

CHAPTER 4

IMPROVING OTHER ASPECTS OF EDUCATION AND TRAINING

Nursing work is diverse, complex, requires critical thinkers and technically skilled practitioners...Nursing's diversity requires a varied approach to education, clinical supervision and support, and ongoing education that extends beyond initial transition to clinical practice.¹

4.1 This chapter discusses the opportunities to improve the current arrangements for the education and training of Enrolled Nurses (ENs) and midwives. It also reviews the continuing education and postgraduate study needs of nurses. The chapter also discusses the role of advanced practice nursing and unregulated healthcare workers and concludes with a discussion of the information technology and nursing research needs of the profession.

Enrolled nurse education

4.2 As previously noted, ENs generally undertake their education in the vocational education sector at a Certificate IV or Diploma level.

4.3 Submissions argued that there was a need for national consistency in the education of ENs.² One submission noted that as the role, functions and education of enrolled nurses varies considerably between jurisdictions 'a national approach is required to provide consistency in enrolled nurse function and education and to enhance their utilisation within the health system'.³

4.4 A commissioned study for the Australian Nursing Council (ANCI) on the role and functions of ENs (the Enrolled Nurse study) also stated that:

The considerable variation in enrolled nurse education across the country and changes over the last decade has meant that it is very difficult for registered nurses to know what enrolled nurses are educationally prepared for. National consistency in education for enrolled nurse practice was seen as essential not only for facilitating mutual recognition, but also national competency standards.⁴

1 *Submission 749*, p.3 (Griffith University School of Nursing).

2 *Submission 728*, p.3 (NENA); *Committee Hansard*, 28.2.02, pp.201-202 (NENA); *Submission 926*, p.12 (ANCI); *Submission 942*, p.16 (Queensland Health).

3 *Submission 736*, p.9 (QUT, School of Nursing).

4 Australian Nursing Council, *An Examination of the Role and Function of the Enrolled Nurse and Revision of Competency Standards*, March 2002, p.50.

4.5 The National Enrolled Nurse Association (NENA) and other submissions argued that all pre enrolment educational programs should be:

- broadly consistent nationally in content and level, and meet the ANCI National Competency Standards for the Enrolled Nurse;
- be available in all States;
- the courses should be as comprehensive as possible with a ‘life span’ (that is, birth to death) approach rather than restricted to a particular areas, for example, aged care;
- be available in a variety of delivery modes, including part time study and distance education; and
- the minimum level entry qualification for enrolment should be, at least, equivalent to Level IV of the Australian Qualifications Framework.⁵

4.6 Specific areas of concern in relation to EN education were identified during the inquiry. Submissions noted the inconsistencies across the States and Territories with regard to the courses available to ENs. Although most courses are offered at the AQF Level IV, Queensland offers a Diploma course (AQF Level V). The Level IV courses are predominantly offered over 12 months or equivalent full-time study, except in the case of WA where the courses are 18 months in duration. The Enrolled Nurse study also found there is a lack of consistency in the level of educational preparation, course title, duration and content. The study found that while all courses use the ANCI competencies as the framework for organising the theoretical and clinical content of courses, they did so to varying degrees.⁶

4.7 The EN study noted that courses are structured into theoretical and clinical components delivered over periods of between 12-18 months, with considerable variation in total course hours, including in clinical settings. The report stated that total course hours varied between 790 and 1 560 hours.⁷

4.8 A commissioned study for the National Review of Nursing Education (the Education Review) provided a different estimate of total course contact hours stating that they varied between 756 hours (Northern Territory) and 1 200 hours (Western Australia). The study noted that a new curriculum is being introduced in the Northern Territory from 2002 that consists of a significant increase in classroom and clinical hours. In Victoria and the ACT total course hours are set at 850 hours generally with 610 hours allocated to classroom teaching. In the majority of courses students spend four full days per week on campus engaged in classroom learning.⁸

5 *Submission 728*, p.3 (NENA). See also *Submission 962*, pp.36-37 (ANF); *Submission 477*, p.6 (NNOs).

6 EN study, pp.49, 114.

7 EN study, p.48.

8 Cited in National Review of Nursing Education, *Discussion Paper*, December 2001, p.142.

4.9 Some submissions argued that the EN courses should have a greater clinical component.⁹ NENA argued that there should be increased funding to facilitate increased hours for the clinical component in EN courses.¹⁰ The EN study noted that all curricula include clinical practice modules, however, some curricula give more emphasis to aged care, while others emphasise acute care. With the exception of traineeships, clinical practice hours ranged from 240 to 1 140 hours.¹¹ The EN study found that the time allocated for the clinical components varied – in some instances time is nominal and dependent on whether the student has achieved a satisfactory level of competence within the area. Other programs allocated a period of time for attaining competence.

