagues in aged care, these workers possess 'invisible skills' that have long been overlooked and undervalued, leading to chronic underpayment and lack of recognition. This now demands immediate and urgent action."

WINS

- Between 17.9% and 23% increase to award rates for Assistants in Nursing (AINs) working in aged care under the *Nurses Award*
- Increases of between 11.8% and 17.6% for Enrolled Nurses (ENs) on top of the 15% interim increase
- Increases of between 6.9% and 16.1% for Registered Nurses (RNs) in addition to the 15% interim increase
- Right to disconnect laws introduced as part of Closing Loopholes reforms
- New rights for union delegates allowing them to speak to members freely about their workplace rights and provide access to training so they can represent workers better
- Multi-employer bargaining laws

ASKS

- Increase minimum rates of pay for nurses, midwives and assistants in nursing (AINs) working under the *Nurses Award* – Work Value Case – Nurses' and Midwives' matter
- Commitment from government to pay increases determined by the Fair Work Commission
- Ensure wins achieved in the Aged Care Work Value Case are implemented and embedded correctly and transparently

AGED CARE

For many years, the ANMF has campaigned for meaningful and substantial reforms in aged care.

Promisingly, recent wins have included the introduction of RN 24/7, ensuring that nursing homes have a registered nurse on duty around the clock, mandatory minimum care minutes requirements, and wage increases for aged care workers through the ANMF's Work Value Case at the Fair Work Commission (FWC). But significant work remains.

One of the most important pieces of draft legislation that was recently passed was the *Aged Care Bill 2024*.

While the ANMF welcomed the government's new 'rights-based' Act, it was left disappointed by some major omissions.

These included:

- Lack of recognition of the crucial role enrolled nurses (ENs) play
- A failure to adopt a positive registration scheme for the currently unregulated aged care workforce
- The abandonment of provisions for a Worker Voice and Quality Care Advisory Body

Last October, the ANMF gave evidence at a Senate Inquiry examining the Bill, highlighting the need for changes to ensure reforms underway continue to achieve their goals. It would be disappointing if failure to undertake bold and fearless reform now simply results in the need for another Royal Commission down the line, the ANMF said in its submission.

"We want to see structures, legislation, reforms put in place that see the capacity for the delivery of genuine, high-quality, safe care, across the sector for all older Australians, whoever you are," ANMF Federal Secretary Annie Butler told the Community Affairs Legislation Committee.

According to Ms Butler, attraction and retention remain some of the biggest challenges

facing aged care. Numerous strategies should be considered, such as creating more genuine career pathways, utilising nurse practitioners more strategically, and investing in the existing workforce, particularly enrolled nurses and the vital contribution they provide to the skills mix.

"Our members consistently report that the most critical, it doesn't matter where they work, what sector they're in, the most important thing is their safe workload and the capacity to be able to deliver the care that they've been educated to, and is part of their professional being, to know that they're delivering their best care," Ms Butler told the committee.

"In this case. it's care minutes, staffing ratios, safe reasonable workloads, wherever they are. Obviously, they need to be paid and rewarded properly, and we've gone some way to now achieving that."

WINS

- From 1 October 2024, the mandated sector average care minutes requirements increased to 215 minutes of care per resident per day, including an average of 44 minutes of care from a registered nurse. This now includes enrolled nurses being able to fill 10% of care time specified for RNs.
- Between 17.9% and 23% increase to award rates for Assistants in Nursing (AINs) working in aged care under the *Nurses Award*
- Increases of between 11.8% and 17.6% for Enrolled Nurses (ENs) on top of the 15% interim increase
- Increases of between 4.2% and 25.5% for Registered Nurses (RNs) in addition to the 15% interim increase

ASKS

- Mandated enrolled nurse care minutes
- Effective regulation of minimum care minutes requirements and transparent enforcement measure in the rules
- Ensure implementation of aged care reforms empower aged care workers to be a respected and valued part of continuous improvement in care delivery to ensure quality care
- Provide a positive regulation registration scheme for aged care workers
- Increase nurse practitioner access for older people

NURSING AND MIDWIFERY WORKFORCE REFORM

The ANMF remains committed to the development of strategies to: enhance the recruitment of nurses and midwives, especially new graduates; reduce undergraduate attrition; and address workforce retention.

Photo: Christopher Hopkins

Unsustainable workloads are a key driver of the workforce crisis. The ANMF is advocating for a range of strategies to improve retention, including: increasing nurse practitioner positions, boosting the nursing and midwifery workforce through scholarships, increasing support for continuity of care models, improving clinical placements, and increasing support for RUSON and RUSOM models of care, and exploring financial incentives like allowances.

After years of lobbying by the ANMF, recent introduction of Commonwealth Prac Payments for nursing and midwifery students from 1 July 2025, may help stem undergraduate nursing and midwifery student attrition. The $319.50 a week (means-tested) provides some financial support for students while undertaking their 800 hours unpaid mandatory clinical placement.

The much-awaited National Nursing Workforce Strategy is due to release its report in 2025. The strategy will provide a national approach to shape the future of nurse workforce planning, investment and reform in Australia. The strategy has come out of the Nursing Supply and Demand (2023-2025) study which found unsurprisingly that our supply of nurses will not meet future demand.

Similarly, the Midwifery Futures report, commissioned by the Nursing and Midwifery Board of Australia (NMBA), exposes widespread staffing shortfalls, especially in non-metropolitan areas. The report makes 32 recommendations including in the scale-up of midwifery models of care. This includes to attract, educate, and retain the Aboriginal and Torres Strait Islander midwifery workforce and maintain ongoing initiatives such as Birthing on Country programs.

Both complement other government blueprints including the Nurse Practitioner Workforce Plan, Independent Review of Overseas Health Practitioner Regulatory Settings, and *Unleashing the Potential of our Health Workforce (Scope of Practice) Review* in how to tackle our critical workforce challenges.

Recommendations to enable nurses and midwives to work to their scope of practice in the *Unleashing the Potential of our Health Workforce – scope of practice review*, will give help provide greater job satisfaction, recruitment and retention of nurses and midwives. Where nurses and midwives have been unable to work to their scope, this has reduced their ability to undertake the work for which they were educated, leading to deskilling and reduced job fulfilment. The ANMF will work with other key nursing and midwifery peak bodies and stakeholders, to see key recommendations are adopted. Many of which align with the ANMF's position on increasing nursing- and midwifery-led models of care which evidence supports leads to better access and health outcomes.

WINS

- Removal of collaborative arrangements for nurse practitioners and endorsed midwives
- Increased Medicare rebates by 30% for standard consults with a nurse practitioner
- New Medicare rebate for a 60-minute consult with a nurse practitioner, and a range of new Medicare rebates for pregnant women and new mothers to benefit from high quality midwifery care
- From 1 July 2025 nursing and midwifery students are eligible to receive a Commonwealth Prac Payment to help support them financially while they do the practical part of their degree

ASKS

- Supporting funding for nurse-led and midwife-led models of care, including additional free nurse-led walk-in clinics and midwifery-led clinics that employ NPs, advanced practice nurses, endorsed midwives and midwives with provision for supported students' placements
- Commonwealth funding to support nationally consistent structured student employment programs across the country
- Increasing funding for Commonwealth Supported Places (CSP) for nurses and midwives to undertake postgraduate studies
- Scope of Practice recommendations enacted, with legislation that allows NPs and endorsed midwives to their scope of practice.
- Appointment of a Commonwealth Chief Midwife.
- Fund a National Midwifery Strategy including an implementation plan
- Strategies to increase the number of Aboriginal and Torres Strait Islander midwives, and midwives from culturally and linguistically diverse backgrounds
- Funding for pilot sites midwifery-led primary care clinics in regional, rural and remote areas for women's health
- Funding of incentive based programs, education and mentorship, particularly for new graduates

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ICN President Dr Pamela Cipriano confident about nurses' power to change the world

As the 2025 International Council of Nurses (ICN) Congress approaches, set to be held in Helsinki, Finland, from 9-13 June, ICN President Dr Pamela Cipriano sat down with *ANMJ* journalist Robert Fedele to discuss the congress and the critical global challenges currently facing the nursing profession.

Dr Pamela Cipriano was elected the 29TH President of the International Council of Nurses (ICN) in late 2021, as the world grappled with the "dark cloud of COVID" and the pandemic's wide-ranging effects.

For the ICN, a federation of more than 130 national nursing associations (NNAs), representing more than 20 million nurses worldwide, the unprecedented situation demanded providing leadership and support to the global nursing workforce Dr Cipriano's immediate focus was stabilisation.

"Nurses were not valued, they were not protected, they were not respected, they were subject to terrible working conditions," Dr Cipriano tells the *ANMJ*, from her base in Virginia, in the United States.

"Early on, we continued to provide information to nurses and the public and made sure that there needed to be a very different kind of response to recovery from the nursing pandemic.

"We were seeing the significant exodus of nurses from the workforce and that just added to the struggles of nurses who were already working under tremendous stress who did not have sufficient staff, who were getting ill, and were experiencing co-workers dying."

Fast-forward a few years, and nursing's biggest global challenge remains ever-present: workforce issues.

According to Dr Cipriano, there was a shortage of about six million nurses worldwide prior to the pandemic. What's more important, however, and as ICN has come to understand, is what the shortages actually mean.

"For the most part, we think of shortages as there's just not enough people to fill jobs," she explains.

"The shortage reports in nursing are a combination of not enough people and not enough educated nurses to fill the roles. But also, a shortage of positions for nurses and other healthcare workforce individuals that are funded by their healthcare systems, whether it's the government or private systems."

In countries struggling with these issues the most, without enough nurses able to deliver the care patients need, nurses often experience heavy workloads, fatigue, a lack of protection, and rising occupational violence, Dr Cipriano says.

"In some areas, we're hearing that nurses are being told that they have to volunteer, they're not going to get paid, and yet they show up day after day. That's totally inappropriate.

"We also know that nurses don't feel respected. We saw this a lot during the pandemic. The workforce issues are significant because they really affect retention, and they reflect on whether or not we can attract new individuals to become nurses."

Dr Cipriano lists other global challenges including increasing attacks on health workers in war-torn and crisis areas, ongoing efforts to ensure universal health coverage, and improving health security, which includes everything from pandemic preparedness to responding to the health effects of climate change and combatting non-communicable diseases that kill people prematurely.

"If you ask 10 people around the world, are we ready for the next pandemic? They would say no," Dr Cipriano suggests.

"But it's important that one of the key ingredients to that is a robust workforce."

Looking ahead, ICN Congress 2025 will be held in Helsinki from 9-13 June. Showcasing the role of nurses in transforming health systems, healthcare delivery, and strengthening and influencing health policy, the latest theme is: ***Nursing Power to Change the World.***

Delving deeper, Dr Cipriano says sub-themes will include empowering nursing leadership; elevating healthcare excellence; advancing nursing practice; educating the nurses of tomorrow, health equity; and nursing in humanitarian and emergency contexts.

As well as giving current nurses every opportunity to provide the very best care possible, and empowering them to rise to high-level leadership positions, ICN is acutely aware of the need for forward-thinking to prepare the next generation.

"We want to focus on innovation," says Dr Cipriano.

"Nurses have great ideas. They are problem solvers. They don't give up. They figure out what to do to get the care to people that they serve. We want to revolutionise, if you will,

our nursing education programs around the world to make sure that nurses are equipped to face global health challenges."

For example, ICN initiatives already promoting nursing leadership include its Global Nursing Leadership Institute (GNLI) program, which supports about 35 experienced nurses each year to take the next step to becoming global leaders and influencing policy change in their countries and abroad. It has also been lobbying countries to appoint chief nursing officers to influence change, strengthen health systems, and advance nursing at a local level.

While the world has returned to relative normality since the COVID-19 pandemic, the period is far from over, a reality not lost on Dr Cipriano, who identifies mental health issues among the workforce as "the tip of the iceberg".

"At ICN, we haven't forgotten the sacrifice of nurses. We haven't forgotten the needs that nurses expressed to us," she declares.

"One of the things at the top of the list was they needed to be protected, they needed to have vaccination, they needed to have personal protective equipment (PPE). Even if the next pandemic is not an infectious disease, we know that it's important to prioritise what our nurses need in order to take care of themselves as well as their patients.

