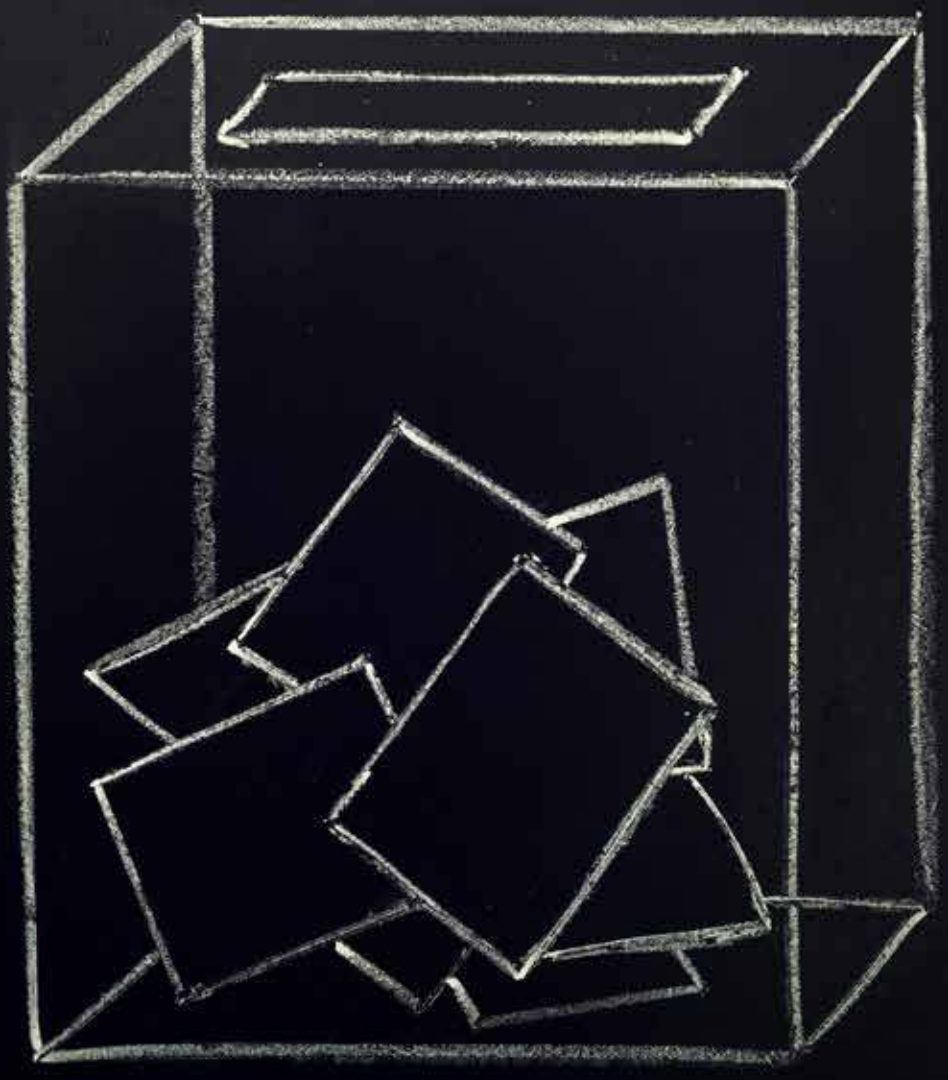
ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL
VOLUME 28, NO.8
APR–JUN 2025

FEDERAL ELECTION 2025:

What matters to you?



A PUBLICATION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

AMH
AUSTRALIAN MEDICINES HANDBOOK

When they put their trust in you, it's vital to have information you can trust.

AMH Aged Care Companion

PRACTICAL REFERENCE FOR AGED CARE
Covers over 70 conditions to assist healthcare professionals in delivering effective care.

DESIGNED FOR OLDER PEOPLE'S UNIQUE NEEDS
Provides information on treatment options to minimise harm caused by inappropriate use of medications.

SUPPORTIVE TOOL FOR MEDICATION REVIEW
Features evidence-based insights to optimise disease management, including deprescribing and frailty.

OPTIMISE HEALTH OUTCOMES
Maximise the benefits of medication to improve and assist overall quality of life.

Available online and in print
Shop today at amh.net.au

SCAN THE QR CODE TO FIND OUT MORE

Annie Butler

ANMF Federal Secretary

As we approach the upcoming election, it's important to reflect on the progress we've made over the past three years in advancing the nursing and midwifery professions and strengthening Australia's healthcare system. Our collective efforts have led to transformative reforms that set the stage for a stronger future.

In aged care, we've achieved long-overdue reforms that have significantly improved conditions for nurses, aged care workers, and residents, including substantial wage increases, the introduction of mandatory 24/7 registered nurses onsite, and mandated care minutes for residents. These initiatives are already elevating care standards across the country.

We've also made meaningful progress toward gender equity—an issue of critical importance given our predominantly female workforce. The gender pay gap has been reduced, and women's workforce participation has reached record highs. Legislative victories, such as enshrining gender equality in the *Fair Work Act* and expanding paid parental leave, have further strengthened workplace rights. Additionally, the introduction of 10 days of paid family and domestic violence leave has provided crucial support for workers experiencing violence, ensuring they have the time and resources to seek help without risking their livelihoods. The government's commitment to universal access to 30 hours of free childcare per week will be a game-changer for many working nurses and midwives, easing financial stress and making workforce participation more accessible.

Supporting students is crucial to addressing workforce shortages, reducing attrition rates in education, and ensuring a steady pipeline of skilled nurses into the healthcare system.

To help address these issues, the government introduced fee-free TAFE courses in nursing and aged care which has provided significant financial relief while opening new pathways into the profession. Enrolments in the *Diploma of Nursing* have surged nationwide, offering more people the opportunity to enter nursing at a time when cost-of-living pressures are high.

The introduction of the *Commonwealth Prac Payment*, which provides eligible undergraduate nursing and midwifery students with $319.50 per week during mandatory clinical placements, will also help ease financial pressures while they are on placement. Moreover, a 20% reduction in all student loans from 1 June 2025 will help lower their HECS/HELP debt burden.

To further support students and the workforce, the Albanese Government has acknowledged the mental health and wellbeing challenges faced by students, nurses, and midwives. In response, it has funded the establishment of the *Nurse Midwife Health Program Australia*—a dedicated national initiative providing confidential support and mental health resources specifically tailored to nurses and midwives.

Additionally, key industrial reforms have been implemented to strengthen workplace protections, enhance job security, and improve working conditions for nurses and midwives.

Beyond these workforce supports, the government's removal of collaborative arrangements for nurse practitioners and endorsed midwives marks a historic milestone. Previously, they were unable to independently provide services under Medicare or prescribe PBS medicines without a mandated agreement with a medical practitioner. This change will greatly improve healthcare access, especially in rural, regional, and remote areas where GP services are scarce.

Building on this momentum, the ANMF, along with other peak nursing and midwifery organisations, is advocating for nurses and midwives to work to their full scope of practice and expand models of care that they work in.

In this issue of the *ANMJ*, we explore what this means for the professions and the broader Australian healthcare system. The independent review, *Unleashing the Potential of Our Health Workforce*, has put forward key recommendations to improve accessibility for health consumers. These proposals align with our vision for the future, ensuring that nurses and midwives can practice to their full potential with funding models that support this expansion. The Albanese Government has committed to reviewing the report with the intention of implementing its recommendations.

As a strong advocate for innovative, multidisciplinary, and nurse- and midwife-led models of care, the ANMF continues to push for government investment in these transformative approaches to improve healthcare access nationwide.

To help you make an informed decision at the ballot box this election, we have reached out to all major political parties, and crossbenchers, asking whether they will support these gains and others made under Labor if elected. Their responses are published in this issue.

As we head to the polls, remember that your vote is a chance to support policies that recognise our professions, improve working conditions, and strengthen healthcare for all Australians. Together, we can continue to advance nursing and midwifery, ensuring a healthcare system that truly serves our communities.

Let's use our collective voice to continue to drive change. Now more than ever, it's time to stand together and make our voices heard.

DIRECTORY

ANMF FEDERAL & ANMJ

Level 1, 365 Queen Street,
Melbourne Vic 3000
anmffederal@anmf.org.au

To contact ANMJ:
anmjadmin@anmf.org.au

FEDERAL SECRETARY

Annie Butler

ACT

BRANCH SECRETARY
Carlyn Fidow

OFFICE ADDRESS
2/53 Dundas Court,
Phillip ACT 2606

POSTAL ADDRESS
PO Box 4,
Woden ACT 2606
Ph: 02 6282 9455
Fax: 02 6282 8447
anmfact@anmfact.org.au

NT

BRANCH SECRETARY
Cath Hatcher

OFFICE ADDRESS
16 Caryota Court,
Coconut Grove NT 0810

POSTAL ADDRESS
PO Box 42533,
Casuarina NT 0811
Ph: 08 8920 0700
Fax: 08 8985 5930
info@anmfnt.org.au

SA

BRANCH SECRETARY
Elizabeth Dabars

OFFICE ADDRESS
191 Torrens Road,
Ridleyton SA 5008

POSTAL ADDRESS
PO Box 861
Regency Park BC SA 5942
Ph: 08 8334 1900
Fax: 08 8334 1901
enquiry@anmfsa.org.au

VIC

BRANCH SECRETARY
Lisa Fitzpatrick

OFFICE ADDRESS
535 Elizabeth Street.
Melbourne Vic 3000

POSTAL ADDRESS
PO Box 12600, A'Beckett Street.
Melbourne Vic 8006
Ph: 03 9275 9333 / Fax: 03 9275 9344

MEMBER ASSISTANCE
anmfvic.asn.au/memberassistance

NSW

BRANCH SECRETARY
Shaye Candish

OFFICE ADDRESS
50 O'Dea Avenue,
Waterloo NSW 2017
Ph: 1300 367 962
Fax: 02 9662 1414
gensec@nswnma.asn.au

QLD

BRANCH SECRETARY
Sarah Beaman

OFFICE ADDRESS
106 Victoria Street
West End Qld 4101

POSTAL ADDRESS
GPO Box 1289
Brisbane Qld 4001
Phone 07 3840 1444
Fax 07 3844 9387
qnmu@qnmu.org.au

TAS

BRANCH SECRETARY
Emily Shepherd

OFFICE ADDRESS
182 Macquarie Street
Hobart Tas 7000
Ph: 03 6223 6777
Fax: 03 6224 0229
Direct information
1800 001 241 toll free
enquiries@anmftas.org.au

WA

ACTING BRANCH SECRETARY
Romina Raschilla

OFFICE ADDRESS
260 Pier Street,
Perth WA 6000

POSTAL ADDRESS
PO Box 8240
Perth BC WA 6849
Ph: 08 6218 9444
Fax: 08 9218 9455
1800 199 145 (toll free)
anf@anfwa.asn.au

CONTENTS

Editorial

Editor: Kathryn Anderson
Journalist: Robert Fedele
Journalist: Natalie Dragon
Production Manager: Cathy Fasciale
Level 1, 365 Queen Street,
Melbourne Vic 3000
anmjadmin@anmf.org.au

Advertising

Chris Masters
cmasters@anmf.org.au
0428 052 138

Design and production

Graphic Designer: Erika Budiman
pixelsandpaper.studio

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.

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.

Printing: IVE Group
Distribution: D&D Mailing Services

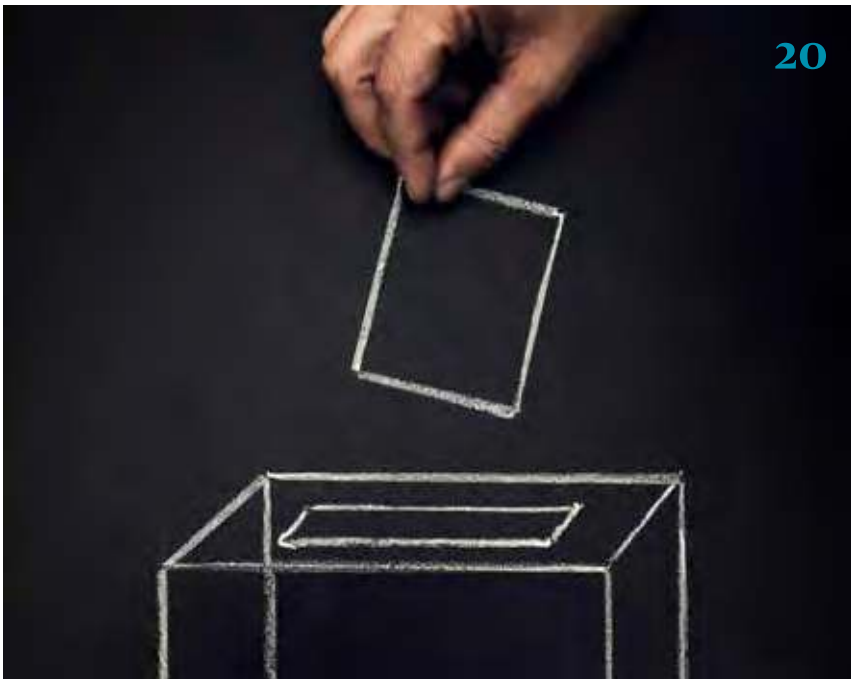
ANMJ is printed on A2 Gloss Finesse, PEFC accredited paper.

The Journal is distributed by D&D Mailing Service and is wrapped in post consumer recycled (PCR) plastic which reduces environmental waste

PCR – Post Consumer Recycled

ANMJ
AUSTRALIAN NURSING & MIDWIFERY JOURNAL

APR–JUN 2025
VOLUME 28, NO.8



REGULAR COLUMNS

1 Editorial
2 Directory
4 News Bites
6 Industrial
13 Midwifery
14 Reflection
16 International Days
30 RN Prescribing
34 Viewpoint
36 Research & Policy
38 Climate
40 Issues
46 Legal
56 Healthy Eating

CLINICAL UPDATE

24 Exploring barriers to antenatal education for CALD women in a tertiary hospital setting
42 Revisiting nephrology nurse training

FEATURE

8 Unlocking potential: Rethinking how we can deliver care
20 Federal Election

FOCUS

47 Chronic Health

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.

AUSTRALIA'S GENDER PAY GAPS REVEALED

Nearly three out of four of all employers in Australia have a gender pay gap that favours men, new analysis from the Workplace Gender Equality Agency (WGEA) has found.

High-paying employers are most likely to have a gender pay gap in favour of men and a larger gender pay gap. Just one in five (21%) of employers have an average gender pay gap in the target range of –5% and +5%, according to the WGEA reports, which provide insights into workplace gender equality for 5.3 million Australians working for 7,800 individual employers across 2023–24.

Despite challenges, progress to end the gender pay gap is happening, stressed WGEA CEO Mary Wooldridge, with 56% of employers reducing their gender pay gap in the last year.

"Each employer has a unique set of circumstances that impacts the size of their gender pay gap," Ms Wooldridge said.

"Where an employer's gender pay gap is beyond the target range of +/-5%, it indicates one gender is more likely to be over-represented in higher paying roles compared to the other. This can be a sign of structural or cultural differences for one gender within an occupation, organisation, or broader industry.

"For employers that haven't made progress, it's time to ask why – dig into the data to find out what's causing any gender differences and use evidence-based solutions to address them."

SNAP POLL HIGHLIGHTS DEMAND FOR MORE URGENT CARE CLINICS

A recent ANMF social media poll has highlighted the increasing reliance on Medicare Urgent Care Clinics, with more than half of respondents stating they had used one.

The poll, which gathered responses from over 200 people, found that while many valued the service, others faced challenges, including clinics operating at full capacity and being redirected to hospital emergency departments. Some also pointed to a lack of clinics in rural areas.

In response to the growing demand for clinics, the Albanese Labor Government has pledged to invest $644 million to open an additional 50 free Medicare Urgent Care Clinics across the country if re-elected.

The government has already opened 87 urgent care clinics, which provide fully bulk-billed, walk-in care for urgent but non-life-threatening illnesses and injuries—helping ease pressure on hospital emergency departments.

Under the expansion plan, the largest number of new clinics would open in New South Wales (14), Victoria (12), and Queensland (10) during the 2025-26 financial year.

Once fully operational, four in five Australians will live within a 20-minute drive of a Medicare Urgent Care Clinic, according to Department of Health and Aged Care analysis. The government estimates that around two million Australians will use these clinics each year.

Relief could be on the way for UTI sufferers

Researchers have uncovered new insights into what causes the painful and disruptive symptoms of urinary tract infections (UTIs), offering hope for improved treatment.

A new study led by Dr Luke Grundy from Flinders University, and Dr Steven Taylor from SAHMRI offers fresh insights into the causes of urinary tract infections (UTIs) and their painful symptoms.

UTIs, among the most common bacterial infections globally, cause bladder nerves to become hypersensitive, leading to the urge to frequently urinate, pelvic pain, and a burning sensation while urinating.

The study found that UTIs caused by bacterial infections such as E. coli, can disrupt the function and sensitivity of the nerves that usually detect bladder fulness.

A normal bladder will expand to store urine and can store up to two cups of urine for several hours. Once full, the bladder's nervous system will signal that it is time to urinate or empty the bladder.

Researchers analysed how UTIs cause sensory nerves that respond to bladder distension to become hypersensitive, so that they send signals of bladder fulness, even when the bladder is not yet full.

"Our findings show that UTIs cause the nerves in the bladder to become overly sensitive, which means that even when the bladder is only partly filled, it can trigger painful bladder sensations that would signal for the need to urinate," he says.

"We think that these heightened sensory responses may serve as a protective mechanism, alerting the body to the infection and prompting more frequent urination to expel the bacteria."

Findings deepen the understanding of how UTIs affect bladder function and the nervous system, and raise important questions about the role of bladder hypersensitivity in the development of UTI-related symptoms.

Latest rural snapshot shows higher death rates and dismal healthcare access

Rural, regional and remote Australians are dying at higher rates than their urban counterparts, with avoidable deaths in the regions nearly four times higher, according to recent National Rural Health Alliance (NRHA) data.

The *Rural Health in Australia Snapshot 2025* shows the expectancy gap is stark, with men in very remote areas dying up to 13.6 years earlier and women up to 12.7 years earlier than those in metropolitan areas.

Nearly 18,500 people in Australia still have no access to essential primary healthcare services within an hour's drive of their home, although there has been significant improvement from the last data collection.

The *Snapshot* compiles essential data on health risks, outcomes, disease burden, healthcare workforce, domestic violence, maternity health, and funding disparities – revealing how far rural areas lag behind their metropolitan counterparts.

The data highlighted the shameful failure to adequately provide funding and services to rural Australians with $848 less spent per person per year on healthcare than their metropolitan counterparts, said NRHA Chief Executive Susi Tegen.

"For decades, we have known about the healthcare challenges, the additional costs, and the tyranny of distance, but there has been too little action. Rural Australia has its own identity and requires tailored, place-based solutions to meet its unique geographic and societal needs."

The NRHA has called for a National Rural Health Strategy under the National Health Reform Agreement, along with equitable 'block' and infrastructure funding.

Thousands rally to reinstate care for Queensland trans youth

Thousands took to the streets all over Australia to call on the Queensland government to reinstate care for trans youth and make gender-affirming care accessible and affordable for everyone who needs it.

The Queensland state government's recent ban on puberty blockers and hormone therapy will impact 491 young people and their families, many who have been on the waiting list for months, and even years.

Peak medical bodies including the Royal Australian and New Zealand College of Psychiatrists, Australian Medical Association Queensland, and senior members of the Royal Australian College of General Practitioners have condemned the ban and warned that denying vital medical care to trans youth could have devastating consequences.

"Accessing gender affirming treatment two years ago changed my life. I'm settled in my life, I'm settled in my body, and I'm a better person for accessing the treatment I needed," said Matt (he/him), a 16-year-old patient of the Cairns Sexual Health Service.

Rallies were held in Canberra, Sydney, Brisbane, Melbourne, Perth, Adelaide, Cairns, Wollongong, Broome, Geelong, Ballarat, Wagga Wagga, Shepparton, Newcastle, Busselton, Armidale, Merimbula, Lismore, Albany and Geraldton to demand the Queensland government reinstate care for trans youth and make gender-affirming care accessible and affordable for everyone who needs it.

A third of children worldwide forecast to be obese or overweight by 2050

One in six children and adolescents worldwide are forecast to be obese by 2050, according to a new study by Murdoch Children's Research Institute (MCRI), prompting calls for urgent action.

Published in *The Lancet*, the research found a third of children or adolescents will be overweight (385 million) or obese (360 million) within the next 25 years.

Global obesity rates among 5-24-year-olds tripled from 1990 to 2021, rising 244% to 174 million, suggesting current approaches to curbing obesity increases are failing. As of 2021, 493 million children and adolescents were overweight or obese.

The analysis found the United Arab Emirates, Cook Islands, Nauru and Tonga are forecast to have the highest prevalence, while China, Egypt, India and the US will have the greatest number of children and adolescents with obesity by 2050.

In Australia, by 2050 for those aged 5-24, 2.2 million are forecast to be obese and 1.6 million overweight.

MCRI's Dr Jessica Kerr said if immediate five-year action plans are not developed, the future would be bleak for youth.

"Children and adolescents remain a vulnerable population within the obesity epidemic," Dr Kerr said.

"Prevention is key as obesity rarely resolves after adolescence.