4.10 Submissions also argued that pre enrolment education should be as comprehensive as possible rather than being restricted to particular subject areas.¹² The EN study noted that while the emphasis in most curricula is on acute care, all courses include aged care and rehabilitation clinical placements, and increasingly community and mental health placements.¹³

4.11 These areas of concern highlight the lack of a consistent approach to the education of ENs. The EN study argued that ideally, national consistency in education ‘would involve nationally supportive legislation and policy’ to enable EN roles to develop within contemporary contexts at the same time as promoting nationally consistent standards of nursing practice. The study argued that while State and Territory registering authorities should remain the bodies to endorse course and training providers for EN programs, nationally consistent EN education based on ANCI Enrolled Nurse Competency Standards would assist in differentiating the role of ENs from RNs and other unlicensed workers. The EN study argued that the ANCI should consult with key stakeholders to determine the structure and content of the educational preparation for ENs.¹⁴ NENA argued that national consistency in curriculum should be formulated collaboratively with all relevant parties involved, that is, EN representatives, training providers, employer groups, nurse registration boards and union groups.¹⁵

4.12 Issues related to the administration of medications by ENs were also raised in evidence. States and Territories have varying legislation stipulating what level of medications ENs can administer. The States and Territories, in consultation with the nurse regulatory bodies, are responsible for controlling and regulating areas that affect the scope of nursing practices. As noted above, legislation and regulation differ

9 *Submission 706*, p.7 (Royal Perth Hospital Nursing Executive Council).

10 *Submission 728*, p.3 (NENA).

11 EN study, p.49.

12 *Submission 728*, p.3 (NENA); *Submission 962*, pp.36-37 (ANF).

13 EN study, p.48.

14 EN study, pp.50, 52.

15 *Submission 728*, p.3 (NENA).

significantly between jurisdictions in relation to scope of practice, including the administration of medications. Each State and Territory has legislation regarding the handling of poisons and drugs, including medications. This legislation regulates the activities of pharmacists, medical practitioners, RNs and ENs as well as managers and providers of facilities in which these scheduled drugs are stored and administered.¹⁶ This issue is discussed further in chapter 7.

4.13 In Queensland, South Australia, Western Australia and Tasmania ENs can administer up to Schedule 4 medications, and in NSW up to Schedule 3. In Victoria ENs are not permitted to administer any medications.¹⁷ NENA argued that ENs should be permitted to administer medications up to and including Schedule 4 drugs.¹⁸ Changes to legislation will be required in some States and Territories to enable the administration of medication up to and including Schedule 4 by ENs.

4.14 The EN study noted that the issue of medication administration is a complex area with some in the profession agreeing that the task is suitable to delegation by a RN to an EN, others, however believe that it should be the sole responsibility of the RN. The study noted that there have been calls for medication administration to be included in the EN curricula.¹⁹ The Australian Nursing Federation (ANF) indicated that it supported extended practice options for ENs, including medication administration, supported by education, and appropriately remunerated.²⁰ The Revised Enrolled Nurse Competency Standards do not preclude an EN role in the administration of medications.²¹

Conclusion

4.15 The Committee believes that there needs to be national consistency in enrolled nurse education in relation to course structure, duration and content. The Committee considers that a national framework or guidelines for the education of ENs should be developed by the Australian Nursing Council, in conjunction with professional bodies, training providers, State nurse regulatory bodies and unions. The

16 Relevant State and Territory legislation includes poisons and drugs legislation; controlled substances legislation, Nurses Acts and regulations, and Health Acts and regulations. See Department of Health and Aged Care, *A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions*, August 2001, pp.8, 17.

17 Some States permit the administration of medications via all routes, others exclude intravenous administration. See *Submission 728*, Additional Information, 10.5.02 (NENA). Drugs and poisons are classified by the National Drugs and Poisons Schedule Committee into Schedules for inclusion in the relevant State/Territory poisons legislation. Poisons are listed in eight Schedules according to the degree of control recommended to be exercised over their availability to the public.

18 *Submission 728*, pp.2-3 (NENA); Supplementary Information, 10.5.02, p.1 (NENA).

19 EN study, pp.38,51.

20 *Submission 962*, p.38 (ANF). See also *Submission 477*, p.7 (NNOs).

21 EN study, p.51.

Committee believes that the educational preparation for ENs should be, at a minimum, equivalent to Level IV of the Australian Qualifications Framework.

4.16 The Committee also believes that the variations between the States in regard to the administration of medications by ENs need to be addressed by the adoption of consistent legislation across all States.

Recommendation 25: That the Australian Nursing Council, in consultation with major stakeholders, develop a national framework for the education of enrolled nurses in relation to course structure, duration and content.

Recommendation 26: That State and Territory Governments develop nationally consistent legislation in relation to the administration of medications by Enrolled Nurses.