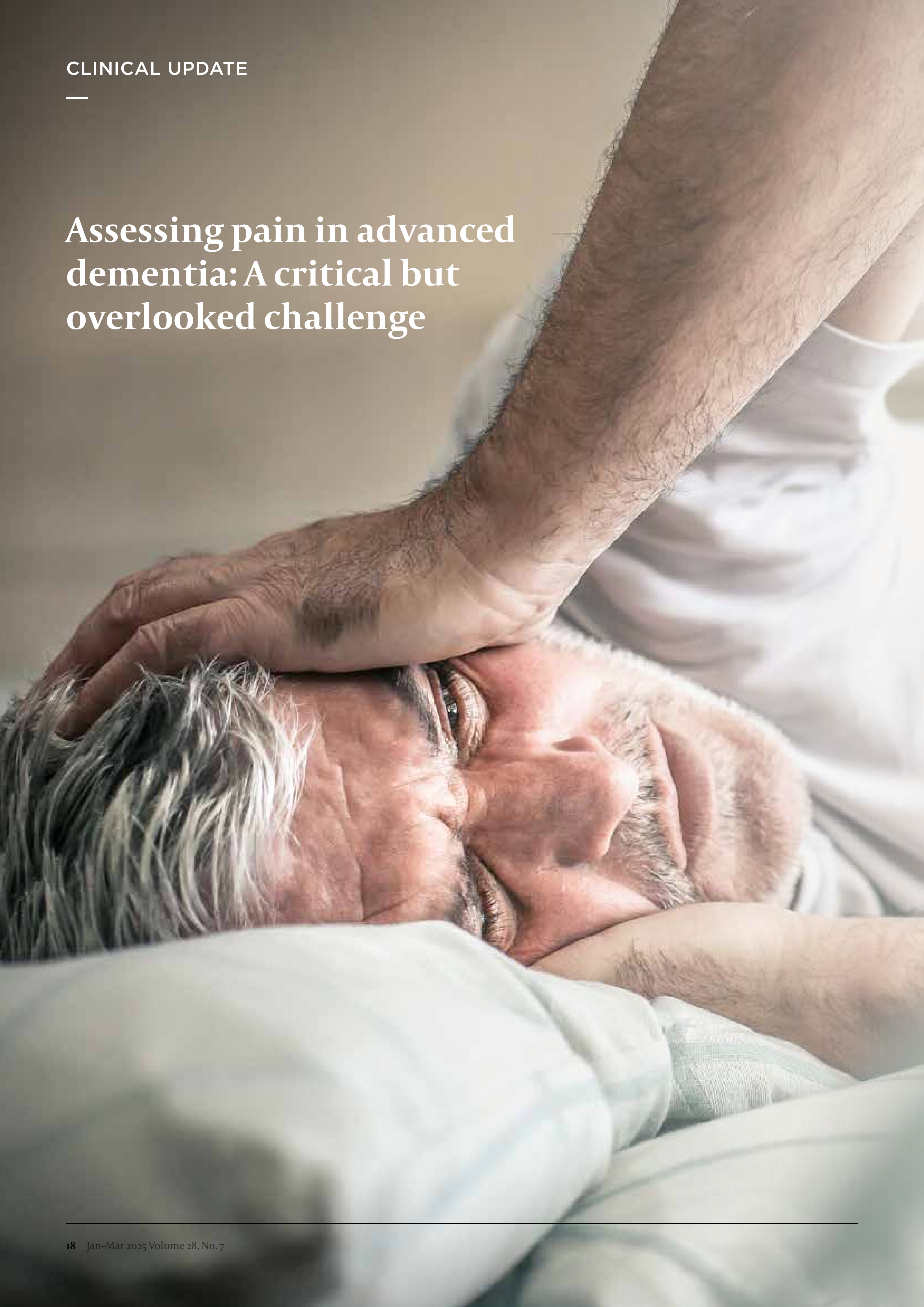
"At the same time, we know that these situations are crisis situations, so there has to be intervention to deal with the stress, burnout, trauma and heaven forbid, significant deaths that nurses are experiencing. We learned that it's important to advocate early on, and to make sure that the nurse's voice is in the discussion."

As the global voice of nursing, Dr Cipriano says ICN remains poised to represent the profession as it tackles significant issues moving forward. This includes advocating for better and safer working conditions, including fair pay, preventing burnout, navigating the emerging use of artificial intelligence (AI) in healthcare, and promoting greater pride in the profession. Supporting global peace by calling for ceasefires and providing humanitarian aid amid growing unrest and conflicts across the world, is another fundamental priority.

To mark International Nurses Day 2024, ICN adopted the theme *The economic power of care*. Dr Cipriano says that focus, which outlined evidence showing the return on investing in nurses, will continue.

"We know that numbers talk," Dr Cipriano says.

"While we can keep saying nurses contribute to quality, we can show improved outcomes, we can look at our ability to increase access to care, sometimes the only numbers that speak volumes are being able to show financial savings and how we can boost the economy."



Assessing pain in advanced dementia: A critical but overlooked challenge

By Paula McLeister

The ability to assess pain in a patient with advanced dementia can be an extremely challenging skill for healthcare professionals, and one which can often be overlooked and undertreated.[1]

It has been reported as many as 40% of residential aged care facility (RACF) residents are unable to express their pain due to cognitive and communicative impairments.[1]

There is consensus in literature that pain in general is under diagnosed and under treated, compounded by dementia, this figure increases exponentially, with reports as high as 80%.[2]

Pain as a term can be separated into acute and chronic, with estimates of 93% prevalence of chronic pain in residents residing in RACFs.[3] Chronic pain is defined as pain which persists longer than three months, described as an unpleasant sensory and emotional experience, associated with actual or potential tissue damage.[2]

There are many confounding factors in chronic pain management within RACF settings, including cognitive impairment and dementia; non standardised approaches to pain assessment; lack of knowledge in pain management; lack of multidisciplinary input; staff shortages and high staff turnover.[3]

Acute pain management can occur as a result of falls related injuries; genitourinary infections; gastrointestinal and cardiac pain are among the most common contributors.[4] Access to adequately controlled pain is a recognised fundamental human right, the Australian Commonwealth Department of Health and Aged Care Accreditation Standard 2.8 mandates 'all residents are as free as possible from pain'.[4] There is a requirement for RACFs to document evidence of identification; assessment; review of pain and appropriate programs for managing symptoms,[4] however in practice there are still shortfalls in these goals being achieved.[4,5]

SETTING

South-east Queensland is Australia's fastest growing metropolitan region. The population is expected to increase by 30% in 2025, and the 70 years-plus population is expected to grow by 224%.[6] Metro South Health Service (MSHS) has 93 residential aged care facilities (RACFs) within their remit with upwards of 10,000 residents. A mobile emergency team (MET) is embedded in MSHS within the comprehensive aged residents' emergency partners in assessment and treatment (CAREPACT) team. The MET team are deployed to RACFs for emergency reviews and treatment, operating between 08:00-18:00 seven days per week 364 days per year. The team is comprised of medical staff; nurse practitioners (NP): clinical nurses (CN) and administrative staff.

CASE 1

Mrs A is an 82-year-old female RACF resident who has sustained a left eyebrow laceration following a mechanical fall. The mobile emergency team (MET) were requested to review this lady in the RACF to assess the laceration. On arrival she was found in her room in an agitated state, she was looking into a mirror and exploring the wound with her fingers, the wound was actively bleeding. She was displaying signs of delirium, presumed secondary to pain. Gentle diversion was employed to allow ability to review the laceration, it measured 4.5cm in length and wound depth evaluated as 4mm. It was determined on clinical evaluation suture closure would be the most appropriate technique. Exploration and cleaning of the wound was planned following local anaesthesia, however due to her agitation this could not be attended to immediately.

Handover was given from the Registered Nurse (RN) to the MET team, the RN provided details on how the laceration had occurred from a fall, where the incident occurred, where the resident was at the time and how it was a witnessed mechanical fall. During this handover a review of medications incurred, which included assessment of any additional as required medications. There was no documented pain relief since the time of the injury. The MET Nurse Practitioner (NP), discussed with the RN the medications which had been provided and asked rationale why no pain relief was administered. The rationale provided by the RN for not giving any pain relief was Mrs A had not displayed any signs of pain, and when asked if she had pain, she said 'no'.

Pain relief was administered immediately to this lady, time was provided for her agitation to settle prior to local anaesthesia administration and wound closure.

CASE 2

Mr B is a 91-year-old male RACF with a diagnosis of vascular dementia, he has been displaying aggression to the staff in the facility. He has tried to hit two of the nurses and another resident in the past 24 hours. Staff had documented he may have had an unwitnessed fall in his room three days ago, as he was found getting himself back into bed overnight but no signs of injury. These behaviours and psychological symptoms associated with dementia (BPSD) are a new presentation for him within the past week. He normally attends the day room during the day and has limited interaction with other residents, however when he does, he is normally pleasant with no signs of aggression displayed. He was reviewed by his GP and no injuries were evident. His agitation and aggression have been treated with risperidone which has been administered with limited efficacy.

When MET NP attended the facility it is very evident, he was agitated, he was pacing near the front door, stating he wanted his mum to come and get him and take him home. With some gentle diversion and a warm drink, the MET NP were able to escort him to his room for assessment. On clinical examination of Mr B, he was noted to have tenderness to his right humerus, further inspection showed bruising evident at proximal end.

A review of his medications indicated he had paracetamol as required but had not received any pain relief in the past week. The NP prescribed oxycodone, his arm was placed in a shoulder immobiliser and a mobile x-ray ordered of his right upper arm which noted a non-displaced proximal humerus fracture. Subsequent follow up found Mr B was settled, his agitation had ceased with adequate pain relief, and he had not required further risperidone.

CASE 3

MET NP attended to review Mr G a 76-year-old male RACF resident in terminal phase of life, his regular General Practitioner (GP) was on leave and the facility were unable to access afterhours GP. MET were requested to provide end-of-life (EOL) review and control of symptoms. On review Mr G was unsettled, he was plucking at his blankets and reaching into the air, he was grimacing, and his breathing was laboured. Following a clinical examination a review of his medication list noted the only prescribed pain relief was oxycodone; however, he had not received any for more than 24 hours. Further investigation with the RN uncovered the reason he had not received any oxycodone was because he was unable to swallow, he was no longer able to eat or drink.

Mr G's family were present at the RACF which provided the opportunity for the MET NP to have a family meeting to discuss end-of-life and medical options to treat the symptoms being displayed. On consultation with his family, it was decided his goals of care were to remain in the RACF, he had a complex medical history with metastatic cancer and his GP had referred him to palliative care services with a visit planned for the following week. A discussion with the family included subcutaneous administration of EOL medications, with a description of each medication, how it is delivered and what it is used for in relation to the symptoms he was experiencing. The MET NP prescribed subcutaneous morphine sulfate; midazolam; hyoscine butylbromide and haloperidol. These were prescribed as required or PRN for the first 24 hours with telephone review by MET the following day. On review it was decided to change administration to continuous subcutaneous infusion with effective management of symptoms and he died peacefully two days following initial review.

DISCUSSION

When managing pain in the aged population who reside in RACFs it is vital nursing and medical staff do not lose sight of the human aspect. A person may not be able to vocalise their pain due to their cognition, however when empathy is employed it can guide a clinician's perspective on what can be classified as painful. Therefore, empathy as a care provider will lead clinical assessment and correct interventions to ensure patients are treated with respect and dignity.[7] The association between pain and delirium is not a novel concept, it has been widely explored in the literature, however there is a lack of evidence from RACF settings.[8] Pain control is an important focus for preventing delirium in RACFs,[8] staff having adequate training and education on how to recognise and treat pain is integral in caring for a population who cannot advocate for themselves.[9]

Behaviours such as restlessness and aggression can in fact be symptoms of untreated pain, with researchers highlighting people with dementia are prescribed less analgesia than aged matched groups.[10] A patient displaying a change in behaviour such as aggression or agitation should in the first instance be managed with non-pharmacological interventions.[11] Use of an appropriate validated pain assessment tool is invaluable for documenting and monitoring pain in cognitively impaired individuals, consistency is vital and when individuals cannot communicate they have pain, staff must be educated to assess based on nonverbal cues.[7,12] There is no consensus about which assessment tool to utilise and how to document, and has been described as haphazard in some establishments.[10] It is valid to conclude the assessment and evaluation of pain requires critical thinking, wherein a patient's behaviour along with clinical parameters are assessed in full to ensure pain relief targets their individual needs.[10,13] It is important to remember when a patient has a fall with no apparent injuries, should they develop a change in behaviour in subsequent days, strong suspicion of injury should guide care.[14]

The World Health Organization (WHO) describes palliative care as an approach that improves quality of life of patients and their families facing life limiting illnesses, through prevention and relief of suffering.[15] It is vital clinicians have the skills and knowledge to recognise signs and symptoms of EOL. They need to have confidence to act early and advocate on behalf of the patients in their care, to ensure medications to treat symptoms of EOL have been prescribed for patients and avoid crisis management. Early involvement with palliative supportive services results in increased levels of satisfaction and decreased stress in clinicians, patients and/or their families.[15,16]

As a nursing cohort we need to increase the salience of pain in goals of care, we need to raise awareness and have it embedded into nursing handovers and rounding. If approximately 80% of RACF residents are in acute or chronic pain, we need to ensure we are considering it in our daily practice.[14] There is nothing new or novel in this discussion, rather it is a reminder to us all to consider pain when reviewing older patients. As opposed to treating the symptom (namely delirium or agitation), look for the cause and explore pain and treat same.

Author

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Looking after your older self – Caring for your superannuation

In Australia, superannuation plays a crucial role in securing financial stability for individuals in retirement. Australia continues to have a gender super gap, and the gender pay gap contributes to this.

Nursing and midwifery are female dominated professions and women face unique challenges that can place them at a disadvantage when it comes to retirement savings. While retirement may seem a long way into your future, understanding the importance of superannuation is essential for achieving gender equality, and ensuring a dignified and secure retirement.

According to the Australian Bureau of Statistics, in May 2024, the gender pay gap averaged 11.5%, meaning for every dollar earned by a man, a women earned 89 cents. This gap varies according to state and territory and ranges from 5% in Tasmania to 19.4% in Western Australia and is influenced by the types of industries and work available.[1] This gap subsequently influences women's superannuation contributions, because they are calculated as a percentage of income and in 2023, the Association of Superannuation Funds of Australia, found the average superannuation balance for women at retirement was 23.4% lower than men. Several other factors contribute to this disparity. Many women take time off work to care for children or elderly relatives, significantly reducing superannuation contributions. As a result, women can find themselves in difficult financial positions as they retire. Additionally, women returning to the workforce and seeking flexibility for caring responsibilities, may opt for lower-paying or part time work, further contributing to the superannuation gap.[2]

Another significant issue is created when women access superannuation early, making lump sum withdrawals and reducing funds available for retirement. During the COVID 19 pandemic, 725,000 Australians wiped out their superannuation accounts with 70% being 30 and under. The Super Members Council (SMC) is a peak body established in 2023 by the profit to member superannuation organisations. The SMC advocate for super fund members to ensure superannuation policy is stable, effective and equitable. SMCs analysis of early access to super found that a 30-year-old who withdrew $20,000 from super, could be left with about $93,600 less at retirement.

Purchasing a house is increasingly difficult and suggestions have been made from the conservative side of politics that people should be able to access their superannuation early to assist with house purchase. Modelling by the SMC suggests withdrawing super for this purpose will increase house prices by approximately $75,000 across capital cities, adding to unaffordability. This has been seen in New Zealand, where people could withdraw super for housing. Not only did house prices surge but home ownership fell and cost people retirement savings. SMC modelling shows a 30-year-old couple who withdrew $35,000 each from their super today could retire with about $195,000 less.

CARING FOR YOUR SUPER

Superannuation is a worker right in Australia and one to be protected to ensure it protects us as we age.