"This giant burden will not only cost the health system and the economy billions, but complications associated with high Body Mass Index (BMI), including diabetes, cancer, heart problems, breathing issues, fertility problems and mental health challenges, will negatively impact our children and adolescents now and into the future."

Paul Yiallouros

Federal Industrial Officer

6 things ANMF members should know about artificial intelligence (AI)

In a rapidly evolving world of technology, AI is presenting us with an increasingly uncertain future. So much of what AI may be able to offer is unknown.

Will it improve health outcomes for patients, or pose a risk to their wellbeing? Will the work of nurses and midwives become easier or harder? What is certain is that our lives will be dramatically changed when AI becomes a feature of our workplaces.

Here are three potential positives and negatives that you should be aware of about AI in your workplace:

✓ Healthcare settings are strictly regulated

In Australia, the Therapeutic Goods Administration (TGA) is responsible for approving and assessing the continued use of medicines and medical devices, which extends to programs and software used in medical settings. For this reason, nurses and midwives have not been exposed to the rise of AI in their workplaces to the same extent as other parts of the workforce. Very few AI-based products have been approved for use in clinical settings, and it seems they are not being widely used at this stage.

AI can never truly replicate the complex and often physical aspects of care-based work, so nurses and midwives will not be replaced by AI. Decision-making in healthcare requires accountability, which only registered professionals can provide.

✗ Workplace surveillance

The ANMF is concerned about the capacity of employers to extend their surveillance of workers using unblinking and invasive AI systems as a way to monitor employees. Some early examples include the monitoring of toilet breaks, or the rate of keystrokes in office jobs as a way to measure worker productivity. Members who become aware of the use of AI surveillance should contact their ANMF workplace delegate.

✓ Work augmentation

History has shown that technological advances have often resulted in the enhanced performance of work. Think of the way that the internet and the availability of online resources has changed the way we learn and access information.

Early research shows that AI could support the work of nurses and midwives through the use of automatic speech recognition technology to automate clinical documentation, which would allow for extra time to provide direct care to patients. Other research suggests that AI could be used to assist in diagnostics, for example, to double check a practitioner's mammogram reading, without producing inferior screening results for patients.

AI should only ever be used by workers as a tool to make their jobs easier and more effective, rather than replacing workers entirely.

✗ Work intensification

AI may have the ability to complete the simpler and more mundane parts of a worker's job. This might free up the worker's time to perform more complex work. For professions such as nursing and midwifery, this may seem to be a blessing where the workloads are relentless, time is short, and understaffing is persistent.

The flipside of AI taking away the dull work and leaving employees with the more complex tasks is that there would be no reprieve from high-level complex work. The opportunities to mentally decompress would shrink and the pace and pressure of work becomes more frantic – Picture Charlie Chaplin working on a production line in *Modern Times* (1936).

✓ Education

At its best, AI will be a tool that makes the work of nurses and midwives more effective, delivering better patient outcomes. The effective use of AI requires workers to have input into how AI software is developed and implemented within workplaces, as well as education programs to make sure that workers know how to make use of AI safely and effectively.

There are huge opportunities here for workers to be involved at the heart of the AI revolution, but this requires employers to recognise the importance of involving workers at the implementation stage, and their obligation to provide ongoing education and support to all workers.

✗ Accountability

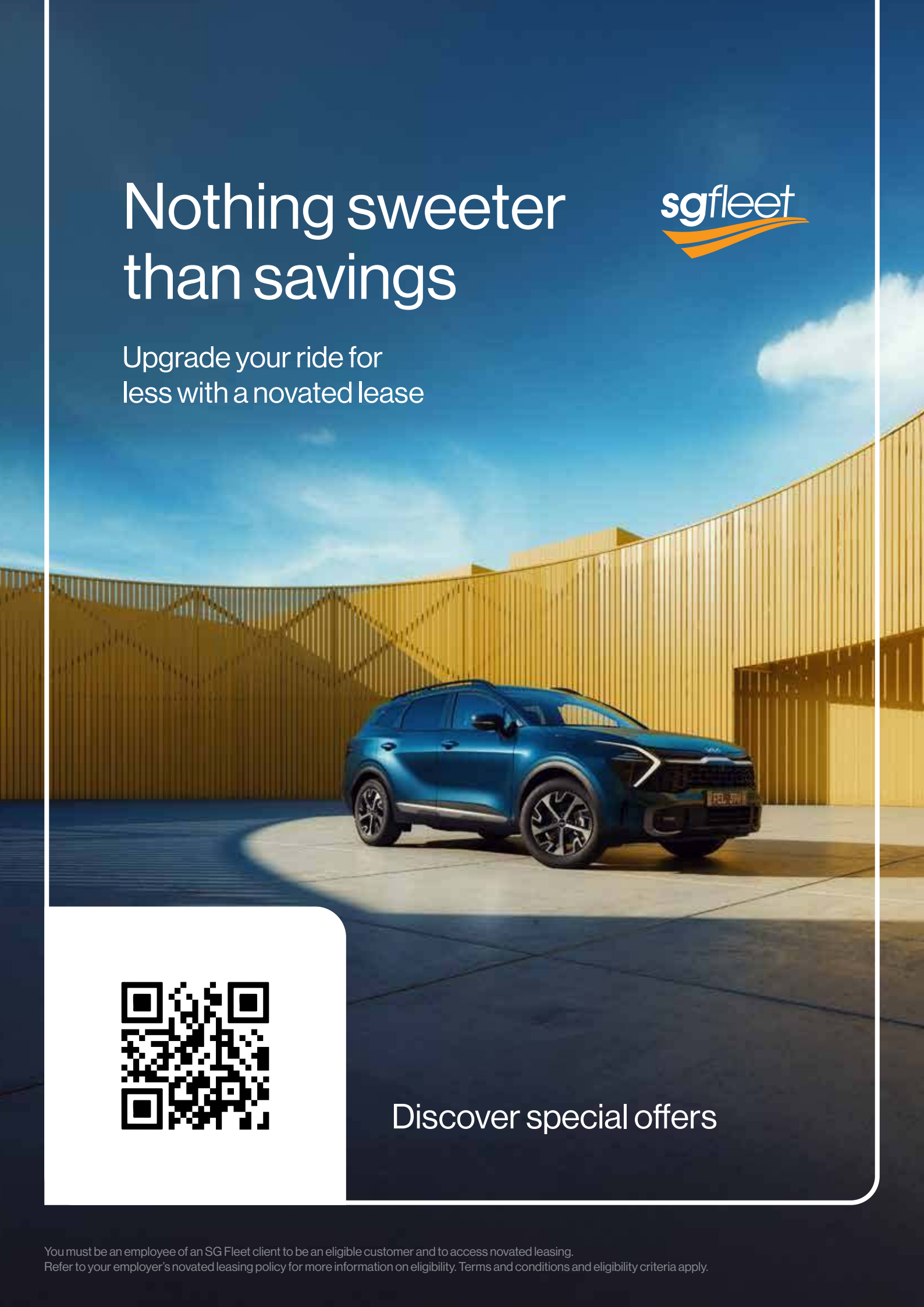
As with any form of technology, things can go wrong. It would be a mistake to assume that AI will deliver perfect outcomes every time.

Patients need to be protected from harmful products in medical settings. As discussed above, this is the job of the TGA.

Once AI programs are approved in clinical settings, who is liable for mistakes made by AI? Employers may seek to blame workers for mistakes, or even the companies that develop AI software. Software developers may shrug off responsibility and say that employers who decide to use AI in their workplaces are responsible for overseeing its safe use.

The ANMF maintains that liability for the use of AI in workplaces sits squarely with the employer, and that this obligation should be reflected in legislation.

The ANMF is in discussions with the federal government around the regulation and use of AI in Australian workplaces. The rights of ANMF members and the community are rightly at the forefront of these discussions.

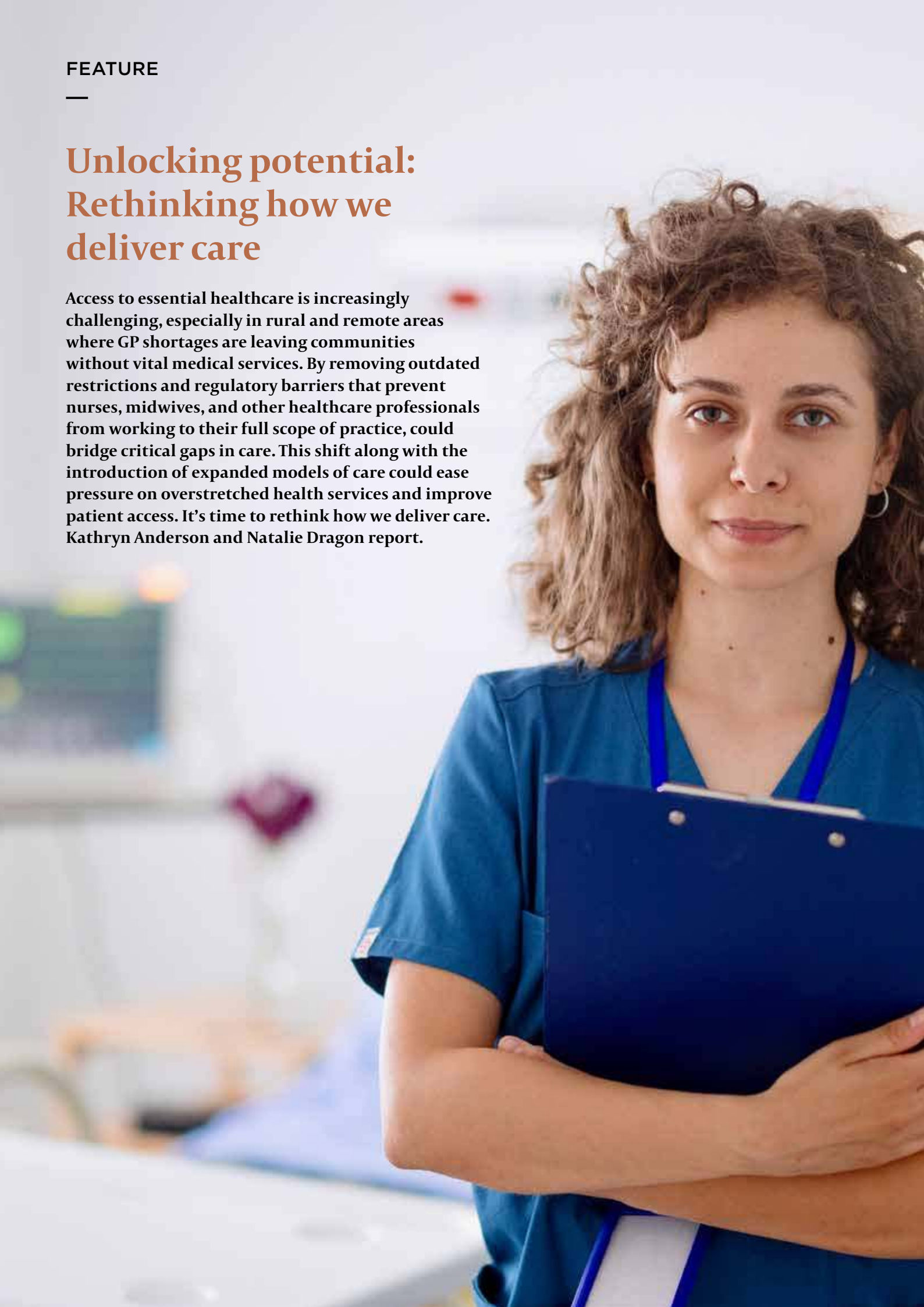


You must be an employee of an SG Fleet client to be an eligible customer and to access novated leasing.
Refer to your employer's novated leasing policy for more information on eligibility. Terms and conditions and eligibility criteria apply.

FEATURE

Unlocking potential: Rethinking how we deliver care

Access to essential healthcare is increasingly challenging, especially in rural and remote areas where GP shortages are leaving communities without vital medical services. By removing outdated restrictions and regulatory barriers that prevent nurses, midwives, and other healthcare professionals from working to their full scope of practice, could bridge critical gaps in care. This shift along with the introduction of expanded models of care could ease pressure on overstretched health services and improve patient access. It's time to rethink how we deliver care. Kathryn Anderson and Natalie Dragon report.



THE BENEFITS OF WORKING TO FULL SCOPE OF PRACTICE

Research both within Australia and globally has shown that when nurses and midwives are able to fully use their skills, healthcare delivery becomes more efficient, and health outcomes improve.

The Australian Nursing and Midwifery Federation (ANMF) wholeheartedly supports this approach.

ANMF Federal Secretary Annie Butler has been vocal about the importance of nurses and midwives working to their full scope of practice. She emphasises that doing so was essential to meet the healthcare needs of many Australians, especially those who are marginalised or live in rural and remote areas, where access to care can be even more limited.

"We know that when nurses work to their full scope of practice in rural and remote disciplinary health services, multidisciplinary health services, community health services that target high risk vulnerable groups and multidisciplinary general practice models, people do better," Ms Butler said at Parliament House in front of politicians and peers late last year.

Benefits include improved patient experiences, better health outcomes, reduced costs, enhanced clinician wellbeing, and advanced health equity, she said.

"We've measured the impact of nurses and midwives working to their full scope on cancer care, mental health, chronic disease management, birth outcomes, and reducing interventions—all of which contribute to keeping people healthier.

"All this points to a significant opportunity for the health of Australians if nurses and midwives are fully utilised and supported to work to their full scope of practice," she said.

However, Ms Butler stated that for these improvements to happen, barriers to care need to be removed.

Research has identified key barriers to nurses and midwives working to their full scope and expanding models of care, including difficulties in raising awareness and gaining acceptance within implementation settings, and a lack of resources to establish and sustain these roles. Limited support from other health professionals further complicates adoption, often due to misconceptions about nurses' scope of practice and concerns about costs. Additionally, integrating nurse-led care models with external services and referral pathways remain a significant challenge, requiring improved coordination and investment.[1]

WHAT IS SCOPE OF PRACTICE?

"Scope of practice refers to the boundaries of a profession, established through professional standards, codes, and guidelines that ensure safe and competent practice," Dr Jane Douglas, ANMF Strategic Lead, Workforce and registered nurse explained.

"For nurses and midwives, the Nursing and Midwifery Board of Australia (NMBA) sets these standards, outlining that the foundational education of registered nurses, enrolled nurses, midwives, and nurse practitioners in Australia encompasses the full breadth of the profession's scope at the graduate entry level."

An individual's scope of practice depends on education, authorisation, competence, and confidence in performing their role. However, it can vary based on the work setting, the health needs of the community, experience level, and employer policies.

Despite comprising 54% of the health workforce, many nurses, nurse practitioners, and midwives are not supported to work to their full potential. One-third of those in primary healthcare rarely practice to their full scope.

Dr Douglas warned that restrictive work practices, which prevent some nurses from working to their full scope could lead to reduced job satisfaction, missed opportunities to enhance primary healthcare access and improve health outcomes.

Kerrie Duggan - Medicare Champion with after hours nursing team in 2023

EXPANDING MODELS OF CARE

A key factor in successfully expanding scope of practice is how these roles fit within existing and evolving models of care. Modern models of care emphasise team-based, patient-centred approaches where nurses and midwives can take on expanded roles in primary care, chronic disease management, aged care, and maternity services.

Already, nurses across Australia are working in nurse-led care models, including:

- Emergency department triage and pre-admission clinics
- Diabetes education and chronic disease management
- Stomal therapy and breast cancer nursing
- General walk-in clinics and telehealth services

Nurse led success stories

INCREASED ACCESS BY TASMANIAN NP

Kerrie Duggan is the co-owner, managing director, and a nurse practitioner at Cygnet Family Practice in Tasmania's Huon Valley. She stepped in as co-owner with the support of philanthropic investors to save the practice after the previous owner decided to close it.

Now a thriving multidisciplinary clinic, Cygnet Family Practice has a team of over 20 staff, including five GPs, and provides essential healthcare to around 2,000 local residents who might otherwise be left without access to medical services.

New nurse-led processes have improved patient care by capturing baseline health data, conducting health checks, and developing care plans for chronic conditions.

With state government funding, Kerrie and her colleague, dually qualified nurse practitioner and paramedic Alison Spicer, established an Urgent and After-Hours model of care. This nurse practitioner-led, community paramedic-supported service runs three days a week alongside the general practice, ensuring patients receive same-day care when needed.

Kerrie is hoping to secure funding to increase the service from three to six days a week.

In the last eight months the practice has had to close its books to new patients. "Every day we're sending away between five and 25 patients to the urgent care services in Hobart. But some people have challenges with transport to Hobart. We have people coming into our urgent care service that refuse point blank to go to the hospital."

"This means that people who get sick on the day can be treated by health professionals who are safe, qualified, and effective," Kerrie explains.

Practice data shows that 99% of patients using the Urgent and After-Hours service receive care from nurse practitioners and paramedics, with an additional 1,700 appointments provided in 12 months. The service has also delivered significant cost savings—$520,000 in the last six months alone—against an annual operating cost of $250,000.

Kerrie Duggan – Medicare Champion with Prime Minister

THE *SCOPE OF PRACTICE REVIEW:* A STEP TOWARDS CHANGE

Recognising the pressure on the healthcare system, the Australian Government launched the *Scope of Practice Review* late last year.

The review aimed to address the underutilisation of nurses, midwives, and allied health professionals due to outdated regulations and restrictions, while ensuring patient safety remains a priority.

The review involved extensive consultation with healthcare professionals, unions, regulatory bodies, and medical groups. It examined how regulations could be updated to allow nurses and midwives to take on greater responsibilities, such as prescribing medications and leading nurse-led clinics, ultimately improving healthcare accessibility across Australia.

Speaking about the review at Parliament House, Assistant Minister for Health and Aged Care Ged Kearney said nurses and midwives were not only not working to their full scope of practice but there were inconsistencies in scope across states and territories that created additional barriers to care.

"Healthcare activities supported in one state may be blocked or restricted in another. Removing unnecessary barriers will make it easier for Australians to access high-quality care."

The government is now considering the 18 recommendations from the review, which focus on modernising healthcare policy and regulatory frameworks to support an expanded scope of practice.

BREAKING DOWN BARRIERS

The federal government has already begun taking steps to remove barriers and expand the role of nurses and midwives that will help strengthen the healthcare workforce, improve patient access to timely care, and reduce the strain on general practitioners and emergency departments.

A key reform has been the removal of collaborative arrangements, which previously required nurse practitioners (NPs) and endorsed midwives to secure formal agreements to access Medicare and Pharmaceutical Benefits Scheme (PBS) services. This requirement often created unnecessary administrative barriers, limiting access to care—particularly in rural and remote areas facing persistent medical practitioner shortages.

Now, NPs and endorsed midwives can provide Medicare-funded services and more time is available to discuss and assess expectations and emotional needs for gender affirming care. Nurse practitioners are also able to refer patients to multidisciplinary care teams for specialist care. For example, patients might wish to access fertility appointments to discuss sperm or ovary freezing and storage. This can be an important consideration for TGD people, as gender affirming hormones will affect an individual's fertility and highlights that TGD patients should receive sensitive and inclusive counselling regarding fertility preservation prior to commencing some medical gender affirmation therapies.

> ***"All this points to a significant opportunity for the health of Australians if nurses and midwives are fully utilised and supported to work to their full scope of practice."***
>
> ***Annie Butler***

ACCESSIBLE, INCLUSIVE HEALTHCARE

Nurse Practitioner Toni Slotnes-O'Brien works at the University of South Australia City West Health Clinic and has developed a nurse practitioner-led transgender and gender diverse clinic for people aged 18 years and over. The aim of the clinic in the primary care setting is to provide quality, safe, and inclusive healthcare for TGD people.

Statistics show that LGBTIQA+ people are twice as likely to experience poor health.

"They're a community that have the most stigmatisation and the lowest socioeconomically disadvantaged group of people in Australia," said Ms Slotnes O'Brien.

"There's two GPs in South Australia and myself, and we're the only ones that take new patients for gender affirming care. I've closed my books now because I've got 280 patients with many more on the wait list. They have to go mainstream and hope the GP or nurse practitioner they see is going to refer them into the adult public gender clinic and then they have to wait two to three years."

The clinic is inclusive and utilises an interprofessional model of care that addresses the unique physical, mental, and social needs of those seeking care in a person-centred and culturally safe fashion. The goals of the clinic are to improve clients' mental health, prevent suicide and suicidal thoughts, and provide best practice gender-affirming care and coordination of care to enable TGD people to live a life without barriers.

"A lot of what I do is reintroduce people back into the healthcare system because they just disengage completely. A lot of trauma they experience trying to access healthcare happens in primary care.

"It's not only having a lack of knowledge, but sometimes it's having an opinion on something and that influences the way they [health practitioners] deliver healthcare. People are not getting referred to where they need to go, people are being denied a pathology form to check their hormone levels. Regardless of what your opinion is, you should still refer to someone that's willing to provide healthcare even if you don't."

Nurse Practitioner-led, gender affirming healthcare for TGD people in the primary health sector provides many advantages. The enhanced scope of practice of NPs allows them to prescribe and monitor gender affirming hormone therapies. This reduces the need for clients to attend unnecessary medical appointments with general practitioners who may not understand the ongoing monitoring required unless they have a special interest or expertise in this field.

Further, as NPs can offer extended appointment times of 40 minutes,

Nurse Practitioner Toni Slotnes-O'Brien providing care to a client at her transgender clinic

Nursing and midwifery peaks meeting with politicians at Parliament House in Canberra.