Midwifery education

4.17 As noted previously, entry to practice as a midwife requires completion of a postgraduate course, generally at the graduate diploma level, following initial registration as a nurse.

4.18 Submissions and other evidence from organisations representing midwives argued that current education programs for midwives need to be improved. The Australian Midwifery Action Project (AMAP) stated that in relation to the midwifery courses offered at universities across Australia:

It is apparent there is no overall consistency in design, duration or level of award both nationally or within each separate state...At present there is no national monitoring system to guarantee comparability or an adequate baseline competency. Not all states and territories have adopted the current ACMI midwifery competencies.²²

4.19 One witness noted that the standards of midwifery education ‘have dropped considerably over the last 10-15 years’.²³ The Australian College of Midwives (ACMI) has attempted to address this issue by issuing draft ACMI Competency Standards for Midwifery, which develop standards of midwifery competence and practice in line with international standards.

4.20 Research commissioned for the Education Review to investigate midwifery education found ‘serious inconsistencies’ across the States in both the education and regulation of Australian midwifery and expressed concerns about the standard of midwifery education in Australia, particularly when compared with other Western countries.²⁴ The research found that the shift to university training meant that midwifery education was ‘submerged’ within general nursing training. The research

22 *Submission 912*, p.9 (AMAP).

23 *Committee Hansard*, 22.3.02, p.434 (NSW Midwives Association).

24 Cited in the Education Review, p.125.

found that the limited midwifery education within the comprehensive nursing undergraduate degree is ‘insufficient to prepare new graduates for practice in the field’.²⁵ The research concluded that the current arrangements for midwifery education lead to a ‘lack of preparedness of new nursing graduates for midwifery practice, and inadequate preparedness of some graduates of some postgraduate midwifery programmes’.²⁶

4.21 A recent study into midwifery issues also found a lack of consistency in the standards of midwifery education and regulation nationally. The study found that universities offering midwifery education show a lack of comparability in midwifery curricula, including number of clinical and theoretical hours, assessment of competency, duration of courses and nomenclature of awards. Not all nurses Boards have adopted the ACMI Competency Standards for Midwives – three of eight Boards (NSW, WA and the NT) have not adopted these standards. The study argued that it was crucial that agreed standards in education are established nationally and that these are consistent across curricula in the various States.²⁷

4.22 With regard to approval of courses and institutions, the study found that there were wide variations across States. For example, in NSW all students of midwifery are required to meet the particular competencies of a midwife as set out by the Board plus complete a list of clinical requirements. In other States, such as South Australia, Western Australia and Queensland, midwives are assessed through a competency based approach that does not stipulate a specific number of clinical requirements.²⁸ The study found that course accreditation standards, evaluation systems and processes to ensure standards of midwifery and nurse education and practice vary between the States – ‘there is not an explicit link, agreed minimum standards or any benchmarking possible between the different Boards’.²⁹

4.23 Submissions also argued that ‘culturally appropriate’ midwifery education at tertiary level needed to be introduced to facilitate the education of Indigenous midwives.³⁰ AMAP noted that programs that provided Indigenous communities with their own midwives could contribute significantly to improving perinatal healthcare for mothers and their infants.³¹

4.24 In an attempt to address the educational issues – and the cost of postgraduate training of midwives – the ACMI has proposed the introduction of a three year

25 Cited in the Education Review, p.126.

26 Cited in the Education Review, p.126. See also *Submission 912*, Additional Information, 14.6.02, pp.4-5 (AMAP).

27 P. Brodie and L. Barclay, ‘Contemporary Issues in Australian Midwifery Regulation’, *Australian Health Review*, vol.24, no.4, 2001, pp.106, 108.

28 Brodie study, p.106.

29 Brodie study, p.109.

30 *Submission 891*, p.4 (NSW Midwives Association).

31 *Submission 912*, p.2 (AMAP).

undergraduate degree program in midwifery (Bachelor of Midwifery), without the current prerequisite three-year nursing degree (that is, direct entry midwifery).³² An undergraduate degree program began in 2002 in universities in Adelaide and Melbourne and has 150 students enrolled.³³ One witness noted that ‘the profession recognises that as a significant step forward in raising the standard of midwifery care provided to women and also addressing the work force shortage’.³⁴

4.25 The Committee received a range of views on direct entry midwifery programs. AMAP stated that in several overseas countries undergraduate education to degree level for midwives is the standard practice. The UK and New Zealand prepare the majority of midwives in three year undergraduate degree programs and plan to close postgraduate midwifery courses in favour of the direct entry model.