One of the best things people can do is learn about their superannuation, even though retirement might seem a long way off. Most super funds offer free, general advice to members and their websites contain useful information. The SMC website has free and accessible information to help people learn about superannuation and how to protect it.

More broadly there are measures that must be reformed to address structural drivers of the gender super gap, for example the social norms related to unpaid carer responsibilities, lower workforce participation rates for women and the situation where highly feminised industries and jobs continue to attract lower wages and therefore lower superannuation contributions. Thankfully, the Federal Government has announced that they will pay 12% superannuation to workers taking Commonwealth Paid Parental Leave (PPL) from 1 July 2025. Of those accessing PPL 99.5% are women. While more action is needed to address the gender super and pay gap, this is a great start.

Engaging with your super is likely to result in better outcomes in retirement. When was the last time you checked your super balance?

This information is of a general nature. It does not take into account your objectives, financial situation or specific needs so you should look at your own financial position and requirements before making a decision. You may wish to consult an adviser when doing this.

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Rebecca Millar

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Navigating the digital minefield

The rapid evolution of digital technologies has fundamentally transformed both healthcare and education.

Advances in electronic health records, medication management systems, and patient care documentation have streamlined nursing practice and improved patient outcomes. New technologies such as generative artificial intelligence (AI) tools like ChatGPT and homework help websites like Chegg, are raising significant challenges to academic integrity. While academic misconduct has long been a concern, the scope and complexity of this issue have expanded with the rise of digital tools, particularly in nursing education leading to an increase in academic misconduct related hearings in Court.

Academic integrity is defined as a commitment to six fundamental values: honesty, trust, fairness, respect, and courage (International Centre for Academic Integrity, 2021). These values serve as a guide for ethical decision-making and academic behaviour. However, the introduction of technologies like generative AI has blurred the boundaries of academic misconduct. The use of AI tools to 'assist' students with assignments raises complex ethical and legal questions about what constitutes cheating. In nursing education, where academic performance directly impacts the preparation of students for safe and competent clinical practice, these issues are particularly troubling. Concerningly, students who engage in academic dishonesty are also more likely to engage in clinical misconduct,[1] highlighting broader implications for patient safety.

A Bachelor of Nursing degree must adhere to governance frameworks set by bodies such as the Tertiary Education Quality and Standards Agency (TEQSA) and the Nursing and Midwifery Board of Australia, ensuring that students graduate with the necessary knowledge, skills, and ethical foundations to maintain patient safety in practice. TEQSA plays a critical role in safeguarding the quality of Australian higher education. Mandated with monitoring and accrediting institutions to ensure they meet national quality standards, TEQSA's legislative powers were enhanced in 2020 with the introduction of subsection 114A(3), prohibiting the offering or arranging of academic cheating services for higher education students. First invoking these powers in 2024, TEQSA launched legal action against the homework help site Chegg. Alleging that Chegg was used for cheating in Australian universities, TEQSA are seeking a fine of over $150,000, a declaration from the court that Chegg has breached Australian law, and a demand for Chegg to pay TEQSA's legal costs. Currently before the Court, this highlights the seriousness with which Australian regulators are addressing academic misconduct, aiming to protect the integrity of the Bachelor of Nursing and other degrees.

Whilst legislation is relatively clear when it comes to contract cheating, the issue of student use of generative AI is far more complex. AI tools like ChatGPT assist students by generating answers or content then passing it off as their own, blurring the line between legitimate academic assistance and academic dishonesty and making it far more challenging to prove as misconduct. For nursing students, academic dishonesty is not just a violation of university policy but a potential threat to their careers. Where patient safety is paramount, any form of cheating compromises the integrity of the degree and preparedness of graduates. Nearly 50% of Australian nursing students have engaged in some form of academic misconduct during their studies with consequences ranging from repeat in subjects to expulsion.

Universities are increasingly developing policies that address the use of AI tools by students. For example, the University of Sydney has made it clear that generating content with AI tools in any way constitutes cheating.[2] However, even well-crafted university policies cannot guarantee the detection or penalisation of academic misconduct. Detecting AI-generated content remains a challenging task, and universities are still in the early stages of developing reliable detection methods that meet the necessary evidentiary standards. The rise of AI-assisted cheating has not only raised ethical concerns but also legal challenges. Many students have contested academic misconduct allegations in court, seeking judicial review over unfair dismissal from programs, grades, and breaches of contract. Legal action can result in students being reinstated or awarded significant financial compensation. Student unions have raised concerns that poorly worded assessments and unclear university policies on AI use may contribute to these disputes, highlighting the need for clearer guidelines.

In response to these challenges, many universities have reverted to traditional in-person exams to combat the use of AI tools and other forms of digital cheating. However, this is only one approach in a rapidly evolving landscape. Experts warn that the battle between universities and digital cheating tools is becoming an "arms race," with institutions developing detection technologies only to be outpaced by newer, more sophisticated AI tools.[3] As the legal and ethical issues surrounding AI-assisted assessments continue to evolve, nursing educators must remain vigilant, ensuring that policies are clear, enforcement is consistent, and students are held to the highest ethical standards.

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Respiratory syncytial virus (RSV) is a prevalent and highly contagious virus[1]

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Can an introvert survive in the world of nursing academia?

By Andrée Gamble

Are you seen as quiet, reserved, and reflective? Or are you perceived to be distant, withdrawn, reluctant to engage in activities with a room full of people and therefore not considered a 'team player.'

Do people see you as someone to be tolerated or do they see you at all? Do opportunities bypass you because no one ever thinks you are capable of anything? They might if they actually took the time to listen instead of talk, observe instead of doing.

Introverts are often quiet, reserved and find speaking in public challenging. Being an introvert is usually an inherent personality trait and often one that has been present since forever!

Regardless of previous work experience, there is an unwritten expectation that nurses have effective and well-developed communication skills. Given the patient centred nature of nursing practice, and the time often spent with patients at different points throughout their healthcare journey, nurses communicate. Beyond patient communication, nurses are expected to engage with families, healthcare professionals and a myriad of stakeholders involved in the delivery of care to patients in various settings. Interestingly, even the introvert can usually engage and effectively communicate in these interactions.

The transition from direct clinical care to the academic setting can be full of exciting challenges, with an equal mix of trepidation, nerves and uncertainty. When a nurse moves to academia, so many things change; work requirements, location, access to support and expectations to name just a few. However, expecting the introverted person to also change is at best aspirational, at most unrealistic and perhaps even unreasonable. Having undertaken this journey, it is not until quite recently that I realised my introversion was far more challenging to manage in the academic setting than the clinical environment.

Being an introvert and an academic presents a dichotomy that often challenges the mindset. How can someone who barely contributes to meetings and rarely attends social events stand up in front of a class and teach a group of people they don't know? Unfortunately, there appears to be limited tolerance of the 'quiet person' who speaks when they have something to say, but retreats when others are more forceful in their communication. That is the life of an introvert.

Experience suggests that this is not a pleasant space at times and certainly not one that is always recognised or well supported in the academic setting.

"Quiet to the point of being rude," "Only speaks when they have something important to say" and "not a team player" are labels. Equally so, labels are also frequently ascribed by and to introverts; reflective, thoughtful, nurturing and observant are just a few. There is no pigeonhole that declares all introverts are insightful, reflective, and nurturing. There is also no 'one size fits all' approach to determining whether someone is an introvert or an extrovert. That is where the discussion gets a little murky. In some situations, an extrovert can become quite introverted, and vice versa. Maybe environment, expectation and personalities are influential in determining how one reacts.

Diversity within a team is important; how boring would life be if everyone were the same. But it remains challenging for some to actually acknowledge that a team requires more than one type of person. In the spirit of diversity and accepting difference, there is no doubt that extroverts are important members of the academic team.

The voice that is always heard is that of the extrovert. The dominant personality, the loudest voice, the one who feels comfortable speaking their mind knowing they will not be challenged. Perhaps even the one who satisfyingly sits amidst their like-minded peers knowing their voice will always be heard. And being heard has benefits.

So, can it be said that because introverts are quiet, or retreat if someone else is dominating a conversation, they are lesser members of the team and therefore less likely to be seen as an individual capable of engaging with others in different situations? Sometimes it feels like this.

Perceptions are important, and if you are quiet or reserved, then perhaps your true value is not recognised. As an introvert, it is easy to joke about how long it takes to decide what to have for lunch because it requires thoughtful contemplation before a decision is made. However, this is not a weakness. In contrast, it is perhaps a strength for nurses who should consider the benefits of decisions before embarking upon them. Obviously, there are exceptions to prolonged decision making; it is not feasible to contemplate whether you need to resuscitate a patient or not! But it is reasonable to teach novice nurses that choices have consequences that need to be considered before action.

There are ways of working that enable teams comprised of different personality types to effectively work together to achieve a goal. It is important for leaders to inspire others and implement strategies to draw out the introvert and perhaps quiet the extrovert. This is achievable and only needs minor changes in the way we work to ensure all voices are given equal opportunity to be heard. One to one rather than large group meetings, written instead of verbal contributions, leveraging strengths rather than focusing on what they aren't doing and actively listening are just a few of many actions that can be utilised to draw in the introverted members of a team.

However, if the introvert doesn't want to be drawn in, then that shouldn't be an issue. Yet, experience suggests, it is yet often not for the learners we teach, who recognise the introversion traits in an academic but who also identify there is inherent value in an academic who carefully reflects and considers before responding. Experience suggests that learners are more tolerant and accepting of introverts than other academics.

I have taken a broad-brush approach to this topic, noting that the experience is not the same for every introverted academic in every educational setting. However, my experience, perhaps a little tainted, is that introverts have knowledge and insights to share, but are not 'brave enough' to say them aloud for fear of ridicule. Ridiculous right? Not so, for those who have palpitations, perspire, and feel nauseous at the very thought of speaking in a group of peers.

Acknowledgement of how people might feel is one step forward in creating a level playing field for contributions to be equally heard.

So, can an introvert survive in the world of academia? Theoretically, the answer is yes. Maybe the answer should come from the individual themselves.

Author

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Personal reflections on becoming a clinical nurse educator

By Lisa Evans

FACTS

Commencing a full-time role as a clinical nurse educator, the author has been on a steep learning curve learning things she didn't know she needed to learn.

Main learnings have come in the form of new IT skills, awareness of the team and their selfcare needs, awareness of herself and how she practices and recognising the need to develop some leadership skills.

At first, being a clinical nurse educator was a completely new role and there was a requirement to learn the basics.

Needing to learn new technology skills, excel spreadsheets, Microsoft forms, Canva, PowerPoint presentations and templates. There was a requirement to organise, communicate, document and store vast amounts of information. The author was required to learn to communicate effectively on various platforms, across 20 nurses and 55 work sites.

Following this, the author learned organising training is the easy part, it's the human component that's tricky. When organising training about trauma, alcohol and other drug use, domestic and family violence, and sexual assault team members may experience events in their personal life which unsurprisingly, can be triggering.

With training the author learnt, the need to amend how to approach the team ensuring to cater to their needs, offering options and space for selfcare.

The author learned about herself. She likes to be efficient. She's been told she's a 'doer'. This is her second year working as a clinical nurse educator- we're halfway through the school year. Training is organised every school holiday and through the terms, there are visits to staff. During these visits, staff have begun to say that they need time to implement what they've learned. The author reflects that in her desire to be efficient, she has booked and delivered training at such a pace that she now recognises the need to slow down. There is a need to allow time for staff to implement what they've learned and to allow time for implementation, collaboration and growth.

Most recently she has become aware of the elements of leadership involved. She had anticipated being a role model but had not needed to speak up when others were behaving in a manner not aligned with our program's values. This was a new realisation and will be a skill which will require practice and reflection to develop.

FEELINGS

During the last 18 months, the author has been surprised by the journey and the learning experienced. She has been surprised at the depth of the role and the leadership components. Original concepts of the role were simplified ideas about booking training, delivering education and keeping spreadsheets up to date. The author feels like she is doing a good job in this role and plans to continue reflecting on the process and to develop the ways of working within the role to ensure that staff are supported, educated and have time for personal growth.

The author is enjoying this challenge, enjoying learning new things and doing everything to the best of her ability.

FINDINGS

Being a clinical nurse educator is a broader role than expected, its multifaceted, interesting and at times exhausting. There is a need for the author to slow down on organising and educating and to work on ways to support the implementation of learning and helping staff to grow. The author also acknowledges the need to ensure that staff are not overburdened with training which may trigger them and ensure that they are supported and aware of all internal and external services that can help and support when necessary.

FUTURE

In the future, the author will adjust her approach. She plans to organise training less intensively, allow more time for collaboration and team building. Looking to 2025, when staff are visited, the author will formulate a way to provide coaching and goal setting. Utilising some learnings from her current study of leadership she plans to use the Grow model of coaching[1] to help goal setting, and an appreciative inquiry approach to build on what staff are already doing well, because there is so much of that. The author is still evolving as a nurse educator, and wonders what her next lesson will be.

> *"We do not learn from experience; we learn from reflection on experience."*
>
> **JOHN DEWEY**

This reflection has been written using Greenaway's model of reflection the four F's of active reviewing.

Author

Lisa Evans, Clinical Nurse Educator, School Health Nurse Program, Learning Services Northern Region, Department for Education, Children and Young People, Tasmania

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Dr Micah DJ Peters

Associate Professor Dr Micah DJ Peters is based in the ANMF National Policy Research Unit (Federal Office) in the Rosemary Bryant AO Research Centre, UniSA Clinical & Health Sciences, University of South Australia.

Madeleine Manning

Madeleine Manning is an undergraduate midwifery student undertaking a Vacation Research Scholarship project in the Rosemary Bryant AO Research Centre, UniSA Clinical & Health Sciences, University of South Australia.

Getting students into research through mentorship programs

Many universities offer summer vacation research scholarships as opportunities for students to supplement formal studies with paid internships to work with academics.

To foster the next generation of midwives, I am mentoring an undergraduate midwifery student (coauthor Madeleine Manning) to lead a research project to explore the evidence surrounding uterine rupture in women with past myomectomy. This topic is not widely addressed in current clinical guidelines and is a personal interest of mine as my partner experienced this very rare and potentially fatal event during the birth of our first child in January 2024. Our project will help underpin future maternity care policy and practice by equipping midwives and other clinicians with new knowledge. It will provide a student with hands-on exposure to research – an experience that will be invaluable when transitioning to clinical practice.

