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Australian Nurse Teachers' Society
Working Together for the Future of Nursing and Midwifery Education

Volume 19 Issue 2

The Educators' Exchange
WINTER EDITION

Cathy Boyle discusses Clinical Supervision: *It's about time...*

ANTS

Australian Nurse Teachers' Society

Working Together for the Future of Nursing and Midwifery Education

CONTENTS

Acknowlegement of Country

We acknowledge the Traditional Custodians of the land on which we live, work and gather, and pay our respects to Elders past and present. We recognise and celebrate the continuing connection of Aboriginal and Torres Strait Islander peoples to Country, culture, and community, and extend that respect to all First Nations peoples today.

From the

President's Desk

In this issue

Welcome to this seasons edition of the eBulletin.

I am delighted to announce that our eBulletin has an amazing team working on it and have continued to amaze us with great content and refreshed looks. In addition, it will now be known as :
The Educators Exchange.
This new title reflects our shared commitment to collaboration, innovation, and the open exchange of ideas that strengthen nursing education.

I am also excited to share that we continue in our time of growth and renewal within our community. Our new website has officially launched, and while we are still working through a few early kinks, it is already shaping up beautifully as a modern hub for our members. We appreciate your patience as we refine the experience and welcome your feedback as we continue to enhance functionality and content.

Looking ahead, I encourage you to mark your calendars for a key event in our professional year. Please save the date for **5–7 May 2027** for the upcoming NNEC Conference. This promises to be an inspiring opportunity to connect, learn, and celebrate excellence in nurse education within a truly unique setting. Further details will be shared in the coming months, and we look forward to welcoming you to what will undoubtedly be a memorable and enriching conference.

Judy Van Tatenhove
ANTS President
Tommeginne Country

Editor's Note

ANTS eBulletin - The Educators' Exchange

The ANTS ebulletin editorial team work together to bring new content to each publication, each of us take on the lead editor role for each new issue. This is our fourth issue as the 'new' editorial team. While we were awaiting the publication of the ANTS new web site, we continued to work on each edition and develop our skills. We strive to provide relevant and meaningful content related to nursing education in our publications. It is our commitment to provide the latest content on nursing education nationally and internationally.

In this issue

The ebulletin new name is The Educators' Exchange, - thank you for voting

Promotion of ANTS members' recent publications

Hellen Kaneko

Winter edition - editor

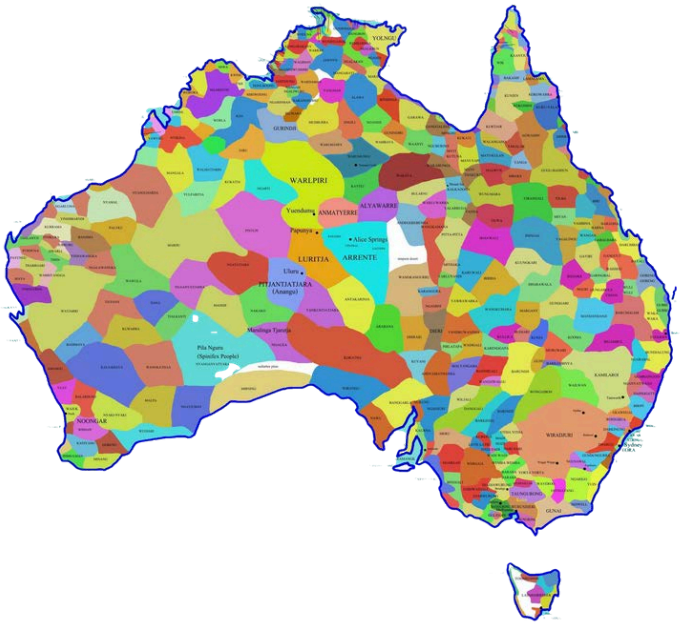
Editorial Team

Four Corners and

MEMBERSHIPS

The National Committee would like to acknowledge and welcome our new members who have joined ANTS in 2026. It is exciting to see so many educators from different states, education platforms, and specialty areas - we would love to hear about what you are doing in your area. If you would like to share a story, please send a bio piece (200 words) to for inclusion in our next edition. Email to ANTSBulletin@gmail.com

New members	State
2	NSW
1	VIC
2	QLD
1	SA
1	WA



"Aboriginal peoples" by Daniel Brown CCBY-SA2.0

Not an ANTS Member?

To join us download an application form from our website www.ants.org.au, fill in the appropriate sections noting the eligibility criteria below, and send to office@ants.org.au

Eligibility for membership: ANTS comprises of Ordinary, Honorary, and Life Members.

Ordinary Membership categories are:

- Category One: Registered Nurses or Midwives who are engaged in the teaching of nurses and scholarship.
- Category Two: Registered Nurses or Midwives who are engaged in teaching of nurses as part of their role, but generally it is not their primary role.
- Category Three: Other persons who are primarily engaged in the teaching of nurse and midwives.

Are you looking for a scholarship or grant?
ANTS offers scholarships and grants to eligible members.

Individual grants up to $2000
Scholarships to a maximum of $1000
Both are available in the field of education nursing and midwifery educators and academics.

Interested in applying? Application forms are on the ANTS website. To apply, submit a completed ANTS Scholarship and Research Grant Application form to office@ants.org.au by the closing date of the relevant funding round. The 2026 opening and closing dates for each funding round are:

Round	Opening date	Closing date
1	January 1st 2026	Closed
2	April 1st 2026	Closed
3	**July 1st 2026**	**July 30th 2026**
4	October 1st 2026	October 31st 2026

Clinical Supervision: It's about time...

Cathy Boyle is a registered nurse and a credentialed mental health nurse who trained in the UK. As an experienced mental health nurse educator with close to 4 decades of mental health experience, clinical supervision is an integral part of her practice. Cathy is a Fellow of the Australian College of Mental Health Nurses and a member of the Australian Clinical Supervision Association. She has been recognized through multiple awards, including the Dr Lesley Fleming OAM Professional Practice & Clinical Excellence Award (2023).
In 2024, Cathy and her colleague Kobie Hatch won Best Paper at the 19th National Nurse Education Conference (NNEC) at Sea World Resort on the Gold Coast, Queensland for the presentation: The Development, Delivery and Evaluation of a Clinical Supervision Education and Training Workshop for Nurses and Midwives in Queensland (Boyle & Hatch, 2023)
Connect on Linkedin

To the nurses and midwives of Australia; My name is Cathy Boyle and in a somewhat dated manner I am writing you a letter! My hopes are that I will share with you in conversation my experiences of clinical supervision; the principles, fundamentals and factors which influence engagement and outcomes to develop your understanding beyond purely academic pursuit.

I was introduced to clinical supervision as a student mental health nurse in the UK and though I had several years of practice in Queensland without it, I have now been fortunate to both provide and engage in clinical supervision for over 20 years. I can honestly say that clinical supervision has been a major factor in how I have remained engaged, motivated, restored and contemporary in my practice over what has been a long and fulfilling career.
The original publication of the Australian College of Midwives, Australian College of Nursing, and The Australian College of Mental Health Nurses (ACM, ACN, ACMHN). Position Statement: Clinical Supervision for Nurses and Midwives in 2019 (1) provided the impetus for myself and my colleague Kobie Hatch to seek support and funding from the Office of the Chief Nursing and Midwifery Officer in Queensland to build capacity for clinical supervision for all nurses and midwives in Queensland. Since 2020, I have played a central role in the development of Queensland's Clinical Supervision Statewide initiatives.
This has included leading the development of Clinical Supervisor Education and Training programs, co-authoring the Clinical Supervision Framework for Queensland Nurses (2) and Midwives (2021) the Clinical Supervision Implementation Planning Guide (3) and the Clinical Supervision Implementation Readiness Barometer (2023) (4). Currently, I am managing a program building capacity for clinical supervision for all nurses and midwives in the largest Health Service in Australia based in Brisbane, Queensland. I provide individual, group, and supervision-of-supervision (SoS) practice and I am an accredited Reflective Practice Group Facilitator.
As a mental health nurse and clinical supervisor of over 20 years, I am clear on what clinical supervision is and is not, what challenges there may be to engaging, and why it is important for me to participate. Bear with me, as I try to share my thoughts...

