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Annie Butler

ANMF Federal Secretary

As this edition of the *ANMJ* hits mailboxes, we're gearing up for the *ANMF*'s 17th Biennial National Conference (BNC) – one of the most important gatherings on the Federal Office's calendar.

Every two years delegates from every state and territory come together to reflect on where we are and decide where we're heading as a united voice for nurses, midwives and care workers.

For the Federal Office, it sets the course for the next two years. Together, we examine the issues shaping your working lives, the care you are able to provide, and how we continue to improve conditions across the country. Through your delegates, your voices help shape the national agenda.

To learn more about the importance of BNC, head to page 16.

This year's BNC theme – "Productivity with Purpose: Empowering Nurses, Midwives and Care Workers" – couldn't be timelier. Right now, there's a national conversation, led by policymakers, about productivity, which includes delivering quality care more efficiently, and how it connects to economic recovery, workforce planning, and service sustainability.

But productivity can't just be about doing more with less. Not for us.

Real productivity — the kind that actually improves care and makes a difference must be purposeful. It means having the tools, time, and trust to do our jobs safely and well. That means safe staffing levels; fair pay; proper recognition of our skills; investment in education and professional development, and workplaces where we feel safe, supported, and respected.

Purposeful productivity lifts everyone – patients, staff, and systems. Overall, good productivity sees everyone's living standards rise, driven by investment in people, research, innovation, and inclusive management that values the workforce. Advancing productivity also means promoting gender equity and eliminating discrimination that holds back our national economic potential.

I've had the privilege of attending several productivity roundtables, including, health, disability and ageing

economic reform; skills attraction, development and mobility; and climate and economic reform. These forums provide us with a vital seat at the table, ensuring the voices of nurses, midwives, and care workers are heard at the highest levels of policy-making. They allow us to challenge outdated economic narratives and highlight the true value our professions bring to health, aged care, and the broader economy. Most importantly, they affirm that your daily work is being recognised as essential to building not just a more productive system, but a fairer Australia.

You'll also read in this issue about our powerful *Nurses and Midwives for Peace* campaign. In response to the horrific attacks on healthcare in Gaza, where more than 95% of health services have been destroyed, our profession is standing up and speaking out. Not just for Gaza, but for all conflict zones where health workers and facilities are under fire. Many of you have signed our open letter in solidarity with colleagues on the frontlines. Your messages of care and courage are being delivered to them by the Red Cross because no nurse or midwife should ever be a target.

We will also launch a petition at the Biennial National Conference, calling on the Government to act against these horrendous crimes targeting healthcare in conflict zones. I encourage you to visit our campaign website to add your signature.

These acts of solidarity matter. They send a powerful message: that nurses and midwives around the world stand together, even in the darkest times.

Thank you for being part of this collective force – for showing up, speaking out, and standing strong. Whether it's fighting for safer workplaces, pushing for reform, or standing in solidarity with our global colleagues, we're in this together.

Visit our Nurses and Midwives for Peace campaign page here:



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Moving state.

Transfer your ANMF membership

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

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REGULAR COLUMNS

- 1 Editorial
- 2 Directory
- 4 News Bites
- 6 Astrid
- 15 Strategic Programs & Engagement
- 21 Legal
- 22 Viewpoint
- 24 Issues
- 27 Industrial
- 28 Climate
- 30 Reflection
- 32 Research & Policy
- 40 Wellbeing
- 56 Healthy Eating

FEATURE

- 8 When healthcare becomes the target: Nurses and midwives in the crossfire of war
- 16 ANMF powerhouse: The Biennial National Conference

CLINICAL UPDATE

34 Community nurses' knowledge, attitude & practice of standard & transmission-based precautions

FOCUS

43 Midwifery and maternal health Part 2



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.













New resources support culturally diverse older adults leaving hospital

New multimedia resources have been developed for Greek, Italian and Chinese carers, and older adults, to support their interaction with health professionals and care providers.

Culturally specific and accessible educational videos and brochures have been translated across four languages to support culturally diverse carers to cope with the transition from hospital to home.

The project funded through the National Centre for Healthy Ageing (NCHA) is a partnership between Monash University and Peninsula Health.

The brochures include checklists to use for when in hospital, preparing to go home and when at home. The brochures also include a list of key words and services in aged care, handy tips and

links to services to get help and information after being discharged from hospital.

The team found each community brought a slightly different approach, often framed around their level of English and digital proficiency and how they liked to access information, through either booklets, videos or personto-person.

While people from culturally diverse backgrounds had poorer health outcomes, they took longer time to access health and support services, said Project lead Associate Professor Jacqui Allen.



"Going online or ringing up support services can be quite challenging, particularly for people who may have never had the opportunity to go to school and don't read and write. They rely on other family members, younger family members to assist them with accessing services and support.

"Things like respite can be quite challenging for carers from culturally diverse backgrounds because the idea of putting the older person into a residential facility for a couple of weeks so the carers can have a break may not make sense to them. You don't separate your family."

The resources are available at: monash.edu/medicine/ national-centre-for-healthyageing/home

NURSE TO PATIENT RATIOS EXPANSION IN WESTERN AUSTRALIA

Nurse to patient ratios have been rolled out to all Perth hospitals as part of the state government's commitment for more sustainable workloads and improved patient outcomes.

The ratios have already been introduced at Perth Children's Hospital emergency department and North Metropolitan Health Service, including Sir Charles Gairdner and Osborne Park Hospitals. Early evaluation of pilot sites indicated reduced patient hospital stays and readmissions.

Ratios are now being implemented at Royal Perth Hospital, Fiona Stanley Hospital, Fremantle Hospital, Rockingham General Hospital, Armadale Health Service, and Royal Perth Hospital.

Under the new ratios, there will be one nurse for every four patients during the day and one nurse for every seven patients at night. These will apply to general medical



and surgical wards with further roll out of ratios in specialty areas including intensive care and high-dependency units in the next 12 months.

Implementation of the ratios had been phased to ensure adequate staffing, training and resources were available said Western

Australian Health Minister Meredith Hammat. "We are proud to deliver the ratios that the Australian Nursing Federation (WA) has advocated for because every patient deserves safe, high-quality care and every nurse and midwife deserves the support to provide it."

Two-thirds of teens get health information from social media

New research by the Royal Children's Hospital Melbourne has found two-thirds of teens are getting health information from social media, with the leading topics being fitness and diet.

The latest National Child Health Poll from the Royal Children's Hospital surveyed 2,012 Australian parents and 1,488 children, aged between 12-17. Both parents and children responded to questions addressing their knowledge, attitudes and behaviours related to health information and social media use among teens.

Key findings include many teens making health decisions based on social media content, with over a third (42%) having tried or considered trying something new after seeing it on social media; more than a third (42%) of teens saying social media makes them wish their body was different; and the majority of teens (77%) and their parents (79%) reporting it is hard to tell what is true and untrue on social media.

According to researchers, the findings suggest teens are exposed to health information on social media even if they're not actively seeking it, as only 27% say they would turn to social media when intentionally looking for health information. Of note, 70% of teens said they would speak to their parents if they needed health advice.





Medication administration ban on unregulated workers in aged care

The ANMF Victorian Branch has welcomed new state government legislation that will see only qualified health practitioners such as registered and enrolled nurses administer specific medicines and drugs in residential aged care.

The Drugs, Poisons and Controlled Substances Amendment Bill 2025, introduced into Victorian Parliament on 30 July 2025 will mean medication administration will no longer be performed by unregulated staff. Personal care workers will continue to assist competent residents with self-administration.

ANMF Victorian Branch Secretary Maddy Harradence said the union had campaigned for the change which would reduce clinical risk and improve outcomes for residents. "Medication administration is a core nursing responsibility and an essential part of delivering safe, high-quality, person-centred care.

"Nurses use the medication round not only to deliver prescribed treatments but to assess the resident's condition, engage in clinical decision-making, and detect early signs of deterioration. This strengthens continuity of care, supports early intervention, and ensures the delivery of holistic, safe, person-centred care."

COMMON PAINKILLERS LINKED TO ANTIBIOTIC RESISTANCE

Common over-the-counter painkillers such as paracetamol and ibuprofen are fuelling antibiotic resistance, according to University of South Australia research.

Assessing the interaction of nonantibiotic medications, the broadspectrum antibiotic ciprofloxacin, and Escherichia coli (E. coli) – a common bacteria that causes gut and urinary tract infections – researchers found ibuprofen and paracetamol significantly increased bacterial mutations, making E. coli highly resistant to the antibiotic.

The study assessed nine medications commonly used in residential aged care: ibuprofen (an anti-inflammatory pain relief), diclofenac (an anti-inflammatory to treat arthritis), acetaminophen (paracetamol for pain and fever), furosemide (for high blood pressure), metformin (for high sugar levels linked to Diabetes), atorvastatin (to help lower cholesterol and fats in the blood), tramadol (a stronger pain medication post-surgery), temazepam (used to treat

sleeping problems), and pseudoephedrine (a decongestant).

Lead researcher, UniSA's Associate Professor Rietie Venter, said the findings raise important questions about the risks of polypharmacy in aged care.

"Antibiotics have long been vital in treating infectious diseases, but their widespread overuse and misuse have driven a global rise in antibiotic-resistant bacteria," Associate Professor Venter said.

"This is especially prevalent in residential aged care facilities, where older people are more likely to be prescribed multiple medications - not just antibiotics, but also drugs for pain.



Astrid Tiefholz

ANMF Federal Vice

President

A future vision for mental health service equity in Australia

Australia's mental health landscape is undergoing significant transformation, driven by a surging demand for services, needing a workforce capable of delivering high-quality, accessible care.

At the heart of this evolution is the mental health nurse (MHN), whose expertise and evolving scope of practice position them as a cornerstone of the future multidisciplinary workforce.

Mental health nursing is a demanding, yet rewarding, specialty, requiring advanced interpersonal engagement to provide therapeutic care to individuals and their families. MHNs have eclectic capabilities, comprising both technical skills and non-technical attributes. Technical skills include psychotherapy and counselling skills, crisis intervention, risk mitigation (including suicide prevention), psychopharmacology, and comprehensive biopsychosocial assessments. MHNs also address physical health issues, recognising the complex interplay between physical and mental wellbeing. Beyond these, MHNs demonstrate vital nontechnical capabilities such as empathy, self-awareness, emotional regulation, compassionate engagement, and fostering hope. They are adept at navigating complex systems and advocating for consumers and carers. The Australian College of Mental Health Nurses (ACMHN) explicitly states that MHNs promote optimal physical and mental health, prevent illness, and provide therapeutic interventions.

Mental Health Nurse Practitioners (MHNPs) represent an advanced level of practice, educated at a Master's degree level with extensive clinical training. MHNPs are endorsed to function autonomously and collaboratively, with expanded skills including diagnosis and treatment of health conditions, advanced psychotherapeutic skills, ordering and interpreting diagnostic tests, prescribing and adjusting medications, and referring to medical specialists. MHNPs are well-placed to offer high-quality mental healthcare across various settings, including private hospitals, homes, clinics, medical practices, community agencies, and schools.

One of the most significant future possibilities for MHNs lies in addressing the patchy distribution of mental health professionals across Australia, particularly in regional, rural, and remote areas. These areas currently have significantly fewer mental health professionals per capita compared to major cities. MHNPs, offering an affordable and quality choice in mental healthcare, can drastically improve access to services in these underserved communities. Nurse-led models of care, including those led by MHNPs, are seen as a viable solution to enable people to remain in their communities for mental health support, rather than having to travel to major centres. The Australian

Nursing and Midwifery Federation (ANMF) strongly advocates for trialling and expanding these models, recognising their potential to increase accessibility and quality of care.

However, the current Medicare funding model presents a significant barrier to fully utilising the MHN workforce. While Medicare rebates are available for MHNP services outside the public health system, mental health nurses are largely excluded from the Better Access Initiative, which subsidises psychological services provided by psychologists, and social workers and occupational therapists with mental health accreditation. This is despite the proven success of previous initiatives like the Mental Health Nurse Incentive Program (MHNIP), which demonstrated cost-effective, community-based mental healthcare that improved client outcomes and reduced hospital admissions. The ANMF continues to lobby for wider access to Medicare Benefits Schedule (MBS) items for mental health nurse practitioners to be recognised as being able to provide independent mental health services and be appropriately remunerated under MBS item numbers. Without consistent and adequate funding, the job uncertainty for mental health nurses can disrupt continuity of care for vulnerable individuals.

For mental health nurses to work to their full scope in the multidisciplinary workforce, there needs to be greater acknowledgement and support for their unique contributions. Historically, MHNs have faced under-recognition and role ambiguity within multidisciplinary teams, with a perception that their work is subservient to medical disciplines. Despite this, they play an essential role in coordinating care, supporting consumers through crises, and providing therapeutic interventions. Promoting clarity in the MHN role, fostering collaborative practice, and ensuring appropriate remuneration and career pathways are essential for recruitment and retention. This includes providing robust post-graduate education opportunities, clinical supervision, and transition-to-practice programs.

Mental health nurses, offer a versatile and valuable solution to Australia's escalating mental health needs. By improving access to educational pathways, securing equitable Medicare funding, and fully integrating them into multidisciplinary teams across all geographical areas, Australia can move towards a future where high-quality, person-centred mental healthcare is truly accessible to all.



Are you looking to complete accredited training and expand your knowledge of sexual violence?

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- Darwin
- Adelaide

Register here for upcoming online and face-to-face intakes



When healthcare becomes the target:

NURSES AND MIDWIVES IN THE CROSSFIRE OF WAR



Nurses and midwives are united by a commitment to provide care wherever and whenever it's needed. But in war zones and conflict-ravaged communities around the world, our colleagues are being targeted simply for doing their jobs. Healthcare workers, hospitals, and ambulances are under fire, in blatant violation of international law and humanitarian principles.

Whether it's Gaza, Ukraine, Sudan or Syria, these attacks are not isolated incidents. They are part of a growing pattern of violence against those who care.

As Australian nurses and midwives, silence risks complicity. Our solidarity, however, can help shine a light on this global crisis and show that we care. Kathryn Anderson and Natalie Dragon investigate.



A CRISIS WITHOUT BORDERS

According to the World Health Organization (WHO), over 4,000 attacks on healthcare were recorded globally between 2016 and 2022. Meanwhile, the Safeguarding Health in Conflict Coalition (SHCC) documented another 2,562 incidents in 2023 - a 25% **increase over 2022** and the highest annual total since reporting began. In 2024, violence escalated further: SHCC's Epidemic of Violence report recorded more than 3,600 attacks on healthcare, marking a 15% rise from 2023 and a 62% increase from 2022.