> *"Scope of practice refers to the boundaries of a profession, established through professional standards, codes, and guidelines that ensure safe and competent practice."*
>
> ***Dr Jane Douglas***

prescribe PBS medications in line with their skills and experience, without these restrictions.

In addition, the government has announced that appropriately educated registered nurses (RNs) will soon be able to prescribe certain medications under a prescribing agreement with an authorised health practitioner. This new endorsement, registration standard, and guidelines are set to take effect mid-2025.

To qualify, RNs must have sufficient clinical experience, complete a postgraduate qualification, and undergo a six-month clinical mentorship with an authorised health practitioner following endorsement.

KEEPING THE MOMENTUM

Despite strong support, some medical groups remain cautious about expanding the roles of nurses and midwives. Overcoming misconceptions and refining policy frameworks will be crucial to successfully implementing reforms that strengthen Australia's primary healthcare system.

The ANMF, alongside eight leading nursing and midwifery organisations, is at the forefront of this effort. They are actively working with the government to ensure these changes move beyond proposals and become fully realised, delivering tangible improvements in healthcare access and patient outcomes.

With the federal government reviewing recommendations from the *Scope of Practice Review*, there is momentum for further reform. Strengthening workforce policies, standardising regulations across states, and investing in nurse-led models of care will be key to ensuring that all Australians receive timely, high-quality healthcare. The challenge now is for policymakers, healthcare organisations, and professional bodies to work together to unlock the full potential of nursing and midwifery in shaping a stronger, more accessible healthcare system for the future.

Reference

1. Beks H., Clayden s., Wong Shee A., Binder M.J., O'Keeffe S., Versace V. Evaluated Nurse- led models of care implemented in regional, rural, and remote Australia: A scoping review, *Collegian* 30 (2023) 769-788

Naomi Riley

Strategic Lead – Midwifery

Midwifery Endorsement – not just for privately practising midwives

Since 2010, women and people giving birth have been able to access Medicare rebates for midwifery services, and some Medicare-funded pathology and radiology services provided by eligible midwives.

To be eligible to apply for a Medicare provider number, midwives must meet certain requirements as articulated by the Nursing and Midwifery Board of Australia (NMBA). Midwives who meet these requirements as approved by the NMBA are known as 'endorsed midwives.'

Endorsed midwives are eligible to apply for a Medicare provider number and also authorised to prescribe within their scope of practice in accordance with the legislation and policy in their local jurisdiction. As a result, privately practising midwives (PPMs), Medicare eligibility and prescribing by midwives have been intrinsically linked. Many make the assumption that only midwives seeking to be a PPM need to consider becoming a midwife prescriber.

However, prescribing by midwives should not be confined to PPMs.

Providing holistic and personalised care underpins the midwifery philosophy of being with woman. Continuity of midwifery care and carer are considered valuable elements of a cohesive, quality maternity service.

When midwives prescribe, they are enabled to provide holistic and personalised care, continuity of care (CoC) and carer are enhanced and outcomes are optimised for women and people giving birth, babies and families.

When midwives prescribe, women and people giving birth gain timely access to medicines, treatments and preventative care, particularly important in regional, rural and remote areas. Fragmentation of care is reduced, CoC and carer are facilitated, and costs are reduced for individuals and the health system.

When midwives have the authority to prescribe in any context of practice – as a PPM or an employed endorsed midwife in a public health service or private health service entity, they can offer cost effective, timely comprehensive care, and the overall experience of care becomes less repetitious, consistent and coordinated for women and people giving birth.

It is essential the value of widespread midwife prescribing to the maternity care system is recognised and elevated.

The latest NMBA statistics demonstrate endorsed midwives make up 4.2% of midwives with general registration.[1] Due to a lack of national consistency, leadership and local policy that promotes and authorises midwife prescribing, this component of care delivery is almost non-existent outside of the private sector.

There is also a professional barrier to normalising prescribing for all midwives. For many midwives, prescribing is just not on their radar. Pursuing further education in prescribing and diagnostics may seem superfluous to their context of practice.

However, midwifery prescribing is well established as a core component of midwifery practice in New Zealand, Canada and the United Kingdom. There is growing sentiment in Australia that prescribing and diagnostics are a foundational skill for all midwives and prescribing by midwives practising in any context will optimise outcomes for women and people giving birth.

United, Australian midwives can change this.

In 2024 bargaining, ANMF Vic Branch secured a 4% allowance for endorsed midwives utilising their endorsement in the public sector from 1 June 2025. This demonstrates the added value of prescribing by midwives to service delivery. Whilst many health services do not yet have the policies and procedures in place to enable endorsed midwives to prescribe, discussions are underway to change this.

West Australian midwives, Sonya Mahoney and Lauren Papalia, identified the underutilisation of prescribing by endorsed midwives in their health service and acted for change. Through advocacy and collaboration, barriers to midwifery prescribing were gradually addressed to enhance continuity of care for women and people giving birth within their health service, whilst enabling midwives to practice to their full scope. This grass roots approach demonstrated the power of midwives to make change to broader policy and the care women and people giving birth receive.

Nationally, through ANMF and other stakeholder advocacy, scholarships are available to support midwives to undertake the education required to apply for endorsement. For more information see **health.gov.au/our-work/primary-care-nursing-and-midwifery-scholarship-program**

Prescribing by midwives is about all women and people giving birth having access to seamless, timely services that meet their needs, and midwives practising to their full value in a challenged system. Start the conversation today in your workplace.

Reference

1. Nursing and Midwifery Board of Australia. 2024. Nurse and Midwife Registration Data Table September 2024. Accessed 10 February 2025 atahpra.gov.au/documents/ default.aspx-?record=WD24%2 f341668&d-bid=AP&chksum=mcROD-5MET4V8ZTGklb%2f9q Q%3d%3d&_gl=1*b4hgsc*_ga* MTgwNjIwNTQwNC4xNzM5 MTU1OTQw*_ga_F1G6LRCH ZB*MTczOTE1NTkoMC4xLjAu MTczOTE1NTkoMC4wL-jAuMA.

Nurses are in federal school funding agreement, but more is required

By Dr Brent Hayward and Dr Anita Moyes

Education is primarily the responsibility of state and territory governments, but federal policies play a crucial role in shaping national standards and funding.

A recent example is the *Better and Fairer Schools Agreement*[1] which outlines federal funding of public schools alongside several reforms to improve outcomes for Australian students. One of these reforms is about student wellbeing, Section 84(b)(ii) states:

Parties commit to continue and/or build on existing efforts in the areas of … wellbeing … through … structured initiatives that support wellbeing for learning and engagement, for example in-school wellbeing coordinators or access to school counsellors, psychologists, mental health workers and/or youth health nurses.

Australian state and territory governments continue to implement many school health and wellbeing initiatives designed long before the Agreement was conceived. However, 80% of these initiatives show no significant effect on student wellbeing outcomes.[2]

The specification of nurses in the Agreement is therefore welcomed because school nursing is an evidence-based specialisation which has been established in Australia for more than 100 years.[3] School nursing services are a cost-effective investment of public money,[4] improve access to health and social care, and reduce school absenteeism and hospital presentations.[5] However, each state and territory government have different school nursing programs, making it difficult to compare jurisdictions.

This lack of national consistency appears to have developed "on an ad hoc trajectory, influenced by the employer and local or regional circumstances".[6 (p.2)]

This underscores the findings of our recent research which shows limited public awareness of nursing work in Australian schools.[7] A scoping review currently underway indicates that research about school nursing in Australia is varied but haphazard[6], and nurses working in special schools for students with disability have a different role compared to other school nurses.[8] School nursing programs experience "siloed approaches to policy and program development between health and education organisations, [and] a lack of consensus between these organisations on the goals and roles of [nurses]".[9 (p.58)] These findings undoubtably contribute to Australian school nurses feeling undervalued.[10]

To address these issues, and before state and territory governments decide to invent more school wellbeing initiatives to comply with their Agreement with the federal government, we implore state and territory governments to consider the existing models of school nursing in Australia[5], review the effectiveness of existing school nursing programs, and bolster the school nursing workforce to do their jobs on a larger scale. This is important because school nursing was not mentioned in the consultation paper for the Agreement, suggesting that it may be vulnerable to exclusion during implementation. Despite this, the *National School Nursing Standards for Practice in Australia*[11] provides a strong foundation for school nurses to provide input on their inclusion in federal, state, and territory school health and wellbeing initiatives, and identify national targets and improvement measures for the Agreement.

Authors

Dr Brent Hayward, PhD, M.Ed, PGDipAdvClinNurs(Psych), B.Nurs., FACMHN, CMHN, is Senior Lecturer, School of Nursing and Midwifery, Monash University, Victoria, Australia.

Dr Anita Moyes, PhD, MN, GDipYthMenHlth, B.SciNurs., FACCYPN, CMHN, is Lecturer, School of Nursing and Midwifery, Edith Cowan University, Western Australia.

References

1. Department of Education. *Better and Fairer Schools Agreement*. 2024; https://www.education.gov.au/recurrent-funding-schools/resources/heads-agreement
2. Gunawardena H, Voukelatos A, Nair S, Cross S, & Hickie IB. Efficacy and effectiveness of universal school-based wellbeing interventions in Australia: A systematic review. *International Journal of Environmental Research and Public Health*. 2023; 20(15), 6508. https://doi.org/10.3390/ijerph20156508
3. Moyes, A. Australia has had school nurses for more than 100 years – but we don't use them enough. *The Conversation*. 2023, August 3. https://theconversation.com/australia-has-had-school-nurses-for-more-than-100-years-but-we-dont-use-them-enough-210058
4. Wang LY, Vernon-Smiley M, Gapinski MA, Desisto M, Maughan E, & Sheetz A. Cost-benefit study of school nursing services. *JAMA Pediatrics*, 2014; 168(7), 642–648. https://doi.org/10.1001/jamapediatrics.2013.5441
5. Moore G, Du Toit A, Thompson S, Hutchinson J, Wiryoatmodjo A, Prakash Sivaprakash P, Gordon R. *The effectiveness of school-located nurse models on student health, education and wellbeing: A rapid evidence summary*. 2021. https://www.saxinstitute.org.au/wp-content/uploads/22.02_Rapid-Evidence-Summary-Effectiveness-of-school-located-nurse-models.pdf
6. Williams C, Rankin E. & Moyes A. Scope of nursing work and models of service delivery in Australian primary and secondary schools: A scoping review protocol. *JBI Evidence Synthesis*. 2024; Advance online publication. https://doi.org/10.11124/JBIES-24-00151
7. Moyes A. & Hayward BA. 'Are you sure they're a nurse?': Public perceptions of Australian school nursing. 2025; *Collegian*. Under review.
8. Hayward BA. A job analysis of mental health nursing in a school for students with intellectual and developmental disabilities. *International Journal of Mental Health Nursing*. 2024; 33(4), 957–66. https://doi.org/10.1111/inm.13297
9. Jones D, Randall S, White D, Darley L, Schaefer G, Wellington J, Thomas A, & Lyle D. Embedding public health advocacy into the role of school-based nurses: Addressing the health inequities confronted by vulnerable Australian children and adolescent populations. *Australian Journal of Primary Health*. 2021; 27(2), 67-70. https://doi.org/10.1071/PY20155
10. Moyes A, Rankin E, & Williams C. What clinical, professional or educational issues do expert non-government school nurses in Western Australia perceive as a priority for research investigation? *Journal of Children and Young People's Health*. 2024; 5(1), 5-11. https://doi.org/10.33235/jcyph.5.1.5-11
11. Australian Nursing and Midwifery Federation. *National school nursing standards for practice: Registered nurse*. 2019; https://www.anmf.org.au/media/x1gaxvbj/anmf_national_school_nursing_standards_for_practice_rn_2019.pdf.

Celebrating Nurses and Midwives

Every year, we take time to acknowledge and celebrate the incredible contributions of nurses and midwives around the world. On International Day of the Midwife (5 May) and International Nurses Day (12 May), we recognise the dedication, skill, and compassion of these essential professionals who provide care when it is needed most.

As we mark these important days, we extend our gratitude to all nurses and midwives for their unwavering commitment to their patients, their communities, and the profession. Their expertise and dedication are the foundation of quality healthcare, and their impact is felt in every corner of society.

This year's International Day of the Midwife theme, *Midwives: Critical in Every Crisis*, highlights the vital role midwives play in ensuring safe, quality care for mothers and babies, even in the most challenging circumstances.

For International Nurses Day, the theme *Our Nurses. Our Future. Caring for nurses strengthens economies,* reinforces the importance of supporting the health and wellbeing of nurses – not only for their own sake but also for the strength of healthcare systems and economies worldwide. Caring for nurses means caring for our future.

Robert Fedele and **Natalie Dragon** explore these themes within the Australian context.

INTERNATIONAL DAY OF THE MIDWIFE 2025

By Natalie Dragon

This year's theme for International Day of the Midwife on 5 May is *Midwives: Critical in Every Crisis*.

The world is facing an unprecedented number of compounding crises – natural disasters, conflicts, and the ongoing impacts of climate change.

These crises disproportionately affect women, girls, and gender diverse people, exposing them to heightened risks such as pregnancy complications and gender-based violence, while also limiting their access to essential health services.

Midwives are trusted first responders within their communities, who can prepare health systems to be ready for any crisis. Yet they are often excluded from preparedness planning and response efforts.

Midwives can provide up to 90% of sexual, reproductive, maternal, newborn, and adolescent health services, even during humanitarian crises. With minimal resources, they:

- Provide safe births, antenatal, and postnatal care
- Provide contraception, comprehensive abortion care, and care for survivors of gender-based violence
- Support breastfeeding, ensuring newborns receive safe, clean, and reliable nutrition
- Educate and prepare communities with the knowledge and tools they need to stay safe and healthy during emergencies.

This year's theme advocates for the inclusion of midwives at every step of crisis preparedness and response.

For midwives to adequately respond, they must also ensure they are safe and are equipped with the training, tools, and resources they need to save lives and protect rights in the most challenging settings.

HUMANITARIAN CRISIS

Clinical midwife and pilot Jan Becker coordinates emergency responses in floods, bushfires, and other emergencies. Having worked as a midwife in hospitals and remote settings across Australia, New Zealand, Papua New Guinea and Africa, she is passionate about reducing child mortality and improving maternal health in some of the world's most under-resourced countries.

With her daughter Chloe, Captain Becker co-founded *Midwife Vision Global*, a not for profit organisation dedicated to neonatal resuscitation for midwives and doctors in Tanzania.

"When you walk into a labour ward in Tanzania, you don't know what you're going to get. In an eight to nine-hour shift, you might deliver 20 babies, or you might deliver 40. It's like, 'Oh, we've got seven babies being born and there's four of us.'

At times the workload is overwhelming, she said. "It's hard to do because it's terrifying when a baby doesn't breathe at birth and there's chaos. There's multiple births going on, so you've got to focus, 'for one minute we are the focus for that baby. We are the champion for that baby. Nothing else matters.'

"Their mothers have one dream – it's that they live through labour and their baby lives – that's their birth plan."

"In poor areas with high rates of very early neonatal deaths, midwives are impacted by the trauma almost daily", said Ms Becker who provides education of lifesaving measures to local midwives within those first critical moments during and post-birth.

"Initially it was just a couple of midwives, my daughter (who was a student midwife at the time) who is a doctor now and myself, and so we decided to train midwives on how to resuscitate babies at birth and teach them all the major emergencies when a mother is having a baby – bleeding, sepsis, prolonged obstructed labour."

INTERNATIONAL NURSES DAY 2025

By Robert Fedele

For International Nurses Day (IND) 2025, the International Council of Nurses (ICN) is highlighting the critical importance of a healthy nursing workforce in strengthening economies, improving health systems, and ensuring better outcomes for communities globally.

This year's IND theme *Our Nurses. Our Future. Caring for nurses strengthens economies*, emphasises the need to support the health and wellbeing of nurses.

"Nurses face numerous challenges: physical, mental, emotional and ethical, and it is imperative we address these challenges in a way that promotes their overall health," Dr Pamela Cipriano, ICN President, highlighted.

An IND report, to be released on 12 May, will outline evidence-based solutions improve nurses' health. The report will focus on key challenges such as mental health, workplace safety, and physical wellbeing. It will advocate for more supportive work environments, which in turn can improve the quality of patient care to boost workforce retention.

In Australia, the Nurse Midwife Health Program Australia (NMHPA), a free and confidential counselling support service launched in 2024, is working to improve the health and wellbeing of nurses, midwives and students across the nation. Modelled on the successful Nursing and Midwifery Health Program Victoria (NMHPV), the NMHPA provides support via dedicated hubs Australia-wide offering telephone, telehealth and face-to-face peer support.

The NMHPA tackles a range of health issues including burnout, mental illness, addiction, bullying, and family or occupational violence.

Outgoing ANMF Federal Assistant Secretary Lori-Anne Sharp, who joined the NMHPA as Deputy CEO in March, says it's critical nurses and midwives are supported to work to their full potential.

"As the largest profession in the health workforce, nurses and midwives are the anchor of the health system, and it's important that they have access to peer-led services to support them and address any sensitive health issues," Ms Sharp says.

"Whilst it is very meaningful work, it can be very stressful and emotional and physically taxing. The shift work can be demanding. We know that nurses and midwives aren't immune to mental health and substance abuse issues. It's reflected in society, and that's reflected in our workforce.

"It's important that nurses, midwives and students have a service that they can trust and rely upon. This is peer-to-peer, so, they've got an opportunity to be counselled from people who understand what it's like to work as a nurse or midwife in the health sector."

As awareness of the service grows nationally, Ms Sharp hopes more nurses and midwives will seek help.

"There's still a long way to go to reduce the stigma around accessing help," she says.

"Nurses and midwives are often the last ones to get help because they're busy caring for others all the time and tend to put themselves last. We must normalise the importance of seeking help when needed."

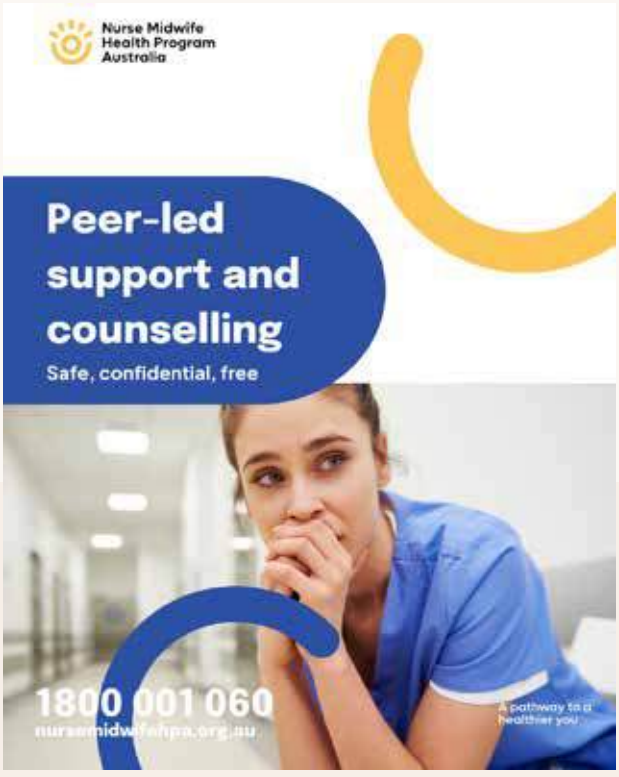
Concerned about the health and wellbeing of nurses and midwives, the Australian Nursing and Midwifery Federation (ANMF) lobbied the Albanese Government to expand the successful NMHPV program nationally. The efforts resulted in a $25.2 million grant over five years to establish the NMHPA.

Ms Sharp, who played a key role in advocating for the program, considers it a privilege to now help ensure its long-term sustainability beyond 2027.

"The health and wellbeing of nurses is crucial for workforce retention and recruitment," she says.

"With a peer-led service, nurses and midwives can be confident that they're being supported by those who understand their challenges and the pressures they face in their personal and professional lives.

"Our goal is for nurses and midwives to have access to a service they can rely on that supports them with sensitive health issues they're experiencing."



aware super

Helping ANMJ members find their rhythm of retirement

Whether retirement's just around the corner, or still a while away, let's talk.

As Chant West's Super and Pension Fund of the Year 2024*, we'll help you find your tempo, so you don't miss a beat.