What is Clinical Supervision?

The term 'clinical supervision' is one that some nurses and midwives find confusing. Clinical supervision, as it is defined in the CS Joint Position Statement, is distinct from point-of-care or 'at the elbow' supervision provided by preceptors, clinical teachers or educators, operational and line management processes, clinical management processes, coaching and mentoring, and personal staff support services or supervised practice.
All these professional development systems are valuable and offer integral mechanisms of support and guidance to the nursing and midwifery workforce. All exist for a purpose, with clear remits and role descriptions. It is therefore important in conversation with nurses and midwives to clearly articulate what clinical supervision is, is not, and how clinical supervision differs from other forms of professional development supports (2, 5).

'Clinical Supervision is a formally structured professional arrangement between a supervisor and one or more supervisees. It is organised around a purposefully constructed regular meeting that encourages critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. The supervisor facilitates the supervisees to critically examine their work issues to gain a deeper understanding, consider alternative perspectives, develop insights, and where required, determine what next steps need to be taken. Clinical Supervision facilitates development of the reflective practice and professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace'. (Australian College of Midwives, Australian College of Nursing & Australian College of Mental Health Nurses, 2024, p1).

Why is Clinical Supervision Important?

Experience alone does not lead to new learning. Reflecting on events, considering what happened, and engaging with emotional content, is the key to developing insight and understanding (6,7). Please refer to Effective Clinical Supervision Infographic.

Clinical supervision is a specific professional relationship that is trusting, safe, confidential, culturally safe and non-hierarchical. My reflections as a clinician and a clinical supervisor (this is called Supervision of Supervision) are my own and my clinical supervisor does not ask me, 'to please explain', follow up, or report back on my actions. In this manner this clinical supervision relationship exists to support my practice in a very different way to the relationships I have with my line manager, operational manager or discipline head (2,5). This does not mean that the relationship is devoid of structure and accountability. The parameters of confidentiality are clearly understood as 'a confidential relationship within the ethical and legal parameters of practice' (5, p.1). Which means I can't go rogue and then cite confidentiality as a form of nursing and midwifery 5th amendment!

Choice is a key element of the clinical supervision process. Nurses and midwives (known as supervisees) choose to engage with a clinical supervisor of their choice, drive the agenda for and construct their own goals and preferred outcomes for supervision (2).

I chose my clinical supervisor who is another mental health nurse who works in the drug and alcohol field and had completed clinical supervisor training, which is fundamental to the success of the clinical supervision relationship (2,8). This relationship, often described as the 'alliance' is the single best predictor of outcome in clinical supervision (2,9).

Reflections of my clinical supervision

My clinical supervisor and I have a strong alliance. We had known and respected each other professionally for some time but do not work alongside each other, have no line management or operational connection and though we both identify as specialists in our fields we have no other professional relationship.

As a supervisee I rate my clinical supervisor as one of the most amazing humans I have had the privilege to know. I suspect this is predominantly based on the alliance we share (2,5,9) and that they embody the attributes of a clinical supervisor. Attributes of compassion, patience, acceptance, honesty and integrity are evident in the person they are and how I experience them.

Training clinical supervisors is an integral factor in the delivery of effective clinical supervision (2,8). A word of caution, if tasked with selecting nurses and midwives to train as clinical supervisors, choose a person and not a role (7,10). Choose the person others are drawn too; to share confidences and seek support. If you have any ambivalence about disclosing an element of your own practice to a nurse or midwife nominated to train as a clinical supervisor - think again...

I attend clinical supervision monthly for one hour and my supervision occurs away from my practice setting. The evidence states an hour a month is optimal (2,5). I appreciate I am fortunate to have control over my diary and day to day activities, and this is not the case for all nurses and midwives. The literature advises that risks to engaging in clinical supervision are time and space (2,8) however it has been my experience that creative leadership can and do find this time, and when nurses and midwives are supported to take the time, they not only do so, but that they use the time well.

Elements of my practice as a mental health nurse and clinical supervisor can be confronting. I am often listening to stories where harm, distress and trauma are frequent visitors. It is important for my own wellbeing that I can manage, tolerate and 'let go' (11) of the vicarious impact these narratives may have on me. As a clinical supervisor, I also need to hold space for the nurses and midwives I supervise to enable them to do the same. Understandably, from this reflection shared, there remains a myth that clinical supervision is a form of therapy (2). This is most definitely not the case, but it has been my experience that not everyone appreciates this.

In developing clinical supervision relationships/alliances (either mine with my clinical supervisor or me with the supervisees I work with in supervision) which are safe, trusting and confidential, (2,5,9) there is a need for distinct boundaries between clinical supervision and therapy. My clinical supervisor assists me to manage the angst of my professional life, and not my personal world. This is important. Clinical supervision is a professional development support which must know it's limitations by not crossing boundaries that a trusting relationship may enable.

Clinical supervision has helped me to understand the parts of my practice which confuse, challenge, validate and affirm me. It also helps me to examine and process parts (the harder parts that often can't be openly shared) to make sense of, learn from, and ultimately to process those pesky parts! As a practitioner I am not 'Robinson Crusoe' on the island that is nursing and midwifery practice.

Chronic short staffing, rising workloads, burnout, emotional strain, and exposure to trauma are all well-documented contributors to nurse and midwife stress in the Australian healthcare system (12).

As Proctor's domains would attain to, clinical supervision has supported and restored me, kept me safe in my practice and after 30 years allows me to continue to grow (13,14).

Clinical Supervision Challenges

It has been my observation that a challenge to engaging with clinical supervision is nursing and midwifery culture itself. Nurses and midwives prioritise the needs of others over themselves, patient needs, the task, communication, their team and other colleagues. This is not the case with our allied health colleagues who prioritise their clinical supervision regardless of activity or demand (and are supported to do so).

If the reader were to do a word search for 'time' thus far in our conversation they will note, it appears 5 times. This is not coincidental. As part of the clinical supervision project, I am currently leading to influence nurses and midwives to priorities their own needs, we have developed a communications and marketing concept which speaks to nurses and midwives with the single-minded message (15) that clinical supervision is 'about time'. That it 'takes time', that it is 'their time' and that it is 'time' they had it.

The literature further uses the analogy of 'pit head time' and the British Miner's Strike of the 1920s where British Miners fought for the 'right to wash off the grime in the boss's time' (16, p.163).

History informs that miners felt they did not deliberately get themselves dirty - the work made them dirty and grimy, and therefore they had the right to wash this off in work time (the boss's time). To this day, miners across the globe have time incorporated into their workday to wash and clean off. Considering the burden of the work nurses and midwives carry the analogy is not lost...

I have therefore embedded clinical supervision in my practice and ensure that no other events take precedence - bar illness or fire! Clinical supervision therefore is not an additional element to my practice; it is an integral part. The literature supports this and provides the analogy of clinical handover as being integral to the function of care delivery and that for clinical supervision to be embedded in nursing and midwifery practice it needs to hold the same level of importance to practice as clinical handover (9,16).