4.26 AMAP argued that in most Western countries three and four year programs in midwifery are seen as the most appropriate and cost effective way to educate midwives to be practitioners in their own right and to maintain high standards of midwifery education and practice. AMAP further stated that:

Midwifery education is not seen as a postgraduate extension of nursing education since the knowledge base, and educational requirements for practice are seen as separate. There is a trend towards nurses wishing to become midwives having to undertake at least two years of the same course and in many countries they have to undergo the full three or four years. The rationale is based in the international definition of the role and sphere of practice of the midwife.³⁵

4.27 AMAP argued that although it is recognised that there are ‘some limited skills and knowledge’ useful to midwives that can be obtained in undergraduate nursing courses the current educational requirements are not seen as providing an adequate midwifery education especially when compared with other Western countries– ‘in essence, nurses entering midwifery education in Australia can only experience a one year program to develop knowledge and exposure to midwifery practice compared to the three or four years that is considered necessary in many other comparable countries that do not see any links between nursing and midwifery programs’.³⁶

4.28 AMAP noted the undergraduate degree program will produce graduates in three rather than five plus years and will not attract current postgraduate fees. In countries other than Australia, where the Bachelor of Midwifery is the preferred education model for midwives, the AMAP argued that ‘course enrolments are at full

32 *Submission* 886, p.4 (ACMI). See also *Submission* 891, p.4 (NSW Midwives Association); *Submission* 912, p.9 (AMAP).

33 *Committee Hansard*, 22.3.02, p.435 (NSW Midwives Association).

34 *Committee Hansard*, 22.3.02, p.435 (NSW Midwives Association).

35 *Submission* 912, Supplementary Information, 14.6.02, p.1 (AMAP).

36 *Submission* 912, Supplementary Information, 14.6.02, p.9 (AMAP).

capacity while attrition rates have fallen significantly'. This demonstrates that this model may be a more attractive course option for many students.³⁷

4.29 The ANF argued that there should be a wide variety of midwifery educational models available but did not support direct entry midwifery programs. The Federation noted that evidence from the UK suggests that direct entry midwifery courses have had to provide basic nursing education and skills to prepare their students for midwifery practice and that 'this appears to defeat the purpose of the course'.³⁸

Conclusion

4.30 The Committee received evidence of inconsistencies and discrepancies in the education and regulation of midwifery in Australia. The Committee believes that there needs to be national approach to these issues to ensure that standards are comparable between States. The Committee believes that a national curriculum framework or guidelines needs to be developed for midwifery education courses to overcome the inconsistencies evident in current course curricula.

4.31 The Committee believes that educational courses to obtain midwifery qualifications should be available in a variety of delivery modes, as well as, but not excluding the current postgraduate qualifications. With regard to direct entry Bachelor of Midwifery programs, views on this matter to the inquiry indicated a divergence of opinion. The Committee believes that it is too early to comment on the effectiveness or otherwise of this approach to midwifery education in Australia. The Committee considers that the Australian Nursing Council should conduct a review into the effectiveness of direct entry midwifery programs after five years of operation.

Recommendation 27: That the Australian Nursing Council, in conjunction with key stakeholders such as state regulatory bodies, professional nursing bodies, universities and unions, develop a national curriculum framework or guidelines for midwifery courses.

Continuing education and professional development

4.32 Submissions emphasised that all nurses need access to continuing education. Continuing education was seen as essential for the maintenance of professional competence and therefore of professional skills and standards. Competence is a combination of skills, knowledge, attitudes, values and abilities that underpin effective performance in an occupation. Continuing competence is the ability of nurses to demonstrate that they have maintained their competence in their current area of practice.

37 *Submission* 912, p.9 (AMAP).

38 *Submission* 962, p.32 (ANF).

4.33 The ANF stated that:

Health is a dynamic environment and it is increasingly difficult to retain a current knowledge base. Conditions of employment for, and employers of nurses must support, encourage and facilitate ongoing education.³⁹

4.34 Continuing education may be delivered at hospitals or other health facilities, or be provided through seminars or workshops conducted by the colleges. There are different standards adopted by nurse regulatory authorities in the States in relation to continuing education and requirements for registration renewal. Some State boards require evidence of continuing education and professional development for renewal of registration. This usually takes the form of self assessment of competency levels whereby a nurse examines his or her practice against national competency standards and submits a declaration of competence form to the regulatory authority. Issues relating to postgraduate education are discussed in the next section of the report.

4.35 Submissions noted that nurses in rural and remote areas in particular have great difficulties in accessing continuing education and attending conferences as there is often no staff to backfill their positions when they take time off for educational purposes. It was also argued that issues such as access to paid study leave, staffing levels which allow staff replacement for nurses on study leave, paid professional development/conference leave entitlements and assistance with the cost of continuing education need to be addressed.⁴⁰ The ANF suggested that the Commonwealth and State Governments commit to, and work towards enabling access for all nurses to paid study leave, including staffing levels which allow replacement for nurses on study leave or attending conferences, and assistance with the cost of continuing education, particularly for nurses working in rural and remote areas.⁴¹

4.36 The National Nursing Organisations (NNOs) argued that continuing professional development should be provided through flexible delivery modes to facilitate nurses' access to these programs, especially in rural and remote areas – 'the education must be affordable, accessible and clinically relevant to the changing workplace'.⁴²

4.37 In relation to ENs, submissions argued that post enrolment education must be available to facilitate career development. NENA argued for the provision of conference and study leave in line with RNs and encouragement by employers for ENs to participate in ongoing education.⁴³

39 *Submission 962*, p.41 (ANF); see also *Submission 477*, p.12 (NNOs).