These attacks ranged from bombings and facility takeovers to looting, ambulance destruction, and the kidnapping or killing of healthcare personnel and the destruction or damage of health facilities across more than 30 countries.

The most severe consequences are seen in Gaza, where the health system has virtually collapsed. Most hospitals have been destroyed or forced to close, access to essential supplies is blocked, and critical

infrastructure has been decimated. Similar breakdowns have occurred in Sudan, Burkina Faso, the Central African Republic, Ethiopia's Tigray region, Ukraine, Lebanon, and Myanmar.

According to SHCC's Epidemic of Violence report, these attacks not only destroy infrastructure but also spread fear, deterring civilians from seeking care. Looting and hijacking of medical vehicles and supplies further erode health worker morale and safety despite their continued, heroic efforts to serve communities under fire.

The report's Lead, Leonard Rubenstein, Chair of the SHCC, says perpetrators have even sought to weaken legal protections for healthcare workers and civilians. Disturbingly, he adds, there has been little accountability for these crimes.

WHY HEALTH FACILITIES **BECOME MILITARY TARGETS**

While some attacks on healthcare are random, many are now a deliberate tactic to weaken the enemy by disrupting access to medical care.

Hospitals and clinics, once seen as neutral sanctuaries, are increasingly treated as strategic targets. Armed forces may attack them to eliminate wounded combatants or prevent their recovery, directly undermining a side's capacity to recover and regroup.

At times, hospitals are accused of harbouring fighters or storing weapons. While using medical facilities for military purposes is itself a war crime under the Geneva Conventions, such claims are often made without evidence and used to justify otherwise unlawful attacks. This blurring of lines endangers both patients and staff and undermines the legal protections meant to safeguard health services in war.

According to WHO and SHCC, these patterns of targeting healthcare infrastructure have become disturbingly common. The International Committee of the Red Cross (ICRC) has also warned that attacks based on unverified military claims set a dangerous precedent, enabling impunity while obliterating critical health infrastructure.

IMPACT ON HEALTHCARE **WORKERS**

According to SHCC in 2023, more than 480 health workers were killed in conflict zones nearly double the number reported in 2022. Among the dead were nurses, doctors, ambulance drivers, paramedics, pharmacists, lab technicians, and psychologists.

Russian forces in Ukraine were found responsible for killing military medics while they provided frontline care. In Israel, first responders and hospital staff were among the victims of the Hamas attacks on 7 October 2023. However, Gaza has recorded the highest number of health worker deaths documented by SHCC since its reporting began in 2016.



Australian emergency nurse Jean-Philippe Miller has been deployed to Gaza three times with Australian Red Cross since early 2024 and has witnessed the situation deteriorate rapidly.

Jean-Philippe says in his last deployment, there were brutal killings of 15 medical and humanitarian personnel, eight of which were medics for the Palestinian Red Crescent Society.

"We've lost ICRC staff and Palestinian Red Crescent Society volunteers. It's incredibly distressing - these are people risking their lives to support others."

Jean-Philippe says, Gaza is the most dangerous place he's ever worked.

"I've deployed with Red Cross 14 times over the last 10 years to different kind of crises, refugee settings and conflict areas. Gaza is the most extensive security briefing I've ever had. It's active conflict, it's incredibly insecure.

"You're hearing gunfire, you're hearing and feeling explosions, the buildings shake and the windows rattle. The dangers have significant ramifications for our work. Security can override clinical care. That means you have to stop activities suddenly to make sure that you remain safe and that can put patient care at risk."

Jean-Philippe says often new evacuation zones can restrict movement, severely impacting access to care.

"Sometimes our staff are unable to reach the hospital due to active hostilities or risk. All our staff are displaced, and they've been displaced many times."

The dangers also impact healthcare, not iust for our staff, but for ambulances where their movements are being restricted, Jean-Philippe explains.

"It was quite common that patients' presentation to hospital would be delayed. I have no doubt that some patients died because they were unable to reach hospital because they couldn't get there or an ambulance could not reach them."

After 20 months of devastating conflict, Jean-Philippe says healthcare staff are exhausted, malnourished, and still trying to care for others.

"They've been displaced many times living in tents with no electricity and no running water. You just really hope for a reprieve and that things can start to improve."

HEALTHCARE CRISIS

Jean-Philippe says around 80% of the strip is now under displacement orders. The hostilities have increased in the south to the point where hospitals have mass casualty incidents almost every day or every second day.

"Hospitals in Gaza are facing so much pressure, and they've got these critical shortages of medicines and supplies,"

"Most patients have penetrating trauma gunshot wounds, shrapnel wounds, explosive blast injuries – or sometimes blunt trauma crush injuries, generally from a blast wave or falling debris."

In May 2024, the ICRC and 12 Red Cross and Red Crescent Societies, including the Australian Red Cross, opened a 60-bed field hospital in Rafah. Bed occupancy has surged to 150-200%, with up to 120 patients admitted at a time. Staff work 10-12 hour shifts to keep up with the constant influx of trauma cases.

"The field hospital has experienced a surge in mass casualty incidents; many patients have been wounded and injured while on their way to seek aid at nearby distribution sites. Hospital staff have logged more than 200 deaths over this period," says Jean-Philippe.

FRONTLINE WORKERS IN THE CROSSHAIRS

Healthcare workers are being killed for doing their jobs.

HEALTH WORKERS KILLED IN 2023

Nurses, midwives, doctors, paramedics, pharmacists, and ambulance drivers

GAZA:

HIGHEST DEATH TOLL OF HEALTH **WORKERS SINCE SHCC BEGAN REPORTING**

Ruth Jebb: A nurse on the frontline in Gaza

By Robert Fedele

For Brisbane-based nurse Ruth Jebb, providing care in the world's most dangerous emergencies has always felt like a calling.

"I've never known a day consciously that I haven't wanted to be a humanitarian," says Ruth, a Clinical Nurse Consultant at Princess Alexandra Hospital and one of Australian Red Cross' longest-serving aid workers.

Ruth, a Florence Nightingale award recipient, has spent over two decades responding to disasters in Sudan, Nepal, and the Philippines. However, her most recent mission to Gaza was unlike anything she has experienced.

Deployed in April 2024, Ruth worked in the European Gaza Hospital during escalating conflict between Israel and Hamas.

"Unlike other war zones I've worked in, the majority of war injuries were directly war-related," she reveals. "We saw bomb blast injuries, gunshot wounds, and lots of burns.

"The war was on top of us. Bombs were dropping just 500 metres from the hospital."

Ruth says Gaza tested her resolve like never before.

"It was just day in, day out, and you couldn't escape it, she says. "What really stood out to me was the reaction from the local people and staff. They were scared and they were fearful every single day."

One year on, the crisis continues. Ruth stays in contact with staff still working in field hospitals overwhelmed by trauma cases.

"I don't know how [the staff] are functioning, but they continue to remain admirably resilient and focused on their role as healthcare workers" Ruth says.



"It's the lack of supplies that are getting into the country, but also the volume of trauma that they're still receiving. The field hospital, which is still running, have had an enormous number of mass casualty events in the last fivemonths that have just overwhelmed their resources, including receiving 200 trauma patients from one incident. That's not uncommon; they're having those multiple times a week."

Ruth supports ANMF – Nurses and Midwives for Peace campaign, advocating for healthcare access and humanitarian protections in conflict zones. She believes this solidarity matters.

She suggests nurses and midwives in Australia can show solidarity by "focusing on standing up for humanity and basic human rights such as unrestricted access to healthcare, food and clean water, rather than debating political sides or opinions.

"The fact is humanity is suffering, including the most vulnerable – the disabled, elderly, children and women and that is the greatest tragedy and something we need to continue to advocate for. It doesn't matter who the perpetrators are, they should be held accountable" she says.



COMMUNITY IMPACT

The consequences extend far beyond hospitals. Jean-Philippe stresses the urgent need for safe, unimpeded humanitarian access.

For local communities, the collapse of healthcare in conflict zones is devastating and has long term implications.

Attacks on healthcare do more than destroy buildings. They sever access to lifesaving services, strip communities of their universal right to health, and deepen the suffering of already vulnerable populations.

Women are forced to give birth in makeshift shelters without skilled support. Children die of injuries and infections that would otherwise be treatable. Patients with chronic conditions such as cancer, diabetes, heart disease are left without medication or monitoring, according to reports.

ACCOUNTABILITY FOR INTERNATIONAL **HUMANITARIAN LAW?**

Following World War II, the Geneva Conventions of 1949 and their Additional Protocols established clear legal obligations: all parties in conflict must protect civilians, medical staff, the wounded and sick, and humanitarian workers.

But today, these protections are rapidly eroding. In many conflict zones, healthcare is no longer seen as neutral or protected. Violations of international humanitarian law are now widespread - and almost always unpunished according to the International Committee of the Red Cross.

"It's quite scary, and it's not just in this context. We're seeing around the world increasingly that there's a breakdown of that protection, and the respect for IHL is being degraded; and we're seeing attacks on medical facilities and we're seeing a politicisation of aid," says Jean-Philippe.

Despite thousands of documented attacks on healthcare, no perpetrators have been held accountable. Legal mechanisms like the International Criminal Court exist but are frequently weakened by political resistance, particularly from powerful states.

The military often justify their actions by alleging military use of health facilities, without evidence. This undermines the very protections the Geneva Conventions were designed to uphold.

Compounding the crisis, access to humanitarian aid is increasingly being obstructed. In many conflict zones, vital supplies such as food, water, fuel, and medical equipment are being delayed, restricted, or outright denied.

These blockades not only violate international humanitarian law but have devastating consequences for civilians and healthcare workers on the ground. Hospitals are forced to shut down due to lack of resources, patients die from preventable causes, and humanitarian organisations are unable to deliver life-saving care. The deliberate targeting or obstruction of aid operations represents yet another way that healthcare and the people it serves are being weaponised in war.

According to Médecins Sans Frontières, aid blockages have become a strategic tool in conflicts such as Gaza, Sudan, and Yemen, placing entire health systems in jeopardy.

In response, Red Cross along with other humanitarian organisations and the United Nations are calling for aid to be distributed in a safe and dignified manner at scale and in accordance with humanitarian principles.

"The current aid that's coming in is not meeting the needs of the population. It's grossly insufficient," says Jean-Philippe.

Like many ANMF members, Jean-Philippe struggles with feelings of helplessness.

He says coming back to Australia is always difficult and, in many ways, more difficult than when in Gaza.

"There's this discordance when you return. I very much leave my heart in Gaza, and [when] I return home, it's trying to transition to some normality again."

Jean-Philippe says he feels a pull to go back to Gaza.

"I can help save lives, I can help alleviate suffering.

"Although we can't do everything that we want and we haven't got all the resources that we need, it's incredibly important and valuable to provide care and support."

While Jean-Philippe is in Australia, he maintains contact with his colleagues in Gaza to check in.

"There's nothing I can say or do from here that's going to make anything better, but I reach out to them, and I tell them to stay strong, that I'm proud of the work that they're doing, and that I haven't forgotten them," he says. "It seems grossly insufficient given the gravity of the situation. But I think it's something small that is appreciated and is just an example of how the small things can help."

STANDING IN SOLIDARITY

The Australian Nursing and Midwifery Federation (ANMF) is taking a stand against the ongoing atrocities targeting healthcare workers and facilities in conflict zones.

Through the Nurses and Midwives for Peace campaign, ANMF members have signed an open letter and shared messages of support to express solidarity with nurses and midwives on the frontlines in Gaza. These heartfelt messages are being delivered via the Red Cross – a gesture to show our colleagues they are not alone.

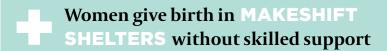
The campaign also includes a dedicated page on the ANMF website with information and resources, a national social media push, and, at the time of print, plans to launch a petition calling for greater protection of healthcare workers in conflict.

"As nurses and midwives in Australia, we may be far from the frontlines, but we are not powerless," says ANMF Federal Secretary Annie Butler. "We are part of a global community committed to care, and we stand with our colleagues who risk their lives to uphold the values we all share - compassion, courage, and care without discrimination.

"By standing in solidarity, we send a powerful message: we see you, we hear you, and we will not be silent."

COMMUNITIES **CUT OFF FROM CARE**

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- MSF, 2024



Stand with healthcare workers and join the campaign



"We see you. We hear you. We will not be silent."

Annie Butler, ANMF Federal Secretary



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SUPPORT YOU CAN COUNT ON

Meet the ANMF's Strategic Programs and Engagement Team

The ANMF Federal Office has appointed a new team of specialists to lead change in key priority areas for the Federation, including education and aged care. Building on its established midwifery work, the Strategic Programs and Engagement Team will drive initiatives that deliver impact at political, branch, and member levels.



TEAM LEAD DR NOELLEEN KIPRILLIS

At the helm is Team Lead Dr Noelleen Kiprillis, who is energised by the opportunities ahead.

"The depth of experience within our team will ensure the Federation can meaningfully contribute across the board," she says.

Noelleen brings an extensive career history as a registered nurse, with a strong foundation in nursing education. After graduating in the late 1990s, she spent many years as a critical care nurse in Intensive Care before transitioning into educationfuelled by her passion for teaching and lifelong learning.

Her early education roles included supporting nursing students on placement and providing ward-based education She later moved into academia, contributing to both undergraduate and postgraduate nursing degrees while balancing family life and completing her PhD - a significant career milestone.

Following her doctorate, Noelleen returned to a senior healthcare leadership role, cementing her reputation as an innovative nursing leader with a strong focus on leadership and nursing and midwifery education. Always looking ahead, she sought a role where she could shape the future of the profession and support the next generation of nurses and midwives. She found that opportunity at the ANMF.

As Team Lead, Noelleen is committed to initiatives that will strengthen the profession and improve outcomes for members, the wider nursing and midwifery community, and the people they care for.



STRATEGIC LEAD - AGED CARE: DR KHALIL SUKKAR

Dr Khalil Sukkar has worked across nearly every corner of aged care - as a nurse, manager, educator, and now as the ANMF's Strategic Lead - Aged Care.

With more than 30 years in the sector, he has seen first-hand the challenges aged care workers face and is passionate about building a system that is fairer, safer, and more supportive for both staff and residents.

Khalil's career spans managing services of all sizes, leading workforce projects, lecturing at universities, and even designing aged care software. This breadth of experience gives him unique insight into what works—and what needs to change.

"I'm fortunate to bring a mix of operational, quality, and research experience," Khalil says. "I know what's possible, what's achievable, and what's required - and that will keep me in good stead to make meaningful change."

Based at the Federal Office, Khalil works closely with ANMF state and territory branches to coordinate national policy approaches. He uses his lived experience to amplify members' voices, influence aged care reform, and push for better staffing, stronger protections, and systems that make a difference at the bedside.