Myomectomy is surgery to remove uterine fibroids. These are common benign tumours that can cause heavy menstrual bleeding, pelvic pain, and infertility. While surgery helps preserve fertility and can provide symptom relief, it also leaves scar tissue which can lead to pregnancy complications including risk of uterine rupture.

Despite the well-established risks of uterine rupture following a caesarean section, much less attention has focussed on women with a previous myomectomy. This gap makes it difficult for healthcare professionals to provide clear, evidence-based advice to women who may be planning a pregnancy after this procedure. Given the increasing prevalence of myomectomy in women of reproductive age this issue is of growing importance.

While adding additional work to already demanding study requirements and personal responsibilities is not possible for some students, paid scholarship opportunities can increase accessibility and attraction. Providing undergraduate midwifery (and nursing) students with opportunities to gain mentored research experience via funded programs such as UniSA's Vacation Research Student initiative is a great way for emerging clinicians to have practical, hands-on experience in research while also contributing to an important area of professional practice. It also provides a supportive environment for students who may be interested in further postgraduate education a chance to explore this area of practice prior to committing to postgraduate study.

By carrying out this research in a supportive environment in the Rosemary Bryant AO Research Centre at UniSA, Madeleine will not only contribute to the body of knowledge on a crucial aspect of maternal care, but also gain firsthand experience of the research process and build valuable networks. As Madeleine navigates this complex and evolving field, there will be opportunities to engage with experts in the field, the latest literature, and to critically evaluate existing evidence and identify gaps in knowledge that could guide future research.

In collaboration with her mentor team Madeleine will receive topic and methodology-focused guidance as she delves deeper into the evidence and intricacies of scoping reviews. Mentorship opportunities such as these are pivotal in helping students build confidence in their research skills, while also developing a deeper understanding of how to incorporate evidence-based practices into clinical care. The opportunity also helps mentors and researchers develop a keener understanding of the experiences of undergraduate students and how to support them on their journey to professional practice.

Through this project, Madeleine is gaining exposure to the broader healthcare landscape beyond the standard undergraduate curriculum with opportunities to explore how research influences clinical practices and informs the development of guidelines and best practice recommendations.

For midwifery students, it is crucial to not only understand the theoretical aspects of care but also to be able to critically appraise and apply research findings to improve outcomes for women and babies. The ability to interpret research and use it to inform clinical decisions is a cornerstone of safe, effective, and evidence-based maternity care. These skills are also the foundation for reflective practice which can be applied to continuing professional development and is a requirement of midwifery registration. This scholarship program provides a unique blend of academic rigor and clinical relevance, helping to bridge the gap between research and practice and preparing students for their future role as skilled, evidence-informed professionals. As the healthcare field continues to evolve, this kind of research exposure will be essential for midwives seeking to improve care and outcomes for women and their families.

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Co-design research: What does it mean, and why should we do it?

By Jo River, Katherine Gill, Mark Goodhew, Chloe Sinclair and Fiona Orr

Internationally, lead agencies, consumer and disability movements emphasise the need for people with lived experience to be involved in all stages of the research process (NHMRC, 2018; NIHR, 2015).

Research Involvement sits on a continuum from 'non-participation' where people with lived experience are recruited as subjects or participants for a study, to mid-level participation, where people are consulted about the research, but have little influence over the research design or conduct; through to high-level participation, using approaches such as co-design or co-production, which involve genuine research partnerships with people with lived experience in one or more stages of the research process (Bellingham et al. 2023).

The 'gold standard' for co-design research has been described as a process of continuous, paid, and equitable participation of people with lived experience who work alongside non-lived experience academic or clinical researchers. In other words, co-design research is not simply consulting people about a research issue or method. Rather, best practice co-design is about co-deciding with people with lived experience through all stages of the research process, including co-planning, co-designing and co-conducting research, and co-disseminating research findings (Bellingham et al. 2023).

Co-design research is particularly pertinent to people living with stigmatised health conditions, such as people with mental health challenges, substance dependence, blood-borne illnesses, or illnesses with no known functional cause (eg. Functional Neurological Disorder [FND]). These groups often face multiple disadvantages in accessing support, including experiences of discrimination in health services, with impacts on access to services and health outcomes.

While we look to research to improve the situation of people who face discrimination in health services, research itself can reinforce rather than challenge stigmatising perspectives. Millum et al. (2019) gives the example of public health research, which, in aiming to prevent foetal alcohol syndrome by de-normalising drinking during pregnancy, inadvertently contributes to the stigmatisation of people with foetal alcohol syndrome and their parents.

Lived experience participation in research is associated with improving the relevance of research priorities and outcomes to affected communities and raising the quality of research interpretation and translation in health services (Brett et al. 2012). However, lived experience participation in research is not only a matter of improving research quality and relevance – with associated benefits for health services – it is also a matter of knowledge justice. Consumer and disability movements have argued for *'nothing about us without u'*, which points to the rights for self-determination of people with lived experience in the design and conduct of research that is not only about *them* but can have significant impacts on their lives and their health service experience.

To give an example. Functional neurologic disorder (FND) is a common neurological condition related to problems of functioning and connectivity of the central nervous system without structural damage that leads to involuntary motor, sensory, and/or cognitive symptoms. People with FND frequently face disadvantages in accessing support and experiences of stigma and discrimination in health services (Bailey et al. 2024). Yet, the research base for FND – which is dominated by researchers and clinicians working in institutions and organisations that have perpetuated stigma towards people with FND (Foley et al. 2022) – has itself been criticised for being deficit-based and stigmatising (Gill, 2019).

For instance, although FND is involuntary, research can reproduce the idea that people with FND fabricate or exaggerate symptoms to manipulate health providers. To improve the quality of FND research, and reduce the potential for stigmatisation, there have been calls internationally for involvement of people with lived experience of FND in health research (Foley et al., 2022).

In response to this call, our team co-planned, co-designed and co-conducted research with people with lived (and

living) experience of FND. Our team found that the involvement of people with FND was vital for shifting the research from deficit-based to strength-based. This included focussing on the skills and knowledge of people with FND in navigating daily life and health services and what kinds of service provision supported them in doing so. This has led to important findings about the skills and unmet support needs of people with FND, as well as findings about how health professionals can use their personal agency to perpetuate or prevent stigma and discrimination towards this patient group.

Many systemic barriers to high-level participatory research remain, including inadequate knowledge or funding to support genuine partnership (Bellingham et al. 2021). However, co-design will likely become the 'new normal' in research-informed policy and services (Jones, 2022, p.125) as a matter of knowledge justice, positively impacting the relevance and quality of research knowledge and health service provision to stigmatised communities.

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Superannuation on paid parental leave: Addressing gender inequity in retirement

The ANMF, along with other unions, has welcomed landmark reforms that go some way in rectifying a historic inequity that costs women thousands of dollars in retirement savings and contributes to the stark gendered retirement gap.

The Albanese Labor Government has legislated paying super on government-funded paid parental leave (PPL) with the passage of the *Adding Superannuation for a More Secure Retirement Bill 2024* in the Senate. From 1 July 2025, from 11.5% to 12% superannuation will be paid on government-funded PPL.

"This announcement comes off the back of more than a decade of ANMF members campaigning to win equal retirement outcomes for women, it's an outstanding result for so many who campaigned long and hard for this reform," said ANMF Federal Assistant Secretary Lori-Anne Sharp.

Paying superannuation on PPL was a key recommendation of the Women's Economic Equality Taskforce and has long been campaigned for by unions and the women's movement to secure fair retirement outcomes for women.

Parental leave is the only commonly taken form of paid leave that does not include superannuation, sending a clear message that paid caring work is undervalued. The new legislation will bring Commonwealth PPL in line with other workplace entitlements.

"This will go part way in closing the Superannuation gap that ensures women retiring with up to a third less retirement savings than men." said Ms Sharp.

Further strengthening of paid parental leave entitlements is important to nurses and midwives, said Queensland Clinical Nurse (CN) Kathleen Dyer-Moore who underwent stomach hernia surgery five weeks after delivering her daughter by caesarean.

"I was forced to start my 14 weeks of maternity leave early, and after giving birth to my daughter via c-section, I required a second surgery five weeks later for a stomach hernia. I found myself out of paid leave and unable to lift my daughter or care for my 20kg three-year-old son." This left her family in thousands of dollars of debt.

GENDER INEQUITY

More than 180,000 women receive parental leave payments a year, making up 99.5% of Commonwealth PPL recipients, meaning the inequity of the loss of super has been nearly entirely on women.

Women with children face an average 55% drop in earnings in their first five years of parenthood, and on average retire with 25% less superannuation than men.

Some women remain blissfully unaware until they check their super balance, as was for Melbourne clinical nurse Alison Crane. "I didn't even think that superannuation payments weren't included in my pay. I estimate I have about $47,000 less than my husband's superannuation balance, due to the time I took off to look after our children."

In addition to the loss of super is the absence of compounding interest on retirement savings when parents take time off work to care for their children.

Research conducted in 2022 by super fund HESTA found a significant proportion of members surveyed were stressed about the financial penalty they would pay later in life from taking time out of the workforce to raise children – which is not insignificant. The survey found the average total parental leave taken amounted to approximately 14.7 months, and more than half of those respondents had taken two or more periods of parental leave.

"Birth is a life stage that should be celebrated, not a crisis to worry about," said one full-time aged care worker, aged 31.

Proposed amendments by the Coalition to the government's legislation on superannuation for Commonwealth PPL would see workers tap into their retirement savings by allowing for cashing out of super on Commonwealth PPL through taking a lump-sum or extra leave. The move was met by disapproval by some super funds and unions alike.

"No one should be forced to choose between supporting their babies now and their own financial security in retirement. Unions know we can and should do both," said Australian Council of Trade Unions (ACTU) President Michele O'Neil.

PAY DAY SUPER REFORM

A further win for Australian workers under the new reforms is that super is paid with wages which will come into play by 2026.

Super Consumers Australia is an organisation who stands for ensuring that the superannuation industry is held accountable for the outcomes they deliver to Australian consumers. It considers requiring employers to only pay super every three months is the product of a bygone era which is no longer reasonable or relevant and makes it more difficult for employees to track unpaid super.

Previous government efforts to fix the challenge of unpaid super have had varied levels of success. The aligning of super contributions with wages allows the ATO to better monitor super payments in real time and gives greater visibility to workers to monitor payments and detect underpayments.

FURTHER EQUITY REFORMS

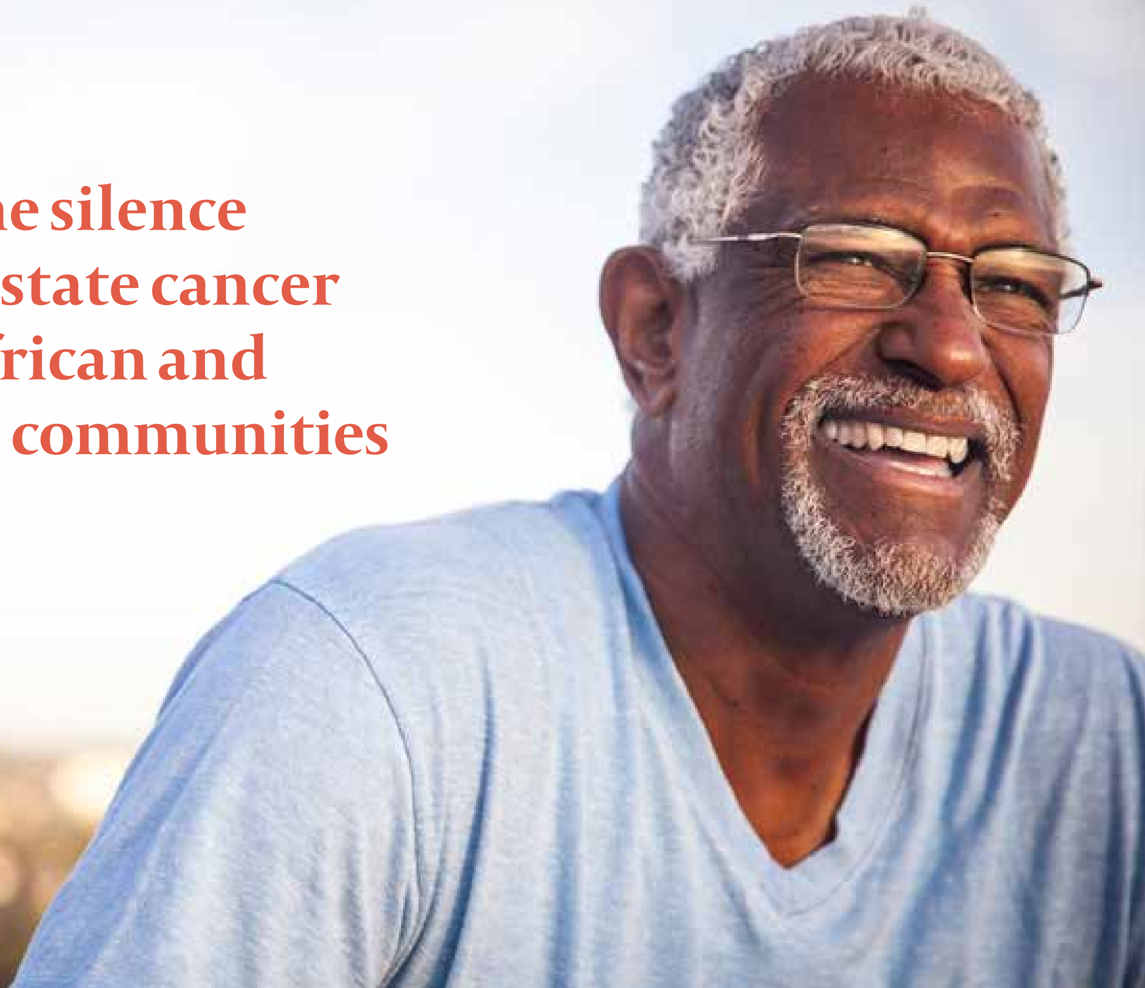
The ANMF has welcomed these reforms and will be seeking commitment from political parties to further equity measures in the lead up to the upcoming federal election.