What are the benefits of clinical supervision?

Beyond the focus of my own supervision, I am in conversation with nurses and midwives and with nursing and midwifery leaders to outline the benefits. I consistently cite that clinical supervision has a strong and consistent evidence base showing clear benefits for nurses and midwives, the organisations they work in, and the individuals they care for.

At an individual level, engagement in clinical supervision is associated with improved job satisfaction, stronger professional support, and enhanced retention, particularly among graduate nurses. Clinical supervision provides structured support during transition to practice, reducing early career stress and contributing to lower attrition rates over time (17,18). Studies further indicate that clinical supervision reduces burnout and psychological stress, lowers absenteeism risk, and increases compassion satisfaction, supporting both wellbeing and sustained workforce participation (18, 19, 20, 21, 22).

Evidence shows that structured clinical supervision helps nurses and midwives link theory to practice, improve clinical reasoning, and build confidence in complex decision making (23,24) contributing to improved professional practice and a reduction in emotional fatigue and burnout associated with high-demand environments (25,26).

At a team and interpersonal level, clinical supervision enhances collaboration, strengthens professional relationships, and reduces feelings of isolation by providing a safe space for shared reflection and validation that 'I am not alone' in my experiences (23, 26).

Clinical supervision has also been shown to contribute to safe patient and clinical outcomes as it encourages clinical accountability, supports safer decision making, increases awareness of risk and prompts escalation of concerns and identification of near misses (27). Further studies have reinforced a reduction in poor clinical outcomes, fewer patient complaints and improved therapeutic relationships (28).

In summary, nurses and midwives engaging in clinical supervision consistently report positive impacts on both their practice and wellbeing, reinforcing clinical supervision as an essential professional development mechanism (23,24,25,26) which supports the development of a workforce emotionally resourced to deliver compassionate, person-centred care (5).

I fear that in my enthusiasm to highlight the benefits of clinical supervision I may have wondered from my 'path' of having a conversation, I therefore would like to add my own reflections. It has been my observation that nurses and midwives who engage in clinical supervision consistently, share a sense of feeling restored, of 'letting go', of feeling heard and understood and appreciating that they are not isolated or alone in their experiences. Working in group supervision further provides an opportunity for nurses and midwives to connect with one another in a way that promotes team communication, collaboration and cohesion.

Where to from here?

I hope that this conversation ignites interest and curiosity in the nurses and midwives of Australia to know more about, and to explore the transformational experience that is clinical supervision.

I am who I am and where I am as a clinical supervision advocate, educator and practitioner because I had the privilege to stand on the shoulders of my clinical supervision elders. Individuals who taught, mentored, held and steadied me, and allowed me to go on a journey I otherwise would not have taken.

The clinical supervision community is warm, welcoming and inclusive. Please reach out in conversation via the Clinical Supervision website or via Linkedin.

Regards.
Cathy

Visit our ANTS Health and Wellness section to read testimonials from those engaged in clinical supervision.

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Digital Corner

H.Kaneko

Australia's Push for Data Sovereignty: What Nurse Educators Need to Know About Cloud Servers and Healthcare Data

In today's digital age, data is the backbone of healthcare systems, driving everything from patient care to research and education. For nurse educators, who are increasingly integrating digital tools and informatics into their teaching and practice, understanding where and how data is stored is critical. With the rise of global cloud service providers, concerns about ***data sovereignty****—ensuring that data is stored and governed within Australia—have become a pressing issue. This is particularly important in healthcare, where sensitive patient information must be protected under strict privacy laws.*

The Cloud Act and its implications for Australian Healthcare Data

The **CLOUD Act** (Clarifying Lawful Overseas Use of Data Act), enacted in the United States in 2018, allows US law enforcement agencies to compel US-based technology companies to provide access to data stored on their servers, even if that data is physically located in another country. For Australian healthcare providers and educators, this raises significant concerns:

- **Data Sovereignty Risks:** If patient or healthcare data is stored on Australian servers operated by US companies (e.g., Microsoft Azure, Amazon Web Services, Oracle Cloud, Palantir, or Google Cloud), it could potentially be accessed by US authorities under the CLOUD Act.

- **Privacy Concerns:** This extraterritorial reach could conflict with Australian privacy laws, such as the **Privacy Act 1988**, which governs the handling of personal and sensitive information, including health data.

For example, **Oracle** and **Palantir Technologies**, both US-based companies, play significant roles in healthcare data management globally. Oracle, following its acquisition of **Cerner Corporation**, now manages electronic health records (EHR) systems for many organisations worldwide. Similarly, Palantir provides advanced data integration and analytics platforms, such as **Palantir Foundry,** which has been used in healthcare projects, including COVID-19 response efforts in other countries. While both companies operate data centres in Australia, they remain subject to US laws like the CLOUD Act, raising concerns about data sovereignty for Australian healthcare organisations.

Nurse Educators - what does this mean?

For nurse educators, this means that the platforms and tools used to store and analyse healthcare data—whether for teaching, research, or patient care—must be carefully evaluated to ensure compliance with Australian laws and to protect sensitive information.

Australia's Data Soverinity Framework

To address these challenges, Australia has implemented robust data sovereignty laws and policies to ensure that sensitive data remains under Australian jurisdiction. Key elements include:

1. **Privacy Act 1988:** Governs the handling of personal information in Australia. It requires organisations to protect personal data and ensure that any overseas transfers comply with Australian privacy standards.
   - **More information:** Office of the Australian Information Commissioner (OAIC) – Privacy Act 1988

2. **My Health Records Act 2012**: Governs the use and protection of data in the My Health Record system, Australia's national digital health record platform.
   - **More information:** Australian Digital Health Agency – My Health Record

3. **Hosting Certification Framework:** Requires Australian government data, including healthcare data, to be stored in certified data centres located within Australia.
   - **More information:** Australian Government Hosting Certification Framework

4. **Australian Government Information Security Manual (ISM)**: Provides guidelines for securing government information, with a strong emphasis on data sovereignty and local hosting.
   - **More information**: Australian Cyber Security Centre – ISM

The Shift to Australian Cloud Servers

Recognising the risks posed by foreign jurisdiction over data, the Australian Government is actively encouraging the use of **sovereign cloud providers**—cloud service providers that are Australian-owned, operated, and located within the country. These providers ensure that data remains under Australian legal jurisdiction and is not subject to foreign laws like the CLOUD Act.

Sovereign Cloud Providers in Australia

For healthcare organisations and educators, Australian-owned cloud providers such as **Vault Cloud** and **AUCloud** offer secure and compliant solutions for storing sensitive data:

- **Vault Cloud:** Vault Cloud Website
- **AUCloud:** AUCloud Website

Both providers are certified by the **Australian Signals Directorate (ASD)** to handle sensitive government data and meet strict security and privacy requirements.