One of his key priorities is improving the sector's ability to collect and use meaningful data. "If we can measure it, we can manage it and improve," he says.

Khalil has already met with the newly appointed Aged Care Minister, sharing reallife concerns from members and advising on priorities for reform.



STRATEGIC LEAD - EDUCATION: ALICE KETT

As the ANMF's Strategic Lead - Education, Alice Kett's role is to represent the education priorities of nurses and midwives across every stage of their careers - from student, to re-entry, through to retirement.

"My focus is on advocating for members' interests with industry, education providers - whether in the VET sector, universities, or professional bodies – and in policy and regulatory settings," Alice explains. "I want to ensure our members have access to quality education that supports them to be confident, innovative and safe in their practice."

One area she is particularly passionate about is digital health education.

"It's such an emerging space," she says. "We're navigating priorities like telehealth, AI, and digital records management - and our role is to help members feel prepared and empowered to use these tools effectively."

Alice's vision has a strong focus on nurse and midwife wellbeing, leadership development, and working closely with Workforce Lead Jill Maguire on issues such as retention strategies and workforce reform.

With 15 years experience across the tertiary, health, and community sectors, her expertise spans learning design, workforce development, and strategic educational leadership.

She has led large-scale education initiatives, developed nationally recognised training programs, and supported health professionals through major workforce reforms. Alice is currently completing a Master's in Health Professional Education, researching how to prepare clinicians to engage compassionately in telehealth consultations.

ANMF powerhouse: The Biennial National Conference

The Australian Nursing and Midwifery Federation will be holding its Biennial National Conference (BNC) on the Gold Coast in October. What is the BNC, who attends and why is it important to nurses, midwives and care workers?

The ANMF is Australia's largest union with over 345,000 nurses, midwives and care workers who are members of the union in one of eight Branches established in each state and territory.

While Branches respond to issues at a state and territory level and actively represent the industrial and professional interests of members at the local level, the ANMF Federal Office coordinates the activities of the Branches and advocates and responds to national issues of importance to nurses, midwives and care workers.

The ANMF Biennial National Conference (BNC) held every two years and attended by more than 140 delegates, is an important means by which ANMF members can make recommendations on any aspect of the professions to democratically influence the direction of the union.

"It's an opportunity where workplace delegates get together nationally to discuss things of importance to them and to represent their state and territory Branches," ANMF Federal Secretary Annie Buttler said.

"Many achievements of the union have resulted from resolutions that have come out of the Biennial National Conference starting with a motion put forward by a delegate on the floor."

MOTIONS AND RESOLUTIONS

The BNC welcomes delegates to collectively discuss and debate motions. A motion is a change or improvement in any aspect of workplace or the professions put forward by a member of the union on behalf of themselves, their colleagues and Branch.

Motions presented at the Biennial are usually related to national matters, but can be state based, particularly if a Branch is seeking national support on an issue.

If an idea is accepted as a formal motion, it is debated by all the delegates at the conference. Motions that get majority support are passed and become resolutions. A resolution is an official statement of intent that guides ANMF's direction in future years.

"The biennial national conference is more than the ANMF as a whole - uniting Branches on federal issues," says ANMF President Sally-Anne Jones.

"It gives Branch officials who are the true rank and file nurses and midwives the chance to get together in their elected positions."

The 2025 BNC will be held on the Gold Coast on 16-17 October.





HISTORY

During the 1960s the then RANF (Royal Australian Nursing Federation) held biennial conventions, but they were not a policy-setting forum with member representation like today.

The Federal Council passed a resolution at its 16-18 September 1991 meeting to add a new rule (Rule 27 A) to the ANF (Australian Nursing Federation) Federal Rule for a biennial delegates' conference. Along with members of the Federal Executive, a designated number of elected job representative delegates representing each Branch of the Federation would attend.

Rule 27 A further specified that the 'Biennial National Conference be a forum for consideration and debate on matters of national policy'.

The inaugural Biennial National Conference was held in Melbourne on 6-7 October 1993. Rule 27 A has been amended over the years to refine the process and remit of BNC.

RECENT SUCCESSFUL ANMF AND UNION CAMPAIGNS

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

Many of the union's biggest wins have come from resolutions put forward at BNC. Some in more recent times include:

- Commonwealth Prac Payment
- Superannuation paid during parental leave
- End of collaborative arrangements for nurse practitioners and endorsed midwives
- 10 days legislated domestic family violence leave
- Aged care mandated care minutes and minimum award wage increases
- Protecting penalty rates for nurses, midwives and









Glenistair Hancock

VIC

Glenistair Hancock has been a job rep for nine years. He was inspired to join the ANMF Victorian Branch as a new graduate working in a regional public hospital where there were no union workplace reps on his ward.

"I'm interested in the union both nationally and globally. It's been a battleground with unions in how we can be progressive and relevant today. How we as unionists can have influence so that we can have good outcomes for society in general, for example for better outcomes in childcare and housing, and what practically on the ground that looks like for us.

"Our union, the ANMF is unique. I'm looking forward to seeing the whole process at the Biennial National Conference, how it works and what it achieves.

"My main focus is on giving a voice to rural nurses. Often unfortunately our health system is city centric. A lot of people leave rural locations to work in the city, compounding workforce shortages and difficulties in accessing healthcare. It's one of my drivers along with mental health."

Mental health remains a challenging space, says Glenistair. "It is a lot more de-stigmatised but there's still a fair bit of stigma. I've had the opportunity to be on the ANMF Victorian Branch working group for the Royal Commission into Victoria's Mental Health System. It's given me good insight into the process and the document."

The Commission's final report in 2021, included 65 recommendations aimed at transforming Victoria's mental health system over the next decade.

Glenistair is looking forward to BNC and comparing with interstate colleagues on what's happening in their jurisdictions. "I think we're fairly progressive in Victoria and so I'm also looking

forward to sharing what we've been doing."



Phil Ohman

ACT

An RN in the public hospital in the ACT, Phil has been a workplace delegate for about two years. He became an ANMF member whilst a mature aged student.

"My wife and daughter are both RNs and ANMF members, so I saw the benefits of the union from an early stage in my career."

Phil is also a first timer to BNC and is looking forward to developing relationships with delegates from other states and territories.

"I'm hoping to discover what issues they are facing in their regions, and both support them in their endeavours and also be supported in issues we're facing in the ACT."

Phil considers one of the ANMF's greatest achievements is the introduction of nurse-to-patient ratios.

"We've had ratios in our ED for a little under a year and it has made a tangible difference in the workplace. It has allowed for more time for patient interaction, less stress and pressure due to lower workloads, and fewer staff absenteeism."

Phil is putting forward two resolutions at BNC, on workplace violence and people trafficking.

"I have lived and worked overseas and have seen the impacts of people trafficking. At the ANMF ACT Biennial Conference, I was a little surprised to discover that another delegate had worked with a colleague who had been trafficked. I'm passionate about social justice, which is why I'm presenting this resolution."

Working in the ED, Phil witnesses workplace violence daily, and considers it should not be an acceptable part of being a nurse/midwife.

"There must be very few nurses that have not experienced some form of workplace violence, either physical or verbal. I would like to see not only legislation to protect nurses but legislation that delivers what it promises when sentencing transgressors, to make people think twice before abusing nurses and midwives."

"Workplace violence needs addressing urgently; not just that received from patients but also horizontal and vertical violence. The culture of intimidation and bullying remains within the nursing/midwifery profession, and I believe this is a reason for young nurses in particular leaving."

Phil would like to see action from the ANMF and buy-in from workplace delegates to encourage members to step up and bring the issue to light.



Lannelle Bailey

NSW

Working in regional aged care, Lannelle Bailey is excited to network with job reps across the country at BNC.

"I am excited, I think mainly because I work in the federal system, not state based and I'm looking most forward to connect with those in other states and territories who have the same issues and how we can move forward to get improved conditions and wages. We still have a long way to go."

On the Albury/Wodonga border, Lannelle works in community care in Victoria and in RACF in NSW. She has been in the aged care sector for 12 years and joined the NSWNMA at the end of 2020.

Lannelle grew up on a dairy farm and worked in various industries including automotive, food, manufacturing, warehousing before she turned to aged care.

"I often feel worn out and downtrodden, but I am the most passionate about this [aged care] than I have been about anything else in my life."

Aged care membership in the NSWNMA has grown by about 12% in the last 12 months, says Lannelle. Resolutions passed on aged care at the NSWNMA State Delegates' Conference were unanimously passed because they are not unrealistic resolutions, she says. "Our colleagues support us because we are still fighting for the basic needs of our residents."

NSWNMA will be putting forward a multipoint resolution around aged care at BNC, including calling for a thorough investigation of the misuse of government funding by some private aged care providers.

"We want the best for our residents and for providers to be accountable for the funding they are provided with by government. Some employers are not compliant. If we do not meet care minutes, there are consequences

"There are not enough staff to do pad rounds on night shift which can result in skin excoriation of residents. That extra five minutes you can spend with a resident for them to feel heard, or you can have behaviours that will play out for the rest of the day. We also need to ensure there are mechanisms for reporting."

Lannelle was with an ANMF delegation that travelled to Parliament House in Canberra in 2021 and was inspired listening to ANMF Federal Secretary Annie Butler talk to politicians about the issues in aged care.

"It's exciting to be a cog in the wheel. It's the sense of power that we have in numbers. We have some wins. and we have to keep the momentum and go forward, not backwards."

Jack Shiner

Jack Shiner is excited to be representing the ANMF NT Branch for the first time at the 2025 BNC.

"As the smallest branch nationally, the NT has unique challenges and perspectives, so I'm eager to connect and collaborate with colleagues from across Australia. It's a valuable opportunity to exchange ideas, learn from others' experiences, and bring forward issues that matter most to nurses and midwives in the Territory, ensuring our voice is heard on the national stage."

Jack originally joined the union for the professional indemnity insurance that comes with membership, but the union has become much more important to him.

"Over time, as I became more involved, I've come to understand the significant role the ANMF plays in our profession, from industrial representation during EBA negotiations to day-to-day support from our Branch organisers. The ANMF is pivotal to the protection, support, and advancement of nurses and midwives."

Jack will be moving a motion calling on the ANMF to advocate for increased federal funding and recruitment of lung cancer specialist nurses.

"Lung cancer is Australia's leading cause of cancer-related death, yet there are only 12 specialist nurses nationally compared to over 400 breast cancer specialists. Increasing specialist nursing support would significantly improve patient outcomes and address this disparity.

"Additionally, I'm passionate about legislated nurse-to-patient ratios. With successful implementation in Victoria and Queensland improving patient safety and nurse wellbeing, I hope the NT branch can push for this important reform during upcoming EBA negotiations next year."

There are several key issues the NT nursing and midwifery workforce are facing that Jack is keen to hear discussed at BNC, including workforce shortages due to retention and staff turnover, particularly due to the transient nature of the NT workforce; and housing and infrastructure for remote area staff.

"Poor quality housing, safety concerns and limited access to stores and the internet are significant issues. Workplace violence particularly in our emergency departments and remote clinics has been a problem that needs to be addressed further."

Jack says he's proud of several recent ANMF achievements. "The scope of practice reforms removing collaborative arrangements have empowered advanced practice nurses and midwives to work more autonomously, improving access to care and professional satisfaction.

"Another major win is the introduction of the Commonwealth Prac Payment from 1 July, addressing placement poverty among student nurses and midwives. This financial support is crucial in ensuring students can complete their clinical placements without undue hardship, ultimately helping to attract and retain future healthcare professionals in Australia."

Kim Luby

WA

Kim last attended BNC several years ago when she was the ANF Federal Vice President and enjoyed the camaraderie amongst delegates.

"Delegates are full of enthusiasm with discussions about how they motivate and advocate for nurses and midwives in their workplaces."

"There's robust debate on matters affecting the professions and, on the priorities the ANMF Federal Office should seek change around ie. Nursing Hours per Patient Day (NHpPD), access to university based professional education, remuneration for higher degrees and political lobbying on workplace issues such as 12-hour shifts.

"Delegates share their experiences on dealing with common workplace issues and how they have achieved proactive local change and feedback on how their union has provided education for job representatives."

Kim is passionate about workloads, workplace safety and bullying, education and the ongoing political lobbying of matters important to the membership.

Kim believes in order to optimise opportunities no matter the career pathway registered nurse or midwife, enrolled nurse or carer is a wonderful, challenging, ever changing, but rewarding experience."





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

Assaults against healthcare workers and criminal law

In Victoria, workplace safety is regulated under the Occupational Health and Safety Act 2004. The Act places an onus on employers to provide and maintain (as far as reasonably practicable) a safe workplace.

In addition, employers hold a non-delegable duty of care for their employees under tort law, which includes the need to maintain employees' mental wellbeing and to prevent foreseeable risks of injury.

Failure to meet this duty where there is a foreseeable risk of injury can result in awards of compensation in favour of the employee and payable by the employer in civil law actions. In addition, employers are also at risk of significant fines if charged and prosecuted by bodies such as Work Safe Victoria.

However, whilst legislative amendments have been made in other areas of law protecting specific classes of emergency workers, such as in criminal law to protect ambulance, police or first responders, to date no similar priority category is given to nurses.

Historically, assaults against healthcare workers by patients have not been considered aggravating factors in sentencing in criminal law or when considering compensation in civil law.

This is despite nurses and healthcare workers experiencing extreme rates of workplace violence often with disastrous impacts. In many nursing settings assaults are increasingly being normalised as being "just a part of the job", particularly in psychiatric settings where there is an overlay of mental health legislation requiring patients be treated in the least restrictive manner creating a tenuous balancing act between patients freedoms and nurses safety on a daily basis.

Over the past five years there has been a 65% increase in the number of serious workers' compensation claims for assault and exposure to workplace violence in Victoria alone. This includes a 73% increase in assaults against women in the workplace. In 2018-2021 in Victoria, healthcare and social assistance sector employees made up the highest category of workers compensation claims for assault or exposure to occupational violence. They were the second highest group to report having experienced work-related violence in the past six months at the point of data collection in 2023. These reports included a variety of experiences of aggression, from verbal abuse (87%), physical assault (12.5% up from 8% in 2021), and spitting (9%).

It is estimated that only between 3 and 12% of violence incidents are actually reported, meaning the real number of those affected is significantly higher.