"It is crucial that super equity reform continues to address the disparities many women face," said Ms Sharp. "It is also vital that superannuation is preserved to be used for a dignified retirement and not be the solution for social and economic problems.

"For example, the Coalition are pushing for early access to superannuation to solve the housing crisis. This will potentially only lead to an increase in demand in housing, higher home prices and reduce savings in retirement.

" Superannuation is intended to provide for retirement using it for housing undermines that purpose."

Breaking the silence around prostate cancer for black African and Indigenous communities



By Michelle King-Okoye

Prostate cancer (PCa) is the most prevalent cancer and main cause of cancer death among men of black African and Indigenous communities (BAIC).[1,2] These subgroups tend to have poorer outcomes due to being diagnosed at advanced stages (Stage IV and metastatic PCa), at younger ages (less than 40 years), and are more likely to be diagnosed with aggressive pathologies than other races.[3,4]

BACKGROUND AND IMPORTANCE

In addition to these disparities, there is a concerning lack of awareness of PCa across these communities and a critical dearth of data representing black men, which links to lack of participation in clinical trials and genomic studies.[5,6]

SILENCE AMONG MEN WITH PCA

A culture of silence intrinsically linked to distrust in healthcare providers (HCP) and health systems emerged in a study conducted with diverse ethnic subgroups of black men diagnosed with advanced PCa.[7] More recent work conducted with similar subgroups of men in the United Kingdom (UK) and supported by the International Collaboration for Community Health Nursing Research (ICCHNR), echo these findings.[8] Interestingly, the culture of silence was twofold for both studies, as seen in **Figure 1**, particularly among physicians, who were also reticent about prostate symptoms and overall prostate health during consultations. Black British men and partners emphasise lack of engagement with their GPs: pre-diagnosis, diagnosis, and post-treatment stages. This substantive theory highlights complex intersections of healthcare, socioeconomic, masculinity and cultural factors. Distrust experienced by BAIC are underlined by historical injustices, such as slavery, ethical malpractice, and longstanding systemic discrimination. Reflecting on the 'USPHS Untreated Syphilis Study at Tuskegee', which lasted for 40 years and resulted in many deaths; these are grave concerns contributing to lack of trust and unwillingness to participate in research.[6,9]

COMMUNITY NURSES AT THE FOREFRONT TO RE-ESTABLISHING TRUST

Described as, *"an interpretative bridge between the acute sector and community services"*, by the Australian Primary Health Care Nurses Association (APNA), community nurses play an instrumental role as advocate and navigator for service users.[10] Re-establishing trust requires a multifaceted approach, with nurses leading different care pathways. Translating the findings provided a framework for the SPEAK app prototype.[8] Men and partners verbalised *'Wanting to connect'* with HCPs in safe non-judgemental spaces and a smartphone app was highlighted by most participants as a platform and mediator to share concerns and engage with HCPs. For BAIC, cultural capital is a core element (**Figure 2**), which is one functionality of the SPEAK app.[11,12]

Co-production with nurses, different subgroups of men, information specialists, charities, and oncology staff, are critical in breaking multifactorial barriers underlying silence. Re-building trust with marginalised communities is indeed a long-term goal that may involve transparent processes and mass but intimate communication, utilising trusted health and cultural champions and health promotion strategies targeting BAIC.

FIGURE 1 shows the substantive theory of silence[7]

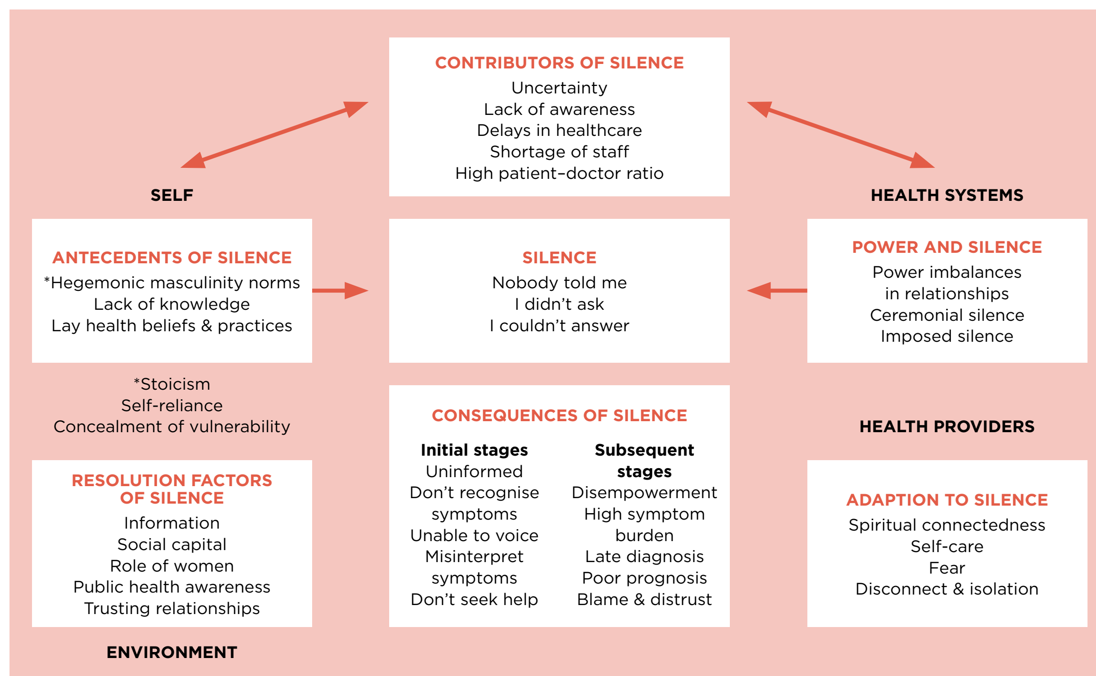


FIGURE 2: Theoretical framework that includes cultural elements related to health and illness[7]

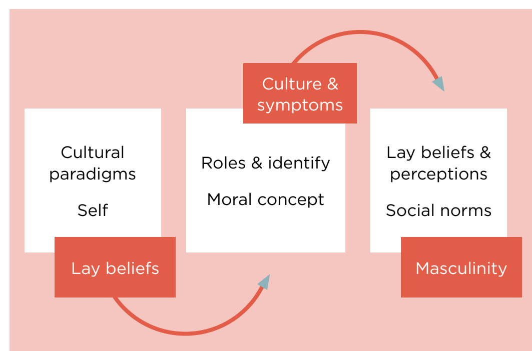


FIGURE 3: Components of the SPEAK AP and multifaceted approach involving nurses[8]

The SPEAK app involves nurses' pivotal role in breaking the silence.

The SPEAK app prototype (SPEAK AP) can be used on any smartphone device and web-browser and facilitates diverse accessibility needs (**Figure 3**). Designed for BAIC, SPEAK AP is offered as a mediatory solution to tackle the culture of silence. SPEAK AP uses a family and community framework, involving nurses as cornerstone to re-build trust with BAIC communities. Nurses' role as gatekeepers in providing men and their partners with access to SPEAK AP, offering 1:1 for any questions and concerns via engagement stages, facilitating focus/support groups to reflect on during follow-up care and leading randomised control trials to evaluate the SPEAK app's role towards self-reporting prostate symptoms for PCa. Re-building relationships and re-establishing trust will facilitate earlier diagnosis and timely treatment and reduce mortality rates for cancers across BAIC. Although the SPEAK app prototype design and functionality are grounded in data, there is a critical need to conduct more feasibility studies with larger groups of men to determine its effectiveness in reducing PCa deaths and applicability to other cancers across BAIC, including other subgroups.

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Dalya Holowinski

Dalya Holowinski, RN, Grad Cert critical care, Grad Cert International Health, Grad Cert Health Services Management, Bach. Train and Development, Graduate ACN Nurse Director Program is District Nurse Educator at Murrumbidgee Local Health District in NSW

A roving clinical nurse educator role

"We can't solve problems by using the same kind of thinking we used when we created them. If you want different results, do not do the same things."

ALBERT EINSTEIN

This quote from Albert Einstein has often inspired thinking outside the norm. Using the same kind of thinking in nursing has led to some of the issues we face daily. Rostering, retention, attraction, and career development are many processes that have not changed in rural and remote health in Australia.[1]

Delivering education in practice settings where learners are experiencing moderate-to-severe stress is a huge barrier to learning. It is time to acknowledge the limitations of the educational model that have focused on large institutions in big cities. If teaching in large metropolitan hospitals has yet to deliver on improving the scientific basis of everyday clinical practice, the argument for focusing teaching and training in such institutions is losing validity.[2]

There are areas in healthcare education that have tried something new and succeeded, such as the introduction to change in education programs demonstrated by the NHS led T-Moments.[3]

In this way, learners can develop skills and attributes for effective partnership working and enhance their nursing practice by developing their understanding of patients' illness experiences and perspectives.[4]

However, many are still mostly afraid to think differently. So, that got me thinking: What if trying something different will work?

Whilst the world deals with a shortage of nurses, we also experience this in nursing education. Burnout is causing nurses to exit the profession en masse. A 2021 report illustrates that 62% of hospitals are reporting a nurse vacancy rate higher than 7.5%; Health Workforce Australia (HWA) is estimating that there will be a shortage of over 100,000 nurses by 2025 and more than 123,000 nurses by 2030.

In my rural workplace in Australia, we have been compelled to rethink our approach to nursing education vacancies. The current model of a part-time onsite educator has not been attractive during the current nursing shortage. This is evidenced by long-term vacancies at multiple locations in rural areas in Australia. Sites remain without educators for long periods or have educators working on the floor.

So, how do we fill long-term vacancies in nursing education during the current nursing workforce shortage? Advertising campaign after campaign on the same platform has not produced interest from any of the experienced educators or nurses still practicing in rural my healthcare district.

The same way of thinking and problem-solving in nursing education has not solved the modern problems of an ageing workforce, declining retention rates, declining professional development, and an increasing junior workforce.

Radical, wide-ranging reforms are urgently required from the government and other decision-makers to effect widespread and sustainable changes that ensure a suitably sized, supported, and recognised nursing workforce.[5]

How do we embrace the thought process of Albert Einstein in nursing and, more specifically, in nursing education? We do this by thinking differently and embracing some new ideas. Nurse Educators can impact nursing practices and indirectly improve patient outcomes, making them an integral component of the interprofessional team in healthcare.

> ***Radical, wide-ranging reforms are urgently required from the government and other decision-makers to effect widespread and sustainable changes that ensure a suitably sized, supported, and recognised nursing workforce.[5]***

Why not have a different model for staffing our educators? Why not centralise nursing education? How do we stop the Educators' gap-filling the workforce so they can spend time attending to essential education and early career nurse support? It is why not do it that triggered a change of thinking. Embedding education in care provision and developing the conditions needed for effective learning may bring benefits across an organisation.[6]

We all understand how lack of education and support can lead to low morale and errors in the workplace. There are multiple and interrelated factors that can lead to patient harm, and more than one factor is usually involved in any single patient safety incident: system and organisational factors: the complexity of medical interventions, inadequate processes and procedures, disruptions in workflow and care coordination, resource constraints, insufficient staffing and competency development.[7]

So, if we do something different, we may get different results. A perspective from a Clinical Nurse Educator found that workplace education can be given more prominence and support across the nursing spectrum and that the clinical educators of Australia can find more opportunities to share their ideas and innovations with each other.[8] Why can't we commit to valuing education and its impact on career development, nurses working at the top of their scope, retention, and job satisfaction?

Thinking like Albert Einstein helped me create and develop an idea to change our current Clinical Nurse Educator Model into a centralised source of education that moves nurse educators to where they are required.

> ***The Roving CNE model can be claimed as a successful implementation of how to do something different, work through changes and have permanent success noted, which has gained attention from other locations.***

Considering our increasing junior workforce, a pilot was created for a District Clinical Nurse Educator model that allowed for qualified Clinical Nurse Educators (CNEs) to "rove" around the district and come to the workplace for education needs. This new model would allow the CNEs to not be rostered to take a clinical load at any time and their reporting line will be to a district manager and/or district nurse educator. Within health, ensuring that nurses can work to their full scope of practice and operate as respected and equal members of multidisciplinary teams with funding models that effectively and appropriately support nursing care is vital to creating a context where nursing shortages can be solved in the long term.[5]

The chief executive and district director of nursing supported the pilot through a business case application process. Funding was requested for two three-month temporary Clinical Nurse Educators as part of a solution to supporting our graduate workforce. The role was advertised internally, and over 10 applicants with significant clinical experience applied.

Negotiations commenced with, managers and directors of nursing for a secondment into the role for three months. This required a lot of tact and convincing for the greater good of the district for staff to be released and placed into the new Roving Clinical Nurse Educator position.

During the three-month trial, data was gathered on the impact of percentage change to mandatory training, individual skills development, and staff feedback. Immediately after the first week, one site saw a 30% increase in mandatory training. Skills were identified at individual sites through the CNEs speaking and working onsite with staff, including nasogastric tube insertion, indwelling catheter insertion practice and accreditation, venepuncture and cannulation, ECG transmission, A-G focused assessment, deteriorating patient scenarios, and sepsis education. Onsite staff and managers immediately adopted this roving CNE support to help with the completion of skills and mandatory training built into their working shifts. Nurses appreciate these shorter sessions and managers can collaborate with the clinical instructor on areas or topics that are problematic for the staff.[9]

Immediately, the nurse unit managers (NUM) at multiple sites welcomed the assistance of a district CNE and requested that the CNEs return to the site later. Managers and staff sent highly positive feedback to the District Director of Nursing and Midwifery Services and District Educator. Planning in the Educator's calendar was quickly required to keep up with demand. Before we knew it, this information and highly positive feedback reached the Chief Executive. From this, and before the completion of the pilot, two permanent clinical nurse educators' positions were funded with another two funded in the following three months.