40 *Submission 962*, p.41 (ANF); *Submission 899*, p.8 (NSW Nurses' Association); *Submission 379*, pp.3,9 (ANF (Victorian Branch)); *Submission 800*, p.36 (NRHA).

41 *Submission 962*, p.42 (ANF).

42 *Submission 477*, p.12 (NNOs).

43 *Submission 728*, pp.5-6 (NENA).

4.38 Concern was expressed that nurses may not be aware of the continuing education opportunities that do exist through the staff development units or education centres that operate in many hospitals, for example at Queen Elizabeth, Royal Adelaide and Flinders Hospitals in South Australia. The comment was made that ‘whilst there are systems in place to provide an ongoing education resource within most metropolitan hospitals, the continuity of information from the education to the clinical setting is regularly disrupted and nurses are generally not aware of their education support or options’.⁴⁴ This was regarded as a management issue at individual hospital level.

Conclusion

4.39 The Committee believes that continuing education for nurses needs to be more widely promoted and considers that paid study leave needs to be available to encourage nurses to undertake this important area of professional development.

Recommendation 28: That nurses be informed of their continuing education support and options, and encouraged to undertake continuing education courses.

Recommendation 29: That State nurse regulatory bodies examine the feasibility of introducing the requirement of continuing education and professional development as a condition for continuing registration.

Recommendation 30: That research be undertaken into the costs of providing paid study leave entitlements for nurses.

Recommendation 31: That paid study leave arrangements for nurses be negotiated by the Australian Nursing Federation and employers.

Postgraduate education

4.40 Submissions argued the current arrangements for postgraduate education are essentially ‘punitive’. The Deans of Nursing stated that:

...students are penalised financially, psychologically and socially because of the negative impact of doing further study. There are no tangible rewards or incentives to do this, no added remuneration; promotion prospects are not significantly enhanced and progression within the current role does not automatically follow. If we want people to take lifelong education and professional development seriously we must have in place an incentive model which rewards their efforts.⁴⁵

4.41 Submissions emphasised the lack of Commonwealth funding for postgraduate education. The Deans of Nursing commented that:

44 *Submission* 969, p.3 (Lt Mark Mudge).

45 *Submission* No.192, p.8 (ACDON). See also *Submission* 962, p.30 (ANF).

The majority of universities have gone to full fee paying for coursework postgraduate education. Therefore there are very few Commonwealth funded places in higher education for specialist education across the country.⁴⁶

4.42 Most postgraduate nursing research programs are HECS liable, while coursework postgraduate nursing programs are funded by both HECS and up-front fee-payment, with the fee structure of individual courses varying on a year to year basis. There has been a decrease in HECS liable places in postgraduate courses at universities in recent years and the virtual elimination of employer-funded places.

4.43 Beginning in 2002, the Commonwealth Government introduced the Postgraduate Education Loans Scheme (PELS) to assist students undertaking fee paying postgraduate non-research courses. PELS enables eligible students to obtain an interest-free loan from the Commonwealth Government to pay all or part of their tuition fees incurred from 2002 onwards. It is available for both commencing and continuing students. It is similar to the deferred payment arrangements under HECS. Students repay their loan through the taxation system once their income reaches the minimum threshold for compulsory repayment.⁴⁷

4.44 State Health budgets also provide funding for specialist nurse training places, but the amount of support varies between the States and between institutions.⁴⁸ In Victoria, the Government funds 200 postgraduate scholarships per annum in specialist areas.⁴⁹ The Victorian Department of Human Services stated that 'it is a pure substitution for the Commonwealth not having sufficient HECS funded places for postgraduate work. On top of our 200, a number of the hospitals use the grant we give them, the graduate year grant, to provide scholarships as well'.⁵⁰ In NSW, the Government has provided additional funding in 2002 to the New South Wales Nursing Scholarship Fund.⁵¹ In South Australia, the Government provides funding for postgraduate scholarships. The Premier's Nursing Scholarships provide four scholarships to the value of \$15 000 per scholarship for nurses to undertake study overseas.⁵²

46 *Committee Hansard*, 28.2.02, p.139 (ACDON). See also *Committee Hansard*, 28.2.02, p.221 (NNOs).