Oracle and Palantir as Key Examples

Global providers like Oracle Cloud and Palantir Technologies also play significant roles in healthcare data management:

- **Oracle**: Oracle's acquisition of Cerner Corporation, a leading provider of electronic health records (EHR) systems, has made it a major player in the healthcare sector. Oracle operates data centres in Australia and offers cloud services that comply with local regulations. However, as a US-based company, Oracle remains subject to the CLOUD Act, which could raise concerns about data sovereignty for Australian healthcare organisations.
  - **More information**: Oracle Cloud
- **Palantir**: Palantir provides advanced data integration and analytics platforms, such as Palantir Foundry, which has been used in healthcare projects globally, including COVID-19 response efforts. While Palantir's tools are powerful for managing and analysing large datasets, its status as a US-based company also makes it subject to the CLOUD Act. This has raised concerns about the potential for foreign access to sensitive Australian healthcare data.
  - **More information:** Palantir Technologies

Government Policies Supporting the Shift

State and federal governments are leading the way in adopting Australian-based cloud servers:

- The **Queensland Government ICT Strategy** requires sensitive government data to be stored within Australia to ensure compliance with local laws.
  - **More information**: Queensland Government ICT Strategy
- The **NSW Government Cloud Policy** mandates that agencies use cloud services that adhere to Australian data sovereignty and privacy standards.
  - **More information**: NSW Government Cloud Policy

Challenges and Opportunities for Nurse Educators

Digital Corner

While the move to Australian cloud servers is a positive step towards ensuring data sovereignty, it does come with challenges:

- **Cost:** Australian sovereign cloud providers may have higher costs compared to global providers like Oracle, Palantir, AWS, or Microsoft, which benefit from economies of scale.
- **Limited Features**: Global providers often offer a wider range of advanced tools and services, which local providers may not yet fully match.
- **Migration Complexity:** Transitioning data and applications from global cloud providers to Australian-based servers can be a complex and resource-intensive process.

However, these challenges are outweighed by the benefits of ensuring that sensitive healthcare data remains secure and compliant with Australian laws. For nurse educators, this also presents an opportunity to lead the way in advocating for secure, sovereign data solutions in healthcare education and practice.

What Can Nurse Educators Do?

As leaders in healthcare education and informatics, nurse educators play a critical role in shaping the future of data management in the sector. Here's how you can contribute to Australia's data sovereignty efforts:

1. **Evaluate Digital Tools:** When selecting platforms for teaching or research, prioritise those that store data locally in Australia and comply with Australian privacy laws.
2. **Advocate for Sovereign Cloud Solutions:** Encourage your organisation to consider Australian-owned cloud providers, such as Vault Cloud or AUCloud, for storing sensitive healthcare data.
3. **Educate Future Nurses:** Incorporate data sovereignty and privacy principles into your curriculum to ensure that future nurses understand the importance of protecting patient information in a digital world.
4. **Stay Informed:** Keep up to date with changes in data sovereignty laws and emerging technologies to ensure that your teaching and practice remain compliant and secure.

Conclusion

For nurse educators, the shift towards Australian cloud servers is more than a technical change—it's a critical step in safeguarding the privacy and security of healthcare data. By prioritising data sovereignty and adopting Australian-based cloud solutions, educators and healthcare organisations can ensure that sensitive information remains protected and under Australian control. As digital tools and informatics become increasingly central to healthcare education and practice, understanding and advocating for secure data management will be essential to building a resilient and trustworthy healthcare system.

For further information, visit:

- Australian Digital Health Agency (ADHA)
- Australian Cyber Security Centre (ACSC)
- Vault Cloud
- AUCloud
- Oracle Cloud
- Palantir Technologies

Together, we can ensure a secure and compliant future for healthcare education and practice.

HEALTH & WELLNESS CORNER
with M. Stead

Testimonials for Clinical Supervision

As an avid Clinical Supervision user and provider I hope our Spotlight provides some understanding on the importance of creating time for wellbeing and resilience building practices. Clinical Supervision has been the reason I have continued in my nursing career however I have been fortunate to engage in this practice since my graduate year of nursing. Read below from nurses across Queensland regarding their experience with Clinical Supervision.

What I've seen is a genuinely valuable approach; creating space to think clearly, build confidence, and translate ideas into action. Grounded in kindness, it makes a real difference in both how I work and the outcomes I achieve.

Julie Bunting- Director of Nursing & Midwifery Performance and Planning
Royal Brisbane and Women's Hospital

I am a nurse currently working across two very different clinical environments: acute mental health in a Metropolitan hospital and providing emergency care for older persons based four hours from Brisbane. Clinical Supervision provides a supportive space to reflect on my practice, process challenging cases, navigate workplace complexities, and manage the emotional and psychological impacts of my work. Clinical supervision is a vital component of my practice, enabling me to work effectively across diverse healthcare settings while continuing to grow as a clinician.

Annette Ferguson- Mental Health Nurse
Bundaberg Hospital

Personally; Clinical supervision reminds me to take a deeper dive into situations and has assisted in improving my professional interactions and improve workplace culture. Prioritising clinical supervision is essential, and having regular planned monthly appointments enables me to prioritise these sessions around my busy work schedule.
My team I feel have had great growth following implementation of group clinical supervision. The team are more proactive in approaching senior leaders, putting suggestions forward including suggested pathways and over all improved consultation and communication. They have opened their clinical ownership of care and planning for clients, and I feel that this is highly reflective of their ongoing participation in clinical supervision. I would highly recommend Clinical Supervision to all health care workers.

Liz Taylor- Clinical Midwifery Consultant Educator
Longreach Hospital

The addition of clinical supervision (providing and receiving) to my nursing practice has been a pivotal point in my career. I could not be performing as well as I am in my clinical and leadership roles without it. Planned supervision sessions throughout 2025 provided me with consistency, support and direction through an intense period of workplace unrest. The opportunity to reflect on my nursing practice, leadership style, values and goals has without doubt helped me grow into a more resilient and capable employee. Supervision has made my work sustainable.

Erin McBride- CNC Cairns Sexual Health Service

The Clinical Supervisor course has been the most profound training I have undertaken in my 30 year nursing career.
Having suffered burnout which required me to take 4 months of long service leave, my only question post the course was why haven't I heard about it sooner and if I was participating in supervision it is likely I would not have reached burnout!

Juanita Fox- Clinical Nurse Consultant
Digital Support Clinical Informatics
Brisbane

Clinical supervision has made a real difference for me, both in giving it and receiving it. It gives me space to slow down, talk things through, and be honest about the challenges of my work. It helps me stay curious, care for myself, and maintain a deep sense of professional commitment to nursing.