Personalised super help, at no extra cost

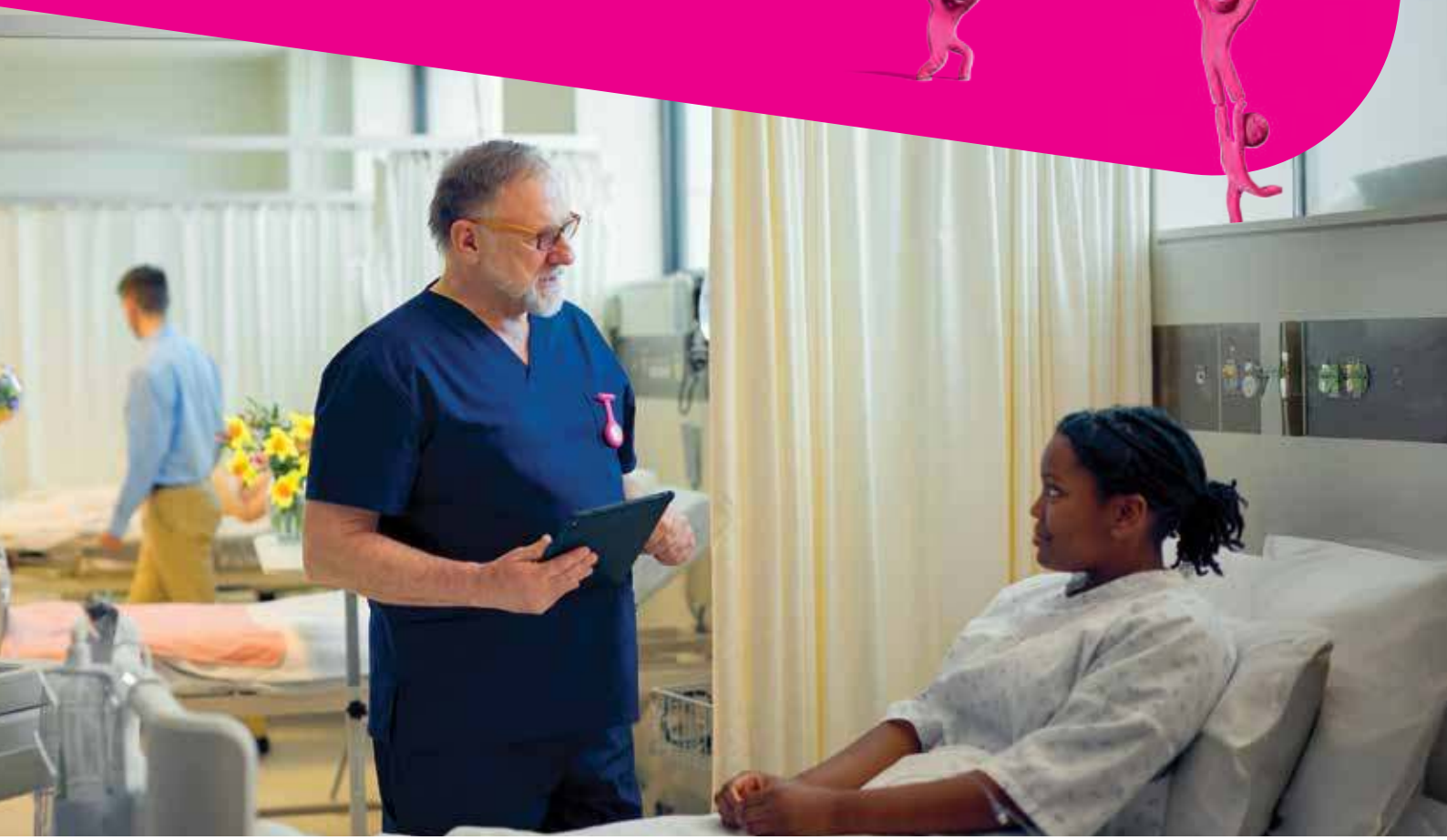
Members can chat to one of our qualified financial advisers with a Super Helpful Check-in at no extra cost.† They'll provide help with everything from how best to access your super, to trickier things like tax. Visit **aware.com.au/appointment** to book.

If retirement is just around the corner...

You can also check out our digital Retirement Guide which offers plenty of tips, advice and real member stories, plus a helpful checklist to guide you every step of the way.

With super advice and super returns Aware Super is super helpful.

Scan the QR code to download our Retirement Guide



FEDERAL ELECTION 2025:

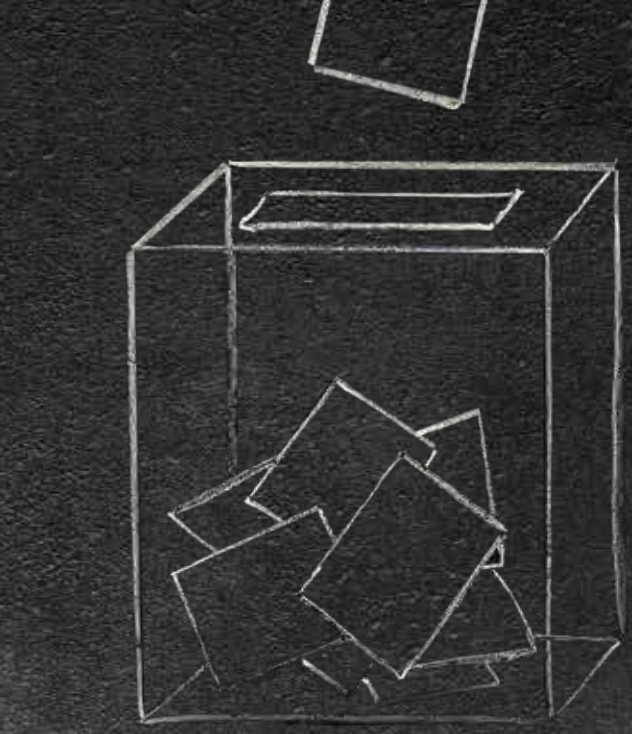
What matters to you?

Gains for nurses, midwives and care workers under the Albanese Government

Hon Peter Dutton MP
Leader of the Liberals

Hon David Littleproud MP
Leader of the Nationals

1	10 days of paid family and domestic violence leave.	?	?
2	Wage increases for aged care nurses and aged care workers.	?	?
3	Better staffing levels in aged care including a registered nurse on duty 24/7 and mandated care minutes for every resident.	?	?
4	The removal of collaborative arrangements between nurse practitioners, and medical practitioners. The removal of collaborative arrangements between endorsed midwives, and medical practitioners.	?	?
5	Scholarship program enabling registered nurses and midwives to undertake postgraduate study. This includes supporting registered nurses to become nurse practitioners and midwives to become endorsed midwives in the primary care and aged care health sectors.	?	?
6	Support payments for undergraduate nursing and midwifery students to relieve financial pressures while on placements allowing them to complete their study. To commence 1 July 2025.	?	?
7	A 20% cut off all student loans to reduce the debt burden for Australians with a student loan from 1 June 2025.	?	?



Over the past three years, the Federal Government has made significant progress in addressing key issues for nurses and midwives.

We identified 18 major achievements and asked 20 political parties, politicians, and crossbenchers whether they would uphold and support these gains if elected.

Five politicians responded with a mix of positions. The Liberals declined to participate, stating they would not answer questions until after the election was called. The other major parties failed to respond.

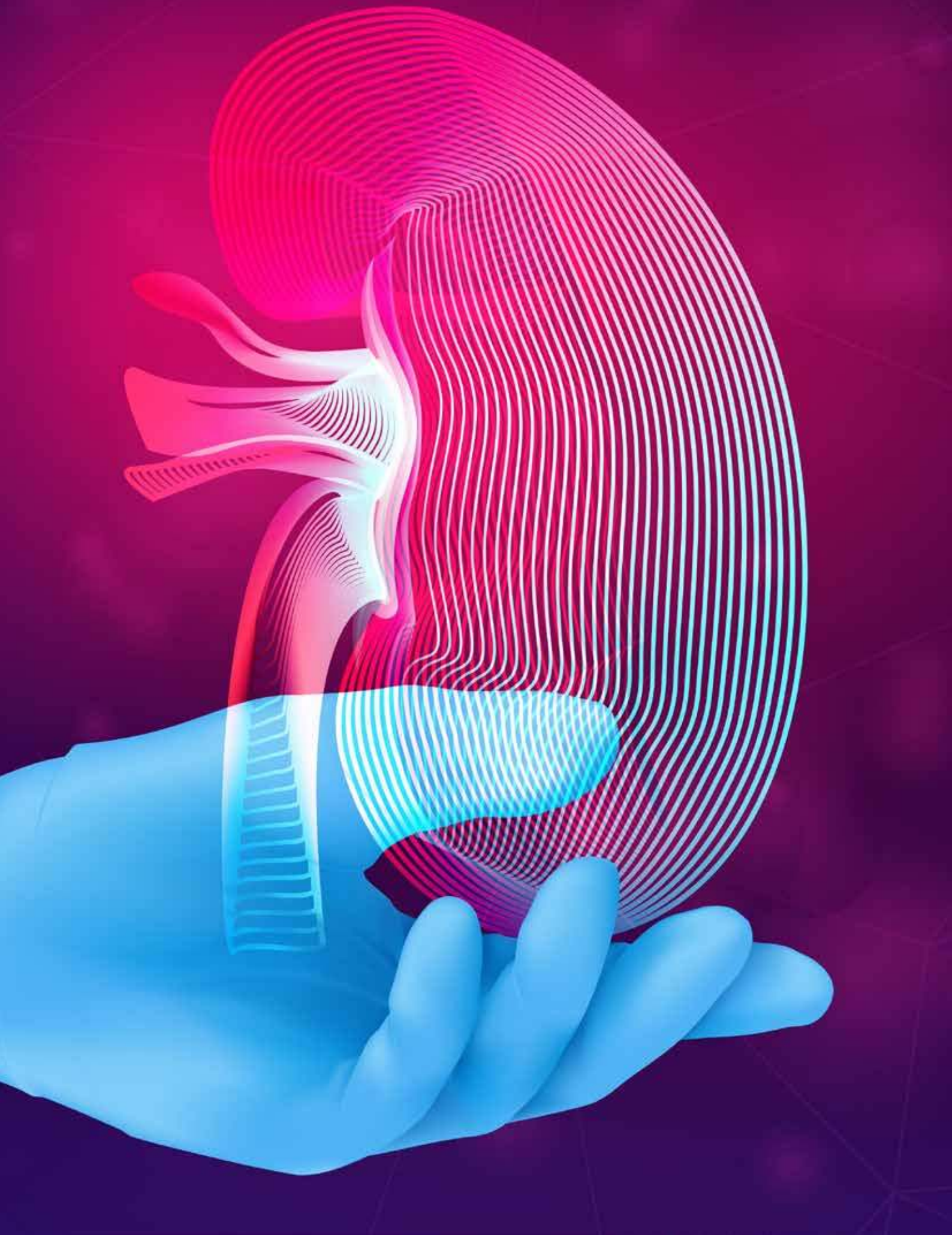
At the time of printing, the election had not been announced.

Adam Bandt MP Leader of the Australian Greens	Dr Helen Haines MP Independent	Andrew Wilkie MP Independent	Rebekha Sharkie MP Centre Alliance	Allegra Spender MP Independent	Senator Fatima Payman Australia's Voice Whip
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	?	✓

FEDERAL ELECTION

		Hon Peter Dutton MP Leader of the Liberals	Hon David Littleproud MP Leader of the Nationals
8	Fee-free TAFE to help fix skills shortages in nursing and aged care.	?	?
9	Establishment of the Nurse Midwife Health Program Australia offering peer support and counselling to nurses, midwives, and students to address health and wellbeing concerns.	?	?
10	Three days of subsidised childcare a week, regardless of whether parents are working or not.	?	?
11	An increase of the superannuation guarantee to 12% starting 1 July 2025.	?	?
12	Superannuation on government-funded Parental Leave starting 1 July 2025 reducing the gender gap in retirement incomes, benefiting nurses and midwives, helping to address lower superannuation balances many may have due to caregiving responsibilities, so they can retire with greater financial security.	?	?
13	Pay day super which requires employers to pay their employees' super guarantee (SG) at the same time as their salary and wages.	?	?
14	Funding for women's health, including better access to long-term contraceptives and more menopause support.	?	?
15	Introduction of Urgent Care Clinics, making healthcare more accessible for those who need it most.	?	?
16	An extra $1.7 billion in public hospital funding 2025/26, giving a 12% boost to the Commonwealth's contribution to help reduce wait times in emergency departments, support better wages for nurses and midwives, and tackle challenges like an ageing population and more complex health needs.	?	?
17	Industrial relations reforms amending the Fair Work Act to strengthen workplace protections including: • Better protections against unfair dismissal at work • Multi-employer bargaining, prohibit pay secrecy clauses, and enhance workers' rights to request flexible working arrangements • Fairer definition of casual worker allowing more casuals to access job security • Criminalise wage theft • The right to disconnect that allows employees to disconnect from work communications outside of their standard working hours • Delegates rights • Protection of penalty rates	?	?

Adam Bandt MP Leader of the Australian Greens	Dr Helen Haines MP Independent	Andrew Wilkie MP Independent	Rebekha Sharkie MP Centre Alliance	Allegra Spender MP Independent	Senator Fatima Payman Australia's Voice Whip
?	✓	✓	?	?	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	✓	✓	?	✓	✓
?	?	✓	?	✗	✓



Revisiting nephrology nurse training

By Kathy Hill

Chronic kidney disease (CKD) in Australia affects one in 10 people over the age of 18.[1,2] There has been a 30% growth in people receiving Kidney Replacement Therapy (KRT) in the last decade[3] for which specialist nursing care is required.

Demand for nephrology nurses is increasing aligning with the increased case load and globally there is a shortage of trained nephrology nurses able to provide this care.[4,5] Staff shortages are leading to increased pressure to undertake overtime and extra shifts to meet the case load need[5,6] which ultimately contributes to burnout and further negative impact on the workforce.[7]

Nephrology nursing is specialty practice often independent of physician oversight and the workforce is considered highly skilled, however the workforce is also ageing and careful planning is needed to assure the future of skilled nephrology nursing care.[8,9]

BACKGROUND

In 2022, SA Health introduced the Clinical Specialisation Program, which offered up to 1,000 scholarships per year to nursing staff to undertake a postgraduate (PG) program of study at the University of South Australia. As part of this program, and to address workforce shortages, a nephrology nursing PG course of study was developed which has 13 weeks theoretical content covering all aspects of kidney care. The course was a novel co-design by University academics including three with a nephrology nursing background and a clinical advisory group consisting of a large group of senior clinicians in SA Health. However, subsequent to the move to online education at university level a clear need was to rejuvenate the clinical training in the renal unit setting to create a synergy between the theory and clinical components of training.

AIM

The aim of this review is to collate the evidence on best practice models for postgraduate nurse training for advanced practice and clinical specialisation to inform the rejuvenation of nephrology nurse clinical training at a large renal service with oversight for multiple distinct renal units.

METHOD

This scoping review uses the framework recommended by the Joanna Briggs Institute drawn from the work of Arksey and O'Malley[10] and Levac, Colquhoun and O'Brien.[11,12]

STAGE 1 IDENTIFY THE RESEARCH QUESTION

We proposed the following research question; What does a high-quality post graduate training program for clinical specialisation look like?

STAGE 2 IDENTIFYING THE RELEVANT STUDIES

In November 2023* a comprehensive search of the CINAHL, Ovid (Emcare) and Medline data bases was conducted. The key word strings included nephrology/renal, nurs*, train* and educ* and nurs*, educ* and postgraduate. Six hundred and seventy six papers were retrieved for consideration, 13 duplicates were removed. Of the remaining 663 papers retrieved, screening removed 641 that were considered irrelevant to the aims of this review.

*The literature search was repeated in January 2025 prior to publication but no new relevant papers were found.

STAGE 3 STUDY SELECTION

The final 22 papers identified were imported into Covidence™ for screening by the two researchers. Following this screening a further three papers were excluded as they were considered not relevant to meet the aims of this review, and 19 papers proceeded to full text review and are incorporated in this discussion.

STAGE 4 CHARTING THE DATA

The data from the literature was extracted by author, year, country of origin, issue, setting and key findings.

STAGE 5 COLLATING, SUMMARISING AND REPORTING THE RESULTS

With regard to the types of manuscripts included in the review five were from Australia or New Zealand, three were from Europe and the remainder originated from the United States. From the papers included eight were nephrology specific and the others primarily focused on the Nurse Practitioner (NP) role.

RESULTS

NEPHROLOGY SPECIFIC

An Australian study found that the most desirable PG qualification for nephrology nursing is the graduate certificate, but for senior leaders in nephrology it is a Master's

degree.[13] Barriers to achieving this are funding, scholarships, study leave, career opportunities and recognition of the higher study achievement.[13] Nurses generally also believe that education needs to be firmly grounded in clinical practice and a synergy between tertiary and hospital programs enhances theoretical knowledge and critical thinking.[14] However, since PG education moved from the hospital setting to the tertiary setting the ideal timing, teaching and learning approaches are not clear in terms of clinical and academic qualifications for teaching staff, assessment design and the level of PG qualification awarded.[14] Most tertiary educators agree it is important to include clinical input into course design, teaching, evaluation, and assessment but also academic input to ensure the program is academically robust.[14]

For nephrology nurses, professional certification demonstrates the highest level of knowledge and experience and allows the public to recognise safe and quality care[15,16] Certified nurses have greater autonomy in decision-making, empowerment over practice and credibility which in turn has a positive impact on the workplace culture.[15] Health Workforce New Zealand has long funded post graduate education and evidence suggests that professional development leads to improved clinical practice and clinical decision making.[17]

In considering best practice models to address critical shortages in nephrology nursing a US based health service introduced the Nephrology Nurse Residency Program to train newly graduated nurses to perform HD.[18] The structured program consisted of 12 weeks full time (paid) with buddy shifts in tandem with education days for the whole cohort. A similar US based program of dialysis training for critical care staff in ICU was developed to address the KRT workforce shortages consisting of training days using the American Nephrology Nurses Association (ANNAS) core curriculum for Nephrology Nursing and 64 hours of preceptor performance of HD.[19] Similar to the ANNAS the European Dialysis and Transplant Nurses Association and a Swedish Delphi study have also described base core curriculum as educational tools to integrate into training programs.[20,21]

Outside of training for HD it has been recognised that despite the International Society for Peritoneal Dialysis recommendations on uniform training of Peritoneal Dialysis (PD) nurses to train PD patients no such program of education exists and there continues to be wide variation, lack of a proper syllabus and several nurses with differing styles training the one patient.[20,22]

EVIDENCE DRAWN FROM OTHER SPECIALTIES

Renal specific care makes up a very small proportion of undergraduate education and yet one of the most frequent strategies to recruit to the specialty is through the clinical placement. For example, to address workforce shortages in oncology nursing a novel 10 week fully paid fellowship was offered to undergraduate nurses to stimulate and excite them about a career in oncology nursing.[23]

Another option is a transition to specialty practice program which has been successfully trialled in the ICU setting. Participants drawn from medical and surgical general ward areas complete an in-house program comprising of study days, clinical support, online learning and didactic content delivery, orientation and preceptorship.[24] Essentially an in-house development program however subsequently most participants ultimately went on to complete formal PG training. Bridging the gap between specialty clinical practice and PG education allowed the ICU to meet the Australian College of Critical Care Nurses recommendation of ICU nurses having a qualification from the higher education sector.

THE NURSE PRACTITIONER (NP)

A successful combination of theory and clinical practice model is the development of an advanced practice nurse through hospital focussed training and Master's level curriculum used in the United States.[25] Similarly clinical nurse specialists are Master's level prepared with advanced responsibilities and an expanded scope of practice in Europe.[26] The combined academic pathway set core competencies as patient competency, clinical nursing leadership, organisational competency and scholarship competencies to standardise the role.[26]

However as in Australia there is no consistent educational model for the NP in nephrology which evolves through a generic NP Master's degree followed by clinical orientation and mentorship in the US.[27] A preferable model would be to build on the PG certification in nephrology nursing, advancing to a clinical specialist at diploma level, and ultimately the NP, offering different options for staff training through an evolution or staged approach.

An emerging trend in NP education is a post graduate residency in the first year of practice that involves a partnership between the healthcare facility and the tertiary sector focussing on quality and safety, leadership and clinical scholarship and a curriculum based on achieving competencies[28] Likewise, the advanced practice nurse

fellowship which is a 'curriculum to career program' acts in a similar way to the medical residency with a dedicated mentor and practice based support.[29]

Programs such as these must include accreditation in the plan to 'standardise competencies in transition to practice, clinical immersion, professional identity, resiliency training, increased skills competencies, advanced knowledge and a process of self-evaluation'.[29]

The Australian NP standards define the key measures of competence and capability. One way to demonstrate this is by the use of an ePortfolio with a reflective commentary drawing the evidence together as a bridge between theory and practice.[30] Modern learners are 'digital natives' meaning blended learning with components both online and traditional bedside didactic methods offers advantages over one method alone.[31]

Nephrology nurse training needs an online component as well as in person segments to be competitive and stimulating.[27] Haemodialysis is particularly suited to this style of teaching moving HD adequacy, urea, and vascular access to an interactive online format with narrated videos and teaching how to perform HD at the bedside.[31] Nephrology nurse education could model the Australian NP standards through experiential learning and the development of an ePortfolio incorporating clinical science, clinical decision making, assessment, diagnostics and pharmacology, evidence based practice and models of practice to guide the student on understanding their expanded scope of practice.[30]

DISCUSSION

There is currently a clear gap in a thoroughly considered immersive clinical and academic training model for nephrology nursing. Whilst the new clinical specialisation tertiary program in South Australia is likely to attract much needed new nursing staff to renal care, to truly optimise the potential, the new workforce will need to be trained and upskilled clinically to translate the theory into practice. Nephrology nurses prefer a model of training combining theory and clinical training with an emphasis on hospital based competency development.[32] The current Australian and New Zealand dialysis workforce has shown some growth but this is known to not be at the same rate as patient growth and dialysis units are increasingly 'relaying on the good will' of current staff to fix staff shortages through overtime and extra shifts.[33] This practice is contributing to workforce burnout, with the current nephrology nursing workforce reporting moderate levels of burnout that are higher than a global study of nursing burnout[7] highlighting the pressure this workforce is currently under.