47 For further information see: www.hecs.gov.au/pels.htm

48 *Submission 960*, p.12 (Victorian Government); *Submission 940*, p.7 (SA Department of Human Services); *Submission 937*, p.6 (ACT Government).

49 *Committee Hansard*, 28.2.02, p.197 (Victorian Government); *Submission 960*, p.12 (Victorian Government).

50 *Committee Hansard*, 28.2.02, p.197 (Victorian Department of Human Services).

51 *Committee Hansard*, 22.3.02, p.501 (NSW Health Department).

52 *Committee Hansard*, 27.3.02, pp.763-65 (SA Department of Human Services); *Submission 940*, p.7 (SA Department of Human Services).

4.45 The cost of postgraduate nursing education was identified in evidence as a major barrier which is contributing to the current skills shortages in areas such as mental health, aged care, critical care, midwifery and emergency nursing. One of the major reasons for the inability to attract and retain nurses in these areas is the limited opportunity for them to gain access to appropriate postgraduate specialty education programs, especially as many of these are only available on a full-fee paying basis. The costs are therefore often prohibitive relative to nurses' current pay levels and the lack of financial reward for completing such courses.⁵³ The Deans of Nursing stated that up-front fees for a 12 month graduate diploma ranged from \$8 000 to \$12 000 depending on the university.⁵⁴ The Queensland Nurses' Union (QNU) stated that the cost to an individual nurse in completing a Masters degree in certain specialties can be over \$40 000 in terms of fees, lost income and accommodation expenses.⁵⁵

4.46 The ANF stated that the recently announced postgraduate education loan scheme would be of little benefit to nurses – 'adding additional debt, whether it is interest free or not, will not encourage more nurses to undertake further education'.⁵⁶

4.47 Options raised in evidence to encourage nurses to undertake postgraduate studies include the provision of:

- elimination of fees entirely;⁵⁷
- HECS fees exemptions for postgraduate nursing courses in areas of national skill shortage;⁵⁸
- scholarships;⁵⁹ or
- a combination of scholarships and dedicated HECS places.⁶⁰

4.48 The Australian Private Hospitals Association (APHA) argued that Governments and the private sector should provide scholarships for postgraduate training to those students who commit to a nursing position in the acute sector, that is, tied scholarships.⁶¹

4.49 The ANF argued that scholarships and dedicated HECS places should be widely introduced for postgraduate nursing education, especially in areas of shortage

53 *Submission 962*, p.30 (ANF); *Submission 736*, p.9 (QUT, School of Nursing); *Submission 914*, p.16 (RMIT University, Department of Nursing & Midwifery).

54 *Committee Hansard*, 28.2.02, p.139 (ACDON).

55 *Submission 457*, p.28 (QNU).

56 *Submission 962*, p.30 (ANF).

57 *Committee Hansard*, 15.3.02, p.295 (Tasmanian School of Nursing).

58 *Submission 457*, p.28 (QNU); *Submission 960*, p.12 (Victorian Government).

59 *Submission 962*, p.31 (ANF); *Submission 926*, p.11 (ANCI).

60 *Submission 962*, p.31 (ANF).

61 *Submission 835*, p.10 (APHA).

and where entry to practice requires a postgraduate qualification, such as midwifery.⁶² The ANF noted that as most postgraduate courses are now full fee-paying there should be HECS places available. These places are ‘half the cost and able to be paid back over time rather than upfront payments’.⁶³

4.50 The Committee questioned several witnesses who advocated the elimination of fees for postgraduate courses altogether as to whether they would see advantages in making these courses HECS-liable rather than full fee paying. Witnesses generally agreed that this was a suitable ‘second best’ option.⁶⁴

4.51 Submissions argued that paid study leave for part-time students who are working full-time should be provided to nurses during their postgraduate courses. Submissions also suggested that postgraduate courses should have flexible entry and exit points which allow nurses to complete courses in their own time (eg. exit points at a certificate, diploma, and masters degree level), and be capable of delivery in flexible modes, particularly by external or distance study.⁶⁵

4.52 Submissions also argued that more information needs to be available to prospective candidates on postgraduate courses. For further discussion of issues related to career structure and planning see chapter 6. One submission stated that a national database needs to be established to provide information on postgraduate nursing programs, including the content, duration, fees payable and completion rates.⁶⁶

4.53 Currently, the preparation of midwives for clinical practice occurs through postgraduate programs which attract fees. Submissions from groups representing midwives argued that postgraduate fees for midwifery courses should be removed as the cost of these courses is a major disincentive for many RNs undertaking midwifery studies.⁶⁷ The ANF argued that scholarships should be available to support nurses undertaking midwifery education as well as dedicated postgraduate HECS places in universities.⁶⁸

4.54 Research commissioned for the Education Review argued that initial postgraduate education for practice in midwifery should be funded through HECS

62 *Submission* 962, p.31 (ANF).