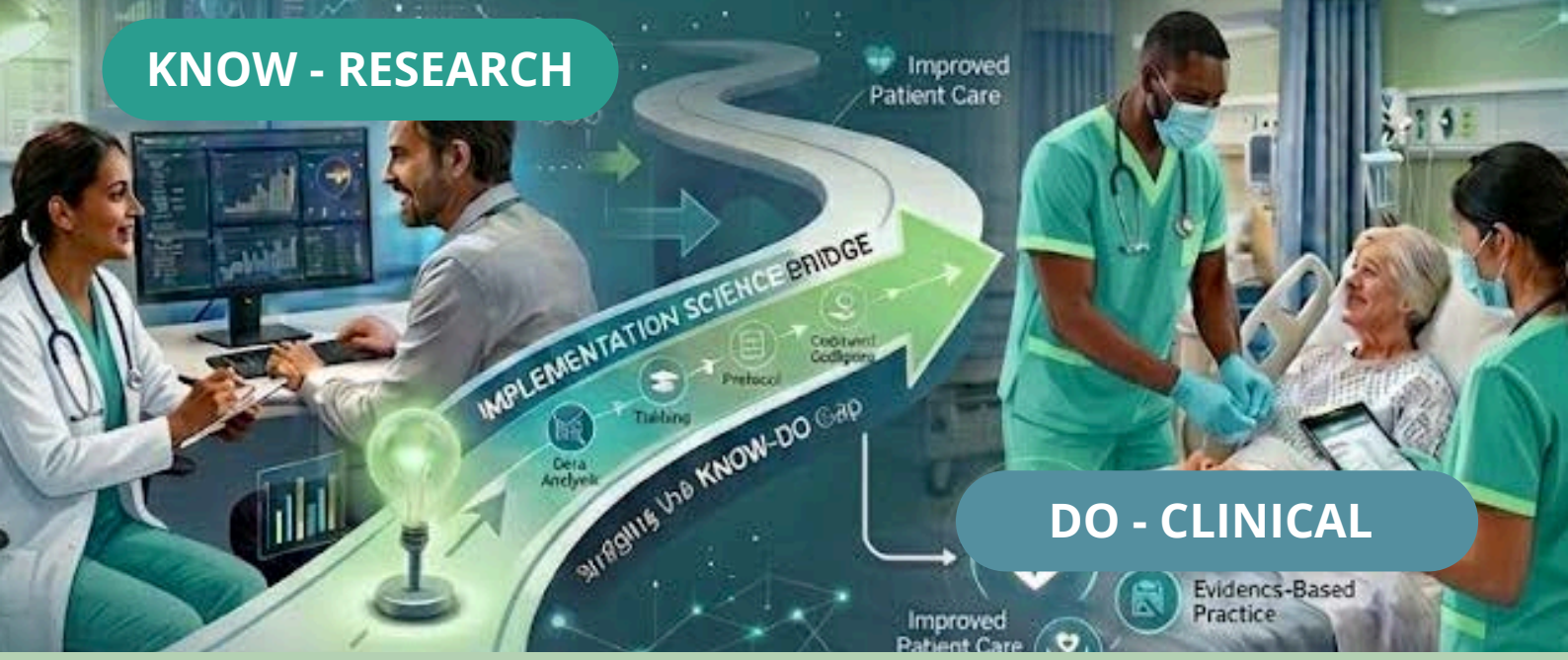
Jo Mewis- Assistant Nursing Director
Clinical Skills Development Service

Amanda Petrie

RESEARCH CORNER

Implementation Science

Bridging the 'Know-Do' gap



> **Implementation research is the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of health services (Eccles & Mittman, 2006).**

Despite a strong evidence base in nursing, meaningful translation into routine clinical practice remains inconsistent. Titler (2018) highlights the persistent gap between the availability of evidence and its application in practice, noting clear implications for patient care and health outcomes. Implementation science has emerged in response to this challenge, focusing on the pathways, barriers, and processes that influence whether evidence is successfully integrated into practice (Eccles & Mittman, 2006).

Why is the science of implementation important?

Evidence capable of shaping nursing practice is continuously evolving and produced at an increasing rate. However, the translation of this evidence into practice often occurs slowly or inconsistently. Balas and Boren (2000) estimated that it can take up to 17 years for research findings to result in identifiable changes in practice, with later work suggesting that approximately half of published evidence may never be implemented at all (Boehm et al., 2019).

This persistent know–do gap is influenced by the clinical contexts in which implementation occurs. Common barriers include variable readiness among nursing staff to adopt new practices, limited understanding of evidence-based practice principles, and organisational environments that do not support learning and change (Crawford et al., 2022; Pitsillidou et al., 2023)

In addition, nursing research continues to be produced outside clinical practice settings, distancing clinicians from both the research process and its outcomes and reducing its perceived relevance to everyday practice (Boehm et al., 2019; Titler, 2018).

Why Implementation Science matters for nurse educators?

Nurse educators play a critical role in shaping future practice and are frequently positioned at the point of care when change is introduced. We support learners and clinicians through transitions in practice and influence how evidence is interpreted, taught, and applied. As nurse educators, we must understand how change occurs in real settings, including behaviour change mechanisms, the influence of organisational and professional culture, and the need for alignment between evidence and clinical realities (Montayre et al., 2025; Oermann et al., 2021).

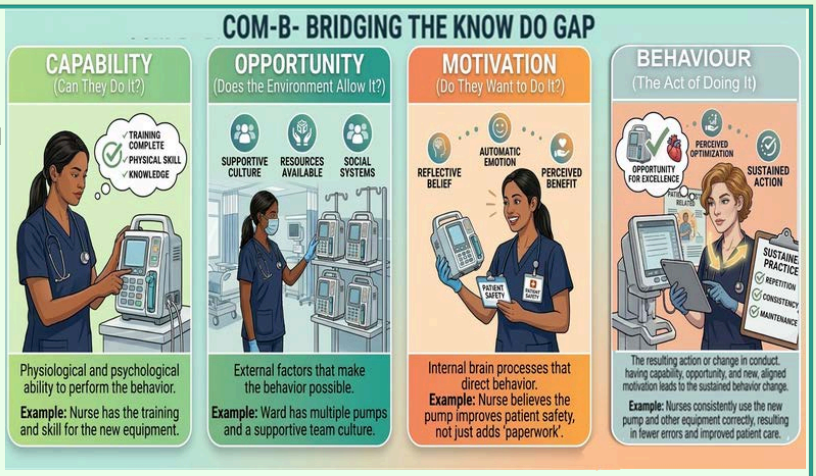
Implementation science shifts the focus from whether an intervention works to how evidence is introduced, taken up, and sustained within complex educational and clinical environments (Eccles & Mittman, 2006). Importantly, the field recognises that while multiple evidence-based strategies may be effective, their success depends on selecting and tailoring approaches that fit the culture, readiness, and priorities of the local context.

Models to Support Implementation in Nursing Education
Implementation science has matured beyond asking "what works?" to addressing the more complex question of "how can evidence be embedded and sustained in real nursing and educational settings?" (Eccles & Mittman, 2006). Conceptual models play a critical role in supporting this work by offering structured ways to understand behaviour, context, and systems that influence practice change (Nilsen, 2015). For this discussion, I have chosen three implementation models—COM-B, PARIHS, and CAS.

What it is
The COM-B model proposes that behaviour change occurs when people have:
- Capability (knowledge and skills),
- Opportunity (environmental and social support), and
- Motivation (beliefs, values, and intentions).

Behaviour (B) is the outcome of the interaction between these three components.

Why it is useful
COM-B is practical and diagnostic. It helps researchers and educators move beyond assumptions that education alone changes practice and instead identify which behavioural levers need attention (Michie et al., 2011).



Example in nursing and health care education
Research question: Why are nurse educators inconsistently using simulation-based debriefing techniques shown to improve clinical reasoning?
- Capability: Educators lack confidence in structured debriefing frameworks.
- Opportunity: Timetabled teaching sessions do not allow sufficient time for debriefing.
- Motivation: Some educators doubt that debriefing adds value compared with traditional feedback.

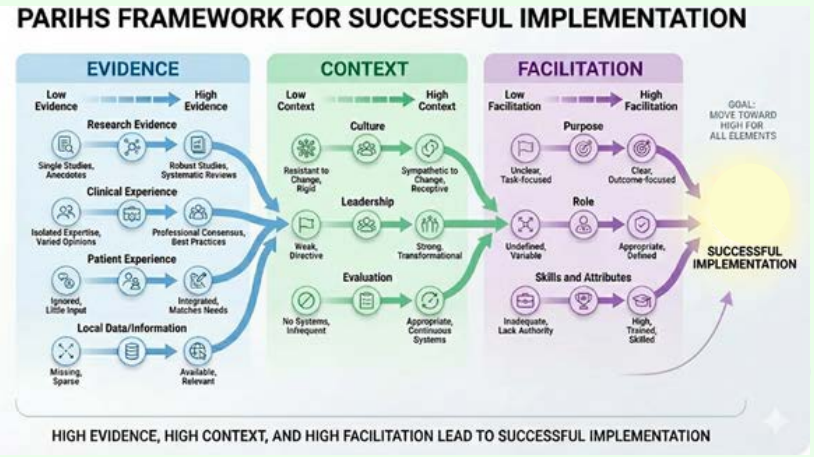
Implementation approach:
- Capability → targeted faculty development workshops
- Opportunity → curriculum leaders redesign session timing
- Motivation → share local outcome data and peer endorsement

COM-B enables implementation strategies to be matched to the real barrier, not applied generically.