CONCLUSION

This review of the evidence has found several initiatives to increase clinical competence and leadership for the PG nurse which could be applied to developing a robust clinical training program in nephrology. One that integrates theory into practice and develops nephrology nurses that are critical thinkers who build competency in advanced practice and collate evidence to corroborate this through the use of an ePortfolio. Addressing workforce shortages in nephrology care is now a national imperative and it is hoped that the body of work being developed in South Australia can be used to inform other health services in regard to training the nephrology nurse.

Author

Dr Kathy Hill PhD MPH Grad Cert (Neph) BN RN, Lecturer & Academic Integrity Officer, UniSA Clinical & Health Sciences , University of South Australia

References

1. Kidney Health Australia. Chronic Kidney Disease Management in Primary Care. 4th ed. Melbourne: Kidney Health Australia 2020.
2. Australian Institute of Health and Welfare. 2021.
3. Australia and New Zealand Dialysis and Transplant Registry. 45th Annual Report. South Australia; 2022.
4. Wolfe WA. Are word-of-mouth communications contributing to a shortage of nephrology nurses? *Nephrology Nursing Journal*. 2014;41(4):371-8.
5. Boyle S, Washington R, McCann P, Koul S, McLarney B, Gadegbeku CA. The Nephrology Nursing Shortage:Insights from a pandemic *American Journal of Kidney Disease*. 2022;79(1):113-6.
6. Hill K, Neylon K, Gunn K, Jesudason S, Sharplin G, Britton A, et al. Sustaining the renal nursing workforce. *Renal Society of Australasia journal*. 2021;17(2):39-45.
7. Hill K, Neylon K, Gunn K, Sharplin G, Eckert M. Understanding burnout in the current nephrology nursing workforce and health service 'magnet' qualities that may help address it: a discreet choice experiment. *Renal Society of Australasia Journal*. 2023.
8. Doss-McQuitly SJ. Assuring the Next Generation of Nephrology Nurses. *Nephrology Nursing Journal*. 2017;44(2):111-2.
9. Bonner A, Douglas B, Brown L, Harvie B, Lucas A, Tomlins M, et al. Understanding the practice patterns of nephrology nurse practitioners in Australia. *Journal of renal care*. 2023;49(4):278-87.
10. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *International journal of social research methodology*. 2005;8(1):19-32.
11. Peters MDJ GC, McInerney P, Munn Z, Tricco AC, Khalil, H. Chapter 11: Scoping Reviews *JBI Manual for Evidence Synthesis* 2020
12. Levac D, Colquhoun H, O'Brien KK. Scoping studies: Advancing the methodology. *Implementation science* : IS. 2010;5(1):69-.
13. Tranter S, Westgarth F, Kemp J, Macneil JWH. The New South Wales renal nursing education survey.(Survey)(Brief article). *Renal Society of Australasia journal. 2010;6(2):67.*
14. Hardcastle JE. 'Back to the bedside': Graduate level education in critical care. *Nurse education in practice*. 2008;8(1):46-53.
15. Ducko JI, Stewart S. The Effect of Peer-to-Peer Education about the Significance of Specialty Certification on Empowering Nurses Working in Dialysis. *Nephrology nursing journal Journal of the American Nephrology Nurses' Association*. 2022;49(3):241-54.
16. Wiseman KC. Nephrology Certification: What Is It? *Nephrology Nursing Journal*. 2013;40(3):241-6.
17. Barnhill D, McKillop A, Aspinall C. The impact of postgraduate education on registered nurses working in acute care. Nursing praxis in New Zealand inc. 2012;28(2):27-36.
18. Hudson-Weires E, Fleming P, Hall M. The Development and Implementation of a New Graduate Registered Nurse Nephrology Nurse Residency Program in Acute Hemodialysis. *Nephrology nursing journal : Journal of the American Nephrology Nurses' Association*. 2020;47(5):429-36.
19. Smith N. An Innovative Approach to Integrating Nephrology Nursing into Acute and Critical Care. *Nephrology Nursing Journal*. 2022;49(5):397-403.
20. Peters A. Supporting and retaining nephrology nurses new to the peritoneal dialysis specialty. *Nephrology nursing journal : Journal of the American Nephrology Nurses' Association*. 2013;40(1):21-3.
21. Lindberg M, Lundström-Landegren K, Johansson P, Lidén S, Holm U. Competencies for practice in renal care: A national Delphi study *Journal of renal care*. 2012;38(2):69-75.
22. Hoekstra B, Amiri F, Beenen S, Winkels B, Leeuwen M, Hesseling L, et al. Training and education, what has changed this last decade? *Journal of renal care. 2021;47(4):250-4.*
23. Coakley A, Ghilono C. A fellowship program preparing students for employment as new graduate nurses in oncology nursing. *Creative Nursing*. 2009;15(1).
24. Madhuvu AE, Plummer V, Morphet J. An exploration of participants' experience of an intensive care nursing transition to specialty practice program. *Australian critical care*. 2018;31(5):311-6.
25. Bryant SE. Filling the gaps: Preparing nurse practitioners for hospitalist practice. *Journal of the American Association of Nurse Practitioners*. 2018;30(1):4-9.
26. Jokiniemi K, Hølge Hazelton B, Kristofersson GK, Frederiksen K, Kilpatrick K, Mikkonen S. Core competencies of clinical nurse specialists: A comparison across three Nordic countries. *Journal of clinical nursing*. 2021;30(23-24):3601-10.
27. Sears A, Davis J, Zuber K. Post graduate education and training for the nephrology physician assistants and nurse practitioners. *Advancing Chronic Kidney Disease*. 2022;29(6):534-8.
28. McGuinness TM, Shirey MR, Cleveland C, Richardson J, Campbell R, Harper DC. An Innovative Approach for Graduate Education for Psychiatric Nurse Practitioners. *Journal of professional nursing*. 2020;36(6):526-30.
29. Goodwin M, Fingerhood M, Slade E, Davidson P. Development of an innovative curriculum-to-career transition program for nurse practitioners in primary care. *Nursing outlook*. 2021;69(3):425-34.
30. Anderson D, Gardner G, Ramsbotham J, Tones M. E-portfolios: Developing Nurse Practitioner Competence and Capability. *Australian Journal of Advanced Nursing*. 2009;26(4):70-6.
31. Krishnan N. A hemodialysis curriculum for nephrology fellows using a blended learning approach: best of both worlds? *J Nephrol*. 2021;34(5):1697-700.
32. Hill K, Neylon K, Gunn K, Sharplin G, Eckert M. The Australian and New Zealand nephrology nursing workforce: clinical pressure and organisational culture. *Contemporary Nurse*. 2023:1-9.
33. Schuck KE, Holt SG, Hosking J, McNeill L, Bennett P. The Australian and New Zealand dialysis workforce study 2021. *Renal Society of Australasia journal*. 2023;19(2):100-7.

THE NATIONAL NURSING FORUM

CANBERRA
23-25 JULY 2025

Where nursing professionals connect

Join the Australian College of Nursing's signature annual leadership and educational event—the National Nursing Forum.

Discover fresh ideas and insights that will challenge your thinking and enrich your practice.

Build meaningful relationships with like-minded professionals and leaders, opening doors to new opportunities and collaborations.

Add your voice to important conversations, contributing to discussions that shape the future of nursing.

Join the conversation.
Shape the future.

Australian College of Nursing

acn.edu.au/nnf2025

26.02.25

Microcredentials

Bite-sized learning. Big career gains.

Advance your practice with an ACN Microcredential

ACN's Microcredentials are designed to allow busy nurses to reach their career goals.

Gain practical skills you can apply immediately by completing a microcredential in just ten weeks.

Explore a specialty area while building credits toward a Single Unit of Study or a Graduate Certificate.

With fully online study options and three intakes per year, you can plan your learning to suit your schedule.

Take the first step.
Your future starts here.
acn.edu.au/microcredentials

NEW ERA: Australian registered nurses empowered to prescribe

In December 2024, Health Ministers approved a new Registration standard: Endorsement for scheduled medicines – designated registered nurse prescriber, paving the way for qualified registered nurses to prescribe Schedule 2, 3, 4 and 8 medicines in partnership with an authorised health practitioner who is an independent prescriber. This landmark change will take effect mid-2025. Robert Fedele reports.

REGISTERED NURSES (RNs) AND PRESCRIBING SCHEDULED MEDICINES

The Nursing and Midwifery Board of Australia (NMBA) has been developing a designated RN prescribing model since 2016.

Under the registration standard, qualified RNs will be able to prescribe within their competence and scope of practice in partnership with authorised independent prescribers, such as nurse practitioners or medical practitioners.

WHO CAN PRESCRIBE?

RNs with at least three years' clinical experience will be eligible to apply for endorsement with the NMBA as designated registered nurse prescribers after completing postgraduate education.

RNs must be employed in a health service and not working as sole practitioners or in private practice.

Post-endorsement, applicants will undergo a six-month clinical mentorship with an independent prescriber before their competencies are assessed against the National Prescribing Service (NPS) Prescribing Competencies Framework.

EDUCATION AND TRAINING

RNs must complete additional postgraduate education approved by the NMBA and accredited by Australian Nursing and Midwifery Accreditation Council (ANMAC) leading to endorsement.

In January, ANMAC released the Registered Nurse Prescribing Accreditation Standards, which outline curriculum requirements for education providers.

These programs must teach and assess legal, medicolegal, ethical and professional principles and be aligned with the National Prescribing Competencies Framework.

Approved Programs of Study will be published on Ahpra's website.

IMPACT ON CARE

The ability for RNs to prescribe scheduled medicines has been explored for years, with positive outcomes observed in comparable countries. Australia's model aims to provide timelier, person-centred care by reducing waiting times and improving access to medicines.

IMPLEMENTATION

The rollout will likely vary across health services.

In some large hospitals, RNs in certain clinical areas will be encouraged to apply in a bid to streamline care and reduce wait times.

According to Julianne Bryce, Senior Professional Officer at the ANMF, the uptake will depend on the specific health service or employer. Some will be early adopters, while others may take a more cautious approach.

"The main benefit for patients will be quicker access to medicines, faster treatments, shorter stays, or even preventing hospital admissions."

SAFEGUARDS FOR SAFE PRESCRIBING

To ensure safe prescribing, designated RNs and their partner independent prescribers will work within a clinical governance framework, employers will need to review existing governance frameworks for quality use of medicines (QUM) to support this prescribing model.

Designated RN prescribers will need to complete an extra 10 hours of continuing professional development (CPD) related to prescribing annually to maintain competence.

WORKLOAD IMPACT

Evidence suggests nurse prescribing improves healthcare teams' efficiency, reduces referral needs, enhances patient satisfaction, and leads to better health outcomes.

Designated RN prescribers will have increased autonomy, professional growth, and be able to provide faster, more efficient care, especially to Australians in underserved areas.

WILL RN PRESCRIBERS BE PAID MORE?

The ANMF advocates for higher pay for designated RNs with prescribing responsibilities. This additional pay should take the form of an allowance.

RECOGNITION OF CURRENT PRESCRIBERS?

The ANMF argues that registered nurses with state-based prescribing recognition for rural and isolated practice should not be disadvantaged under regulatory reforms. The nurses should be granted recognition of prior learning and allowed to complete an ANMAC accredited and NMBA approved bridging program, at no additional cost.

INTERNATIONAL PERSPECTIVE

Countries like the UK and New Zealand have successfully implemented nurse prescribing models which have increased access to medicines, and reduced workloads for medical staff.

Research by the ANMF shows that nurse prescribing is safe and effective, particularly when supported by ongoing education and proper integration into healthcare systems.

In the UK, RNs reported that prescribing allowed for more patient-centred care, streamlined patient journeys, and better continuity of care. Barriers included time-consuming paperwork, insufficient training, and inadequate pay for additional responsibilities.

PREPARING FOR CHANGE

RNs interested in prescribing should explore approved programs, keep updated with NMBA developments, and seek advice from nurses with prescribing experience.

A survey found that more than 80% of Australian RNs are interested in becoming prescribers, signalling strong interest.

RNs should regularly check the NMBA website for updates.

An advance copy of the standard has been published on the NMBA website.

What do nurses think?

"Designated registered nurse prescribing improves health outcomes by enabling timely, holistic care while reducing delays and easing pressure on healthcare systems. It's a step toward a more efficient, accessible, and person-centred approach to treatment. It bridges gaps in access, especially in underserved areas, and allows RNs to use their expertise to its fullest potential."

ANMF Senior Professional Officer
Julianne Bryce

"Registered nurse prescribing has the potential to significantly enhance timely interventions and improve access to medications in underserved communities. However, it requires more than just the ability to write prescriptions; it demands robust post-graduate education and training in pharmacology, advanced assessment, and clinical decision-making. Nurse practitioners can mentor and support registered nurses who have completed this education, helping them develop their clinical expertise and smoothly transition into the pathway for full endorsement as nurse practitioners."

Nurse Practitioner
Juliane Samara

IHM Australia
Powered by
Arizona State University®

Lead the Future of Nursing

Master of Nursing

Specialise and Excel in
Leadership, Education, or
Advanced Practice

Study
On-Campus
or **Online**

FEE-HELP
available for
eligible students*

Apply Now for 2025

www.ihm.edu.au
1800 763 757

*Terms and conditions apply

Nurses and midwives' vital role in blood borne virus testing

By Karen McKenna

Blood borne virus (BBV) testing in the healthcare setting is often initiated by nursing and midwifery staff, including infection prevention and control (IPC) nurses and hospital coordinators for the management of occupational exposure incidents, midwives for antenatal screening, and nurses throughout diverse community settings including community, correctional, refugee and sexual health settings.[1]

Nurses and midwives play a vital role in ensuring BBV testing is undertaken in a way that demonstrates knowledge, confidence and skill, while ensuring consistency with the national guidelines. It is important that they provide compassion and respect the privacy and impact the process can have on the person being tested.

OVERVIEW OF THE ISSUE

Barriers have been identified in the move to normalise BBV testing within community and healthcare settings, including a lack of time, a lack of both confidence and knowledge in how to discuss BBVs, and the presence of stigma and discrimination that impact the testing experience.[2] Pre-and post-testing discussions remain a significant feature of the testing process and given the ongoing stigma that continues to impact people living with BBVs, these discussions need to be conducted with sensitivity and in a supportive manner.[2] Testing discussions and informed consent are critical gateways to link people to treatment and care,[2] and education programs aimed at increasing the knowledge of the nurse and midwife to ensure these discussions are delivered with confidence are vital.

OPPORTUNITIES TO ADDRESS

Nurses and midwives have enormous opportunity to positively influence the lives of their patients, and they have a responsibility to provide care that is person-centred, safe and in a supportive environment.[3] Educational interventions to improve healthcare worker knowledge of transmission and risk, legislation, current guidelines and informed consent, have demonstrated improved outcomes, including increased knowledge of BBV transmission and risk, improved confidence in the discussion process and reducing stigma.[4,5] It is essential all healthcare workers who participate in BBV testing are trained in the testing process and understand the legislation that governs the testing process.

Education courses are available that provide nurses and midwives opportunity for learning outcomes including: epidemiology, transmission, prevention and management knowledge, testing requirements including intervals and window periods, a greater understanding of the personal impact of testing, and building on risk assessment skills and pre- and post-test discussions.[1]

CONCLUSION

The provision of BBV education is limited in undergraduate and post-graduate nursing and midwifery education programs, requiring it to be undertaken in the workplace setting. Mandatory training requirements need to be added to position descriptions for nursing and midwifery roles that are involved in BBV testing, to ensure the healthcare worker can confidently deliver information to consumers and undertake testing and counselling discussions proficiently.

Author

Karen McKenna, Infection Prevention and Control Consultant for Australasian College for Infection Prevention and Control Ltd

References

1. Australasian College for Infection Prevention and Control. Blood Borne Virus Testing Course 2024 [Available from: acipc.org.au/education/blood-borne-virus-testing-course/.
2. Lenton E, Johnson J, Brown G. Upscaling HIV and hepatitis C testing in primary healthcare settings: stigma-sensitive practice. *Australian Journal of Primary Health*. 2021;27(4):255-8.
3. Kerr S, Hassall M. Nurses can be leaders in dismantling stigma and discrimination toward people with blood borne viruses. *Australian Nursing & Midwifery Journal*. 2020 Jan-Mar:43.
4. Johnson J, Carr C, McDonald SJ, Flood MM. Talking testing: Impact of a training intervention on midwives' antenatal HIV, hepatitis B and hepatitis C screening practice. *Women and Birth*. 2021;34(5):e520-e5.
5. Ellen Perrett S, Erricker M, Lyons M. Evaluation of an e-learning package to improve understanding of blood-borne viruses amongst prison staff in Wales, UK. *International Journal of Prisoner Health*. 2014;10(1):47-54.

Dr Micah D J 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.

Now it's personal: Personal care is healthcare

After many years of tireless campaigning by the ANMF and allies, the way aged care is governed, funded, and delivered in Australia is changing.

While many wins have been achieved including landmark pay rises for staff, 24/7 registered nurse (RN) presence, mandated direct care time from RNs, enrolled nurses (ENs), and carers (with ENs and carers now differentiated), and improved accountability for how government and client funds are used, further measures are yet to be realised.

Australian aged care will be underpinned by a new Aged Care Act. We have been working to ensure that pertinent details of this Act and associated Rules support the delivery of best practice care and safe, optimal conditions for workers. These documents necessarily cover a vast array of topics. Among the ANMF's focus has been sections on care delivery. Here, one key concern is to ensure that aged care is understood as inseparable from *health* care and that all members of the care team need to be genuinely supported – particularly in terms of sustained and sufficient funding and support – to spend more direct time with clients/residents.

In these documents, 'clinical care' has been split from 'personal care'. The ANMF views this separation as artificial and has highlighted as much in several recent submissions. This split also risks not only downplaying the important role of personal care and the vital work of carers, but also undermining team-based care delivery. Clinical care, in these documents, refers to medical and nursing care and health professional interventions focussed on diagnosis, treatment, managing health conditions, and administering medications. Conversely, 'personal care' encompasses non-clinical assistance with daily living activities like hygiene, bathing, dressing, eating, and grooming. Such activities being described as typically provided by carers (however titled). The distinction covers not only the type of activity but also how these activities are funded; the Commonwealth Government paying for clinical care (with taxpayer's money) and clients generally paying for at least some of their personal care based on a means test. The paradox is most apparent where the government acknowledges that consumer contributions for personal care 'will be moderate' recognising that many personal care activities 'play an important role in keeping people out of hospital and residential aged care'.[1] To the ANMF, if a care activity is critical to helping individuals avoid hospital or residential aged care, then differentiating it from clinical care seems wilfully obtuse.

Nurses provide person-centred, holistic care that aligns to individual needs and preferences. As the NMBA describes, a core nursing activity is to supervise or provide personal and hygiene care including showering, dressing, and assisting with meals. By directly supervising or undertaking these activities, nurses collaborate with carers to observe, gather, and interpret important data and conduct vital physical examinations and measurements that provide critical insights into an older person's changing health status. In supervising or assisting with bathing and dressing, nurses can notice and respond when skin integrity is compromised or endangered. Regular visual skin assessment is the gold standard for identification of pressure injuries. Pressure injuries in nursing homes occur with comparable prevalence and incidence to in a hospital.[2] This is of huge importance due to the risk of pressure ulcers and skin tears in older adults (which can cause significant morbidity or death),[3] that can go unnoticed and untreated particularly if staff do not have the time, skills, education, and training to identify risk factors and early signs. Likewise, by supervising meals, nurses can assess and identify potential issues with swallowing that might be signs of an underlying illness or condition such as stroke. As with early identification (or ideally, prevention) of pressure injuries, ensuring nurses are supported to directly supervise or engage in team-based personal care is a critical part of keeping residents safe from choking and aspiration.

Every member of the care team in aged care is important. Both RNs and ENs work together with carers as the main providers of direct clinical and personal care and provide supervision and leadership. A hard line between the two types of care should not be drawn, as unscrupulous providers will be influenced by desires to save on staffing costs and understaff nursing homes or provide nursing staff with insufficient time and resources to provide the best care possible. Partitioning nursing time off into 'clinical care only' by incentivising that personal care only be delivered by carers risks relegating nursing to a specialist service rather than a fundamental part of aged care.

References

1. Senate Community Affairs Legislation Committee. Aged Care Bill 2024 – Overview of Aged Care Funding (Chapter 4). Australian Government Department of Health and Aged Care. 2024. (Page 20).
2. Sugathapala RDUP, Latimer S, Balasuriya A, Chaboyer W, Thalib L, Gillespie BM. Prevalence and incidence of pressure injuries among older people living in nursing homes: A systematic review and meta-analysis. *Int J Nurs Stud*. 2023 Dec;148:104605.
3. Song YP, Shen HW, Cai JY, Zha ML, Chen HL. The relationship between pressure injury complication and mortality risk of older patients in follow-up: A systematic review and meta-analysis. *Int Wound J*. 2019 Dec;16(6):1533-1544.

SVRT | Sexual Violence Response Training Australia

MONASH University

FREE TRAINING

IN RECOGNISING & RESPONDING TO ADULT DISCLOSURES OF SEXUAL VIOLENCE

Monash University's Department of Foresnic Medicine delivers training that equips AHPRA registered healthcare professionals to recognise and respond appropriately to adult disclosures of sexual violence.

DELIVERED ONLINE & FACE-TO-FACE

REGISTER HERE

2025 in-person sessions are scheduled to be delivered nationally in metro and regional areas.