Slight alterations to the CNEs reporting structure to include a District-based Nurse Manager Advisor, and communication, weekly online catch ups, also allowed more meaningful conversations, planning and scheduled meetings, along with a title change from District CNE to Roving CNE.

The pandemic, climate change, war, and political and economic pressures are catastrophic for many but could motivate to finally take genuine and decisive action to develop and implement radical, multi-pronged, multi-sector reforms to address nursing shortages and working conditions and to help to solve a range of other healthcare system and social challenges.[5] From Albert Einstein's thinking process and the development of a new model in education, a rural nursing workforce is now thriving in education and proceeding with additional skill development, retention, and support for early career nurses in a large rural workforce. The Roving CNE model can be claimed as a successful implementation of how to do something different, work through changes and have permanent success noted, which has gained attention from other locations. We also see scalability in developing other areas of education and centralising educators that then rove out within the hospital for support and education, not just in the traditional allocation only to a specific area model.

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Daniel Crute

Federal Industrial Officer

An update on our Work Value cases

The ANMF currently has two Work Value cases before the Fair Work Commission (FWC).

WORK VALUE CASE – AGED CARE INDUSTRY

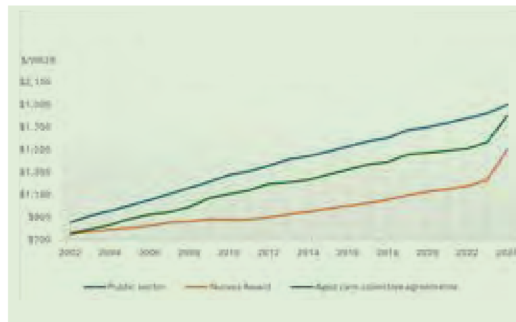
This case commenced in late 2020 and was progressed due to the efforts by the ANMF and Health Services Union.

The wages gap between nurses and carers working in aged care and those working in the public sector has narrowed because of the Aged Care Work Value Case (ACWVC), with the interim decision of the FWC increasing rates of pay for nurses and carers by 15% effective 30 June 2023.

Due to Commonwealth Government[1] guidelines, the full value of this 15% was flowed to nearly all nurses and carers, including those covered by pre-existing enterprise agreements (EAs).

Nationally, 154 EAs have been negotiated in the aged care sector since the ACWVC increases started to flow through to nurses and carers in July 2023. These new agreements have had to factor in the higher rates in the Nurses Award 2020 (Award) and the Aged Care Award 2010.

Nursing wage disparity 2002–2024 Public sector and aged care



The graph above shows an example of the stark increase in nurses wages in the aged care sector since the ACWVC. The weekly full-time top paypoint of the RN Level 1 classification (or equivalent) is shown with public sector figures being an average of the states and territories.

From August 2022 to August 2024 the rates of pay for nurses and carers working in aged care have increased around 25%, including national safety net adjustments.

WORK VALUE CASE – NURSES AND MIDWIVES

This case commenced in early 2024. This second ANMF application seeks to increase wages in the Award for all nurses, midwives and nursing assistants who do not work in the aged care sector. It also seeks to rename and update the Award to acknowledge its coverage of midwives.

This case now also includes the finalisation of the classification structure and rates of pay for nurses working in aged care.

HOW THESE ANMF CASES AFFECT YOU

These cases are most relevant to ANMF members working in Fair Work Act jurisdictions, being private sector members plus the public sector in Victoria, the ACT and Northern Territory. However, public sector employers in all jurisdictions are acutely aware of the case and its potential flow-on effects.

Aged care nurses and carers received an increase in their hourly rate of pay to reflect the 15% interim increase to award wages for aged care workers. This increase may be in your EA or have been passed on in addition to any EA increases. Future increases in this case must also be passed on.

When your current EA is up for negotiation, any new rates must be no less than the Award rate.

When there is an outcome in the Nurses and Midwives Case, the process and effect on your EA will be like the ACWVC. EA rates in the private sector have historically been set at higher rates than Award rates, so the impact of any Award increase on EA rates will vary depending on the employer.

If you are paid above Award rates after any increase, you may still get a pay rise because of enterprise bargaining or requirements to pass on additional Government funding to your sector.

If your current rate of pay is less than the new Work Value Award rate, you must receive a pay increase to ensure you are paid the Award rate as a minimum.

Whatever the FWC Expert Panel decides, it should be noted that the ANMF cannot determine the outcome. For example, the ANMF case has consistently been to maintain the current relativities in the Award. However, as an independent umpire, the FWC Expert Panel may decide to implement something different.

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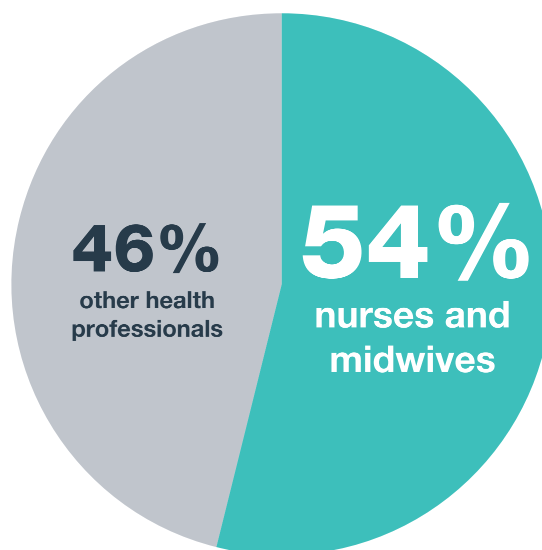
nurses, nurse practitioners, and midwives, and recently retired nurses and midwives in Australia

473,672

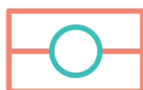
nurses, nurse practitioners, and midwives registered to work in Australia

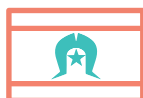
180,000

exited in the past 10 years



54% of Australia's health workforce are nurses, nurse practitioners and midwives.





6,776

nurses and midwives are Aboriginal and Torres Strait Islander, with nearly half employed outside metropolitan areas

nurses and midwives have spearheaded the promotion of culturally safe care, including for Aboriginal and Torres Strait Islander peoples

Nurses, nurse practitioners, and midwives can do more.

Nurses, nurse practitioners, and midwives want to do more.

Nurses, nurse practitioners, and midwives are calling for the adoption of the Scope of Practice Review recommendations and further reforms to fully utilise their skills and improve healthcare outcomes for all Australians.

GRADUATES & STUDENTS

Practice development, improving culture and experience for graduate nurses and healthcare consumers

By Jenna Georgacopoulos

Practice Development (PD) is an effective approach in supporting healthcare professionals at all levels to flourish.[1]

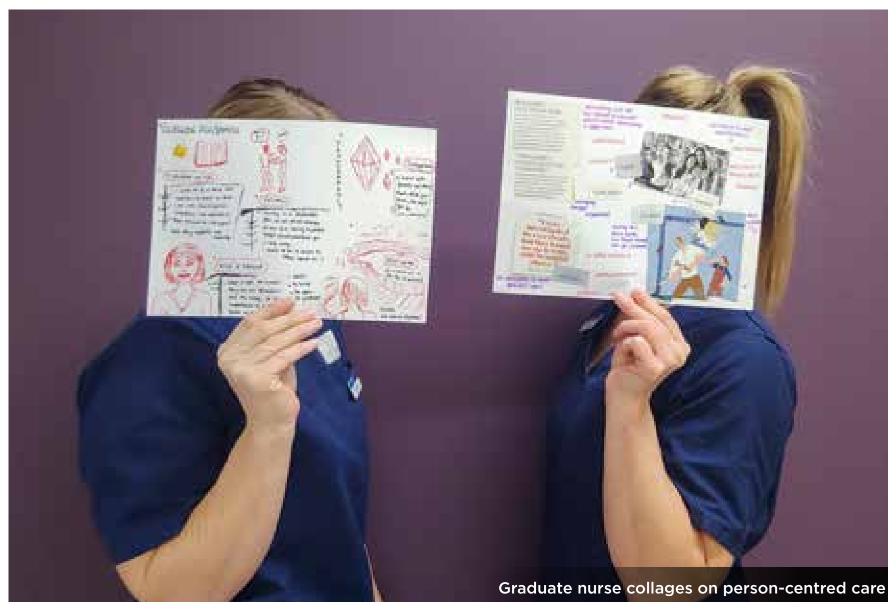
The PD process is cyclical, multilayered, and complex however the outcomes are straightforward: to improve staff and consumer experience through building shared values and beliefs and fostering person centred culture.[2]

It is widely documented that graduate nurses experience transition shock when entering the workforce.[3]

Navigating major change personally or professionally is a daunting time, however, a person-centred culture can reduce the impact of this through feeling connected, sharing values and joint decision making.[2]

Nurse Educators at Central Adelaide Local Health Network (CALHN) have undertaken PD study and practical training. This has led PD to become the default approach for many components of their work including team building and curriculum design for the graduate nurse programs. These programs support over 400 early career nurses annually.

The CALHN education team has undertaken significant work over the past 12 months to shape a person-centred culture and build upon shared values and beliefs driving behaviours to achieve agreed upon goals. It was important to immerse the team in PD principles, investing time in the educators who support early career nurses to ensure that team culture was one where all could flourish, and do their best work. This investment is an ongoing process which is nurtured through workshops that utilise CIP principles (collaborative, inclusive and participatory) to ensure any decisions on workplace change or ways of working involve all team members with the removal of any hierarchy. A shared vision of supporting graduate nurses in transitioning to professional practice and delivering person-centred care for CALHN consumers is always front and centre and has underpinned the graduate nurse curriculum redesign.



Graduate nurse collages on person-centred care

A key component in the PD process and within the program curriculum is critical creativity which has evolved over several decades within PD.[4] Critical creativity is used to tap into individuals' artistic abilities for deeper thinking, reflection, and more meaningful learning. An example of how critical creativity is being used within the curriculum at CALHN is the person and family centred care artwork sessions. In the first week of employment graduate nurses receive three days of training. During these days they take part in a session where they reflect on what it means to them to be person and family centred healthcare professionals. Reflecting deeply on past experiences and personal values they are asked to create a collage using various art supplies to represent their top five non-negotiable values. This collage is used to represent their desired professional identity and way of practice. The graduate nurses then commence working in their allocated clinical area.

Approximately two months later in a subsequent education session these collages are provided back to the graduates. They then have an opportunity to reflect on these values and how some of them may have been challenged or difficult to uphold in the demanding healthcare environment. This reflection is often a time of grief when the expectations do not meet the realities of such a challenging role and graduates grieve the nurse that they had set out to be. Educators debrief with those who are experiencing this researched phenomenon and provide reassurance that overtime with experience and confidence graduates can reclaim these values, flourishing into that nurse they set out to be, and the journey continues.

Feedback from sessions like the example provided have been positive with many appreciating the opportunity to reflect and learn in a safe environment and debrief with peers. The educators at CALHN are excited to continue to implement more PD throughout the curriculum, the reward of seeing novice nurses benefit from this approach continues to be worth the investment.

We welcome the opportunity to share more information and collaborate with other health networks.

Author

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Advancing stoma care education through simulation-based learning and lived experience

By Sharon MacLean

Simulation-based education (SBE) has emerged as an effective pedagogy for developing clinical skills in nursing education.[1]

One area where SBE has proven particularly effective is in teaching stoma care, an essential nursing skill for caring for patients who have undergone ostomy surgery. At Curtin School of Nursing, we have integrated SBE with real-life insights from ostomates, providing a comprehensive learning experience for our nursing students. Semester 7 students, who are completing an Advanced Wound Care Unit as a specialty, benefit greatly from this approach. By combining SBE and ostomate experiences, student nurses are better prepared to handle the complexities of patient care in this specialised area.

Stoma care requires nurses to master intricate skills, such as proper pouch changes, skin care, and managing complications like leakage, peristomal skin infections, irritation, allergic reactions, and trauma.[2] SBE offers students a safe environment to practice these skills, allowing them to gain confidence without the risk of harming a patient.[3] Through this method, students practice, receive feedback, and refine their techniques. In our nursing laboratories, students engage with high-fidelity realistic stoma models that mimic real-life scenarios, enabling them to develop critical thinking skills. By combining theoretical knowledge with hands-on simulation training, our wound care unit empowers students to become competent and compassionate stoma care nurses, ready to make a positive impact in the healthcare industry.

While SBE provides an excellent foundation for skill development, it is the human experience that truly brings stoma education to life. To complement the SB, we invite ostomates – individuals who live with a stoma – to share their personal stories with our students and teach them how to apply and troubleshoot caring for a stoma. This collaboration offers students invaluable insights into the day-to-day challenges and emotional aspects of living with an ostomy. Ostomates share their experiences, demonstrate how they manage their own stoma, answer questions, offer practical advice and allow our students to change their appliance and trouble shoot common complications such as leakage. For our students, this firsthand knowledge helps them understand the broader context of long-term stoma management, bridging the gap between classroom learning and clinical practice.

By combining SBE with the real-life experiences of ostomates, we provide a holistic learning environment that prepares nursing students for the multifaceted nature of stoma care. Students gain the technical skills necessary to deliver high-quality care and develop the empathy and communication skills needed to support patients emotionally and psychologically. This comprehensive approach is particularly beneficial for students caring for ostomates, as they integrate enhanced management principles into their stoma care practice. As SBE continues to evolve and emphasis is placed on learning from lived experiences, the potential to enrich nursing education and improve patient outcomes grows stronger. In the area of stoma care, this method is already making a significant impact, especially for our students focusing on stoma management.

Author

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Curtin student gains valuable experience caring for an Ostomate

Curtin student gains valuable experience caring for an Ostomate

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A pathway to success: A collaborative approach to recruiting Aboriginal and Torres Strait Islander new graduate nurses and midwives

By Lorraine Thompson, Amanda Nauman, Aunty Leone Smith, Renae Vaughan, Junel Padigos, Judith Gonzalez and Annette-Faithfull Byrne

Health inequalities exist for Aboriginal and Torres Strait Islander peoples.[1,2] A key element of closing the gap and reducing health inequities requires building a culturally capable and safe workforce.[3,4,5]

Increasing the number of qualified Aboriginal and Torres Strait Islander professionals is an important step in this process; however, a significant cultural disparity persists in the Australian health workforce, particularly in nursing and midwifery.[6] New graduate programs are an established way of providing support for novices as they transition into their professional roles.[7,8] However, positions in these programs are limited and recruitment processes can be highly competitive. Performing well in interview and successfully navigating the recruitment procedures, are essential skills for potential applicants.