PARIHS Framework (Promoting Action on Research Implementation in Health Services)
What it is
The PARIHS framework argues that successful implementation is a function of:
- Evidence (research, clinical expertise, and patient experience),
- Context (culture, leadership, evaluation), and
- Facilitation (the processes and roles that support change).

Implementation success is strongest when all three elements are robust.

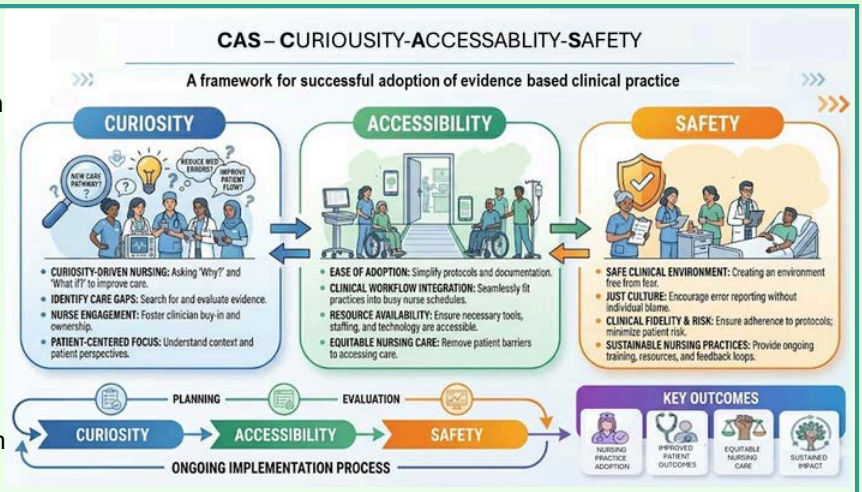
Why it is useful
PARIHS aligns closely with nursing values by recognising multiple forms of evidence and by explicitly addressing workplace culture and leadership—critical factors in education and practice settings (Kitson et al., 2008).



Example in nursing and health care education
Research focus: Implementing an evidence-based clinical assessment framework across undergraduate nursing placements.
- Evidence: Strong research support and alignment with accreditation standards.
- Context: Variable clinical leadership across placement sites; differing learning cultures.
- Facilitation: Appointment of practice educators as local facilitators.

Implementation approach:
Rather than standardising delivery across all sites, facilitators adapt strategies to local contexts—strengthening leadership engagement where weak and embedding feedback mechanisms where evaluation is lacking.
PARIHS helps ensure implementation is responsive to context rather than assuming uniform readiness.

Curiosity-Accessibility-Safety (CAS) Model



What it is

The CAS perspective views healthcare and education systems as:

- Non-linear,
- Dynamic,
- Made up of interacting agents (MDT, consumers, educators, clinicians, organisations).

Change is not predictable or controllable in a linear way; it emerges from relationships and interactions.

Why is it useful

CAS is powerful for understanding why carefully designed educational interventions succeed in one setting but fail in another. It reframes implementation as ongoing adaptation, not one-time rollout (Braithwaite et al., 2018; Plsek & Greenhalgh, 2001).

Example in nursing and health care education

Research aim: Scaling an interprofessional education (IPE) model across multiple hospitals.

From a CAS perspective:

- Hospitals respond differently based on professional hierarchies, workload pressures, and informal networks.
- Small changes (e.g. senior nurse support) can have disproportionate effects.
- Resistance is data, not failure.

Implementation approach/ Researchers focus on:

- Creating conditions for collaboration,
- Supporting local experimentation,
- Continuously learning and adapting rather than enforcing fidelity.

CAS encourages researchers to study how systems respond, not just whether an intervention was delivered as planned.

Bringing the models together

These models were selected because they align with the behavioural, organisational, and relational dimensions of nursing practice and education, and together offer complementary perspectives on how evidence is taken up, adapted, and sustained (Kitson et al., 2008; Michie et al., 2011; Plsek & Greenhalgh, 2001).

While these models are not intended to be exhaustive, they provide practical and conceptually distinct lenses through which nurse educators and researchers can examine implementation processes and design contextually responsive strategies.

These models are not competing - they answer different implementation questions:

Model	Visual Similarity
COM-B	Linear logic (inputs-outcomes)
PARIHS	Conceptual Domains
CAS	Human and relational lens

Implications for Nursing Education

Nurse educators occupy a critical position in translating evidence into both educational and clinical practice. They frequently support students and staff during periods of change and are well placed to influence how evidence is interpreted and applied. Understanding implementation science enables educators to plan change initiatives with greater attention to behaviour, context, and system dynamics (Oermann et al., 2021).

Rather than asking whether evidence should be adopted, implementation science encourages educators to ask how change can be supported in their specific setting. This includes selecting strategies that fit local culture, resources, and readiness, rather than relying on generic solutions (Eccles & Mittman, 2006).

Opinion Takeaway

My own experience with implementation science started with using the COM-B model to guide a project plan. However, through researching this discussion piece, I have gained a much clearer appreciation of why behaviour and early engagement are so central to successful implementation. It has also reinforced the value of understanding the different components of implementation models and frameworks, so that strategies are chosen thoughtfully and aligned with both the project aims and the clinical setting.

If implementation science is to improve nursing education and practice, implementation must be understood as a behavioural, contextual, and adaptive process rather than a technical task. COM-B, PARIHS, and CAS offer nurse educators practical ways to think about how evidence is integrated into everyday teaching and practice—and how it can be sustained over time.

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EDUCATION CORNER

Tegan Budd

The Mindful Educator: Creating Calm and Connection in Nursing Education

Nursing education occurs across a wide range of settings, including universities, simulation laboratories, acute care, primary health, aged care, clinics, and community environments. In academic contexts, learning takes place in classrooms, tutorials, simulation, and clinical laboratories. In clinical settings, teaching may occur at the patient bedside or in spaces such as handover rooms, ward corridors, patient rooms, and nursing stations, supporting students, graduate nurses, and ongoing staff development.

These learning moments may be formal or informal, occurring during or after handover, within dedicated education spaces, or spontaneously through questions, discussion, and real-time guidance during a shift. Reflection and debriefing are often woven into these interactions, whether through brief in-the-moment conversations or more structured discussions following clinical experiences.

Nurse educators move across these settings, working with learners from novice students to experienced clinicians, requiring adaptability, presence, and responsiveness in every context. In these dynamic and often unpredictable environments, how educators show up matters just as much as what they teach. A mindful educator helps create a learning space where people feel safe, focused, and supported. There is growing evidence that mindfulness approaches can reduce stress and anxiety while supporting wellbeing, self-awareness, emotional regulation, and resilience among learners (Bernstein, 2019; Fenton et al., 2025).

However, even the most well-designed education cannot be fully effective if the learning environment is not first intentionally shaped by the educator. This begins with how the educator shows up. Being a mindful teacher is not necessarily about being calm (although this helps), but rather having intentional presence and entering teaching moments grounded, aware, and responsive rather than rushed or reactive. Learners often take emotional cues from the educator; when the teacher appears stressed or distracted, tension can rise quickly and trust harder to gain. In contrast, when the educator is steady, approachable, and clear, learners are more likely to engage with confidence. Being mindful by paying attention on purpose, in the present moment, and without judgment, allows educators to respond rather than react in teaching moments (Bernstein, 2019).