Upcoming intakes are occuring in Canberra, Perth, Kalgoorlie and Brisbane.

All dates are listed on our website.

This program is funded by the Department of Social Services under the *National Plan to End Violence Against Women and Children 2022-2032.*

2025 Federal Election: Climate action at the forefront as parties face pressure to address Australia's carbon footprint

As the 2025 federal election approaches, voters are seeking strong commitment on climate change action that reduces the nation's carbon footprint and accelerates the transition to green energy and sustainable practices. Robert Fedele reports.

Clear signs of climate change, such as the rise and intensity of extreme weather events like bushfires and heatwaves, impacts many aspects of daily life, particularly public health.

With climate change becoming more urgent globally, political leaders face mounting pressure to balance environmental goals with economic considerations.

The *ANMJ* examines the climate strategies of the two major political parties.

LABOR'S CLIMATE MILESTONES

The Albanese Labor Government has made the biggest investments in climate change action in Australian history. These include:

- **Future Made in Australia plan:** This $22.7 billion investment into developing industries essential for a zero-carbon economy, is the largest investment in Australian manufacturing jobs in decades. Renewable industries are projected to create 400,000 new jobs in the next 15 years.
- **Emissions reduction targets:** In 2022, the government passed legislation to reduce emissions by 43% by 2030 (compared to 2005 levels) and achieve net-zero emissions by 2050. The government has invested heavily in over 70 renewable energy projects, such as the $1 billion Solar Sunshot program and large-scale wind farms.
- **Safeguard Mechanism (Crediting) legislation:** In 2023, Labor passed amendments to the "safeguard mechanism" policy for reducing emissions among Australia's largest polluters. Large industrial facilities must meet emissions baselines that decrease over time. Flexibility allows facilities to reduce their emissions directly or by buying carbon credits/offsets to fund projects like tree planting.
- **National Health and Climate Strategy:** Launched in December 2023, the strategy aims to address the health impacts of climate change, including the role of the health sector in reducing emissions and helping Australia achieve net-zero by 2050.

DUTTON'S PLAN TO GO NUCLEAR

The Coalition argues Australia needs a balanced energy mix to "deliver cheaper, cleaner and consistent 24/7 electricity". Its solution is to re-introduce nuclear energy.

In 2024, the Coalition identified seven locations at closed coal-fired power stations that could be turned into "zero emissions" nuclear power plants. If elected, they say the first reactor will be operational by 2035. Australia banned nuclear energy in the late 90s.

Opposition Leader Peter Dutton claims that unlike Labor's push towards solar and wind, there are 32 countries operating nuclear power plants, with another 50 looking to do so.

"Our plan will deliver a net-zero electricity grid by 2050 and a strong and resilient economy. It will set our country up for decades to come," he said.

While the Coalition has committed to honouring the 2015 Paris Agreement, an international treaty to limit global warming and adapt to climate change, it has steered clear of setting 2030 emissions targets until in government.

HEALTH AND SAFETY CONCERNS OF NUCLEAR

Health professionals across Australia remain concerned about Dutton's nuclear energy plan due to its significant health and safety risks, as demonstrated in the Fukushima and Chernobyl disasters, where catastrophic radiation impacted thousands.

The infrastructure could take over 15 years to deliver energy to homes, and when it does, could increase Australians' average electricity bill by $665 per year, research shows.

There are also widespread concerns nuclear energy will delay the shift to green energy, hindering immediate emissions reduction and disrupting efforts to transition workers impacted by coal mine closures into jobs in renewable energy supply.

Nuclear energy could lead to increased risks to human health and life, power outages, continued emissions, and increased costs.

CLIMATE INTEGRITY

The Australia Institute's 2025 Climate Integrity Summit, held in February at Parliament House, examined Australia's role in global climate action.

Dr Richard Denniss, Director of the Australia Institute, argued that as the world's third largest fossil fuel exporter, Australia has a social responsibility to lead the global transition away from fossil fuels. Yet, the nation continues to subsidise the fossil fuel industry to the tune of $14 billion per year.

Dr Denniss said the science and economics of climate change have been clear for considerable time: Australia needs to stop burning so many fossil fuels.

"We need to tax pollution, we need to subsidise alternatives, and we need to support workers that are affected by the transition," he said.

"It's not complicated. The science isn't complicated, the economics isn't complicated. What is complicated is the politics. And the reason the politics are so complicated is such a small number of people make so much money out of causing climate change. They just don't want to stop."

Australia's approach to climate change lacks integrity, Dr Denniss suggested, because while the government promotes transitioning away from fossil fuels, it continues to approve new coal mines and gas projects.

"We plan to export more fossil fuels and no matter where in the world those fossil fuels are burned, they will warm, not just the globe's climate, but ours here in Australia."

The Summit saw Independent Senator for the ACT, David Pocock outline a plan to introduce an "Ending Fossil Fuel Exploration Bill" into Parliament. He emphasised that Australians are increasingly aware of how climate change will impact their lives, everything from their health to the sports they enjoy.

"We've all got a role to play [in addressing climate change]," he declared.

Healthcare accessibility: A rural and remote Australian case study

By Shirley Papavasiliou and Carmen Reaiche

Research exploring the challenges of providing community palliative care in peri-urban areas was recently undertaken as part of a Doctor of Philosophy program at James Cook University.

With the goal to drive change within the public health sector. This study advocates to shape public policies that support the complex realities of dying, death, loss and grief, while removing barriers that vulnerable populations face in accessing health services.[1]

Most research on healthcare access barriers focuses on geographical barriers in rural and remote areas of Australia. However, few studies address access barriers in peri-urban locations which offer a rural lifestyle in proximity to urban centres and have witnessed a surge in popularity. The resulting population growth has impacted the provision of healthcare services.

What became clear in the literature is the importance of developing an approach in defining peri-urban areas which considers the unique characteristics of these areas.

Evidence suggests that current methods of location classification do not reliably indicate the needs and expectations of peri-urban communities[2] as they rely on population density and proximity to urban centres as a predictor of access to goods and services, to allocate resources and methods of service delivery.[2]

An online survey was used to collect data from those involved in community palliative care across Australia and divided into three groups: clinicians, family caregivers and patients. Participants were invited to provide their voices in free text boxes throughout the survey to add depth to understanding access issues.

Of the participants, most clinicians identified as nurses and many voiced concerns about the difficulties accessing equipment, trained staff and medication due to the time and distance associated with peri-urban locations. Travel was viewed as a challenge when trying to meet daily workload demands without compromising provision of quality person-centred care. Most wanted to provide 24/7 contact for support and in-home care options, with a method of delivery that promoted care from clinicians with an established relationship with the patient. A reliance on digital health was a difficult subject, with many feeling a face-to-face service was important due to the emotional environment of palliative care.

Of most concern, was the overwhelming level of emotional distress expressed by nurses who believed they were unable to provide appropriate care. Words were used such as 'frustrated', 'sad', 'overworked', 'stressed' and 'exhausted'. The common view placed the cause of barriers to access as a lack of support from leadership or the organisation for which they worked, which they believed demonstrated a lack of recognition of staff as an asset to be developed, supported and retained. Organisations that equip nursing and other healthcare staff with the necessary resources, increase staff satisfaction and decrease the likelihood of adverse medical events, poor patient care and unmet patient needs.[3]

An understanding of the challenges and risks that exist in all community care settings, due to complex care needs and family situations was evident. However, many believed that potential risks are exacerbated in rural locations within peri-urban areas due to travelling when fatigued on unsealed and unknown roads in poor

weather conditions and the likelihood of a delayed response to an emergency due to poor mobile coverage. Many believed risk was compounded by a lack of confidence, frustration and disappointment by a lack of support from their organisation.

Many family caregivers in peri-urban locations, expressed feelings of dissatisfaction, disappointment and anger because of poor or limited access to services they required. Unmet needs were a common complaint, particularly when access barriers influenced decisions regarding treatment and place of care. Many reported the need to relocate, particularly at end-of-life, as a direct result of being unable to access services in peri-urban locations.

The highest unmet needs reported by caregivers were psychological issues and direct patient care which they attributed to anxiety, decreased quality of life and complicated grief. Continuity of care with trusted and skilled clinicians is required to develop coping strategies and validate caregiver responses following the death of a loved one; however, many reported difficulties accessing bereavement and grief support in their location.[4]

A small number of patients provided responses, although peri-urban patients were generally more appreciative of care received than family caregivers. Distance and time involved in travelling to receive care and attend appointments was voiced by many as an influencing factor in decisions regarding treatment, care, place of death and the need to relocate to access services.

Analysis of responses demonstrates the relationships between peri-urban locations, system-led and organisational policies, procedures, guidelines, funding, leadership, models of care and culture, and the needs and expectations of communities. Overall, the access barriers known to exist in rural areas were reported in peri-urban locations. The voices all focused attention on the need for the health system and organisations providing palliative care, to understand and explore access barriers specific to peri-urban locations. To fund local infrastructure and resources and evaluate and develop policies, guidelines, and care models tailored to peri-urban needs. Consideration to organisational and leadership culture will be essential to support and retain experienced palliative care clinicians in peri-urban areas.

This research has highlighted challenges for people living and working in peri-urban areas and healthcare providers. It is widely accepted that provision of good quality, holistic palliative care in the location of patient choice improves overall wellbeing for patients and their family members, enables choice of place for end-of-life care and death, and facilitates the grieving process for family and friends. The palliative care being provided in peri-urban locations cannot be labelled holistic if barriers to access are ignored, placing increased pressure on the traditional support mechanisms of extended family, friends and neighbours.

Authors

Dr Shirley Papavasiliou PhD, MPallCAgedCare, RN is a Clinical Nurse in Palliative Care, South Australia

Associate Professor Carmen Reaiche is at James Cook University, Douglas QLD

References

1. World Health Organization (WHO). (2020). *Palliative Care*. World Health Organization. Retrieved 29 April 2023 from who.int/news-room/fact-sheets/detail/palliative-care
2. Buxton M, & Butt A. 2020. *The Future of the Fringe: The Crisis in Peri-Urban Planning*. CSIRO Publishing
3. Perry SJ, Richter JP, & Beauvais B. 2018. The Effects of Nursing Satisfaction and Turnover Cognitions on Patient Attitudes and Outcomes: A Three-Level Multisource Study. *Health Res*, *53*(6), 4943-4969. https://doi.org/10.1111/1475-6773.12997
4. Aghaei MH, Vanaki Z, & Mohammadi E. 2020. Emotional Bond: The Nature of Relationship in Palliative Care for Cancer Patients. *Indian J Palliat Care*, *26*(1), 86-94. https://doi.org/10.4103/ijpc.Ijpc_181_19

Exploring barriers to antenatal education for Culturally and Linguistically Diverse (CALD) women in a tertiary hospital setting

By Delnia Palani, Jenny Fereday, Annette Briley and Julie Tucker

Women who identify as Culturally and Linguistically diverse (CALD), have long been acknowledged as experiencing poorer pregnancy outcomes compared to others.

The reason for this are complex and multifactorial, but include lack of access to resources, low health literacy or resources only available in English language, communication barriers and lack of cultural understanding/cultural sensitivity by healthcare providers. Current antenatal resources are provided through a large local health network (LHN) that offers public maternity services. This large metropolitan LHN provides educational resources on the 'Pregnancy Online Platform' (POPN), and recommended websites listed in the South Australian Pregnancy Record (SAPR) books, in addition to face-to-face education provided during antenatal appointments. Most of these educational resources are offered in English language only. Anecdotally, there is an increasing population of refugees and migrants attending for antenatal care in this service. In the last five years, this LHN has reported 3,945 (22%) women who accessed antenatal clinics identified as from CALD backgrounds. It is highly likely there is a lack of pregnancy resources that meets their educational needs during pregnancy.

Project outline: This paper reports a quality improvement project undertaken in a large maternity tertiary hospital in South Australia to review facilitators and barriers to antenatal resources for CALD women.

Intervention: Women from CALD backgrounds attending antenatal outpatient clinic appointment between 9/9/23 – 23/11/23 were invited to participate in a de-identified QR code survey.

Results: Fifty pregnant CALD women participated in the survey. Of these, 26% stated that the antenatal education received through their pregnancy was not useful, and 20% of these women were not able to understand the content. Forty percent of women stated the information was not culturally appropriate. Results identified different modes and format of resources delivered.

Conclusion: Antenatal information was received by most CALD women attending clinics however, limitations existed in the usefulness, cultural appropriateness, sensitivity, and accessibility of these resources. Deeper understanding of preferred educational resources and mode of delivery for CALD women in their primary language is essential to improve outcomes for these women.

INTRODUCTION

Globally, at least 110 million people have been forced to flee their homes from war, persecution, conflict, and human rights violation.[1] This global refugee crisis is expected to rise to at least 200 million by 2050.[1] Australia is one of the most multicultural countries in the world with proportionally higher immigration rates than other countries including Canada, the United Kingdom, and New Zealand.[2] In 2020, an estimated 30% of Australian residents were born overseas, equating to 7.7 million people.[3] South Australia is home to people from more than 300 culturally, linguistically, and religiously diverse backgrounds.[3]

The term 'migrant and refugee' in this document, refers both to women who are voluntary migrants and women who come to Australia as refugees, humanitarian entrants, or asylum seekers.[4] Migrants and refugees are often referred to as people of culturally and linguistically diverse background (CALD), people born overseas, from minimal to non-English–speaking backgrounds (NESB) or people who speak a language other than English.[4,5] In Australia, people from CALD backgrounds often experience multiple social disadvantages and face challenges in health and healthcare needs.[5] These trends pose as a significant barrier to migrants accessing healthcare, particularly NESB women. Furthermore, the Australian Institute of Health and Welfare[6] indicate that more than a quarter (27%) of mothers who give birth in Australia were born in a mainly non-English speaking country. Considering more women from non-English speaking backgrounds are giving birth in Australia, this represents an important public health issue.[5]

Being pregnant, giving birth and becoming a mother can be a wonderful but stressful time in any woman's life. Of concern is many CALD women have poor pregnancy outcomes. The literature reports CALD women have higher rates of still birth, neonatal death, congenital abnormalities, instrumental births, caesarean section, along with more frequent obstetric complications.[7,8] CALD women also experience significantly higher rates of postnatal depression (28.8% vs 15%) and are more likely to report wanting more practical (65.2% vs 55.4%) and emotional support (65.2% vs 44.1%) in comparison with the general Australian population.[9] Some studies identify the prevalence of postnatal depressive symptoms to remain higher in mothers from the CALD groups (4.2%).[10] Overall, there is limited epidemiological data on perinatal mental health among CALD women, in Australia.

Antenatal education is an important component of care during pregnancy. Evidence demonstrates CALD women have lower access to sexual and reproductive health services challenged by multiple barriers, including language, [5,7,11,12,13] digital health,[7] interpreting services,[8,11,12,13] conflicting cultural barriers,[5,11] lack of cultural sensitivity amongst healthcare workers[5,8,11] and structural barriers.[8, 11, 12]

It is the responsibility of maternity healthcare professionals to provide appropriate antenatal education to ensure women have sufficient knowledge to make informed decisions about their care and build their knowledge, awareness and confidence regarding pregnancy, labour, and birth. Language and communication problems can be improved by ensuring the provision of multilingual information and communication materials through culturally appropriate resources. Digital resources have increasingly become an integral component of pregnant women's maternity care. However, studies show poor engagement and lack of access in vulnerable groups including CALD.[14] A review of the literature identified that current digital health gives additional advantage to those already able to engage with maternity care.[14] Digitisation that does not always incorporate resources for CALD women risks overlooking vulnerable women, who are more likely to be in greater need. Increased access gained through digitalisation is therefore compromised due to primarily language barriers.

PROBLEM

A review of antenatal attendance in one LHN, 2018-2023 identified 22% of pregnant women identified as CALD. The hospital offers women a Pregnancy Online Platform (POPN) as a component of antenatal care. This is an online resource for women to supplement midwifery education during appointments and antenatal classes. This platform is of limited use for CALD women, as all resources are provided in English only. Additionally, all pregnant women in South Australia who register their pregnancy receive the South Australian Pregnancy Record (SAPR). Educational resource links are provided on the back of the book. Of the 20 highly rated information sources, only 10 offer languages other than English on their website. This quality improvement project is grounded in the premise that CALD women using services for maternity care at LHN should have access to resources designed to support all women including those from limited or NESB, to ensure equity in care resources.

METHOD

A quality improvement project was undertaken to explore and identify current barriers within antenatal resources as perceived by CALD women who attended the hospital antenatal services between 9/9/23-23/11/23. This project was undertaken as part of the 'Outstanding Workforce Leadership' (OWL) Program through the Rosemary Bryant Research Centre.

The project was approved by the Divisional leadership and Research Governance Department and was registered within the organisation. Women attending antenatal outpatient appointments were invited by attending midwives to participate in a QR code survey that was de-identified. Six dichotomous questions, including multiple option response and free text, assessed website access, receipt of CALD resources, sensitivity and appropriateness of resources currently provided and preferred mode of delivery. An emphasis on the voluntary aspect of participating was provided and women were made aware that they can take a picture of the QR code and complete the survey at a later time, if they wished to participate. The QR code was only available in English language. Interpreters were provided for women with language barriers.

Fig. 1: Antenatal information: received, useful or sensitive

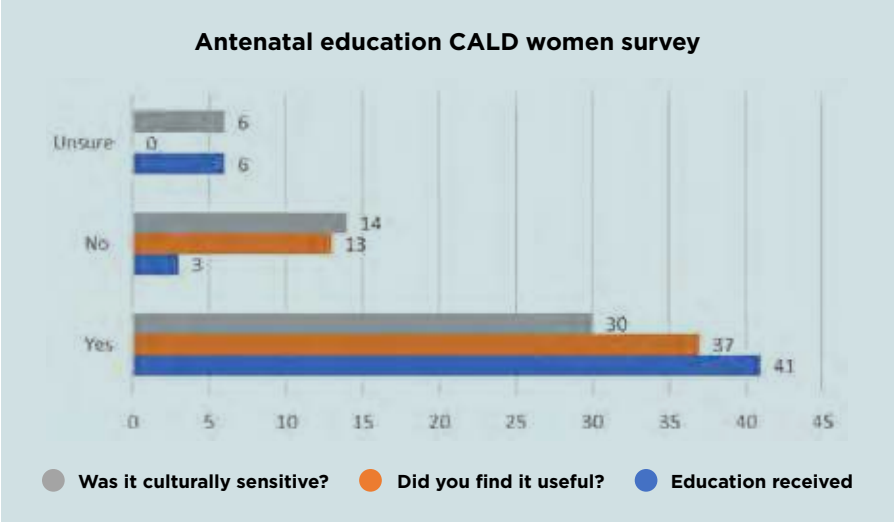


Fig. 2: Preferred educational topics CALD women

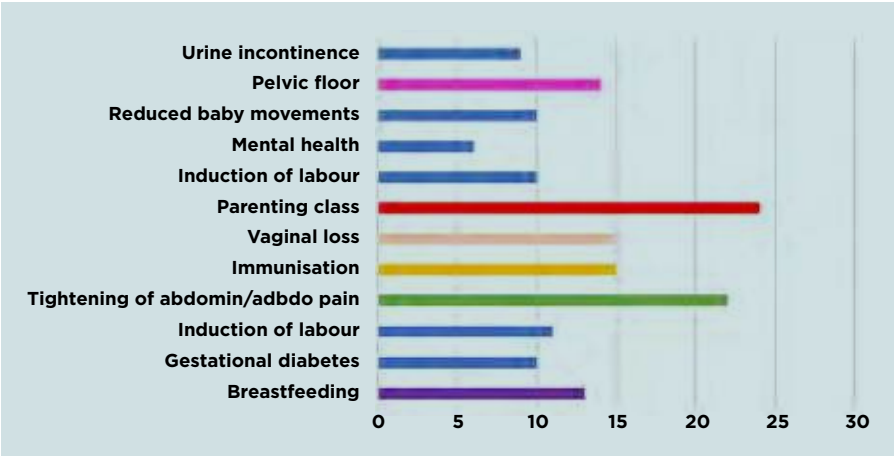
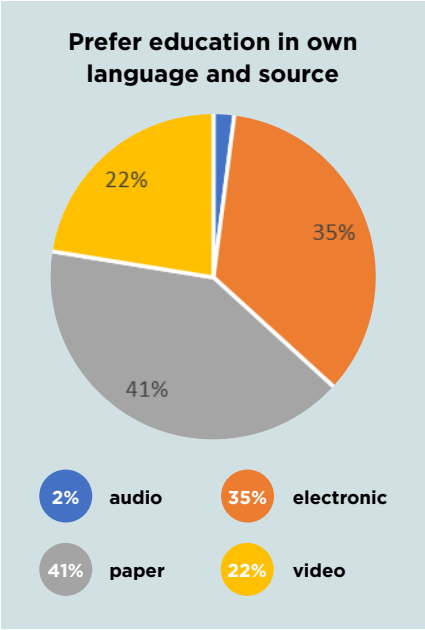


Fig. 3: Education format preference



RESULTS

Fifty CALD women completed the survey with 82% stating they received antenatal education whilst attending antenatal appointment, compared to 6% who stated no information was given and a further 12% who were unsure.

Of the women who received information, 26% stated it was not useful with 20% not able to understand the content. Furthermore, 40% of women stated the information was not culturally appropriate or were uncertain regarding its' appropriateness (Figure 1).