A Melbourne hospital was fined \$30,000 after failing to provide a safe workplace for a psychiatric nurse who was assaulted by a patient. In that matter a representative of WorkSafe argued that "experiencing violence and aggression should never be 'just a part of the job' for any healthcare worker, even when it's committed by people whose clinical condition may be affecting their judgement". Similarly, a regional health service in Queensland in 2022 were facing fines of over a million dollars, however successfully defeated the claims relating to a mental health nurse who had a knife held to her throat by a patient and in a separate incident another mental health nurse who was left with brain damage after being assaulted. The prosecution failed, in part, due to being unable to prove that the presence of a security officer permanently in the HDU would have reduced the risks or impact of the risks posed by patients. However, a different outcome was obtained in a Queensland Supreme Court where a nurse sustained significant injuries whilst restraining a patient. Despite the presence of security holding the patient's arms, the nurse plaintiff had to hold the legs of the patient and was subsequently seriously injured. The court found that the nurse should have been trained not to participate in the physical restraint and that rather their role should have been limited to providing reassurance and medication. The court ultimately found that the health service had breached its duty of care to the plaintiff nurse by not taking reasonably practicable precautions, ordering the defendant to pay \$1,634,418.55 in personal injury compensation.

Whilst there are many initiatives targeting reducing workplace violence, it seems that many nurses have accepted it as a part of their practice, particularly those working in high-risk settings. This is reflected in the low rate of civil claims made by nurses against employers. Nurses have a duty of care to patients, however the point at which that duty is overridden by the responsibility of the employer to keep an employee safe is unclear. What is a 'reasonable' amount of risk for a nurse to accept as a part of their duties is yet to be determined.²

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Reframing End-of-Life Care: A call for courage and compassion in nursing and midwifery

By Kim Devery and Caroline Phelan

How we die is complicated. Health and medical sciences and advances in clinical care have had a dramatic impact on Australians' lives.

Complex chronic illnesses are being treated successfully, and lives are prolonged. At the same time, the end-of-life has become increasingly complex and often protracted.

Australians are living longer than ever, with median age at death now 80 years for men and 85 for women. This ageing population experiences more prolonged periods of illness, often marked by disability, dementia, and multimorbidity. Despite the predictability of decline, only 12% of Australians have an advance care plan in place. Recognition that someone is dying often occurs within the final 48 hours of life, when opportunities for meaningful discussion, preparation, and comfort may be lost.

This presents a challenge to the nursing and midwifery professions: To step forward as both advocates and leaders in improving communication and care at the end-of-life.



THE UNCOMFORTABLE SILENCE AROUND DEATH

The culture of modern healthcare often revolves around recovery, restoration, and cure. Nurses and midwives enter their professions to alleviate suffering, promote healing, and support families. But when restoration of health is no longer possible, many clinicians find themselves in unfamiliar territory. The shift from active treatment to end-of-life care may feel like failure, especially in high-pressure hospital environments where "doing everything" is frequently equated with good care.3 Moving to end-of-life care is often slow or doesn't happen at all.

The absence of quality end-of-life care can be isolating for patients, families and healthcare teams at a time when individuals and families most need clarity, reassurance, and the chance to say goodbye.3

Research shows that offering to discuss endof-life issues does not cause harm.

On the contrary, these conversations often bring relief. Many patients want to talk about their fears, their hopes, their regrets, and what matters most in their final days. Families want to understand what to expect and how best to support their loved ones.3 We need to listen.

A SKILL, NOT JUST AN INSTINCT

Many nurses and midwives lack confidence in knowing when or how to initiate endof-life conversations.4 Yet, these are not conversations that require perfection. They require presence. A listening ear. The willingness to sit with uncertainty, emotion, and the unknown.

Communication at end-of-life is a skill that can be developed. Frameworks such as the SPICT⁵ can help identify when a patient may be nearing end-of-life. Prompts such as "What worries you most about your illness?" or "What would you like to do with the time you have left?" are powerful words to open conversations. The ABCD model - Attitudes, Beliefs, Compassion, and Dialogue⁶ reminds clinicians that their mindset is just as important as their words.

LEADERSHIP FROM EVERY ROLE

It is a common misconception that end-oflife discussions are the domain of senior doctors or palliative care teams. Nurses and midwives are uniquely placed to lead these conversations at the bedside. They hear the patient's fears, hopes, and wishes.

Leadership here does not mean issuing directives. It means modelling openness and curiosity, asking thoughtful questions, supporting colleagues, and advocating for dignity and clarity in care planning. It means recognising end-of-life care not as a separate specialty but as a core responsibility of healthcare, regardless of setting or title.

BUILDING A CULTURE OF PSYCHOLOGICAL SAFETY

Advocating for patients at end-of-life is needed, and nurses are in a prime position to do so. One of the greatest barriers to end-of-life communication is the fear of speaking up. Nurses and midwives may be concerned about overstepping roles, challenging hierarchies, or appearing negative. This hesitancy can be especially strong in interprofessional teams shaped by seniority, discipline, and authority.

To overcome this, nurses and workplaces can cultivate psychological safety, the shared belief that it is safe to ask questions, raise concerns, and admit uncertainty without fear of humiliation or blame.

In such environments, all staff can frame differences of opinion as learning opportunities rather than threats.7

SELF-CARE IS NOT OPTIONAL

It is vital to acknowledge that providing care at the end-of-life can be emotionally taxing. Providing care to the dying and supporting those who are newly bereaved is important work that demands care of ourselves.3 Nurses and midwives must be encouraged to reflect on their own needs, seek support, and engage in meaningful self-care. Asking "Who supports me?" and "What helps me stay well?" are not indulgent questions, they are essential.

A CALL TO REFLECT **AND REFRAME**

As our population ages and demands grow for quality and safe end-of-life care, nurses and midwives have an opportunity to reframe death not as a failure, but as a phase of life deserving of the same attention, compassion, and professionalism as any other.

ARE WE PREPARED TO SPEAK, LISTEN, ADVOCATE AND LEAD? OR WILL WE ALLOW SILENCE TO PERSIST WHERE CONVERSATION IS MOST NEEDED?

The answer lies not in policy documents or medical charts, but in the courage to act, one conversation at a time.

Authors

Associate Professor Kim Devery, Project Lead, End-of-Life Essentials project and Dr Caroline Phelan, Co-Lead.

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New grad registered nurse: Navigating the world of mental health

By Pradip B C

As a newly registered nurse fresh out of university, I was thrilled to be accepted into the specialist Mental Health GradStart program at the Lower North Shore Assertive Outreach Team (LNS AOT).

Beginning my career in LNS AOT of the Mental Health Drug and Alcohol (MHDA) service was an exciting and enriching experience. The AOT is filled with a multidisciplinary team supporting consumers experiencing acute and enduring mental health challenges in the community. The six months I spent in this rotation were both fascinating and filled with growth, laying a solid foundation for the rest of my nursing career in mental health.

A WARM WELCOME AND TEAM SPIRIT

From day one, I was warmly welcomed into a multidisciplinary team comprising registered nurses, social workers, psychologists, occupational therapists, junior medical officers, and psychiatrists. The variety of professionals and the collaborative environment were inspiring. Each team member brought their own unique perspective and expertise to the table, creating a holistic approach to consumer care that I found both effective and motivating.

One of the most remarkable things about the AOT was how seamlessly everyone worked together. Whether it was discussing care plans or coordinating home visits, there was always a sense of unity and shared responsibility for the mental health consumers. What made this experience truly special was how helpful every team member was, always ready to answer my questions and provide guidance. Their generosity with their time made the AOT an exciting place to learn and grow.

EXCEPTIONAL LEADERSHIP AND SUPPORT

In addition to the strong team spirit, I also had the privilege of working under an exceptional team leader and preceptor. Their leadership was not only inspirational but also deeply supportive. Whether it was

providing guidance in difficult cases or simply offering words of encouragement, the team leader and preceptor consistently made time to ensure I felt supported in my role. Their mentorship helped me build my confidence as a new mental health nurse, and their willingness to lead by example left a lasting impression on me.

LEARNING FROM SEASONED PROFESSIONALS

One of the most rewarding aspects of my time in AOT was the chance to learn from highly experienced professionals. Many of my colleagues had been working in mental health for decades, with some possessing over 40 years of experience in the field. Their depth of knowledge and practical insights were invaluable, offering lessons that went far beyond what I had learned in the classroom.

These seasoned professionals not only helped me sharpen my clinical skills, but they also showed me how to approach mental healthcare with empathy, patience, and a deeper understanding of the individual complexities involved. They encouraged me to ask questions, think critically, and approach each consumer's care with an individualised touch. Having such experienced mentors made this rotation one of the most valuable learning experiences of my career so far.

ENGAGING WITH MENTAL HEALTH CONSUMERS

As a new grad, being assigned to support recovery for four mental health consumers was both a challenge and a privilege. These individuals had enduring mental health conditions that required long-term follow-up, allowing me to form meaningful, ongoing relationships with them. I quickly learned that providing mental healthcare is about more than just clinical treatment, it's about engaging with

consumers on a human level, building trust, and understanding their unique journeys toward recovery.

One of my key roles during the rotation was working as a depot nurse and conducting home visits. The home visits focused on monitoring consumers' mental state and providing support to enhance their wellbeing. Long-acting medications, however, were administered at the community mental health centre where our depot clinic was located. This combination of clinic-based care and home visits allowed me to connect with consumers on a deeper level, ensuring they received the support needed to stay on track with their treatment plans. It was both challenging and rewarding to see the positive impact of our care on their recovery journey.

A MEMORABLE SIX MONTHS

Reflecting on my six months with the AOT, I feel incredibly fortunate to have begun my nursing career in such a supportive, dynamic, and educational environment. The experience was not only exciting but also deeply rewarding, equipping me with the skills and confidence I need to succeed in mental health nursing.

I have grown both personally and professionally, gaining a deeper understanding of mental healthcare, building strong relationships with colleagues, and forming bonds with the consumers I worked with. The support from my team, including my exceptional team leader and preceptor played a crucial role in shaping my experience and has further fuelled my passion for nursing in mental health.

The Assertive Outreach Team has given me a strong foundation, and I'm excited to see where this path will lead me next. Armed with the knowledge and experiences gained in AOT, I look forward to continuing my journey as a mental health nurse, confident that I'm making a difference in the lives of people experiencing mental health challenges.

Thank you, LNS AOT team. It was a pleasure to work with such an incredible group of professionals!

Author

Pradip B C, Registered Nurse (Bachelor of Nursing), Current work: Mental Health Inpatient Unit RNSH (MHDA); Previous work: Lower North Shore Assertive Outreach Team (MHDA), NSW Australia.



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Pooled patient-level analysis of ORION-9, -10 and -11 phase 3 trials of LEQVIO vs placebo in 3,660 adult patients (3,655 in safety population) with HeFH, ASCVD or ASCVD risk equivalents (T2DM, FH and 10-year risk of a CV event >20% as assessed by Framingham risk score) and LDL-C above target of 1.8 mmol/L, on a background of maximally tolerated statin (unless intolerant or contraindicated) ± ezetimibe. Co-primary endpoints: placebo-corrected reduction from baseline in LDL-C at Day 510 (17 months) of 50.7% (95% CI -52.9, -48.4; p<0.0001); placebo-corrected time-adjusted reduction in LDL-C from baseline between Day 90 (3 months) and Day 540 (18 months) of 50.5% (95% CI -52.1, -48.9; p<0.0001).²

ASCVD, atherosclerotic cardiovascular disease; CI, confidence interval; CV, cardiovascular; FH, familial hypercholesterolaemia; HCP, healthcare professional; HeFH, heterozygous familial hypercholesterolaemia; LDL-C, low-density lipoprotein cholesterol; T2DM, type two diabetes mellitus; TEAE, treatment-emergent adverse event.

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PBS Information: Authority Required (STREAMLINED) for patients with hypercholesterolaemia.

Refer to PBS Schedule for full Authority information.



V

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Kristen Wischer ANMF Senior Federal Industrial Officer

Seeking safe harbour

The idea of providing 'safe harbour' has its origins in the history of the abolition of slavery. As northern states in America made laws to abolish slavery, southern states passed laws such as the Fugitive Slave Law.

This law made it illegal for escaped slaves to be given assistance, such as food, shelter and transport to Canada, even where the assistance was offered in a jurisdiction that had abolished slavery. Cities such as Boston grew a social movement, known as the Underground Railway, to combat the punitive laws, offering covert shelter and assistance to escaping slaves. Pennsylvania adopted an approach of refusing to assist in the capture of 'runaway' slaves, to thwart the Fugitive Slave Law.¹

The concept of safe harbour is also directly related to maritime law, whereby countries began to introduce laws to limit the use of transportation of slaves by ship. For instance, in 1807, Britain outlawed the slave trade within the British Empire, in part to try and curtail the American slave trade.²

Today, safe harbour laws are most common in criminal and corporate law. In the United States, safe harbour laws operate in many jurisdictions to protect children who have been coerced into criminal activity.

In Australia, the only available safe harbour laws exist under the Corporations Act, which allow a company director who meets set criteria to continue trading and avoid insolvency if it keeps the business afloat.

SAFE HARBOUR AND NURSES

There are two notable pieces of safe harbour legislation for nurses in the states of Texas and New Mexico. In both states, the law provides nurses with protection from being required to carry out unsafe assignments that go against ethical nursing practices, including compromising patient safety.³ The laws protect nurses from disciplinary procedures and from adverse employment outcomes. Nurses can request safe harbour if they are being asked to disobey regulatory standards and rules. The laws are intended both to protect nurses from reprisal and to support the freedom to advocate for quality care.⁴

To invoke safe harbour under the legislation, a nurse must exercise 'good faith judgement' that taking on an assignment could result in:

- harm to the patient
- that the nurse is being asked to participate in unprofessional behaviour or illegal conduct, or
- the nurse has concerns about the appropriateness of a request from another healthcare provider.

Requests for safe harbour must be made before the assignment is carried out and are subject to peer review.

Once safe harbour is requested, either verbally or in writing, the nurse must provide documentation to support the request. This may for example be documentation that shows staffing ratios are below mandated requirements, or that the assignment is outside of the nurse's scope of practice.

It is important for the nurse to demonstrate that safe harbour is being invoked to protect patients or residents and to expose unsafe practices. Its use is guided by an ethical framework and must be engaged to prevent failures in care, rather than to avoid discomfort.

This of course becomes subjective, particularly when there are no clear mandates, for things such as staff to patient or resident ratios. To work successfully health and aged care facilities also need to have clear guidelines about how requests will be dealt with and supporting regulatory standards and understanding from nursing boards.

THE CALL FOR SAFE HARBOUR LAWS IN AUSTRALIA

ANMF members have long called for safe harbour laws in Australia. The need for protection for nurses was tragically highlighted after the death of seven-year-old Aishwarya Chavittupara at Perth's Children's Hospital in 2021. Two junior nurses and a doctor were reported to Ahpra for failing to meet professional standards, in circumstances of chronic and severe understaffing.