In 2021, a review of the Hospital and Health Service (HHS) new graduate program revealed that Aboriginal and Torres Strait Islander new graduates were significantly underrepresented. To address this disparity and respond better to the needs of Aboriginal and Torres Strait Islander graduates, a culturally tailored recruitment and mentorship pathway was designed. The aim was to refine recruitment processes in a culturally safe way that supported the Aboriginal and Torres Strait Islander new graduates. Thorough consultation was conducted over several months with various stakeholders including executive, clinicians, the HHS Aboriginal and Torres Strait Islander hospital liaison officers and the local university's Indigenous nursing/midwifery mentor. This partnership and shared decision-making ensured the initiative aligned with the National Agreement on Closing the Gap.[9]

Outcomes from the initiative included:

- Increase in New Graduate Program capacity of four dedicated places for Aboriginal and Torres Strait Islander graduates annually.
- In the university, tailored education sessions are now conducted by liaison officers for Aboriginal and Torres Strait Islander final year students. Sessions include writing curriculum vitae and negotiating the graduate program selection/interview processes.
- In the HHS, all Aboriginal and Torres Strait Islander new graduates are now offered support and mentorship from the cultural team throughout the recruitment, selection, and onboarding processes. This continues throughout the duration of the graduate year, over and above the existing support provided for new graduates by clinical coaches at the point of care.[10,11]
- Regular communications are maintained and decision-making regarding Aboriginal and Torres Strait Islander graduates, inclusive of any challenges, is shared between the Graduate Program Coordinator and the Aboriginal and Torres Strait Islander cultural team throughout the graduate year.
- In 2021, there were no Aboriginal and Torres Strait Islander applicants selected for the New Graduate Program. Since the collaboration, there has been an increase of Aboriginal and Torres Strait Islander new graduates who have met merit and attained a position: in 2022 (n=5;4%), 2023 (n=7;6%), and 2024 (n=6;5%), respectively. In 2022, one graduate withdrew from the program due to difficulties in living off country from their mob. These numbers demonstrate the success of the program in addressing the disparity.

The Sunshine Coast region has a small population (2.4%) of Aboriginal and Torres Strait Islander peoples[12]. Supporting Aboriginal and Torres Strait Islander new graduates in their cultural and professional development not only increases the overall cultural competence of the entire health workforce but importantly, it also improves the disparity of Aboriginal and Torres Strait Islander employees in the region who are qualified health professionals.

(L-R) Natasha Hawkins, Mitchell Eldridge, Aunty Leone, Nikki Spencer and Amanda Naumann

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Optimising the midwifery workforce: Providing acute care in early pregnancy

By Nicole Freeman

Midwives are recognised as being experts in the provision of primary maternity care,[1] yet women in Australia experiencing unexpected complications in early pregnancy (eg. miscarriage) may not receive care from a midwife.

In Australia, women presenting with acute symptoms such as pain or bleeding in *early pregnancy* (<20 weeks) often receive care in an emergency department (ED) or gynaecology service. These services do not traditionally employ midwives. Midwives' scope of practice in Australia covers a wide spectrum of reproductive and sexual healthcare, including care throughout the entirety of pregnancy.[1,2] However, midwives more commonly work in settings caring for women from 20 weeks. Consequently, midwifery practice in acute early pregnancy care is not well understood.

I'm excited to be undertaking research exploring midwifery practice in acute early pregnancy care in Australia. Although midwives are providing care in some settings, including early pregnancy assessment services (EPAS),[3,4] there has been no documented exploration of the role and scope of the midwife in this area of practice in Australia. This is despite clear evidence that improvements in *how care is provided*, and *who provides it*, is required.[3,4]

My research is improving our understanding of this area of pregnancy care and midwifery practice in Australia. Initial study phases – a scoping review,[4] and clinician interviews,[3] explored the practice of both midwives and registered nurses (RNs). A nationwide midwifery survey is now in progress.

My 'Take 5' from the research so far:

1. In Australia, pregnant women with acute complications <20 weeks often attend non-maternity settings and may not receive midwifery care
2. Many midwives have limited exposure to women with acute early pregnancy complications, facing barriers to employment in settings that traditionally employ RNs
3. EPAS models facilitate autonomous practice enabling scope fulfilment, where midwives provide comprehensive physical and psychosocial care for women and families
4. Midwives and RNs in ED settings may find it difficult to meet women's needs given the limitations of the physical environment, expectations regarding scope capacity, and competing workload pressures
5. The potential for midwives to provide timely, individualised care to women experiencing unexpected complications in early pregnancy is largely unrealised and worthy of further exploration

Follow along with my research at **nicolefreeman.my.canva.site**

Acknowledgements: Nicole is a PhD candidate supported by a Western Australian Future Health Research and Innovation Fund, Clinician Research Training Scholarship, Curtin University and North Metropolitan Health Service, Western Australia. She is supervised by Dr Zoe Bradfield, Professor Tracey Moroney, Dr Jane Warland and Dr Kate Cheney.

Providing opportunities for newly qualified midwives to provide acute early pregnancy care – Nicole works alongside graduate midwife Liz Cornish

Midwife Nicole Freeman is a clinician researcher, working in an EPAS in WA, and exploring midwives' role and scope of practice in acute early pregnancy care through her PhD studies

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Why education makes better nurses

By Cathy Almond

When I first started teaching at TAFE, I was worried that I would not know enough.

When I realised I had enough knowledge, there was a sense of relief – I could teach them something and they would be able to perform procedures because of what I taught them. However, it became apparent, that this was not enough.

I wanted my nurses to become critical thinkers. I wanted them to do something because they understood the rationale behind what they were doing, not because I had taught them the skill.

Being involved with education means being able to transform a person who does not know- to someone who does know, transferring information, knowledge, skills, and capability then ultimately wisdom. I give them the training, skills, ability, and confidence to go from there.

While it's exciting, it can also be daunting. Many students enter nursing uncertain about their ability to reach their goals. Our aim is to support them on their journey, helping them get to where they want to be. We can't do it for them, but we can equip them with the tools to succeed.

Critical thinking is one of these essential tools. It goes beyond problem-solving, it's about taking a holistic view of a situation, carefully weighing the evidence to make informed decisions while being mindful of any biases that may influence your thinking.[1]

Nursing is based around critical thinking; you make sense of a situation and act because of your skills and knowledge. I came to know that my nurses needed to be critical thinkers, so they could decide on a course of action because they understood the situation and could interpret what was going on.

This is also part of the *Enrolled Nurse Standards of Practice*. The Domain 'Reflective and Analytical Practice' covers this under Standard 8, Provides Nursing Care that is

informed by research evidence.[2] Under this domain, Enrolled Nurses are expected to use critical thinking to make decisions, analyse all available information and consult with the RN if unsure.

Over time, the responsibilities of nurses have grown, and with that, the pressure to accomplish more in less time has intensified. This can make the temptation to cut corners stronger. I quickly realised that my students were observing me and following my example. If they saw me doing something that wasn't best practice, they would feel it was acceptable for them to do the same. This removed critical thinking from the action. It enabled them to justify their behaviour, rather than use critical thinking to process what they were doing.

Some students come from a health background. They have been taught to go to their supervisor with a problem. I ask my nurses to go to the supervisor with a solution, using critical thinking to make sense of the situation. This shows initiative, but more importantly, critical thinking.

We discuss "best practice" with students as the ideal standard, though it isn't always the reality during placements. This doesn't mean placements aren't effective, but rather that variations exist in how procedures are performed. When we talk about best practice, we focus on the underlying principles and following these, rather than prescribing a single "right way" to do something.

This is where and why I see critical thinking as important.

Critical thinking teaches students to understand the principles around their actions. By doing this, they relate the principles to the procedure and can then make sense of the actions they saw.

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Authentic assessments enable students to apply knowledge in real world settings

By Renee Molloy, Kayla Kent and Dr Brent Hayward

Nearly 80% of premature deaths of people with mental health conditions are linked to preventable health issues.[1]

Mental health nurses (MHNs) are well positioned to improve this disparity, therefore, post-registration courses that prepare graduate nurses for advanced mental health nursing practice must incorporate this topic in learning and assessment.

Authentic assessments enable students to apply their knowledge and skills to real world settings by replicating activities that would occur in a professional context.[2]

To authentically assess understanding of physical health disparity and how MHNs can influence change, we introduced a podcast assessment into our post-registration mental health nursing course. Podcasts are an example of authentic assessment.[3]

Students of the Master of Advanced Clinical Nursing (Mental Health) course at Monash University reported they were able to demonstrate skills they would use in clinical practice, rather than just writing about them:

"I could see myself having the same conversation that I was recording, with colleagues, other care providers, and clients."

Students not only demonstrated how they could create change, but engaging in this assessment motivated them to create change: *"…I wanted to be sharing the information with colleagues in order to promote the best possible outcomes for every client…"*

Research shows that students often prefer podcasting over traditional essays for assessment. They find it more enjoyable, authentic, and believe it provides more room for creativity. Additionally, podcasting helps build their confidence in communication skills,[3] a fundamental skill for mental health nurses. Similarly, students preferred podcasting over essay writing: *"…I was able to focus more on my growing knowledge and understanding of the topic, rather than how much my assignment aligned with the university's standards for academic writing. I was able to communicate my understanding of the interrelationship between physical and mental health in a way that reflects how I would discuss this topic with colleagues or even clients. I would be more likely to have a conversation about this knowledge with a colleague than to write them an essay about it!"*

This student feedback aligns with findings from a review of podcasting in nursing and midwifery education[4] which found students acquired new knowledge, skills, and confidence by using podcasts. We continue to include this podcast assessment in the course while searching for additional opportunities for providing engaging, authentic assessment.

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Caring for our future workforce

By Cathy Almond

I entered nursing because I was passionate about helping people. I teach because I am passionate about helping others do the same. I want to make a difference and leave nursing in a better place because I was part of it.

It concerns me, therefore, when my students return from placement and speak about staff who didn't want to help them. If our future graduates aren't supported during placement, they may be discouraged from educating the students of the future.

Students in the Diploma of Nursing complete 400 hours of placement, currently unpaid (although this will change in July this year).

Overwhelmingly, the stories they share after placement are positive. However, interspersed with these are accounts of staff who don't want to work with students, who see them as a burden, and who even complain during handover about having to take students. If the staff my students meet on placement aren't caring for and educating the next generation, we risk losing a committed, thriving workforce to continue our legacy.

Nursing is a challenging profession. Along with being the most trusted profession[1] comes challenges to new nurses. My students approach placement with trepidation, concern and excitement. They view it as a stepping stone to their nursing careers. If they encounter staff who are unwelcoming, it can prompt them to question their choice of career and whether they want to continue.

When students return from placement, mostly the stories are positive. They talk about the amazing nurses they met, how helpful they were, how they engaged them, pushed them to learn and discover, and created opportunities for them to learn. Some even actively sought students out when they knew there was a skill that they hadn't yet learnt.

There are always, however, one or more staff members who weren't as welcoming.

Comments relayed by students include: 'I don't want students' or 'you are here to watch, not do'.

Students have had their preceptors leave them alone with ill patients, go on tea breaks without them, ask them to do observations whilst they (the preceptors) go and change a dressing, or disappear without letting the student know where they are.

The students refer to the Nursing Code of Conduct – the Domain Act with Professional Integrity, Principle 5 teaching, supervising and assessing.

They point out that 5.1 states 'It is the responsibility of all nurses to create opportunities for nursing students and nurses under supervision to learn, as well as benefit from oversight and feedback.'

They ask why nurses don't do this. They talk about how all nurses have the same training. They all perform the role of student and graduate at some stage. They all go through the trials and tribulations of applying for graduate years and positions when they are newly graduated. All nurses must start somewhere, and students find it difficult to understand this behaviour.

As a result, we discuss how their experience on placement will change their behaviour and attitude, when they graduate. They all say they will take students under their wing, seek out learning opportunities and engage students who attend their facility.

It worries me, though. Many of us had mentors, formal and informal, when we first graduated. Those were the people we looked to, whom we aspired to be like. If a student's experience is that of being a burden, their impression is that students are hard work and not to be supported.

I wonder what changes these excited, ambitious, talented people into those I hear about who come across as jaded, uncaring and unprofessional. What has happened that they don't seem to remember what it was like to be a student? What experiences they have had, that have made them not want to care for other health professionals? We all start out with the same training, although our experiences along the way may be quite different.

Everyone has different strengths and weakness. Some of my students say they can't imagine being a teacher; I can't imagine working as a midwife, a mental health nurse or in community. Whatever our speciality, we all contribute to the good of society. To continue to be the most trusted profession and provide support and guidance to others, we must look after ourselves – and each other.

I don't believe that Principle 5.1 means that all nurses must teach or enjoy teaching. It does mean nurses need to provide an environment that supports and enables, others to learn. If we, the current nurses employed to care for the next generation, don't care – what happens to our future graduate workforce?

It concerns me that students have experiences like this, before they enter the workforce. This will colour their expectation and experience, when they graduate.

I would love to talk to students after placement and hear that the staff were supportive. That they sought them out, they provided opportunities for them to practice their skills and were insightful and welcoming.

I live for a discussion where there is no mention of 'that nurse', that's forgotten what it's like to be a newly graduated nurse.

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Integrity and cheating at university – Implications for nursing

By Clinton Fildes and Kathy Hill

As nurses, we are trusted to uphold the highest ethical standards in the care of our patients and are often ranked among the most trusted professions.[1] But what do we do when the values of honesty and integrity, central to the nursing Code of Ethics are tested during university life?[2]

Research suggests a link between unethical behaviours in the classroom and similar behaviours in clinical settings.[3,4] With the rise of artificial intelligence (AI) tools, students are increasingly tempted to take shortcuts, raising uncomfortable questions about misconduct in our profession. What does this mean for the future of nursing, and how can we safeguard the core values that define us?