Figure 2 identifies the diverse educational topics CALD women identify as requiring. The top 5 requests were information on parent education classes, abdominal tightening/abdominal pain, vaginal loss, immunisation, and pelvic floor. Mode and format of resources were preferred information in their primary language and delivered in multiple formats (Figure 3). Paper information resources were recognised as preferred mode (41%) compared electronic (35%), video (22%) and audio (2%).

DISCUSSION

Findings established that antenatal information was received by most CALD women attending appointments. However, limitations existed regarding the usefulness, cultural appropriateness, sensitivity, and accessibility of this information. Results from the current study concur with those of others, identifying the main factor influencing communication and understanding of information was language barrier.[5,11,12,13] Poor health literacy reduces antenatal care participation and understanding care, increases late presentation of symptoms, reduces participation in informed decision making or/and utilisation of other health and social services such as maternal child health networks, parenting groups, and antenatal classes.[7,11,13] Interestingly the preferred list of antenatal resources identified by CALD women in our project (Figure 2) corresponds to the needs outlined by Bartlett & Boyle.[7]

Twenty-six percent (26%) of women stated the resources were not useful. However, the survey did not explore the reasons for non-useful resources. The literature reports disparity for CALD community's uptake of information and resources between expected social norms and cultural and social needs, strong religious and cultural values and beliefs regarding health and illness from CALD women country of origin.[13] Issues previously identified, include body image, taboo terms, and vaginal examinations.[5,11,13] Additionally, Olcoń[8] reported that some CALD women cannot relate to certain pregnancy screening tools such as the Edinburgh Postnatal Depression Scale, which has been reported not culturally appropriate.[8] Some have recommended to replace or adapt the screening tool to ensure to make it more culturally appropriate for women of migrant and refugee backgrounds by focusing on specific issues related to them, for example, such as including impact of war, displacement and experiences in refugee camps. This supports the concept of this project by capturing the essence of providing tailored care that meets the needs and requirements of CALD women.

The QI project highlighted limitations and gaps in service provision and indicated the need to improve health literacy by providing language specific education. Language and communication problems

can be improved by ensuring the provision of multilingual information, and communication materials that are culturally appropriate. The development of audio, pictorial and video resources have been strongly recommended within the CALD communities, especially for those with low literacy in their own language, or for those who speak a language without a widely used written form.[15] This partially supports our findings where survey respondents stated multiple mode of information dissemination with higher preference for paper and electronic compared to video and audio.

Interpreters are commonly utilised in clinics, and almost universally within the literature, NESB women report valuing the use of professional interpreters in most of the literature studies.[11] Conversely, Billet and colleagues[11] reported interpreting services as not always appropriate, due to demographics and dialect differences or general mistrust in the service. Additionally, women occasionally reported feeling uncomfortable with the service provided by interpreters during appointments.[11]

Bartlett and Boyle[7] reported CALD women preferred to receive education digitally compared to having an interpreter, since the risk of misunderstanding could be reduced. The limitations of current modes are the provision of information in English language, with no interpreters when education to mother is limited to using pamphlets, lessons, and videos.[13] Findings highlight, in common with all women, multiple and diverse ranges of resources are required to meet the needs of CALD women.

A limitation of our survey was the omission of whether CALD women could both read and write their primary language, an important aspect to consider moving forward in establishing accessible, appropriate, and useful resources for this group. A further limitation being the QR code and survey was only available in English and although interpretation services were available for women choosing to complete it whilst at the hospital, those who chose to complete elsewhere may have failed to do so due to this.

Migrants, refugees, and international students who are CALD continue to arrive in Australia and access healthcare services, and findings of this QI has raised significant questions for all health professionals to investigate their current settings to improve health literacy for CALD communities.

CONCLUSION

Antenatal information was received by most CALD women attending clinics. Limitations exist in the usefulness, cultural appropriateness, and sensitivity. Preferred options for information in their primary language was through diverse information pathways. Considering women may not read or write their primary language, multiple formats would assist in improving health literacy for this population. Educational literature should be tailored to the needs of CALD women. This can be best achieved through co-design with CALD groups of women and their partners. Further investigation is required to gain a deeper understanding of health literacy in this group.

The project has Publication Approval from Central Adelaide Local Health Network (CALHN) Human Research Ethics (Reference Number: 19866).

Authors

Delnia Palani is at Women and Children's Division Northern Adelaide Local Health Network

Jenny Fereday is at University of South Australia

Annette Briley is at Caring Futures Institute Flinders University and at Women and Children's Division Northern Adelaide Local Health Network

Julie Tucker is at Division Surgical Specialties and Anaesthesia, Northern Adelaide Local Health Network, University of South Australia and Caring Futures Institute Flinders University

References

1. United Nations High Commissioner of refugees (UNHCR). Global Trends Forced, Displaced in 2022 [Internet]. UNHCR The UN Refugee Agency; 2023 [cited 2024 Mar 14] Available from: unhcr.org/global-trends.
2. Yelland J, Riggs E, Small R, Brown S. Maternity services are not meeting the needs of immigrant women of non-English speaking background: Results of two consecutive Australian population-based studies. *Midwifery* [Internet]. 2015 July [cited 2024 Mar 26];31(7):64–670. Available from: doi.org/10.1016/j.midw.2015.03.001.
3. Australian Bureau of Statistics (ABS). Census of Population and Housing: Reflecting Australia – Stories from the Census [*Internet*]. Canberra ACT: ABS; 2024 [updated 2024 April 24; cited 2024 Feb 18]. Available from: abs.gov.au/media-centre/media-releases/11-things-you-may-not-know-about-australians-born-overseas#:~:text=Australia's%20population%20included%208.2%20million,increased%2-0to%2030.7%25%20in%202023.
4. Australian Living Evidence Collaboration. Australian Pregnancy Guidelines – pregnancy care for migrant and refugee women [Internet]. Melbourne: Monash University; 2024 Dec [cited 2024 Feb 18]. Available from: files.magicapp.org/guideline/f8d3f9ed-d546-4c0f-99be-282201464991/published_guideline_9371-5_0.pdf.
5. Khatri RB, Assefa Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: Issues and challenges. *BMC Public Health* [Internet]. 2022 May [cited 2024 Apr 01];22(1). Available from: doi.org/10.1186/s12889-022-13256-z.
6. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies 2018—in brief, AIHW [Internet]. AIHW; 2024 [updated 2024 Dec 13; cited 2024 Feb 18]. Available from: aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/summary.
7. Bartlett R, Boyle JA. Developing multi-language maternal health education videos for refugee and migrant women in Southeast Melbourne. *Midwifery* [Internet]. 2022 Aug [cited 2024 Apr 01];111(103369). Available from: doi.org/10.1016/j.midw.2022.103369.
8. Olcoń K, Rambaldini-Gooding D, Degeling C. Implementation gaps in culturally responsive care for refugee and migrant maternal health in New South Wales, Australia. *BMC Health Services Research* [Internet]. 2023 Jan [cited 2024 Apr 01];23(1). Available from: doi.org/10.1186/s12913-023-09066-7.
9. Bandyopadhyay M, Small R, Watson L, Brown S. Life with a new baby: How do immigrant and Australian-born women's experiences compare? *Australian and New Zealand Journal of Public Health* [Internet]. 2010 Aug [cited 2024 May 02];34(4):412–421. Available from: doi.org/10.1111/j.1753-6405.2010.00575.x.
10. Ogbo F, Eastwood J, Hendry A, Jalaludin B, Agho K, Barnett B, et al. Determinants of antenatal depression and postnatal depression in Australia. *BMC Psychiatry* [Internet]. 2018 Jan [cited 2024 May 05]; 18 (1). Available from: doi.org/10.1186/s12888-018-1598-x.
11. Billett H, Vazquez Corona M, Bohren MA. Women from migrant and refugee backgrounds' perceptions and experiences of the continuum of maternity care in Australia: A qualitative evidence synthesis. *Women and Birth* [Internet]. 2022 Jul [cited 2024 April 02];35(4):327–339. Available from: doi.org/10.1016/j.wombi.2021.08.005.
12. Dougherty L, Lloyd J, Harris E, Caffrey P, Harris M. Access to appropriate health care for non-English speaking migrant families with a newborn/young child: A systematic scoping literature review. *BMC Health Services Research* [Internet]. 2020 April [cited 2024 April 02];20(1). Available from: doi.org/10.1186/s12913-020-05157-x.
13. Hoang H. Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *Language, Society and Culture* [Internet]. 2008 Jan [cited 2024 April 02];26:555-561. Available from: hdl.handle.net/102.100.100/587872.
14. Hughson JP, Daly JO, Woodward-kron R, Hajek J, Story, D. The rise of pregnancy apps and the implications for culturally and linguistically diverse women: Narrative review. *JMIR mHealth and uHealth* [Internet]. 2018 Nov [cited 2024 April 12];6(11). Available from: mhealth.jmir.org/2018/11/e189/.
15. NSW Health. Developing health resources for people from refugee backgrounds [Internet]. NSW Multicultural Health Communication Service; 2023 June [cited 2024 Apr 12]. Available from: mhcs.health.nsw.gov.au/about-us/campaigns-and-projects/current-campaigns/health-resources-for-refugee/bestpracticeguidelines.pdf.

Rebecca Millar

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

What will a legal violation of privacy in Australia mean for nurses?

The nursing documentation landscape has transformed dramatically over the past decade, with the shift toward digital record-keeping shaping daily practice.

Over the past 15 years, the adoption of electronic medical records (EMRs) has surged by 50% worldwide, driven by the promise of improved efficiency, accuracy, and patient outcomes. In Australia, the *Health 2040: Advancing Health, Access and Care* plan prioritises digitising medical records as part of a broader strategy to enhance healthcare delivery.

Despite this push toward e-health, many health services continue to rely on paper-based records, creating a fragmented system with varying privacy and security implications. While the fundamental principles of documentation remain unchanged – ensuring accuracy, confidentiality, and accessibility – the transition to digital platforms introduces new legal and ethical challenges for nurses and midwives.

The digitalisation of health records has introduced significant risks for nurses and midwives navigating privacy obligations in an increasingly interconnected world.

Common privacy pitfalls include inappropriate access to patient records (where nurses or midwives may have the ability but not the ethical or legal right to view certain patient information), social media posts discussing patient information (even without naming a patient), and lapses in security, such as failing to log off shared computers. Nurses and midwives are bound by professional standards such as the *NMBA Code of Conduct for Nurses (2018)* which states that nurses must "respect all aspects of a person's privacy" (Principle 3.4) and take proactive steps to protect patient confidentiality.

The *Registered Nurse Standards for Practice* also mandate secure and accurate documentation, requiring nurses to use ethical decision-making in handling sensitive health data. Under the *National Law* (*Health Practitioner Regulation National Law Act* as enacted in each state), breaches of privacy may lead to disciplinary action by the Nursing and Midwifery Board of Australia (NMBA), including suspension or deregistration.

However, it is not just discipline specific consequences that nurses and midwives must be concerned with. Privacy laws in Australia impose strict obligations on nurses and midwives regarding the handling of patient information. The *Privacy Act 1988 (Cth)* and the *Australian Privacy Principles (APPs)* apply to healthcare providers, requiring them to take reasonable steps to protect patient data (APP 11).

Additional state legislation further reinforces these principles, such as the *Health Records Act 2001 (Vic)* which sets out Health Privacy Principles governing the collection, use, and disclosure of health information. Similar legislation is found across most Australian states. Breaches of these laws can result in regulatory action, civil penalties, or even criminal charges for serious misconduct, such as unauthorised access to health records. In circumstances where a patient, has concerns about their privacy being breached, a report can be made to the Office of the Australian Information Commissioner (OAIC), to the Australian Health Practitioner Regulation Agency (Ahpra) or, where there is evidence of significant harm or loss, pursue a civil remedy through court. Until recently, Australian privacy law has been criticised as being 'without teeth'.[1] Often a result of an overburdened and under resourced commissioner, the difficulty in making out a 'significant harm' under section 26WG of the Privacy Act, and the expense of civil court action.

However, if successful with an action for breach of privacy, depending on which legislation is relied upon, individuals who breach privacy law are at risk of significant fines of over $100,000 or years of imprisonment.

In response to these criticisms, in September 2024, the *Privacy and Other Legislation Amendment Bill 2024* (Cth) was introduced to Parliament, passing both houses by November and came into effect from December 2024.

Not only establishing a statutory tort for serious invasions of privacy, the (now) Act also introduced stricter penalties for data breaches and specifically grants individuals the right to pursue legal action if their privacy is unlawfully violated, marking a pivotal shift in Australian privacy law. Additionally, the legislation enhances the powers of the Office of the Australian Information Commissioner (OAIC), increasing its investigatory powers and enabling it to impose substantial civil penalties for data breaches as well as issuing infringement notices.

For nurses and midwives, these reforms underscore the critical importance of safeguarding patient information. Unauthorised access, disclosure, or mishandling of health records by nurses and midwives can lead to substantial legal consequences, including increased civil penalties and potential criminal charges. Whilst nurses and midwives, as healthcare workers, have some protection against accusations of privacy breaches where data has been shared or transferred for the purpose of providing healthcare services, this exemption is limited and does not make a nurse or midwife immune to the threat of legal action for breach of privacy.

Reference

1. Witzleb N. 2020. Another push for an Australian Privacy Tort: Context, Evaluation and Prospects. *Australian Law Journal, 94*, 765-782. ssrn.com/abstract=3705881

CHRONIC HEALTH

Kids in chronic pain: A neglected issue

By Megan-Jane Johnstone AO

Chronic pain in children is a significant yet under recognised global public health problem, with prevalence studies estimating that between 11% and 38% (mean 20.8%) of children live with chronic pain (pain lasting longer than three months).[1,2]

The prevalence of chronic paediatric pain in Australia mirrors these statistics, with Chronic Pain Australia (CPA) concurring that one in five children experience chronic pain across the nation.[3]

THE PROBLEM OF PAIN STIGMA

As is the case internationally, the management of chronic pain in children is complex and challenging. Compounding the complexity of accurately assessing and effectively managing chronic paediatric pain is that children and their parents are often not believed when presenting for care and treatment – a problem that has been prevalent for decades.

The negative pain biases of people (healthcare professionals, teachers, and peers among them) can lead to children and their parents being stigmatised (subjected to 'pain stigma') and treated in a biased and discriminatory way, leaving them feeling distressed, isolated, abandoned, alone and deeply frustrated and fearful of the future. Children and families from diverse cultural and language backgrounds are especially vulnerable to experiencing pain stigma due to racial and ethnic biases in pain assessment, attribution and care.[4,5]

Another complicating factor in the effective management of kids in chronic pain is the lack of accessible and affordable paediatric pain services. According to CPA there are only six paediatric pain clinics nationally in Australia, each with a cap on referrals of around 250 per year. This means that children in chronic pain can wait anywhere between one and three years before being seen. As CPA points out, 'This is a tremendously longtime in a short life, and can span some of a child's critical development years'.[3] This delay can be especially problematic when chronic pain causes children to miss school. In Australia, for example, it is estimated that children in chronic pain can miss up to 22% (almost nine weeks) of their schooling days.[3]

FORMS OF CHRONIC PAEDIATRIC PAIN

Chronic pain in children can manifest in one of two forms *chronic primary pain* and *chronic secondary pain*. Chronic primary pain is characterised by 'significant emotional or functional disability and is diagnosed independently of identified biological or psychological contributors'.[1(P1)]

The most common paediatric primary chronic pain diagnoses include: chronic headaches, chronic abdominal pain (including chronic pelvic pain), chronic musculoskeletal and/or joint pain, and chronic back pain. Another underappreciated paediatric chronic pain

condition is Complex Regional Pain Syndrome (CRPS), a rare and debilitating disease for which delayed diagnoses can prolong disability and emotional distress.[6]

Chronic secondary pain, in contrast, is pain that has 'a clear underlying etiology such as a disease, injury or lesion, or their treatment' (eg. surgery, chemotherapy, radiotherapy)'.[1(P1)] In either case, whether primary or secondary in nature, chronic pain can be extremely traumatising for a child, the consequences of which can have a major impact on their lives and development.

NEGATIVE IMPACT ON DEVELOPMENTAL MILESTONES

A unique feature of paediatric chronic pain is its negative impact on a child's ability to achieve important developmental milestones as they grow from childhood to adulthood. As noted by WHO,[1] chronic pain can significantly affect the emotional, psychological, physical and social development and functioning of children and adolescents in adverse ways. Specific developmental domains which can be severely disrupted by chronic pain include physical functioning (eg. engaging in sport, play, and other recreational activities), mood, interpersonal relationships (eg. making and sustaining friends), social interactions, schooling and educational attainment, and sleep – all of which are critical to the development of a child's self-esteem, personal identity, health-related quality of life, and overall emotional adjustment and regulation.[7]

The consequences of developmental milestones being disrupted in childhood are not restricted to childhood, however. Research suggests that the consequences of such disruption can also have a negative impact on the achievement of important life goals in adulthood such as completing an education, finding employment, establishing and maintaining meaningful social relationships and associated with all these things, a reduction in quality of life and health outcomes – mental and physical.[1]

CONCLUSION

Chronic paediatric pain has been known about for decades with some of the earliest contemporary works on the subject dating back to 1938 and subsequent foundational works published in the aftermath of the second world war.[8] Despite the publication of these and later works, development of the field of paediatric chronic pain management has been frustratingly slow and irregular, with advances in science not always being applied in practice to inform better care.

Over the past 15 years the domain of chronic paediatric pain management has started to shift significantly. This shift can be traced back to new understandings about pain experiences in children and how chronic pain management can be improved through achieving neuroplastic changes in the nervous system via evidence-based pain management using a multidisciplinary team approach involving pain specialists, physiotherapists, psychologists, and dieticians.[9] Also driving this shift is robust advocacy by pain researchers for a public health approach to educating the whole community about the science of chronic pain and its effective management.[10]

Nurses whose work brings them into direct contact with children and their parents have a responsibility to be well informed about pain science. This includes being knowledgeable about the complexity of chronic paediatric pain including its different manifestations, assessment, attribution and management, gaps in care, and how best to support children and parents grappling with pain stigma and system blocks to their accessing affordable paediatric chronic pain services.

Kids with chronic pain need to be believed and their parents supported in getting the help they need to enable their children to live a life that is not defined by their untreated pain. Affordable, high quality and accessible paediatric pain management is a fundamental human right and it is incumbent on the nursing profession to do what it can to promote and protect this right.

Author

Dr Megan-Jane Johnstone AO, PhD, BA, RN is Adjunct Professor, School of Nursing and Midwifery, La Trobe University, Melbourne, and the author of Bioethics: a nursing perspective.

References

1. World Health Organization. *Guidelines on the management of chronic pain in children*. World Health Organization, Geneva; 2020
2. Chambers CT, Dol J, Tutelman PR, Langley CL, Parker JA, Cormier BT, et al. The prevalence of chronic pain in children and adolescents: a systematic review update and meta-analysis. *Pain*. 2024 Oct 1;165(10):2215-34
3. Chronic Pain Australia (CPA), Morningside, Qld. 1 in 5 Children living with chronic pain [Internet]; 2024 [cited 8 Nov 2024]. Available from: chronicpainaustralia.org.au/news/1-in-5-children-living-with-chronic-pain-launch-of-kids-in-pain-week-to-raise-awareness-of-lack-in-treatment-and-support-for-kids/
4. Haas SM, Mullin GJ, Williams A, Reynolds A, Tuerxuntuoheti A, Reyes PG, et al. Racial bias in pediatric pain perception. *J Pain*. 2024 Sep 1;25(9):104583
5. Morales ME, Yong RJ. Racial and ethnic disparities in the treatment of chronic pain. *Pain Med*. 2021 Jan 1;22(1):75-90
6. Limerick G, Christo DK, Tram J, Moheimani R, Manor J, Chakravarthy K, et al. Complex regional pain syndrome: Evidence-based advances in concepts and treatments. *Curr Pain and Headache Rep*. 2023 Sep;27(9):269-98
7. Rosenbloom BN, Rabbitts JA, Palermo TM. A developmental perspective on the impact of chronic pain in late adolescence and early adulthood: implications for assessment and intervention. *Pain*. 2017 Sep 1;158(9):1629-32
8. Unruh AM, McGrath PJ. History of pain in children In: McGrath PJ, Stevens BJ, Walker SM, Zempsky WT, editors. *Oxford textbook of paediatric pain* [Internet]. Online edition Oxford University Press, USA; 2013. Available from: doi.org/10.1093/med/9780199642656.003.0001
9. Cohen SP, Vase L, Hooten WM. Chronic pain: an update on burden, best practices, and new advances. *Lancet*. 2021 May 29;397(10289):2082-97
10. Ryan CG, Karran EL, Wallwork SB, Pate JW, O'Keeffe M, Fullen BM, et al. We Are All in This Together—Whole of Community Pain Science Education Campaigns to Promote Better Management of Persistent Pain. *J Pain*. 2023 Oct 31

Coordinating care design for person centred care

By Jacqui White and Michelle Wilson

The Barwon Health Connected Care program is a publicly funded fee free care coordination service designed to provide person centred care in a timely manner – Right care, Right place, Right time to people living with chronic health conditions and complex care needs in the Barwon region.