The coroner's Inquiry into the death recommended safe harbour laws be considered, noting they would 'protect nurses from Ahpra investigation... in circumstances where known risks in the workplace have been identified and not rectified by the employer'.

Despite the ANMF's calls for this recommendation to be implemented in Western Australia, no legislation has been introduced. The ANMF will continue to advocate for state and federal laws to protect nurses who have the courage to stand up and say 'this is not safe'.

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Building climate resilience: Homes, health, work and community

By Catelyn Richards, ANMF Climate Change Officer

CLIMATE CHANGE IS OUR LANE

At the NSWNMA professional day in August this year, I told the room something I'll keep saying: climate change is our lane. As nurses and midwives, we are there in the heatwaves, the floods, the fires. We see the toll it takes on communities - where we are deeply placed. And we know that resilience, real resilience, is about more than just infrastructure. It is about people.

CLIMATE CHANGE IS HERE

The climate crisis is no longer distant. We are already seeing more frequent and severe heatwaves, bushfires, floods and storms. These events are not only disrupting daily life, they are directly impacting health.

Earlier this year, I had the privilege of attending Climate Action Week. As Lauren Sorkin from the Resilient Cities Network told the audience during her talk, "Context matters." No matter the hazard: increasing temperatures, inadequate green space, or poorly built housing, understanding contextual health vulnerabilities is the first step to addressing them.

CONTEXT MATTERS

The National Climate Risk Assessment and Vulnerability Mapping

Local governments need to map their most pressing climate vulnerabilities and respond accordingly. The National Climate Risk Assessment was recently released: a first-of-its kind report that analyses the most up-to-date information in Australia to provide details on risks to communities. Communities can now use this information to start planning ahead. This approach can help target interventions where they are needed most, reducing health risks and protecting communities.

WHAT DOES CLIMATE RESILIENCE LOOK LIKE?

When nurses and midwives talk about climate resilience, we are talking about keeping people safe and healthy no matter the weather.

Put simply, resilience is our ability to prepare for, adapt to, and recover from tough situations while still looking after our health, our patients, and each other. It is not just about bouncing back but about moving forward stronger and better prepared for the next challenge.

LOCAL ACTION MATTERS

As Emma Bacon from Sweltering Cities said at Climate Action Week, "Climate action is global, but it is also really local."

This means making sure no one is left behind, whether it is a renter without air conditioning, an aged care resident in a blackout, or a nurse working through a bushfire emergency.

CITY RESILIENCE VS PEOPLE RESILIENCE

We often hear about "resilient cities", which is important, but that usually focuses on physical infrastructure. People resilience is different; it is about lived experience.

It is the midwife driving through floodwaters to get to her patients. It is the community health nurse who organises a cool space at the local neighbourhood house during a scorcher.

Resilient cities keep the lights on. Resilient people keep each other going. We need both.

FOUR INVESTMENTS TO MAKE IT HAPPEN

The ANMF is joining forces with Renew Australia for All to champion stronger, smarter resilience for every home, workplace, and community. It is our vision to see that people and communities are resourced to better prepare, adapt and respond to the impact of more frequent, severe weather like heat waves, floods, droughts, cyclones and bushfires.

If we want to be ready for the climate we have now, we need national action in four key areas:

- 1. **HOMES** Fund resilience upgrades, reform the National Construction Code, and support low-income and rental households to adapt.
- 2. **HEALTH** Fully fund the National Health and Climate Strategy so our system can withstand climate shocks and safeguard care.
- 3. **WORK** Update WHS laws for climate impacts, introduce climate disaster leave, and adapt workplaces for extreme conditions.
- 4. **COMMUNITY** Dramatically increase funding for local services, councils, and neighbourhood houses to strengthen connections and emergency readiness.



WHY NURSES AND MIDWIVES MUST SPEAK UP

We are trusted voices in every community. We see firsthand how housing, health, work and community resources shape people's ability to cope in extreme weather. And as architect Caroline Piddock told us at Climate Action Week, "Mindsets are the things that change systems."

For us, that means moving from treating the heat-stressed patient to preventing that heat stress in the first place. It means joining our voices with others to call for systemic change.

A HOPEFUL FUTURE

Resilience is not only possible, it is already happening in pockets across Australia and the world. From green, shaded schoolyards in Paris to community-owned wind farms in Denmark, we know the solutions. The challenge is scaling them up here at home.

As Jane Goodall says, "What you do makes a difference." As nurses and midwives, we can choose to make that difference by advocating for strong, climate-resilient homes, health systems, workplaces and communities, so that no matter what the climate throws at us, our communities cannot just survive but thrive.

WANT TO READ MORE?

If this article has sparked your interest in the role nurses and midwives can play in climate resilience, you might enjoy an editorial on this topic. See below for more details:

Richards C. 2025. From margins to the centre: Positioning nurses and midwives to create climateresilient health systems. Australian Journal of Advanced Nursing, 42(2).

Resilience is our ability to prepare for, adapt to, and recover from tough situations while still looking after our health, our patients, and each other.

Catelyn Richards (R) and Melanie Eslick NSWNMA Professional Officer

Acknowledging over 100 years in nursing and midwifery regulation in Australia

By Lynette Cusack, Linda Starr and Philippa Rasmussen

It was in November 1920 that South Australia led the way, passing the country's first Nurses' Registration Bill. This pivotal moment not only laid the groundwork for professional nursing regulation but also helped shape the identity and status of nurses and midwives in Australia. Reflecting on this history reminds us why regulation remains central to the profession.

Prior to the first Nurses' Registration Bill, Australia had two nurses' associations. The Royal British Nurses Association (RBNA-UK) formed in London in 1887, went on to establish a Branch in Australia.1

Twelve years later (1899) the Australasian Trained Nurses Association (ATNA) was formed from the New South Wales Trained Nurses Association 2

Both the RBNA and ATNA registered nurses trained in accredited hospitals.3 The ATNA covered both professional and industrial matters and by 1905 there were branches in every jurisdiction with a subsidiary branch for midwives.2

As Nursing Regulation Boards (NRBs) were established the ATNA focus became industrial.2,4

For many years, medical professionals held dominant positions on Nurses Registration Boards (NRBs), playing a key role in overseeing nursing regulation. It wasn't until 1978, 57 years later, that South Australia's Nurses Act became the last in the country to reduce medical representation on its board.

The regulation of nursing in Australia began in the early 20TH century. Whilst the Queensland Health Act of 1912 established the Queensland NRB,5 South Australia passed the first nurses Registration Bill in 1920, followed by Western Australia in 1922, and New South Wales, ACT and Victoria in 1924, Tasmania in 1927 and Northern Territory in 1992.6

Nurses Acts empowered NRBs to guard nurses' professional status through examinations and registration to protect the public from incompetent and unprofessional practice.4 The first

registration certificates were issued on 1 January 1922, by the NRBSA2 who also made wearing registration badges mandatory around 1928 to distinguish registered nurses from practicing unqualified persons. 4 The identity of nurses was through wearing of a veil, and changes to SA Nurses Act in 1939, made it unlawful for anyone to wear a nurse's veil unless they were registered.7

NRBs determined entry requirements into nurses training and authorised nurse education providers. In 1921 the NRBSA standard of entry into training schools was grade seven primary school,4 the expected level of education for young women at

The Government was keen to maintain a lower educational entry level due to nursing shortages. However, in 1933 the NRBSA was finally able to raise the education standard to the Intermediate Certificate.4

Regulation of midwives across jurisdictions was subsumed within the legislation that governed nurses.6 Across the jurisdictions there were different categories of nurses with some NRBs having a register for Mental Health Nurses.

In 1963 the NRMSA replaced the Mental Health Nurse Register separating psychiatric and mental deficiency nursing.

In SA the Enrolled Nurse (EN) register replaced the Nurses Aid register in 1970 following the development of EN training programs in the 1960/70s.4

Nurse Practitioner registration began in 2000.7 The first Australian Nursing and Midwifery Practice Act SA (2008) saw the recognition of midwives with two separate professional registers established.7

An important part of Australian regulation history was the partnerships across jurisdictional NRBs, to form the Australian Nurses Council Inc, 1990 (ANCI) which became' the Australian Nursing and Midwifery Council (ANMC) in 1992.

ANMC developed the professional practice framework for nurses and midwives which included a national Code of Conduct and Ethics, and a range of position statements and guidelines for implementation by each of the NRBs.8

Over the last 104 years each NRB has been responsible for developing and reviewing the regulation laws for nurses and midwives in their jurisdiction. The introduction of the Health Practitioner Regulation National Law in 2010, adopted by each state and territory, saw the beginnings of a consistent national law regulating the professions.9 However, the intent of our nursing regulation pioneers remains the same; safety of the public through registration, title protection, education and practice standards.

Authors

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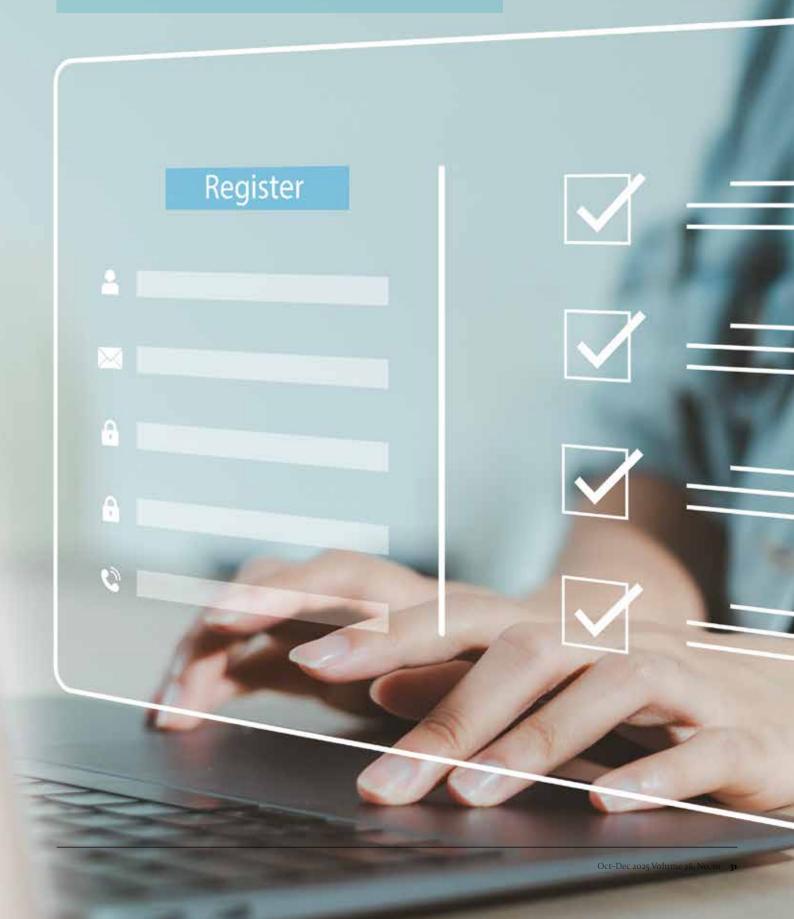
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The identity of nurses was through wearing of a veil, and changes to SA Nurses Act in 1939, made it unlawful for anyone to wear a nurse's veil unless they were registered.⁷





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.

Funding for nurse and midwife clinical support roles in education, training, and research

Nurses and midwives are the largest group of registered health and maternity care professionals in Australia yet their vital contributions to teaching, training, mentoring, and research are not properly funded or recognised.

Clinical support roles - such as supervising students on clinical placement, guiding new graduates, and conducting research - are essential for maintaining safe, high-quality care and ensuring a sustainable workforce. Without allocated time and funding, however, these responsibilities are being carried out on top of already demanding clinical loads, contributing to burnout, poor retention, and compromised care quality.

Federal leadership is essential to ensure nurses and midwives are empowered and supported to train the next generation, undertake vital research, and deliver high-quality care across Australia's health and maternity sectors. Nurses and midwives lead and contribute to high quality research, however despite being a recognised part of professional practice, formal career opportunities for nurses and midwives in research - particularly when employed primarily in clinical and maternity care roles are largely nonexistent. This also makes it very challenging for nurses and midwives to compete for research funding and support on a level playing field with other healthcare professionals - particularly medicine and the medical and pharmaceutical sciences - and means that significantly fewer nurse- and midwife-led research projects are undertaken.

Safe, effective, high-quality patient and client care is contingent on clinical staff having enough allocated time to balance direct clinical care with clinical support responsibilities across teaching, training, and research. Lack of adequately funded, allocated time also has a detrimental impact on both the work-related wellbeing and retention of experienced clinicians and negatively affects workforce growth and the attraction and retention of new nurses and midwives.

Nurses and midwives also undertake research activities in the public health and maternity sector on top of their other responsibilities, however these are not adequately supported by allocated funding and recognition of the value of nurse- and midwifeled research to improving patient and client care, outcomes, and experiences.

Employer-supported, dedicated clinical support roles with adequate funding ensures better patient experiences and outcomes by ensuring that nurses and midwives receive high quality supervision and training from experienced staff. Together with sufficient staffing levels and skills mixes, if nurses and midwives were allocated at least 20% of their normal weekly duties to funded clinical support roles and unit managers had access to at least 50% allocation, health and maternity services could more effectively support their staff to engage in valuable teaching, training, mentoring, and research activities.

The Independent Health and Aged Care Pricing Authority (IHACPA) provides a national classification system for teaching and training activities which occur in public hospital services which aims to provide a nationally consistent approach to how teaching and training activities are classified, counted, costed and funded by the Federal Government. Currently, the funding provided via the Australian Teaching and Training Classification (ATTC) is insufficient and not ring-fenced to provide specific, allocated funding for nurses and midwives. Likewise, currently there is no national classification for research activities undertaken by clinicians in the public health and maternity sectors, so these responsibilities are not well-funded or recognised.

Sustainably, sufficiently funded clinical support roles are fundamental to maintaining the pipeline of new nurses and midwives and ensuring that experienced nurses and midwives are properly recognised and remunerated for their time and expertise on top of their other clinical and administrative responsibilities. Positive clinical and learning environments with well-funded and supported nursing and midwifery clinical support roles will contribute to improved patient care and experiences.

By establishing a sufficient funding base and including clinical support roles in job descriptions and staffing models, health and maternity sectors will be better able to attract and retain new staff, retain and recognise experienced workers, and improve the efficiency and quality of direct care.



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Community nurses' knowledge, attitude & practice of standard & transmission-based precautions

By Nurmeiyati (Jeana) and Jennifer M Jones

Community nurses in Australia provide care to a diverse community including adults or young people who have specific health conditions, infants and young children including premature babies, their families and those with more complex needs.