WHY DO STUDENTS CHEAT?

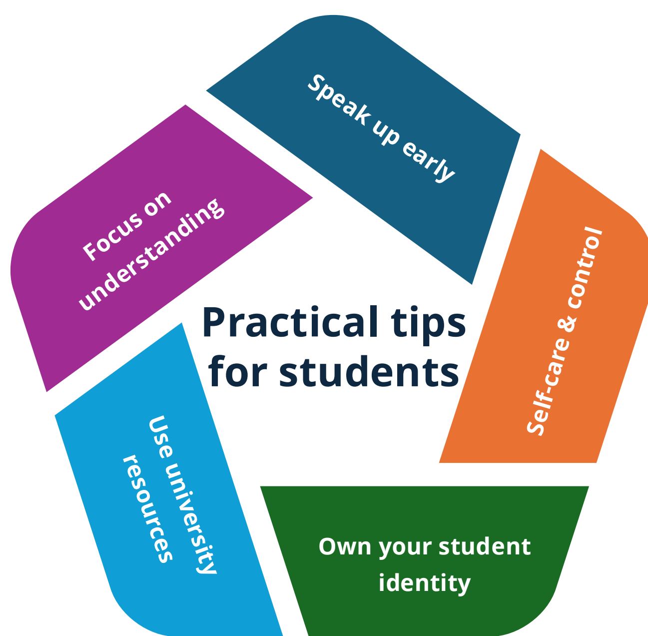
The reasons are usually the same: students do not set out to cheat deliberately, but high expectations and limited time for heavy study loads can lead to pressure and attempts to make things 'easier'. Students who resort to cheating may miss essential learning, leaving them less prepared for future challenges and more likely to rely on dishonest practices again.[5] Recently, this has been seen in the ubiquitous use of AI in universities. Whilst AI can generate responses to prompts, the answers frequently fall short of academic standards as the content is often too vague[6]; additionally, references generated by AI tools can often be incorrect, leading to an academic integrity review. If a student can generate an academic reference without reading the content, how do we maintain integrity and measure learning?

THE CORE VALUES OF NURSING IN UNIVERSITY TRAINING

Maintaining integrity is a multilevel approach, university-wide student education, management of situations that make cheating possible, and rigorous enforcement of individual student remediation.[5,7]

Student academic preparation and a culture of integrity is key to preventing cheating.[8] Specifically for nursing, we have to ensure that students 'honestly acquire knowledge to meet the learning objectives' of the training to ensure that professional standards are maintained.[9]

In nursing, caring is not just a professional responsibility; it is deeply woven into the identity of nursing students. Nursing students are taught the importance of empathy, collaboration, and support in clinical settings, and this 'caring and sharing' perspective often extends to their interactions with peers.[4] This well-intentioned action to support and care for fellow students – especially those struggling academically – can sometimes lead to acts of academic dishonesty, blurring the line between help and misconduct.[4] Nursing students are trained intensively to become excellent nurses but may not always receive the same guidance on academic integrity and being a good student.[4] This culture of caring, while central to nursing, underscores the need for clear boundaries and education on the ethical standards expected in their academic studies and future clinical practice.



Fildes & Hill (2024)

Practical tips that we can share with our students during their studies and clinical placements:

1. SPEAK UP EARLY FOR HELP

Research shows that students are more likely to struggle with academic dishonesty when they feel uncomfortable asking for support.[9] By reaching out to your mentors as soon as challenges arise, you're setting yourself up to understand the material and succeed – without needing to cheat/take shortcuts.

2. Self-care and control

Take advantage of resources like counselling and emotional support to build strategies for managing stress.[4] Use AI as a tool to support your learning and understanding of course content. Be open and honest and acknowledge any AI assistance, ensuring that it compliments rather than replaces your work. To walk that fine line will require self-control – but a lack of self-control is linked to academic dishonesty.[8]

3. Own your student identity

Being a student means staying open to learning, even when challenging or uncomfortable, this is part of growth. Stand firm in your commitment to integrity. If you face pressure to engage in academic misconduct, have the courage to say no. Peer disapproval is often one of the most effective deterrents to cheating.[5]

4. Use university resources

Seek tutoring and mentoring support to build academic skills, especially in writing.[4] Training in academic integrity can help foster a positive, responsible approach to learning and discourage academic misconduct.[8]

5. Focus on understanding of materials

For example, using a reflective journal helps students to connect ideas across placements and coursework during the semester and allows them to create an original/valuable resource for evidence learning.[10]

CONCLUSION

This paper outlines key issues in academic dishonesty among nursing students and provides practical tips to support students in achieving their goals during their studies. Teachers also play a crucial role by designing engaging, 'immersive and captivating tasks' and acting as 'moral anchors' or 'role models', someone students respect and strive to impress.[8-10] By showing genuine interest and helping students connect with the relevance of their learning, teachers can encourage students to stay focused and motivated.[9] Nurses work in environments where the stakes are often life or death. If students cut corners at university now, they may lack the knowledge and skills to make critical decisions for patients tomorrow.

Credit author statement: Clinton Fildes: Conceptualisation, Writing. Kathy Hill: Writing, Supervision.

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Remote placement deepens desire for a career in remote area nursing

By Jessica Mitchell

I recently completed a two-week remote placement as part of the Flinders University Graduate Certificate in Remote Health Practice.

As a registered nurse working in a South Australian hospital, the remote placement provided the opportunity to experience life and work as a remote area nurse.

The prospect of working in a remote area felt daunting at first. My emotions were part excitement, part apprehension, however, all those fears melted away the moment I arrived at the Ti Tree Health Centre, 200 kilometres north of Alice Springs. The staff there were welcoming and supportive, making me feel part of the team from the very beginning.

The health centre is located on Anmatyerre Country and serves not only Ti Tree community, but also two outlying remote communities, Six Mile and Wilora. Having the chance to work in these communities gave me an understanding of the challenges of providing health services in such remote locations. I worked with skilled remote area nurses, Aboriginal Health Practitioners and doctors who all readily shared their knowledge, skills and experiences.

Coming from a fast-paced work environment, this experience offered a refreshing change. I had the time to thoughtfully consider individual presentations, the information shared with me and my clinical findings. As part of my studies, I had learnt to follow the Remote Area Nurse (RAN) Model of Consultation model which helped me consolidate my clinical approach, ensuring every aspect of patient care was thoroughly addressed.

Studying the Graduate Certificate in Remote Health Practice and my placement at Ti Tree Health Centre has deepened my desire to pursue a career as a Remote Area Nurse and I am looking forward to making that dream a reality.

Author

Jessica Mitchell is a registered nurse working at the Tumby Bay Hospital in SA. She has worked in healthcare for 12 years, commencing as a carer in disability and aged care, after completing a Certificate IV in Disability. In 2018, she completed a Diploma of Nursing and began working as an enrolled nurse in Adelaide. In 2022, she completed a Bachelor of Nursing through Charles Darwin University and has since been working as a registered nurse. She is currently undertaking post-graduate studies in Remote Health Practice through Flinders University

Jessica Mitchell at Ti Tree Primary Health Centre

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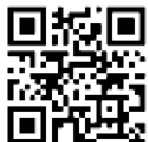

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Introducing the 'student and academic familiarity effect': Nursing academic perspectives

By Annabel Axford, Robyn Harvey and Sherryl Gaston

Small student cohorts in universities can exist and create close-knit communities, fostering strong relationships between academics, students, faculties, and local healthcare providers.

In particular, those tertiary education settings in regional locations and/or settings for students undertaking postgraduate studies, that support the growth of qualified nurses and advancing practice levels.[1] These settings enhance collaborative learning and assists with workforce shortages.[2,3] These tertiary education settings offer unique opportunities for academics to deliver high-quality education and experiences comparable to larger student cohorts. [4,5]

Nursing academics in these tertiary settings can often have established local professional and social networks and firsthand clinical and nursing experience in addressing local consumer's health impacts and disparities. This allows academics to develop solutions tailored to the population group, making teaching in a university-based setting particularly fulfilling. It provides a space where academics can significantly impact student learning and community wellbeing.[2,5,6]

A study by Ebert et al.[7] identified a 'connections' theme between nursing and midwifery academics and their student cohorts. Academics felt this sense of 'connection' with students when there had been prior professional or personal interactions.[7]

Conversely, academics felt challenged in engaging with students without a previous connection. It was found that safe learning environments are developed through fostering relationships with students, although this study did not address whether prior relationships would impact clinical assessments.[7]

Teaching and learning involve a dynamic relationship between academics and students, which is complex and diverse. In small student cohort university settings, the familiarity bond between academics and students can be stronger than in larger settings. This bond can either enhance or discourage the student learning experience creating an *educator-student familiarity* effect. This familiarity can intensify the Halo-Horn and Hawk-Dove effects, influencing academics' perceptions and evaluations of student performance.[8] Blind spots and the Halo-Horn and Hawk-Dove influences or biases, whether conscious or unconscious can significantly impact the educational process.[8] Identifying and managing these influences and bias would appear to be important

in maintaining a safe learning environment.[9-11] Unconscious bias occurs where learned experiences and personal influences result in cognitive reasoning that unconsciously affects situations or people such as living in similar circumstances or holding similar values.[9-11] Compared with conscious bias where the influence is perceptible, such as consciously providing more assistance to a positively connected student.[10] Whilst it can be easy to identify these influences and bias in others, it may not be as easily identified within oneself remaining uncorrected, leading to blind spots.[12]

For educators to address these influences, biases, and blind spots – especially unconscious ones – they must remain open to recognising and receiving feedback on them, as these tendencies are inherent in individuals and societies today.[10,12,13] When the *educator-student familiarity effect* is effectively identified and managed through reflection and supervision, deeper understanding, empathy, and enhanced educational experiences for both academics and students can be found. This fosters a supportive and engaging learning environment, contributing to rewarding academic and student experiences, which is a win-win for tertiary education, people, and communities.[12]

Authors

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Welcome to Healthy Eating

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

Chocolate mousse

Prep time 15 mins
Cook time 15 mins
Portions 12

INGREDIENTS

600ml whipping cream
100ml water
200g caster sugar
3 small eggs
10 egg yolks
400g dark chocolate

METHOD

1. Whip the cream to firm peaks.
2. Place the water and sugar into medium sized saucepan over low heat, allow the sugar to dissolve. Increase the heat to high and bring to 121°C (no colour).
3. Meanwhile place the egg and yolks in a kitchen aid bowl with whisk attachment. Whisk on high until pale and aerated.

Food styling + photo by Erika Budiman © pixelsandpaper.studio

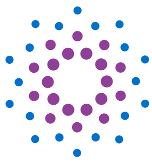
4. Reduce speed to medium, then add syrup in a steady stream, and continue to whisk to room temperature.
5. Place the chocolate into a microwave safe bowl and melt over low heat at short intervals, stirring between each time.
6. Add the chocolate to the egg mix and then fold in the cream, mixing until just combined.
7. Use a ladle to spoon the mixture into a large measuring jug, then gently pour into serving dishes. Set in the fridge.
8. Serve with raspberries, whipped cream and chocolate shavings.

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

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 Emily, on making Maggie's mushroom and lentil sausage rolls, published last issue. We hope you enjoy your $50 Maggie Beer voucher.

"Thank you for the wonderful mushroom and lentil sausage rolls recipe. I cooked them for my sister and her partner for dinner and we loved them!"



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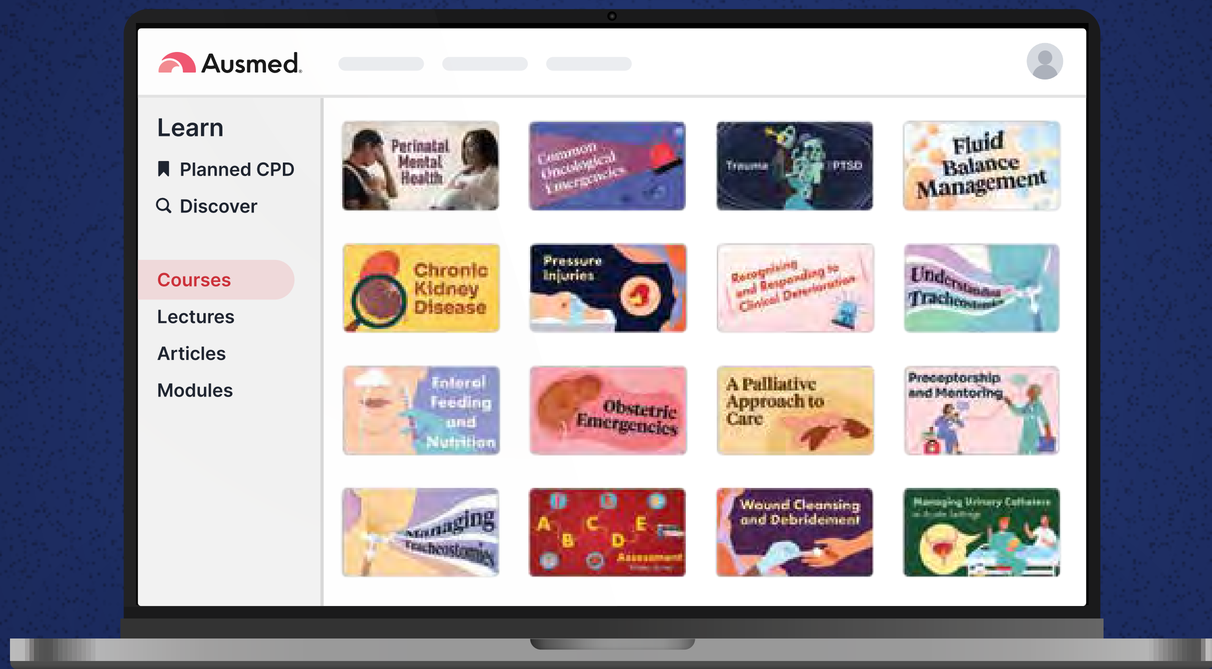

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