It is a service assisting people who frequently present or are at risk of presenting to the emergency department. The aim is to reduce potentially preventable presentations. The multi-disciplinary team includes mental health nurses, diabetes educator, enrolled nurses, occupational therapy, nurse practitioner, physiotherapy, neuropsychology, registered nurses, dietitians, exercise physiology and social workers, as well as medical consultants and pharmacy. The program works alongside the early intervention clinic, MHDAS, outpatients, pain clinic, and surgery services within Barwon Health. The Connected Care team walks alongside the client utilising an evidence-based service delivery model and endeavours to understand a person's chronic health journey (with curiosity on what are the key aspects in an individual's needs – from their perspective- to formulate personalised health goals). The Connected Care program explores a person's wellbeing, confidence, self-esteem, social, spiritual and emotional needs; it promotes healthy life choices while providing authentic, values–based care and embodies a creative ethos to break down the roadblocks in service delivery. Providing 'understanding' into a person's lived experience of chronic health condition(s): for example, cardiac, diabetes, respiratory, other medical comorbidities, drug and alcohol and medication challenges, mental health issues and complex trauma histories. The Connected Care program aims to improve a person's ability to self-manage their conditions and circumstances, it is a short-term program, and it explores linkage and referrals to other services like National Disability Insurance Agency (NDIA), My Aged Care, Services Australia, and Advance Care Planning.

Authors

Jacqui White, Program Manager (BA, BSW, MWH, GradCert Palliative Care), Chelsea Gielen Connected Care Coordinator -South Team (BN, GradDip Health and Human Services Management)

Michelle Wilson, Connected Care Coordinator – North Team (BN, CCN, GradCert Clinical Redesign)

Email enquiries:
connectedcare@barwonhealth.org.au

Contacts:
Jacqui White Community Health Program Manager, Chelsea Gielen Coordinator (South Connected Care) and Michelle Wilson Coordinator (North Connected Care).

Telephone:
(03) 4215 7041

Website:
barwonhealth.org.au/service/connected-care

Bibliography

Brown TL, Pereira RB, Hyett N, Nolan M, Oppedisano L, Riley K, Walker G, Guida A. 2022. A qualitative research study into care coordination experiences of people with chronic disease. *International Journal of Mental Health Nursing*, 31.(S1). pg 6

Pereira RB, Brown TL, Guida A, Hyett N, Nola M, Oppedisano L, Riley K, Walker G. 2021. Consumer experiences of care coordination for people living with chronic conditions and other complex needs: an inclusive and co-produced research study. *Australian Health Review*. Online :16 Feb 2021. 1-13: doi.org/10.1071/AH20108

Brown TL, Pereira RB, Byrnes J, Guida A, Gielen C & Stevens J. 2019. Exploring clinician and consumer experiences of integrated, values-based care within the Hospital Admission Risk Program. *International Journal of Mental Health Nursing*, 28(S1). 7-8.

The SMILE Program: Addressing chronic health challenges through innovative nursing education

By Vanessa Caple, Sharon Zdunic, Elly Greenwood and Cheryle Moss

The increasing burden of chronic conditions, ageing populations, and rising healthcare costs have shifted focus towards primary healthcare.[1]

Chronic diseases place a significant burden on Australia's healthcare system. These challenges are central to the National Health Priority Areas (NHPAs) and highlight the need for a nursing workforce capable of managing complex health conditions.[2] In response, La Trobe University developed the Student Managed Initiative in Lifestyle Education (SMILE) Program, an innovative model of nursing education that integrates community-based learning with chronic health initiatives.

BRIDGING EDUCATION AND COMMUNITY HEALTH

The SMILE program complements second-year nursing students' two-week community nursing clinical placements. It provides students with hands-on opportunities to address chronic health challenges in real-world settings. Facilitated by a registered nurse, the program involves health checks and health education sessions that focus on chronic disease prevention, mental health and wellbeing, and lifestyle modifications. Nursing students also direct participants to local essential services that address social determinants of health.

Operating for six years in Melbourne's northern suburbs, the SMILE program targets communities facing socio-economic challenges and who are disproportionately affected by chronic health issues. This makes an ideal setting for impactful student engagement, community empowerment and experiencing nurses' roles in responding to chronic health conditions.

KEY FEATURES OF THE PROGRAM INCLUDE:

Leadership and communication development: Students lead workshops, enhancing their ability to collaborate, communicate, and engage effectively with patients.

La Trobe nursing students on SMILE placement performing community health checks

Patient advocacy and engagement: Building therapeutic relationships enables students to empower individuals in making informed lifestyle choices.

Interprofessional collaboration: Students work alongside peers, academic staff, and healthcare professionals, gaining a multidisciplinary perspective on chronic disease management.

BENEFITS TO STUDENTS AND THE COMMUNITY

Students have consistently described the SMILE program as transformative, highlighting the unique opportunity to apply their skills in meaningful ways. This experience prepares them for their future roles and also strengthens their ability to lead and collaborate in complex healthcare settings through their understanding of chronic health challenges.

For students, working with interdisciplinary teams within the SMILE Program helps students build their professional identities by improving their communication, facilitation, and leadership capabilities; as well as their practical knowledge and confidence.[3]

As one student shared:

"I learnt so much about chronic diseases from this placement. It really helped me understand the problems community people face and how to support them."

For the community, it provides accessible health checks and education, helping individuals manage chronic conditions and adapt healthier lifestyles. Health checks sessions improve health literacy and assist to connect participants with local resources, earning praise from the participants for their relevance and effectiveness to supporting their chronic disease management.[4]

CONCLUSION

The SMILE program exemplifies how innovative nursing education can address chronic disease management through innovative community engagement. By aligning with Australia's NHPAs, the program contributes to improved health outcomes while equipping future healthcare professionals with the skills and confidence needed to tackle chronic health challenges. This integration of education and community care demonstrates a valuable model for fostering leadership and patient-centred care.

Acknowledgement: The SMILE Program is a La Trobe University School of Nursing and Midwifery initiative working in partnership with DIVRS (Darebin Information, Volunteer and Resource Service).

Authors

Vanessa Caple, RN, BN (Distinction), MNsc is a PhD candidate and a Lecturer in Nursing at La Trobe University, Victoria Australia

Sharon Zdunic, BN, DoN candidate, MNL, Grad Cert Neuroscience Nursing is a Lecturer in Nursing at La Trobe University, Victoria Australia

Elly Greenwood, RN, BN, MNSc, PhD Candidate is a Lecturer in Nursing at La Trobe University, Victoria Australia

Associate Professor Cheryle Moss, RN, BAappSc, GradDipEdAdm, MS, PhD is a lecturer at La Trobe University, Victoria Australia

References

1. Cox R, Robinson T, Rossiter R, Collison L, Hills D. Nurses transitioning to primary health care in Australia: A practice improvement initiative. *SAGE Open Nursing*. 2023 Apr;9:23779608231165695
2. Australian Government Department of Health. Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022–2032.
3. Reissner S, Armitage-Chan E. Manifestations of professional identity work: an integrative review of research in professional identity formation. *Studies in Higher Education*. 2024 Feb 27:1-6.
4. Liss DT, Uchida T, Wilkes CL, Radakrishnan A, Linder JA. General health checks in adult primary care: a review. *Jama*. 2021 Jun 8;325(22):2294-306.

Recommendations for nursing students caring for Aboriginal and Torres Strait Islander peoples and communities, to work towards Closing the Gap targets in chronic disease

By Lynne Stuart and Ali Moloney

Chronic disease management is the healthcare challenge of the century, as chronic disease is the principal cause of death and disability globally.[1] In Australia, to address chronic diseases that are prevalent in Aboriginal and Torres Strait Islander peoples and communities, a government-led campaign 'Closing the Gap' has been in place for over a decade.

This campaign which aims to reduce the gap in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians has had minimal success. The life expectancy gap is currently 8.8 years for Indigenous males and 8.1 years for Indigenous females.[2] This disparity in health outcomes calls for nursing students to be educated about why the gap exists, so they can advocate for Aboriginal and Torres Strait Islander peoples and communities to support them to access Indigenous-specific services.

Chronic diseases greatly disadvantage health outcomes and contributes significantly to the life expectancy gap that exists between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, which represents approximately 80% of the mortality gap.[3] Diabetes, respiratory disease, and heart disease are the predominant causative factors contributing to the life expectancy gap.[4] Similar to the Indigenous Australian context, this trend of chronic disease conditions is mirrored in other Indigenous populations globally that have also been invaded and colonised. Reportedly, the overarching factors that perpetuate the high levels of chronic disease in Indigenous populations in healthcare is racism.[5] Racism remains a significant barrier to cultural safety practice in healthcare and is unacceptable and in direct opposition to the *Standards for Practice for Registered Nurses and Midwives*.[6,7]

Schools of Nursing across Australia are ultimately responsible for educating the next generation of nurses, through clinical practicums and evidence based theoretical underpinnings.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) has specific requirements which include cultural safety education to be embedded across nursing programs and courses to ensure a safe curriculum.[8]

The largest healthcare workforce in Australia is the mainstream non-Indigenous nursing profession. This means that ultimately nursing graduates of all backgrounds will care for Aboriginal and Torres Strait Islander peoples and communities in their day-to-day practice.

Jackson Martin *Totem Poles* 2014. Synthetic polymer paint on wood, dimensions variable. Commissioned for USQ O-Day, 2014, UniSC Art Collection. © the artist.

A culturally safe nursing workforce is urgently needed and would go a long way to support the Closing the Gap targets. This approach will help reduce the incidence of ongoing chronic disease conditions within Aboriginal and Torres Strait Islander peoples and communities relating specifically to the inability for them to access culturally safe care.[9]

The following six recommendations are for *nursing students* to help manage chronic diseases in Aboriginal and Torres Strait Islander peoples and communities.

- To undertake *cultural safety* education specific to working with Aboriginal and Torres Strait Islander peoples and communities. To continue this practice after completing their degrees to remain current and reflective for the duration of their career.[10]
- To become educated about all aspects of the *Closing the Gap* campaign and understand why the gap in life expectancy for Aboriginal and Torres Strait Islander peoples exists.[4]
- Become familiar with the *Closing the Gap PBS co-payment* (CTG) program (inclusive in the Closing the Gap campaign), which reduces or removes the PBS co-payment for eligible Aboriginal and Torres Strait Islander peoples.[11]
- To employ culturally safe practice by asking if the patients' *Identity* is Aboriginal and/or Torres Strait Islander. If affirmative, and with permission from the patient, proceed and engage the support of Indigenous Liaison Officers in their care plan.[12]
- To understand the incidence and hospital policies surrounding *Discharge Against Medical Advice (DAMA)* and the reasons why this occurs in our mainstream health services and importantly the impact this can have on ongoing admissions and healthcare.[13]
- To become aware of the *National Aboriginal Community Controlled Health Organisation (NACCHO)* in relation to Aboriginal and Torres Strait Islander

(continued overleaf)

Lynne Stuart

Ali Moloney

Community Controlled Health Services, and to understand how their chronic disease support services operate across local Indigenous communities.[14]

To become educated about the importance of the *715 Health and wellness check*, which are designed to support the physical, social, and emotional wellbeing of all Indigenous peoples. These checks are crucial in diagnosing and treating chronic disease conditions before they become more serious.[15]

Closing the Gap in Aboriginal and Torres Strait Islander people's health is *everybody's business*. It is therefore imperative that nursing students who will enter the health workforce incorporate these six recommendations into their future nursing practice, so they can do their part in Closing the Gap.

Authors

Lynne Stuart (Mandandanji woman), Senior Lecturer, Nursing, School of Health, Academic Lead – Aboriginal and Torres Strait Islander Curriculum Advisor, UniSC, Sippy Downs Campus

Ali Moloney, Lecturer, Nursing, School of Health, UniSC, Sippy Downs Campus

References

1. World Health Organization. The top 10 causes of death 2024 [Available from: who.int/news-room/fact-sheets/detail/the-top-10-causes-of-death.
2. Australian Government. Chronic disease support for Aboriginal and Torres Strait Islander people 2022 [Available from: health.gov.au/topics/aboriginal-and-torres-strait-islander-health/chronic-disease-support.
3. Rheault H, Coyer F, Bonner A. Time to listen: Chronic disease yarning with Aboriginal and Torres Strait Islander peoples living in remote Australia. *Collegian*. 2021;28(1):10-7.
4. Australian Institute of Health And Welfare. Aboriginal and Torres Strait Islander Health Performance Framework: summary report August 2024. Australian Government; 2024.
5. Kairuz CA, Casanelia LM, Bennett-Brook K, Coombes J, Yadav UN. Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review. *BMC Public Health*. 2021;21(1):1302.
6. George E, Mackean T, Baum F, Fisher M. Social determinant of Indigenous health and Indigenous rights in policy: A scoping review and analysis of problem representation. *The International Indigenous Policy Journal*. 2019;10(2).
7. Moloney A, Stuart L, Chen Y, Lin F. Healthcare professionals' cultural safety practices for indigenous peoples in the acute care setting – a scoping review. *Contemp Nurse*. 2023:1-22.
8. Australian Nursing and Midwifery Accreditation Council. Registered Nurse Accreditation Standards. ANMAC; 2019.
9. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*. 2019;18(1):1-17.
10. Nursing and Midwifery Board Australia, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives. Joint Statement on Culturally Safe Care [Joint Statment]. 2018 [Available from: nursingmidwiferyboard.gov.au/news/2018-02-01-nmba-catsinam.aspx
11. Australian Goverment. Closing the Gap (CTG) PBS Co-payment Program 2025 [Available from: pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure.
12. Australian Commission on Safety and Quality in Health Care. Identifying Aboriginal and Torres Strait Islander people 2020 [Available from: safetyandquality.gov.au/sites/default/files/2020-07/fact_sheet_-_identifying_aboriginal_andor_torres_strait_islander_people_july_2020.pdf.
13. Askew DA, Foley W, Kirk C, Williamson D. "I'm outta here!": a qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital. BMC Health Services Research. 2021;21(1):1-10.
14. (NACCHO) NACCHO. Aboriginal Community Controlled Health Organisations (ACCHOs) 2024 [Available from: naccho.org.au/acchos/.
15. Australian Goverment. 715 health check 2022 [Available from: health.gov.au/news/715-health-check.

Informal nursing assessment of depression in chronic illness

By Robert Batterbee

The identification of depression in people with chronic illness is an important aspect of nursing care. Depression can have a profound impact on the management of chronic conditions, complicate person-centred nursing, exacerbate physical symptoms and negatively impact outcomes.[1] Nurses are uniquely positioned to recognise the early warning signs and can play a key role in identifying depression.[2]

Research indicates that nurses often lack confidence to identify depression in patients with chronic illnesses, particularly distinguishing between what might be considered a normal low mood and more significant depression.[3,4] Rather more worrying is research suggesting that many community nurses may perceive mental health issues as outside their scope of practice.[5,6]

The integration of *informal* assessments into routine nursing may be a strategy to overcome this. Informal assessments tend to be more relaxed, leading to a more open disclosure. Key questions can be incorporated into conversations, aligning more closely with patients' everyday experiences. Informal assessments allow you to observe non-verbal cues and contextual factors that may not be captured in formal assessments. Additionally, informal assessments can help bridge the gap between physical and mental health nursing, utilising your full scope as a comprehensive nurse.

Informal assessment of depression simply requires a focus on **cognitive**, **emotional**, **behavioural** and **physical** symptoms as well as contextual and social observations.

Cognitive: *What's been going through your mind since the last time I saw you?*

Look out for negative thoughts beyond what you'd consider normal. Use your experience to assess if this is a typical stage of adjusting to a chronic condition. Self-negative talk: The person directs negativity inward, blaming themselves with negative expressions like "I'm useless" or "weak". Are they "future focused" and making plans?

Emotional: *How do those thoughts make you feel?*

Feelings like "sad", "bored", "frustration" might all be relatively normal, so again use your expertise. But look out for "red flag" emotions like feeling guilty, shame, despair or anything that suggests a lack of hope.

Behavioural: *What have you been doing since the last time I saw you?*

A decline in behaviours unrelated to the typical activity reduction seen in physical illness. A key symptom of depression is avoidance – neglecting tasks like opening mail and social interactions and a loss of interest in previously enjoyed activities.

Physical: *How's your sleep, appetite, energy?*

The three key physical symptoms of depression. Disturbed sleep, appetite and low energy might be in relation to the physical condition but might also need a closer look.

Ask these questions informally, in any order – what matters is focusing on negativity, connections, and context. Most importantly, trust your judgement. Nurses often underestimate their mental health skills, but your physical health expertise can signal when something is wrong. If you notice significant negativity, consider a referral or guiding the patient to appropriate support.

Author

Dr Robert Batterbee RN PhD is a mental health nurse and academic at Murdoch University, Western Australia. He has practiced extensively in primary care services as a cognitive behavioural therapist, and is the author of Depression, in Chang & Johnson's textbook: Chronic Illness and Disability: Principles for Nursing Practice.

References

1. Batterbee RA. *Depression*. In: Chang E and Johnson A (eds.) *Chronic Illness and Disability: Principles for Nursing Practice*, 4th edition. Churchill Livingstone Elsevier, Chatswood, NSW
2. Cilluffo S, Bassola B, Lyons KS, Lee CS, Vellone E, Pucciarelli G & Lusignani M. 2024. The role of nurse–patient mutuality on self-care behaviours in patients with chronic illness. *Journal of Clinical Nursing*, 33(12), 4772-4780. doi.org/10.1111/jocn.17181
3. Chuang Y & Kuo LM. 2018. Nurses' confidence in providing and managing care for older persons with depressive symptoms or depression in long-term care facilities: a national survey. *International Journal of Mental Health Nursing*, 27(6), 1767-1775. https://doi.org/10.1111/inm.12483
4. Karlsson J, Hammar L, M & Kerstis B. 2021. Capturing the unsaid: nurses' experiences of identifying mental ill-health in older men in primary care – a qualitative study of narratives. *Nursing Reports*, 11(1), 152-163. doi.org/10.3390/nursrep11010015
5. Happell B, Scott D, Nankivell J, & Platania-Phung C. 2013. Screening physical health? yes! but…: nurses' views on physical health screening in mental health care. *Journal of Clinical Nursing*, 22(15-16), 2286-2297. https://doi.org/10.1111/j.1365-2702.2012.04325.x
6. Tzeng W, Su P, Yeh S, Chang T, Lin C, & Feng H. 2022. Nurses' views on the provision of physical healthcare for individuals with comorbid mental illness and chronic disease. *International Journal of Mental Health Nursing*, 32(1), 199-211. doi.org/10.1111/inm.13076

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.

House Braised Beans

Prep time 15 mins **Cook time** 2 hrs **Portions** 6 serves

INGREDIENTS

250g dried cannellini beans, soaked overnight

2 tbsp EVOO

1 large brown onion, finely diced

100g smoked speck or similar, finely diced (optional)

1 clove garlic, smashed and studded with 3 cloves

1 bay leaf

1 large carrot, cut into quarters and chopped ¾ cm thick

5 button mushroom, cut into 6 wedges

2 tsp apple cider vinegar

1 tin x 400g chopped tomatoes

Salt flakes and freshly ground black pepper

1 tbsp Keene's mustard powder

1 tbsp water

1 tbsp brown sugar

2 tbsp freshly chopped mint

2 tbsp flat leaf parsley leaves to serve

METHOD

1. Drain the soaked beans and rinse in a colander.
2. Place into a large pot and cover with 4 times the amount of cold water to beans. Bring to the boil, skim off any foam or impurities that come to the surface. Simmer for approximately 40 minutes or until cooked and tender.
3. In a large saucepan over medium heat sweat down the onion in olive oil, until transparent (about 10 minutes).
4. Add the smoked speck and cook for 4 minutes, add the garlic and cook for a further minute.
5. Add the bay, carrot and mushrooms and cook no colour for 5 minutes.
6. Deglaze the pan with the apple cider vinegar.
7. Add the tomatoes, salt and pepper.
8. Mix the mustard powder with the water and stir in along with the brown sugar.
9. Bring to the boil.
10. Add the cooked beans, cover with a cartouche and foil and simmer over the lowest flame for about 1–2 hours – check regularly.
11. Remove from heat and allow to sit for approx. 1 hour.
12. Discard garlic studded with cloves, and the bay leaf.
13. Season and add the chopped mint and parsley, taste, warm and serve.

Food styling + photo by Erika Budiman © pixelsandpaper.studio

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**

Nurse & Midwife Support

Your health matters

Support for nurses, midwives and students is only a phone call or a click away, no matter where you are in Australia.

We understand that nurses, midwives and students may have health issues that could affect their capacity to work.

Nurse & Midwife Support provides support for nurses and midwives, by nurses and midwives. Experienced nurses and midwives offer free, accessible, compassionate assistance for fellow nurses, midwives and students. We also support their educators, employers, managers and concerned family members.

Nurse & Midwife Support offers a range of resources on the website such as a newsletter and podcasts.

Subscribe to our Newsletter:
nmsupport.org.au/resources/newsletter

Listen to our Podcasts:
nmsupport.org.au/resources/podcasts

Nurse & Midwife Support offers free, confidential and 24/7 health and wellbeing support to nurses, midwives and students across Australia.

1800 667 877

nmsupport.org.au

@NMSupportAU

SKILL TRACK

Your Express Route to a Certification in Wound Management

Developed in partnership with Wounds Australia

Across three expert-led courses, you'll gain a comprehensive understanding of wound assessment, aseptic techniques, dressing, debridement and more.

Validate your knowledge and skills to earn a certification.

Start your journey

Lnk.bio/s/ausmed/wounds

Ausmed®