Care is also provided to adult patients who are elderly and/or frail; those with multiple chronic complex conditions; have wounds or invasive devices immunecompromised or receiving end-of-life care.

Some of these patients may carry existing infections upon referral to community nursing and can harbour causative infectious agents that have become "institutionalised" and resistant to antibiotics. These organisms can become part of the patient's normal flora and function as opportunists waiting for the right environmental conditions for proliferation and infection. Healthcare Associated Infections (HAIs) are no longer confined to the hospital setting and hence, community nursing patients can be at risk of acquiring non-inpatient HAIs.



OVERVIEW OF THE ISSUE

This study reports on research completed with community nurses from a Local Health District (LHD) service in Sydney Australia. The study was conducted prior to the COVID-19 pandemic which delayed study continuance and in post COVID-19.

The community nurses include Child and Family Health Nursing, Sydney District Nursing, Sexual Health and Youth Health Nursing, all who provide patient care in both outpatient and home-based settings.

Studies on HAIs in non-inpatient settings remain scarce in Australia. However, a study by Hoxha, Duysburgh and Mortgat⁷ has acknowledged HAIs are no longer confined to the hospital environment with a considerable shift from inpatient care, provided in hospitals, to outpatient or home-based care, and HAIs continue to be a major cause of morbidity and mortality in healthcare. The rapid emergence and high prevalence of community-acquired infections caused by Multi Resistant Organisms (MROs) such as community-acquired Methicillin Resistant Staphylococcus Aureus (Ca-MRSA), Vancomycin Resistant Enterococci (VRE) and C. Difficile have been recognised in many parts of the world and have the potential to cause serious infections among patients without known risk factors, and many reported outbreaks have also been linked to care provided in the outpatient settings.6

HAIs principally affect frail and vulnerable individuals, but it can also affect patients in home settings who have wounds and invasive devices.⁷ The change of term from hospital acquired infection to HAIs acknowledges that a similar burden may exist in the community settings.2

Community nurses have good knowledge of infection prevention and control, but it may not be fully reflected in the level of their practice.

Egwuenu and Okanlawon³ study has shown that community nurses knew hand hygiene (97.8%), wearing gloves (99.1%) and disinfecting re-usable equipment (95.2%) could prevent infection but in practice, the percentage was below average in wearing gloves (47.5%), disinfection of re-usable

equipment (45.9%), use of face mask (17.7%) and use of eye shield (7.0%). Other studies have also shown community nurses have poor compliance rates in cleaning and disinfecting re-usable equipment such as community nurses' bags, infant weighing scales and infantometers, stethoscopes, blood pressure cuffs, tourniquets, and can be contaminated with MRSA and VRE, and are a potential source of MROs transmission.4,12,13

Community nurses often assume that fewer MROs are present in the home care setting, an assumption which threatens patients' safety and places community services patients at risk of infection.8 Mamhidir et al.11 also found that community nurses have deficit knowledge in MROs and hygiene preventive measures. Hefzy et al.⁶ note a close relationship between the nurses' knowledge and compliance rates, and that lack of knowledge is the major reason for non-compliance to both standard and transmission-based precautions in the outpatient settings. The uncontrolled home environment community nurses work within is another significant barrier to community nurses adherence to infection prevention and control practices in patients' homes. 1,14 However, it is also acknowledged there are steps that can be taken in the uncontrolled environment to reduce cross infections risks as infection prevention and control does not stop at the hospital/clinic door. 15 An evidence based infection prevention and control program in community healthcare or non-inpatient settings is critical in reducing cross infection risks among patients, family/carer, and nurses which in turn aid patient safety, improve patient care and ultimately help prevent hospital admission.

PURPOSE AND STUDY AIMS

To explore community nurses' years of experience, professional qualification, knowledge and attitude against their practice of standard and transmissionbased precautions.

To identify any gaps in current community nursing Infection Prevention and Control (IPAC) program, and to inform future policies/educational programs or resources.

STUDY DESIGN, SETTING AND METHODS

A cross-sectional survey and prospective audit were conducted with community nurses to ascertain their knowledge, attitude, and practice of standard and transmission-based precautions.

A cross-sectional self-reported online survey with a 40-point questionnaire was developed. Demographic information was captured on age, gender, professional qualification, years of nursing experience and the nursing service they worked in. Community nurses' knowledge, attitude towards and practice of HH, Personal Protective Equipment (PPE), cleaning and disinfection of re-usable equipment and HAIs was ascertained. The survey was conducted between May 2017 and September 2019.

The HH compliance audit was conducted periodically by community nursing Australian Commission



on Safety and Quality in Health Care (ACSQHC) accredited Hand Hygiene (HH) auditors using the ACSQHC national HH audit tool in 2019 (pre COVID-19 pandemic) and 2023 (post COVID-19 pandemic) as part of the National Hand Hygiene Initiative (NHHI). The study investigators then conducted a prospective audit of all the HH audits that were collected.

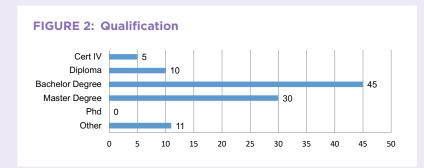
PARTICIPANTS AND RECRUITMENT

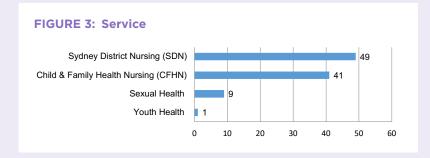
Community nurses were invited to participate in the study. The recruitment period was from May 2017 to September 2019. The participant eligibility criteria included community nurses employed within the LHD who have at least one year of nursing experience. The online REDcap tool survey link with participant information sheet was disseminated via email to all employed LHD community nurses (n = 182)

Community nurses were observed in their HH practice periodically by community ACSQHC accredited HH auditors in both home-based and clinic outpatient settings in 2019 (pre COVID-19 pandemic) and 2023 (post COVID-19 pandemic) as part of the ASQHS NHHI.

Demographic information of community nurses (n=105)







DATA COLLECTION/ANALYSIS

A secure web platform REDcap was used for building and managing the online database and surveys.

Data analysis cross-sectional self-reported online survey with a 40-point questionnaire was conducted between May 2017 and September 2019. Community nurses were asked questions about demographic, knowledge, attitude, and practice of HH, PPE, cleaning and disinfection of re-usable equipment and HAIs. Incomplete surveys and duplicate responses were excluded from data analysis.

Mann-Whitney Test (P value of 0.05 to be significant) was used to analyse the relationship between years of nursing experience, professional qualification, knowledge & attitude against their practice.

A prospective audit of community nurses HH compliance was conducted post COVID-19 pandemic by the study investigators. The total number of HH moments and compliance rates recorded in 2019 (pre COVID-19 pandemic) and 2023 (post COVID-19 pandemic) were reviewed, and the average compliance rate was ascertained for each year.

RESULTS

Fifty eight percent (105/182) of community nurses participated in the self-reported online survey between May 2017 and September 2019. The survey had four domains to complete which include demographic, knowledge, attitude, and practice.

Figures 1–3: Demographic information of community nurses (n=105) summarises the community nurses' year of nursing experience, qualification, and the nursing services they were from.

Level of qualification was not linked to self-reported standard and transmission-based precautions practice. There was evidence that less experienced community nurses were more likely to self-report incorrect standard and transmission-based precautions practice. Two percent (2/105) community nurses self-reported incorrect practice on removing gloves and performed HH before accessing nurses' bags or stocks from stock room/cabinet and were significantly less experienced than the larger group who reported correct practice (Mann-Whitney test, P=0.037).

Eighteen percent (19/105) of community nurses reported incorrect practice in relation to wearing surgical mask when sneezing/coughing before performing a procedure and were less experienced, though this was not statistically significant (Mann-Whitney test, P=0.11).

Figure 4 summarises the community nurses' responses to 19 questions on knowledge in HH, PPE, cleaning and disinfection of re-usable equipment and HAIs (n=105). The red bar highlights questions which had a low percentage of participants responding correctly. Only 3% (3/105) of community nurses answered what PPE consisted of correctly. Thirteen percent (14/105) of community nurses answered the purpose of wearing a surgical mask correctly. Thirty one percent (32/105) of community nurses correctly answered when neutral detergent and hospital grade disinfectant must be used to clean reusable equipment.

One practice domain was influenced by knowledge which is HH after touching the patient's environment. The knowledge score of self-reported incorrect practice on this domain was marginally significantly lower than the knowledge scores for those who self-reported correct practice (Mann-Whitney test, P=0.066). Overall, a strong link between the community nurses' knowledge and their practice of standard and transmission-based precautions was not shown.

Figure 5-6 summarises the community nurses' attitude and practice of standard and transmissionbased precautions (n=105). The red bar in Figure 5 and 6 highlight questions which had a low percentage of participants responding positively and correctly.

Only 73% (73/105) of community nurses agreed 5 moments of HH is practical in community healthcare setting which mirrors Wendt et al.14 study whereas home-based nurses were unsure if the World Health Organization's recommended 'Five Moments for HH' 'fit' the home-based nursing care environment.

Only 67% (67/105) of community nurses wear surgical masks when they are sneezing/coughing before a procedure. Seventy seven percent (81/105) of community nurses performed HH after touching a patient's home environment.

Community nurses who self-reported incorrect standard and transmission-based precautions practice were more likely to report poorer attitudes than those who reported correct practice (Mann-Whitney test, P=0.003). Although this is not significant due to selfreported attitude.

Ninety four percent (1041/1103) of correct HH moments were observed in 2019 (pre COVID-19 pandemic), and 90% (798/884) of correct HH moments were observed in 2023 (post COVID-19 pandemic) indicating community nurses had a consistent high HH compliance rate.

This high compliance rate is on par with the community nurse's knowledge of HH (Figure 4) however, it contradicts with their self-reported attitude and practice as the community nurses are more likely to comply with HH when being observed.10

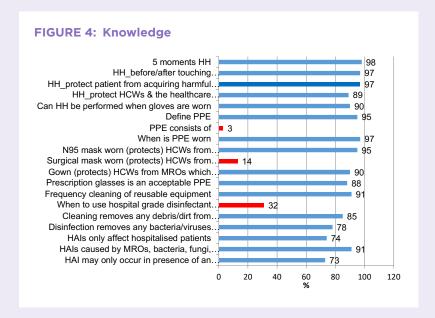
DISCUSSION

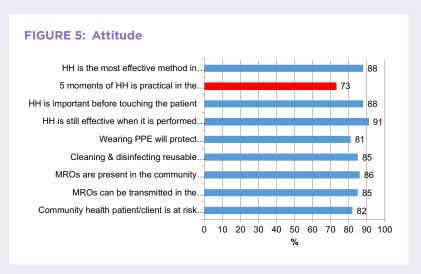
Overall, the link between community nurses' years of experience, professional qualification, knowledge, and attitude against their practice of standard and transmission-based precautions was not significant. This was due to measuring practice via self-report. There is an innate positive skew when the community nurses self-rated their practice.

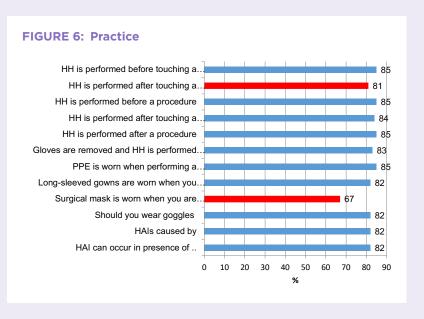
There was evidence that less experienced community nurses were more likely to self-report incorrect standard and transmission-based precautions practice than experienced community nurses which were not explored in previous studies.3,6,11

Community nurses also demonstrated a prominent level of HH knowledge and practice when observed. In contrast, Wendt et al.¹⁴ indicate that home-based nurses' daily infection prevention and control practices such as HH, the proper use of PPE and handling/ cleaning of communication devices was suboptimal during observation. A low percentage of community nurses' knowledge in PPE use, neutral detergent and hospital grade disinfectant for cleaning patient shared equipment, and the practice of wearing surgical face mask when coughing/sneezing before performing procedure and the HH after touching patient's home environment appeared to be consistent with Hefzy et al. and Mamhidir et al. 6,11 studies, which demonstrated lack of knowledge is the major reason for noncompliance. This is in contrast with Egwuenu and Okanlawon³ study which shows community nurses had good knowledge of infection control but not fully reflected in the level of their practice.

This study supplements Egwuenu and Okanlawon³ study by exploring community nurses' attitude against their practice of standard and transmissionbased precautions which had shown community nurses' practice of infection control to be influenced by their attitude and knowledge.







CLINICAL UPDATE

LIMITATIONS

Despite the limitation of the cross-sectional self-reported survey and prospective audit, 58% (105/182) of community nurses from a Local Health District Service in Sydney Australia participated in the study.

The self-reported survey in attitude and practice limits the ability to identify resources gaps in influencing community nurses' attitude and their practice. However, it supplements previous studies which explored community nurses' knowledge and practice of infection prevention and control, by exploring community nurses' years of experience and attitude against their practice.

This study did not explore the barriers of infection prevention practices in the home environment but supplements several studies that identified the barriers and acknowledged community nurses may not have control over the environments they work in, but steps can be taken to reduce cross-infection risks. 1,14,15

This study also did not further explore strategies to influence community nurses' attitude and their practice.

IMPLICATIONS FOR FUTURE PRACTICE

This study highlights the importance of community nurses improving their knowledge in PPE and cleaning of patient shared equipment in minimising the patient's risk of HAIs in the community.

Hence, aligning infection prevention and control policies/guidelines/education programs or resources with home-based nursing care setting is needed to improve their daily practice and knowledge of infection prevention and control, as they face the unique challenge of managing infection control in uncontrolled patients' homes. 13,15,16,17

In addition, a targeted infection prevention and control educational program/resource for less experienced community nurses in both outpatient and home-based settings is needed despite current guides/programs in infection prevention and control for community nurses. 13,15

The targeted infection prevention and control program/resource could include an instructional video on wearing PPE or cleaning of patient shared equipment in home setting with real time support from infection prevention and control personnels or clinical nurse educators.

The study also highlights the need for community nurses to improve their practice of wearing PPE and HH after touching the patient's environment. However, these practices are influenced by their attitude hence exploring strategies that could align, and influence community nurses' attitude and their practice of standard and transmission-based precautions are needed in the future.

CONCLUSION

This study provides an overview of community nurses' knowledge, attitude, and practice of standard and transmission-based precautions in a Local Health District Service in Sydney Australia by exploring their years of experience, professional qualification, knowledge, and attitude against their practice of standard and transmission-based precautions.