63 *Submission* 962, Supplementary Information, 24.4.02, p.1 (ANF).

64 See, for example, *Committee Hansard*, 15.3.02, p.295 (Tasmanian School of Nursing).

65 *Submission* 962, p.31 (ANF). See also *Committee Hansard*, 22.3.02, p.508 (NSW Health Department).

66 *Submission* 914, p.16 (RMIT University, Department of Nursing & Midwifery).

67 *Submission* 891, p.4 (NSW Midwives Association); *Submission* 912, p.9 (AMAP). See also *Submission* 962, pp.31-32 (ANF); *Committee Hansard*, 28.2.02, p.221 (NNOs); *Committee Hansard*, 26.3.02, p.559 (QNU).

68 *Submission* 962, p.32 (ANF).

arrangements, rather than entirely through student fees.⁶⁹ The Education Review noted, however, that while there are ‘valid arguments’ for midwifery to be HECS funded places rather than fee payable ‘if guidelines for HECS took this position...the effect could be to reduce the number of midwifery places in universities due to the competition for these places between university faculties’.⁷⁰

Conclusion

4.55 The Committee believes that postgraduate study opportunities for nurses need to be facilitated. The Committee considers that postgraduate courses currently attracting fees should be HECS-liable, especially in areas of national skills shortage. Evidence to the Committee indicated that fees are a major disincentive to many nurses seeking to undertake postgraduate studies. It is vitally important that additional postgraduate places be available, especially as postgraduate degrees are required in certain specialist areas.

4.56 The Committee also believes that the Commonwealth and States should provide additional postgraduate scholarships. Evidence to the Committee also indicated a need for more information to be made available to prospective students on postgraduate nursing courses including content, duration, fees payable and other relevant information.

Recommendation 32: That the Commonwealth Government provide additional HECS places in postgraduate nursing courses currently attracting fees, especially in areas of national skills shortage.

Recommendation 33: That the Commonwealth and State Governments provide additional postgraduate scholarships in specialist areas, including midwifery.

Advanced practice nursing and Nurse Practitioners

4.57 Submissions to the inquiry noted that advanced practice nursing and nurse practitioner positions provide alternative healthcare choices for consumers, a potential source of cost savings for governments and service providers, and expanded clinical career opportunities for experienced nurses.⁷¹ An Advanced Practice Nurse is an RN with postgraduate qualifications or equivalent experience whose skills and practice are manifested in clinical excellence, which may involve specialisation.⁷² The Nurse Practitioner role, which is an example of advanced practice, allows authorised RNs

69 Cited in the Education Review, p.126.

70 Education Review, p.19.

71 *Submission 962*, p.36 (ANF); *Submission 409*, p.6 (La Trobe University School of Nursing); *Submission 960*, p.16 (Victorian Government).

72 Royal College of Nursing, *The Feasibility of a National Approach for the Credentialling of Advanced Practice Nurses and the Accreditation of Related Educational Programs*, July 2001, pp.18, 73.

with the knowledge, experience and skill to work in an advanced and extended clinical role with an increased level of autonomy.

4.58 Evidence indicated that the States vary to the extent to which they have encouraged the role of Nurse Practitioner.⁷³ NSW, following an evaluation of the role in a variety of metropolitan and rural settings, amended the *Nurses Act 1991* to provide for nurses to practice as nurse practitioners and the title has been protected since 1998. Legislation that renders a title protected means that there are regulatory safeguards around the use of the term, that is, to be able to use the title a person must fulfil the requirements of the regulatory authority. The NSW Health Department stated, however, that the Nurse Practitioner project is ‘moving slowly’ in NSW. Four positions have been approved (all in the far west of the State), but only one position is filled at present. Eight other Nurse Practitioners have been authorised by the Board, while 13 other positions have been approved in principle.⁷⁴

4.59 In Victoria, in 2000 amendments to the *Nurses Act 1933* protects the title ‘Nurse Practitioner’ and provides for the introduction of the role of Nurse Practitioner in that State, which will allow suitably experienced and advanced clinical nurses to be authorised to prescribe a limited range of drugs and poisons. To date, 27 Nurse Practitioner models of practice have been funded to refine and evaluate their services.⁷⁵ South Australia has undertaken a Nurse Practitioner Project in conjunction with the Nurses Board and the SA Department of Human Services. The South Australian Department stated that it was ‘extremely supportive’ of the Nurse Practitioner role and has contributed funding to the development of that role. While they are not formally recognised in South Australia, the Department indicated that ‘we have a range of nurses who are practising in advanced level roles’.⁷⁶

4.60 In Western Australia, the Remote Area Nurse Practitioner report of 2000 recommended that the title ‘Nurse Practitioner’ be protected. In 2001 the Government announced that the role of Nurse Practitioner would be extended to metropolitan areas – rather than only remote areas as was originally proposed. Legislation is currently being drafted governing the role of Nurse Practitioners in the State.⁷⁷ Tasmania is currently undertaking a review of existing Nurse Practitioner models and will be examining their application in the State’s health system.⁷⁸ In Queensland the title is not protected and there appears to be no move to do this, however, legislative changes have been made to enable isolated practice nurses to administer specific medications and order x-rays. Queensland Health stated that funds have been allocated to

73 Education Review, p.69.

74 *Committee Hansard*, 22.3.02, p.519 (NSW Health Department).