The mindful educator becomes a centre of calm in any learning environment. Through tone of voice, body language, pacing, and presence, educators communicate there is time to think, mistakes are part of learning, and challenges can be worked through together. This is especially important in nursing, where learners are developing clinical skills alongside communication, teamwork, and professional confidence. Mindfulness-based programs in nursing education have also shown benefits for communication, self-compassion, and coping capacity (Fenton et al., 2025), all of which are essential for safe, compassionate practice and are often learned through role modelling in clinical environments.

So how do we do this as educators?

Mindfulness begins before the session starts, as preparation can shape the tone of the learning environment. In classrooms, this may mean organising resources and technology, thinking ahead about how the session will flow, and anticipating areas students may find challenging. In clinical environments, this may involve reviewing patient needs, planning teaching opportunities, gathering equipment, and considering privacy and dignity during bedside learning. Taking a few moments to centre yourself before teaching can reduce stress for both educator and learner (Bernstein, 2019). For all educational opportunities, it is important to create a welcoming, psychologically safe environment for discussion and participation. This may also involve viewing the space from the learner's perspective by sitting where they will sit, checking what they can see on whiteboards, screens, and other teaching resources, and ensuring there is enough space, seating, and comfort for everyone to feel included. Consider the lighting, potential distractions, and the surrounding environment, for example, whether nearby patients requiring low stimulation and could be impacted by the session.

Clinical educators, preceptors, and senior staff often teach in busy environments where learning occurs alongside patient care, interruptions, alarms, and time pressure. In these moments, calm leadership becomes even more valuable. At the bedside, mindful teaching may include introducing the learner, gaining consent, maintaining dignity, and checking understanding. In community nursing, it may involve pausing before entering the home and resetting attention between visits. During simulation, it may mean normalising nerves and facilitating supportive debriefing. During double-staffed procedures, it can involve modelling teamwork, communication, and safe practice.

Mindful teaching also includes anticipating difficult moments such as anxious graduate nurses, disengaged learners, emotionally charged events, or staff who feel time-poor. In university settings, this may include students feeling overwhelmed before assessments, hesitant to participate, or unsure how to engage with complex or sensitive content. Preparing calm responses such as, “Let’s work through this together,” or “What support do you need right now?” can help create psychological safety. Learners benefit when environments support reflection, emotional safety, and self-regulation (Fenton et al., 2025). Importantly, mindful teaching does not require perfection. Some days will feel rushed or unpredictable. Returning to the breath, slowing speech, grounding through posture, and focusing on the next helpful step can reset the tone of the interaction. Mindfulness emphasises patience, acceptance, and letting go when things do not go to plan (Bernstein, 2019).

A mindful educator does more than deliver content, they create the conditions for learning, confidence, resilience, and growth. Whether in a classroom, simulation suite, hospital ward, community clinic, or patient home, the calm presence of an educator may be one of the most meaningful lessons learners remember.

Practical Ways to Teach Mindfully

- **Arrive early and prepare the environment**
- **Check equipment and teaching resources in advance**
- **Take three slow breaths before beginning**
- **Set an intention such as clarity, patience, or encouragement**
- **Use a calm and welcoming tone**
- **Pause after questions to allow thinking time**
- **Break complex skills into smaller steps**
- **Slow the pace when learners appear overwhelmed**
- **Model composure when challenges arise**
- **Include brief reflection or debrief opportunities**

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Conference Connections

Networking and Insights

with M. Stead

In March I was able to take some time off and attend **The Hive Experience 'Recharge and Refocus' Nursing** Career Advancement Retreat. This glorious stay was held at Eco View Retreat in beautiful Tallebudgera Valley QLD. Set amongst a picturesque view we were treated to all the luxury's of an all inclusive retreat along with a 3 day Career Alignment and Advancement Program.

Spending time engaging with the participants reframed the way I think about career development; not as a rushed decision-making process, but as something that requires pause, structure, and honest reflection. What stood out most was the deliberate slowing down of urgency. Rather than pushing participants to "fix" their careers, the program begins by helping them understand what is actually happening beneath feelings of burnout, restlessness, or uncertainty. This felt like a powerful reminder that clarity comes from insight, not speed.

Day 1 highlighted how professional identity can blur over time, showing that feeling "off" signals misalignment rather than failure. Reflecting on values and identity, and distinguishing burnout from misalignment, provided clarity without self-judgment, while creating a personal mission statement reinforced the need for an internal anchor while making external changes.

Day 2 shifted to strategic thinking, framing a career as a system shaped by context, environment and influence. Emphasising exploration over immediate commitment challenged "all-or-nothing" thinking and reinforced a sense of agency through informed and aligned choices.
Day 3 focused on action in a sustainable way, reframing confidence as something built through experience. Recognising and articulating strengths fostered self-trust, while focusing on realistic next steps made change feel achievable rather than overwhelming.

Overall, for me the program emphasised that career clarity is not about having all the answers immediately. Instead, it is about developing a structured understanding of oneself, recognising available opportunities that align with personal and professional values, and moving forward with intention so fear doesn't hold us back. Being able to complete this level of CPD learning while recharging was a wonderful way to nourish myself within a learning environment.

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SCHOLARSHIP SNAPSHOTS:
IDEAS WORTH SHARING

We're inviting authors to submit short topic overviews for our bulletin section. These are designed to generate interest—not replace journal articles. To read the full article and for citation purposes, readers should access the work directly via the original journal or publisher's website.

To start the section off the Editors are introducing some of their work and Amy Kim's recent publication.

Padigos, J., & Petrie, A. (2025). From Trauma-informed pedagogy to Trauma-informed andragogy: The ethics of achieving lexical clarity to reframe approaches in adult clinical education. *Nursing Forum,* https://doi.org/10.1155/nuf/2248498.

This article addresses a critical gap in nursing and health professional education: the unexamined use of trauma-informed pedagogy to guide learning in adult, trauma-exposed clinical environments. Nurses and other health professionals routinely encounter distressing material, vicarious trauma, and ethical complexity during education and practice. How trauma-informed approaches are conceptualised—and named—has direct implications for learner agency, professional preparation, and ethical responsibility.

Using duo-ethnography, the authors foreground the lived experiences of nurse educators as a legitimate and necessary source of knowledge. Through reflexive, dialogic conversations, the study treats lived experience and relational dialogue not simply as data, but as core elements of the research process itself. This methodology allows nuanced ethical tensions, power dynamics, and emotional labour in clinical education to surface in ways that are often obscured in traditional research designs. In doing so, the paper demonstrates the value of educator voice and reflexive conversation in advancing trauma-informed scholarship.

By arguing for a shift from trauma-informed pedagogy to trauma-informed andragogy, the article aligns educational theory with adult learning principles and clinical realities. It challenges educator-centric assumptions that place sole responsibility for managing triggers on teachers, instead advancing a model of shared ethical responsibility between educator and adult learner.

This reframing is particularly relevant to nursing education, where learners must be both psychologically supported and adequately prepared for the realities of practice. The article contributes ethically by linking terminology to epistemic justice, power, and beneficence, showing how imprecise language can infantilise adult learners and burden educators. Ultimately, it offers a principled, practice-relevant framework for trauma-aware education that is adult-centred, ethically sound, and grounded in lived experience.

We appreciate hearing from you.