There was no significant link between community nurses' years of experience, professional qualification, knowledge, and attitude against their practice of standard and transmission-based precautions. However, there are correlations between the community nurses' practice of standard and transmission-based precaution and their attitude and knowledge.

Community nurses will need to improve their knowledge and practice in standard and transmission-based precautions to minimise their patient's risk of HAIs which are no longer confined in hospital settings.

A targeted infection prevention and control educational program/resource for less experienced community nurses in both outpatient and home-based settings is needed to improve their knowledge and practice.

Future studies should explore strategies to influence community nurses' attitude and their practice of standard and transmissionbased precautions.

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Just as flowers need sunlight and care to thrive, nurses and midwives flourish in an environment of compassion and respect

By Debra Klages

The Oxygen Mask Theory teaches us to prioritise our own care before helping others. This may seem unusual for some. However, it reveals an important truth: we can only care for others when we first take care of our own wellbeing.

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Nurses and midwives are essential in delivering Trauma-Informed Care (TIC), dedicated to preventing re-traumatisation, fostering compassionate care, and respecting individual autonomy. 1 As these professionals skilfully integrate TIC into their practice, it prompts us to reflect on whether they are also embracing similar strategies to nurture their own wellbeing.

The restorative resilience model of clinical supervision offers a valuable approach to mitigating the effects of vicarious trauma, compassion fatigue, and high staff turnover in nursing and midwifery.² In Australia, restorative resilience clinical supervision³ is endorsed by the Australian College of Mental Health Nursing and, is distinct from operational and task-oriented supervision. It emphasises key themes such as compassion, job satisfaction, and trauma-informed practice, while also promoting the essential qualities of nurses and midwives and encouraging their professional development and resilience. Importantly, restorative resilience clinical supervision is not a form of therapy; it establishes clear boundaries between personal and professional practice and includes referrals for individual counselling when needed.

Evidence supporting the effectiveness of this model comes from quantitative research conducted in the United Kingdom, which found that its implementation correlated with increased compassion satisfaction and a decrease in burnout among nurses and midwives. Initial studies focused on the effects of caring for families dealing with miscarriage and neonatal death on midwives, aiming to determine if restorative clinical supervision could alleviate stress and burnout while enhancing their professional quality of life.4

The researcher utilised the Professional Quality of Life (ProQOL)⁵ scale to evaluate the influence of

restorative clinical supervision on the compassion satisfaction, burnout, and vicarious traumatic stress of 350 maternity staff.4 Despite more than half of the midwives reporting elevated stress levels, the introduction of restorative supervision was found to be beneficial, leading to improved resilience, decreased stress and burnout, and enhanced compassion satisfaction.4 Subsequent research involving larger groups of nurses, doctors, and social workers indicated an average reduction of 40% in burnout and 62% in stress levels.6

Restorative resilience clinical supervision addresses several challenges faced by nurses and midwives:

Vicarious Trauma: Nurses and midwives often experience secondary trauma indirectly during patient care, which can impact their emotional and mental wellbeing.

Compassion Fatigue: Continuous exposure to patient suffering can lead to a decrease in the ability to empathise, known as compassion fatigue.

Burnout: High-stress environments and demanding workloads contribute to burnout, characterised by emotional exhaustion and reduced personal accomplishment.6

By addressing these challenges, restorative resilience clinical supervision aims to enhance the professional quality of life for nurses and midwives, promoting resilience and compassion satisfaction, while reducing their intention to leave the profession.

Author

Debra Klages PhD, RN, BScN, MANP, CMHN, MACN, FACMHN, is Research Fellow at the University of New England





Stand with nurses and healthcare workers in conflict zones ... because healthcare is never a target







MIDWIFERY AND MATERNAL HEALTH

PART 2

Our UniSC Story: Closing the Gap by supporting and graduating Indigenous midwifery students, one midwife at a time

By Jessie Johnson-Cash and Lynne Stuart

Dundalli ally* I wouldn't be here without his mercy... Young Mary stolen from green lands Greening stolen lands Property. Gold ring. Ownership. ... I give great thanks for his humanity And offer my APOLOGY. To right the wrongs of stories past. A life I live by happenstance.

This poem positions the first author's responsibility as a white woman born and living on stolen land, whose ancestors were some of the early settlers within this region. This work of supporting Indigenous midwifery students towards graduation is a way for her to repay that debt.

Although some headway is being made towards Closing the Gap, specifically in relation to Target 2: Aboriginal and

Torres Strait Islander babies with a healthy birth weight, most targets are not on track to be met.2

It is well evidenced that culturally safe midwifery care is central to addressing these disparities.³ Strengthening the capacity of the Aboriginal and Torres Strait Islander midwifery workforce is paramount in developing a culturally safe workforce with growing evidence regarding the benefits of community controlled, and Birthing on Country Models of Care.4

Despite this, Indigenous midwives remain underrepresented. There are currently 460 Indigenous midwives in Australia, comprising only 1.65% of the Australian midwifery workforce with an estimated shortfall of 1,300 Aboriginal and Torres Strait Islander midwives.^{5,6}

Growing the Indigenous midwifery workforce through increased student completions is a priority for Australian universities.

OUR UNISC STORY

Contrary to the broader trends whereby Indigenous midwifery student intake is static,7 UniSC has been slowly growing its Indigenous midwifery student numbers (Table 1).

A designated enrolment pathway into the Bachelor of Midwifery Program, the ongoing success of the Capture and Keep Indigenous nursing and midwifery mentoring program facilitated by Aunty Leone Smith, 8 and a prioritisation towards culturally safe curriculum. This also includes a strong commitment to a strengths-based approach, and authentic experiential learning activities that embed Indigenous knowledges, perspectives and experiences. Indigenous midwifery students are offered placement options within dedicated Indigenous midwifery services, which have included the Birthing on Country program at Waminda, in Nowra, NSW. Additionally, students are supported by midwifery scholarships and Queensland Health Cadetships and are actively encouraged to become members of Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM); approaches identified as significant contributors to increasing the Indigenous

TABLE 1. Aboriginal and Torres Strait Islander UniSC Bachelor of Midwifery student enrolment

Year	1st Year	2nd Year	3rd Year	Total
2022	0	0	2	2
2023	1	0	1	2
2024	3	2	1	5
2025	3	2	1	6

TABLE 2. Aboriginal and Torres Strait Islander UniSC midwifery completions

Year	Bachelor Nursing Science/ Bachelor of Midwifery	Bachelor of Midwifery	Total
2017	1	n/a	1
2018	1	n/a	1
2019	0	1	1
2020	0	0	0
2021	1	2	3
2022	0	0	0
2023	n/a	1	1
2024	n/a	1	1

midwifery workforce.7 Congruent with the UniSC School of Health Aboriginal and Torres Strait Islander Curricula Cultural Safety Action Plan for 'Closing the Gap, 2025 onwards,9 this strategic and multifactorial approach is vital to accelerate the Indigenous midwifery workforce pipeline into industry employment.

FUTURE DREAMING

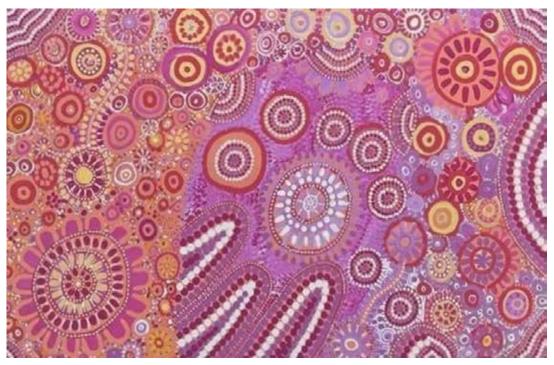
At UniSC, we are working towards growing a sustainable midwifery workforce across our university footprint whereby Indigenous midwifery students are mentored by Indigenous midwives, to undertake Midwifery Professional Experience Placements supporting Indigenous women and babies. We will continue to graduate many Indigenous midwives, one at a time and watch them lead the way for those yet to come. The increase in Indigenous midwives will go a long way towards Closing the Gap.

* Dundalli was an Indigenous warrior of the Dalla people (1840s). It was reported in the Morton Bay Courier that Dundalli performed an act of mercy towards Mary Cash, saving her life during a raid at Cash's station. A friend of Dundalli's was later arrested in possession of a gold ring that belonged to Mary. (Connors L. 2015. Warrior: A legendary leader's dramatic life and violent death on the colonial frontiers. Allen & Unwin, Sydney.)1

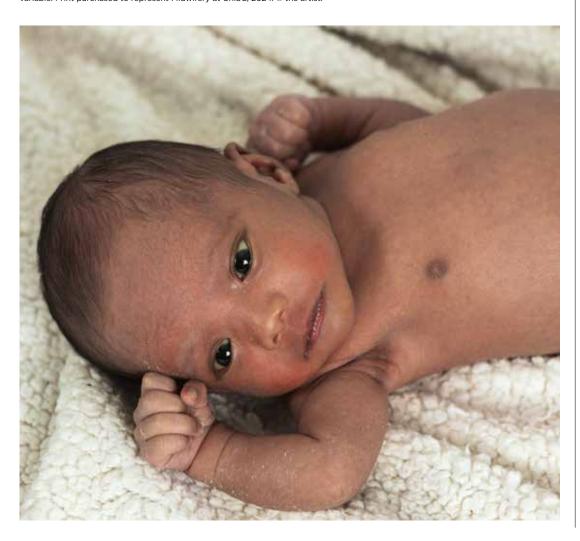
Authors

Jessie Johnson-Cash, Midwifery (Program Lead), School of Health, University of the Sunshine Coast.

Lynne Stuart (Mandandanji woman) - Nursing, School of Health, University of the Sunshine Coast.



Zartisha Davis (Kabi Kabi) Women's meeting places 2024. Acrylic paint on canvas, dimensions variable. Print purchased to represent Midwifery at UniSC, 2024. © the artist.



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As a mother, I can't take my nurse's brain out of my head and put it on the table

By Debra Klages

Research indicates that for the healthcare system to retain experienced and qualified staff, it must address the needs of nurses and midwives who are also mothers.1

My name is Debra Klages, and I have been a registered nurse since 1974. I am also the mother of an adult son who was diagnosed with schizophrenia at the age of 20.

Throughout his illness, I have encountered numerous challenges with the mental health system.

The medico-legal system applied the concept of adult autonomy, which unfortunately led to several suicide attempts. This occurred when his case manager did not believe my assessment that my son was too unwell during a psychotic episode to ask for or receive help.

Importantly, I discovered a lack of research focused on nurses who are mothers of adult children diagnosed with schizophrenia.

This gap in the literature motivated me to pursue my doctoral studies at the University of New England in 2020.

My findings revealed that mothers of adult children with schizophrenia in my study experienced similar marginalisation and lack of support from mental health professionals as mothers who did not disclose their professional status.

One psychiatrist told a mother advocating for her adult child, "You are not his nurse".

The mother responded, "I know I am not his nurse, but as a mother, I can't take my nurse's brain out of my head and put it on the table".2

This lack of recognition and support within the healthcare system highlights a significant gap in awareness and sensitivity toward the dual roles nurses and midwives assume as de facto case managers and lifelong experts by experienced carers for their children living with schizophrenia/psychosis.

In Australia, the current situation highlights the urgent need for nurses and midwives to join the newly established Special Interest Group (SIG) for those who are mothers of adult children living with schizophrenia or psychosis.

Becoming a member of this SIG will create a safe space for nurses and midwives to support one another and mentor their colleagues. Together, we can leverage our specialised knowledge and expertise to advocate for essential changes in the mental health system. While the journey ahead may be challenging, sharing our experiences can strengthen our connections and empower us to navigate these obstacles collectively.

By participating in this SIG, we can serve as catalysts for meaningful change and extend our impact on a global scale in the future. Our shared experiences and expertise can help pave the way for significant improvements in mental health education, offering hope to many families affected by schizophrenia and psychosis.

The only criterion for joining the Australian College of Mental Health Nurses' Special Interest Group is an interest in mental health nursing. Together, we can make a difference.

Author

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'That's how hospitals can do better': Shaping maternity care for Aboriginal and Torres Strait Islander mums and bubs

By Nina Sivertsen, Tahlia Johnson, Annette Briley, Tara Struck, Susan Smith, Megan Cooper, Larissa Taylor, Shanamae Davies and Jaclyn Davey

Our prior research has shown that mainstream maternity care in Australia must include and respect diverse cultural perspectives, particularly those of Aboriginal and Torres Strait Islander families,1 to provide the optimal inclusive care.2,3

We have conducted research exploring what is important to Aboriginal and Torres Strait Islander families when accessing perinatal services in South Australia. 4 Thirteen Aboriginal or Torres Strait islander families shared their thoughts, actionable recommendations and innovative strategies that they considered could enhance culturally safe and inclusive maternity care, particularly in birthing facilities that do not offer a Birthing on Country model of care. 5 This research was instigated in response to one organisation's desire to better meet the needs and enhance the experiences of these families and feedback from Aboriginal and Torres Strait Islander women who birthed in that mainstream maternity service in South Australia. The research is a part of the global shift towards ensuring culturally safe and unbiased healthcare and engaging consumers is essential to this process.6

We adopted a knowledge interface methodology employing yarning for data collection.7 (A novel culturally safe data analysis method was developed during this process and employed to ensure cultural continuity throughout the entire research process including during data analysis. Preliminary findings indicate that participants acknowledged the 'colonial load they carry' impacted their birthing experience and suggested ways of addressing this within maternity services.4 This included health systems engagement with communities to tackle racism and culturally unsafe practices. The participants proposed strategies to support families to 'feel safe' within maternity services, which included enhanced and extended involvement of family members.8

Most participants acknowledged that 'non-Aboriginal staff wanted to help but did not know how' and identified that community involvement in educational practices could address this. Participants acknowledged their own, and family members' previous

experiences influenced their current negative feelings of 'dreading giving birth in such a system'.9

This highlighted the need for authentic change including the adoption of innovative practices, which they were willing to contribute to. Most acknowledged that these changes would take time but agreed that a Midwifery Continuity of Care Model for Aboriginal and Torres Strait Islander women would potentially address many of their concerns.

Overall, participants contributed actionable recommendations including practical and systemic interventions that, in their opinion, could make maternity services safer, more culturally welcoming, and result in improved experiences for Aboriginal and Torres Strait Islander service users. They highlighted issues caused by medical evacuation from rural and remote areas and suggested that better communication between healthcare and other agencies would improve these experiences of medical evacuation for women and their families.