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If you would like to contribute, please use the following Snapshot Format

Title of work:
(As published)
Author(s):
(Include affiliations if desired)
Snapshot (up to 200 words):
Briefly describe:

- The big idea or issue your work addresses
- Why this topic is timely, relevant, or important for nursing or health professional education
- What readers might gain from engaging with the full article

This is an interest-generating overview rather than a summary of methods or results.
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Academic performance of enrolled nurses in Bachelor of Nursing transition programs: A scoping review

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ABSTRACT

Background: Transition from second-level regulated nursing roles into Bachelor of Nursing programs represents an important pathway for career advancement. Despite prior clinical experience, many enrolled nurses encounter academic challenges when adapting to university learning environments, yet the academic dimensions of this transition remain poorly synthesized.

Purpose: This scoping review aimed to systematically map the academic challenges, barriers, and facilitators influencing academic performance among second-level regulated nurses transitioning into Bachelor of Nursing programs.

Methods: A comprehensive search of MEDLINE, Embase, CINAHL, ERIC, ProQuest Nursing and Allied Health, and ProQuest Dissertations & Theses A&I was conducted. Qualitative, quantitative, mixed-methods, and case study designs published in English were included. Two reviewers independently screened studies and extracted data using Covidence. Thematic analysis was undertaken.

Discussion: Thirteen studies were included. Academic writing, critical thinking, information technology skills, and adjustment to university expectations were key challenges. Financial pressure and work-study-family balance were prominent barriers. Mentorship, peer support, recognition of prior learning, and workplace support were identified as important facilitators. These findings suggest that students entering with advanced standing may require more tailored academic transition support than is typically provided.

Conclusion: Enrolled nurses transitioning into Bachelor of Nursing programs experience substantial academic transition demands that can affect performance and progression. Targeted supports, including academic literacy development, structured orientation, mentoring, and flexible institutional support, are needed to strengthen academic success in this group.

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WHAT'S HAPPENING!
CONFERENCES & WORKSHOPS

International Nurse Education Focused Conferences 2026

Canadian Nursing Education Conference. Ontario, Canada. June 1-2. https://www.casn.ca/2024/11/the-casn-biennial-canadian-nursing-education-conference-2026/

7th Asia Pacific Advanced Nursing Practice, Nursing Education, and Leadership Conclave. Singapore. June 18-19.

International Nurse Education Conference (NETNEP). Edinburgh, UK. November 1-4. More details, including the conference app, will be available on the Elsevier website closer to the event date https://www.elsevier.com/en-au/events/conferences

Nursing Conferences 2026

National Nurse Educators Conference. TBA

42nd Annual CRANAplus Remote Nursing & Midwifery Conference. Perth. May 11-13. https://crana.org.au/2026-conference

Australian College of Perioperative Nurses (ACCORN). International Conference. Brisbane. May 14-16. https://www.acorn.org.au/acorn2026-conference

12th Council of International Neonatal Nurses (COINN) Conference. Australian College of Neonatal Nurses. Darwin. August 25-28. https://www.coinnurses.org/coinn-2026-darwin

Australia & New Zealand Orthopaedic Nurses Alliance (ANZONA). Victoria. TBC Oct/Nov. https://anzona.net/education-conferences-and grants/

Nursing Midwifery in Digital Health [NMiDH]. 3-4 August 2026, Sydney. Visit: https://digitalhealth.org.au/?s=conference

College of Emergency Nursing Australasia. 23rd International Conference for Emergency Nurses. 14 – 16 October 2026, Hobart, Tasmania.Visit: https://www.cena.org.au/icen/icen-2026/

Australian College of Mental Health Nurses (ACMHN). 50th International Mental Health Nursing Conference. 7 – 9 October 2026, Adelaide, SA. Visit: https://conlog-acmhn-2026.eventsair.site/

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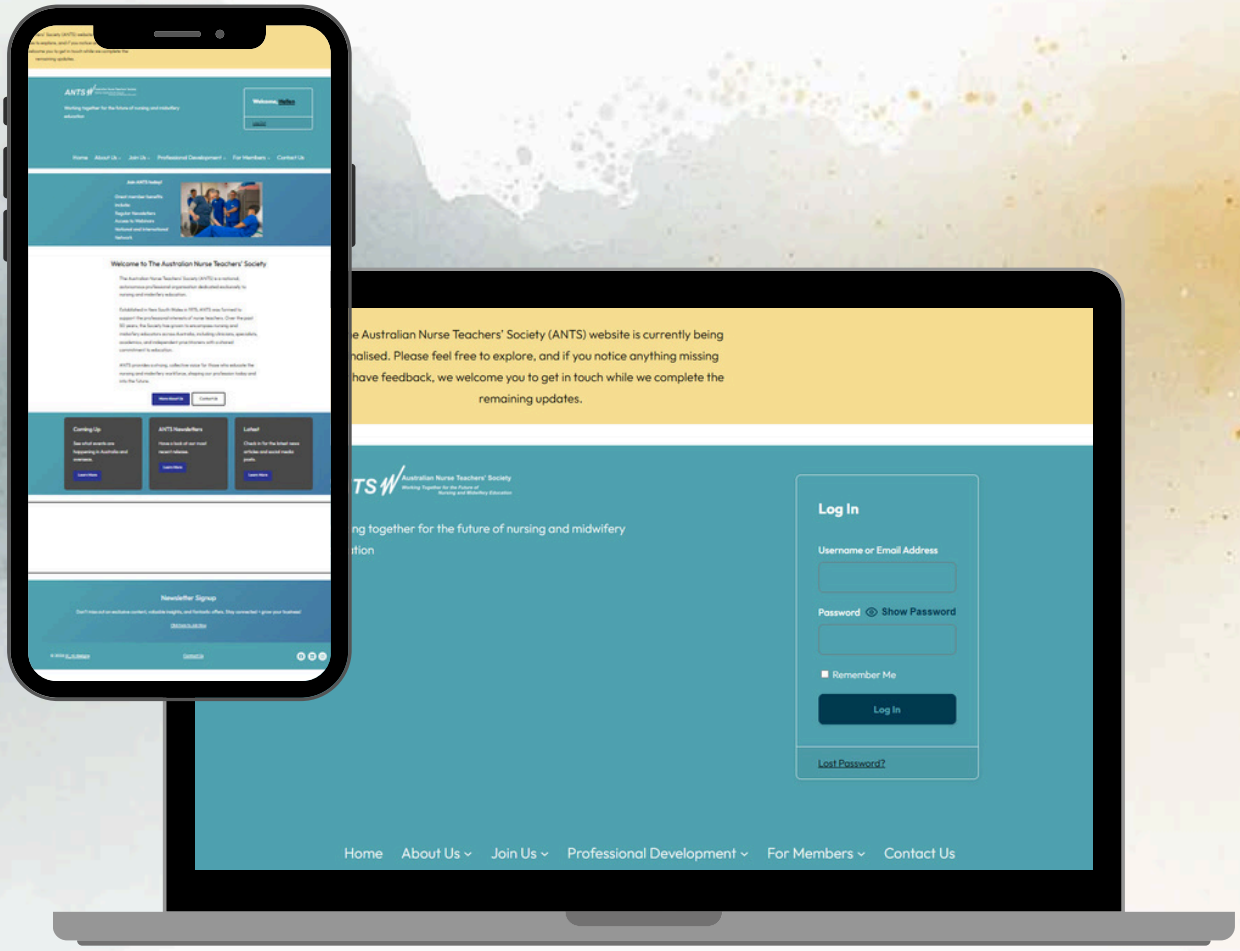

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