Participants strongly expressed that Aboriginal and Torres Strait Islander women deserve better perinatal care and considered this starts with those employed in maternity services acknowledging the limitations within current maternity systems and taking responsibility as individuals, and healthcare professionals to improve the experiences of Aboriginal and Torres Strait Islander birthing families.

The full findings will be available after the project concludes in July 2025.

ACKNOWLEDGEMENT

We would like to sincerely thank the Aboriginal and Torres Strait Islander women and families who generously shared their knowledge, experiences, and wisdom with us throughout this research. Your contributions have been invaluable, and we are deeply grateful for your openness and willingness to engage with us.

This research was supported by a SALHN Inquiry Grant, which has enabled a meaningful collaboration between academics and clinicians. We acknowledge the vital role this support has played in bringing together diverse expertise to address the important issues raised in this project.

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Edith Cowan University Midwife Researchers supporting midwives to stay in midwifery

By Sara Bayes

Like other healthcare disciplines, midwifery across the world, including in Australia, is in crisis: midwives are leaving in unprecedented numbers for many and complex reasons, and this trend is set to continue.

If this attrition is not stemmed, let alone reversed, it was predicted in the most recent 'State of the World's Midwifery' ('SOWMy') report, published in 2021,1 that the world will be short of 900,000, or one-third, of these essential professionals by 2030 - now just five years away. The impact of a shortage this size would be devastating: in a study published around the same time as the last SOWMy report, Nove and colleagues²

modelled the effect of fully resourcing midwife-delivered care by 2035 and found that a full complement of midwives globally could potentially avert 67% of maternal deaths, 64% of newborn deaths and 65% of stillbirths, which adds up to about 4.3 million lives saved per year.

Midwife researchers from Edith Cowan University's Safe Quality Midwifery Care Research Group in Western Australia are helping address this urgent situation through their 'AMPLE' research workstream. AMPLE stands for 'Attractive Midwifery Practice and Learning Environments', and the projects conducted within this workstream focus on producing and implementing research evidence to help support midwifery employers ensure the practice environment is as supportive for midwifery and as workforce-friendly as it can be.

Members of the AMPLE workstream are working together with midwives, midwifery students, midwife managers, colleagues at other universities in Australia and internationally, and PhD, Master by Research and Honours students, on a range of projects, including, for example, discovering and implementing ways

of working to provide midwives with maximum work-life balance at all career stages, initiatives to support midwives and midwifery students to recover from upsetting practice experiences, the use of midwifery skills in caregiving, and novel programs to ensure the graduate year of practice fully nurtures newly qualified midwives in ways that are important to

Clearly, all that can be done to attract and keep midwives must be done, and the ECU midwife researchers are doing their very best to support that endeavour.

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Value of a midwife

BY NIYOOSHA WILLIAMS

Engaging with the philosophy of the International Confederation of Midwives (ICM) has provided a valuable lens through which to explore and affirm my own beliefs and values as a midwife.

Through both academic coursework and professional practice, I have had the opportunity to reflect on the complexities, challenges, and deeply rewarding aspects of the role. This journey has allowed me to examine the tensions that exist within the profession, while also experiencing the empowering and transformative nature of midwifery. To guide my reflection, I have drawn on the holistic reflective framework developed by Bass, Fenwick and Sidebotham, which has supported the development of my critical thinking and deepened my reflective practice.

At the heart of the ICM philosophy is belief in woman-centred, respectful, evidencebased care that honours reproductive rights, cultural safety and autonomy.2 Unquestionably, these principles resonate strongly with my personal values and belief that everyone should receive the highest standard of care that incorporates dignity, informed choice, cultural sensitivity and holistic support across the continuum of pregnancy, birth and the postnatal period. However, when changing the lens to that of critical reflection, I can see where practice and thinking might be in contradiction with one another. In practice, it is imperative that my actions and participation do not unintentionally undermine these principles.

Coming from a nursing background, my early practice was largely shaped by a clinical, task-oriented mindset. The focus for the shift was often on efficiency, protocol adherence and completing tasks within time constraints which left little space for relational care. I have become aware that this way of working, while essential in certain contexts, prioritised action over presence and a 'doing' rather than 'being' mentality. This early exposure to performing this way allowed me to feel efficient, clinically competent and manage complex situations. However, since beginning my journey as a midwife, I have come to see how this mindset mirrors the institutionalised focus on risk

management and intervention, often at the expense of relational and respectful care. The ICM philosophy promotes midwives as protectors of physiological processes and advocates for minimal intervention 2 As I became more familiar and marvelled at the ability that the childbirth process can be intervention free, I realised that sometimes I was found in an environment where repeated vaginal examinations and time-driven decisions are normalised, and this began to feel uncomfortable. I have sat with the unease of knowing even my passive participation in such routines could contribute to trauma and disempowerment.

One experience which highlighted this was witnessing a multiparous woman be subjected to four vaginal examinations by different clinicians within minutes, due to the baby having an episode of bradycardia. While each provider justified their actions, the cumulative effect on the woman was that of violation and loss of dignity. Initially, I deemed these actions necessary, yet the coursework studied prompted me to recognise that these decisions were systems focused, not woman focused. The ICM's vision of partnership and human rights² became an idealist theory and was absent for this woman's lived experience. This moment allowed me to recognise my own alignment and belief in the hospital system. Midwives hold immense power in shaping women's birthing experiences, and we must be held accountable for our actions, words and even our silence as this can empower or harm. I now place informed consent, bodily autonomy and emotional safety at the forefront of every interaction.

I have also witnessed the extraordinary strength and capability of women. My developing philosophy is grounded in the belief that women are inherently powerful, and birth is not something to be managed but to be supported, honoured and protected. Another pivotal moment that reinforced this was witnessing a primiparous woman arrive in birth suite 9cm dilated and in a complete state of control. Her mother gently dabbed her forehead with a cool towel after every contraction, while her husband was by her side, holding her hand and whispering the sweetest phrases- no poet or author could have written words more perfect for that moment. The room was not filled with a clinical urgency, but a deep presence, respect and connection. This experience embodied what the ICM describes the midwife's role as a partner who safeguards and upholds the woman's choices and innate capacity, not as a manager.2

In that room. I witness birth unfold in its most undisturbed form-supported by love, grounded in dignity and guided by the woman. It reminded me that true midwifery practice involves taking a step back just enough to let women lead their own experience, but remaining present to support, protect and advocate when needed.

I can't help but also ask myself, what does this partnership look like when time is limited, hierarchical structures silence both women and midwives and when medicalised birth dominates the birthing space? True partnership requires challenging institutional cultures and deliberate actions. This has changed the way I view my approach to birth. It is not a series of tasks to be completed or problems to be solved, but a deeply human, transformative experience deserving trust and reverence.

The ICM's emphasis on lifelong learning² has also validated my belief that excellence in midwifery is not static. It is something that requires continued education, reflection and listening to the voices of women that we care for. Knowing the latest evidence is not just a professional obligation, but a moral one. Our responsibility extends beyond technical training and into the delicate ethical domain, and ensuring our growing knowledge is translated into best evidencebased practice and respectful care.

To me, midwifery has become the greatest profession on earth. It is where science meets the soul, where clinical knowledge meets intuition and where ordinary becomes extraordinary.

Midwives are witnesses to one of the most sacred events of life, who not only make birth feel safe, but meaningful and full of dignity, power and joy. How lucky are midwives to be handed a sense of purpose, responsibility and connection right here on a silver platter, something most people search their whole lives to find!

The ICM philosophy has not only aligned with mine but strengthened it. It has given me the language for the beliefs I have felt but have been unable to articulate. As I move forward in my career. I carry these reflections with me, not as a completed philosophy, but as a growing guide shaped by each woman, I am lucky enough to care for. There is no greater privilege than to serve in this profession.

Acknowledgements: With heartfelt thanks to Monique Vermeulen and Anna O'Connell for inspiring my passion for midwifery throughout the course.





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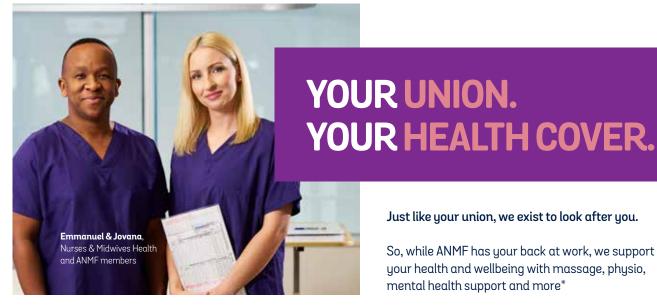
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Raising the profession of Endorsed Midwives

By Janine Martin

In a first for Western Australia, highly trained endorsed midwives lead the new Midwifery Birth Centre (MBC) at Perth's Bentley Hospital. They cater for women from the first positive pregnancy test to six weeks after birth without the need to see a doctor once during their pregnancy.

This game-changing service allows women to register online to give birth at the Centre, rather than requiring a GP referral.

Executive Project Lead Alisha Thompson said the MBC, several years in planning, had raised the profession of Endorsed Midwifery in the eyes of the nation and was acknowledged as an example of excellence in healthcare.

It was recently lauded as one of the top five projects across the East Metropolitan Health Service (EMHS), an extensive hospital and health network in WA that services a catchment of almost 800,000 people.

The MBC was built on the philosophy of "Midwifery centred management" where a work environment and model of care is built to maximise the potential and unleash the full scope of its workforce – resulting in heightened job satisfaction for midwives and the best outcomes for women and babies in a cost-neutral, sustainable environment.

Five years ago, maternity services at the hospital closed, with EMHS giving a commitment to reopen in the same venue.

Midwifery Manager Carli Beange said the closure was difficult for staff and local women who regarded it as their local maternity hospital.

"It was really important when we brought it back that it was servicing the needs of midwives and women in the communitythat it was special and it filled that gap and we didn't just do what we were doing before but took the opportunity to do something exciting," she said.

All the midwives are publicly employed, endorsed and credentialled, streamlining care for women and allowing midwives to use their full scope of practice across all hospitals in the HSP.



The MBC cares for women experiencing low-risk pregnancies. Women can self-refer through the website. They are allocated an endorsed midwife who provides all their care at antenatal appointments and parent education classes. When the woman goes into labour, that midwife is on call and attends the birth.

Women labour in a home-like environment with access to water birth and other active labour devices. Depending on their risk profile, some may plan to birth at another maternity health service, taking their midwife with them.

Endorsed Clinical Midwife Elizabeth Hull said it was satisfying to use her entire skillset to form a rapport with a woman and provide the safest care possible.

"I am lucky to be one of the eight endorsed and credentialled clinical midwives practising in the public system. It's exciting to use my prescriptive authority and order diagnostics and admit women under my name. I can work towards my scope and develop myself and, in turn, use my skills to look after women," she said.

"Knowing that you get to meet a woman from a positive pregnancy test until her baby is six weeks old is quite powerful. You build trust, you build rapport, you know that woman inside and out and she knows you. So, any concerns they are happy to share. Anything to celebrate, they celebrate. And that relationship is just so special," Elizabeth said.

Alisha said it was novel for the midwives to be credentialled across all the hospitals in our health service.

"Depending on the woman's risk profile, the midwives move from place to place with the woman to provide her the safest care possible. That may start here at the Birth Centre and if risks appear over her pregnancy and she needs to give birth at Armadale Hospital, it's a seamless transition with her known midwife taking her there."

Alisha said for the midwives, it was not "just a job".

"It's a special group of people who understand the vision. It's exciting to see the growth in their technical and soft skills and their relationship building - anyone can build a building, but they are willing to do the hard work to provide this service and make it happen."

Women come away having positive birth experiences, knowing they are listened to, and they have a midwife who supports them.

EMHS is leading the way in providing a professional, enhanced practice pathway for midwives.

"It is our hope through continuous improvement, positive workplace culture and teamwork that we will continue to represent the exceptional nature of our service," Carli said.

Author

Janine Martin is Senior Communications Coordinator at East Metropolitan Health Service, WA

Reference

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Baked eggplant, tomato, rosemary, lentil & parmesan bake

Prep time 40 mins / Cook time 30-40 mins / Portions 4-6 serves

INGREDIENTS

½ cup cooked brown lentils (simmer 1/4 cup lentils in 3 cups water for 30-45minutes or until tender)

500g eggplant

1 tsp salt

50ml extra virgin olive oil

2 small onions, finely chopped

1 tsp garlic, finely chopped

1 x 10cm piece rosemary

20ml apple cider vinegar

2 x 400g can chopped tomatoes

2 tbsp tomato sauce

1 tbsp fresh basil, chopped

60ml olive oil

salt and pepper

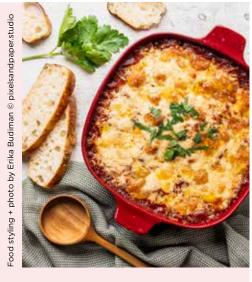
100g bocconcini (torn into pieces)

60g fresh parmesan grated

flat leaf parsley to serve

METHOD

- 1. Preheat a fan forced oven to 200°c and lightly grease a 18 x 12cm baking dish.
- 2. Take a small pot and cook lentils.
- 3. Cut the eggplant lengthways into 1cm slices, sprinkle with salt, place on a tray and set aside.
- 4. Place a medium sized pot on the stove, add oil, chopped onions and a pinch of sea salt flakes, cook gently for 10 minutes without colour.
- 5. Add the garlic and rosemary, cook for a further 3-4 minutes.
- 6. Deglaze the pan with the apple cider vinegar, add the chopped tomatoes, bring to the boil then reduce to a simmer and cook for 15–25 minutes until the sauce thickens.
- 7. Add the tomato sauce, cooked lentils and basil, check seasoning.
- 8. Meanwhile pat the excess moisture from the eggplant using a piece of paper towel. Drizzle with olive oil and cook on a hot BBQ, hot skillet



- or in a large pan, colouring both sides; this will soften the flesh.
- 9. Take your baking dish, place 1/3 of the tomato sauce on the base, followed by a compact layer of eggplant, next 1/3 tomato sauce, sprinkle of Parmesan, remaining eggplant, lastly the remaining tomato sauce, Parmesan and torn bocconcini.
- 10. Bake in the prepared oven for 35–50 minutes or until golden.
- 11. Allow to sit for 10 minutes before drizzling with olive oil, chopped fresh flat leaf parsley or basil and serve with crusty bread or salad leaves.

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

in the next ANMJ and reward you with a Maggie's Savoury Platter Essentials Gift Pack. Send your entry to: healthyeating@anmf.org.au

Nicely done, Rach, on making Maggie's Leek, mushroom and tarragon bread pudding, published last issue. We hope you enjoy your gift pack.

"Great Saturday night meal. The kids loved it!" says Rach.





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