75 *Submission 960*, p.16 (Victorian Government).

76 See *Committee Hansard*, 27.3.02, p.781 (SA Department of Human Services). See also *Submission 86*, p.4 (Nurses Board of SA).

77 *Committee Hansard*, 27.2.02, p.99 (WA Department of Health).

78 *Submission 923*, p.7 (Tasmanian Department of Health & Human Services).

investigate suitable models for the Nurse Practitioner role and the Department stated that ‘we are in the process of working through that’.⁷⁹

4.61 Many submissions argued that Governments should support and encourage the role of Nurse Practitioners.⁸⁰ The Victorian Government stated that:

Pilot and demonstration projects in New South Wales and Victoria support the proposition that Nurse Practitioners are feasible, safe and effective in their roles and that they provide quality health services in a range of settings.⁸¹

4.62 Submissions emphasised the need for the development of a framework for standards and competencies for Nurse Practitioners that are nationally consistent. The Royal College of Nursing (RCNA) stated that to date the Nurse Practitioner role has developed in an inconsistent manner across the States ‘which has resulted particularly in there being discrepancies in their role and practice settings’.⁸² The term ‘Nurse Practitioner’ does not have a standard definition or scope of practice across Australia.⁸³

4.63 The Education Review noted that the trend overseas is to demand at least Masters level qualifications for many expert clinical roles. The Education Review stated that in Australia there has been some development in the area of Masters courses ‘but a more systematic development of nursing roles and their expectations would help education to meet the needs of the industry. There is at present little consistency in the approaches developing in the different States and Territories’.⁸⁴

4.64 In Victoria and NSW there are no mandatory educational requirements such as a Masters degree to be authorised as a Nurse Practitioner, although applicants need post-registration qualifications relevant to their practice. In Western Australia the Nurse Practitioner will be required to complete an appropriate postgraduate diploma which has been accredited by the Nurses Board of WA.

4.65 The NSW Nurses Registration Board indicated that there are two mechanisms by which a person may be authorised – a number of universities have developed courses at Masters level for Nurse Practitioners, which have been approved by the Board (three Masters courses have been approved). Alternatively, an RN with

79 *Committee Hansard*, 26.3.02, p.586 (Queensland Health); Education Review, p.69.

80 *Submission 927*, p.12 (RCNA); *Submission 962*, p.36 (ANF); *Submission 926*, p.8 (ANCI); *Submission 800*, p.48 (NRHA).

81 *Submission 960*, p.16 (Victorian Government).

82 *Submission 927*, p.12 (RCNA).

83 *Submission 800*, p.48 (NRHA).

84 Education Review, p.22.

advanced nurse practice experience may apply to the Board through an interview process supplying the relevant documentation outlining their skills and experience.⁸⁵

4.66 Several witnesses, including the RCNA argued that there should be national consistency in the development of the Nurse Practitioner role.⁸⁶ The Victorian Government argued that Commonwealth funding should be provided for the development of a framework for standards and competencies for Nurse Practitioners and that these should be nationally consistent.⁸⁷ The Victorian Department of Human Services added that:

Competencies and standards guide decision making. They provide a framework... – the boundaries – they reflect the scope of practice... [such] standards should provide a yardstick for measuring beginning and continuing competency in all practice settings and they should provide guidance for practitioners with respect to legal issues, curricula development and on-going professional development. Agreement on a set of national standards for Nurse Practitioners will assist in enhancing the public's understanding of the scope of practice of Nurse Practitioners.⁸⁸

4.67 In Victoria, a Nurse Practitioner Taskforce, including representatives from the AMA and the College of General Practitioners was appointed to develop a framework for the role of Nurse Practitioner. The focus of the role is on health promotion, education and the complementary nature of the advanced nursing role.⁸⁹ The NRHA suggested that the Commonwealth, in conjunction with State Governments and key stakeholders, should develop mutually consistent approaches to Nurse Practitioner issues such as scope of practice, education and training, remuneration and legislative arrangements.⁹⁰ The ANF stated that the Commonwealth Government should support the exploration of models of advanced nursing practice so that they develop in a nationally consistent, safe and structured manner.⁹¹

Conclusion

4.68 The Committee believes that Commonwealth and State Governments should support and encourage the development of the Nurse Practitioner role as a valuable component in the health system to assist with the delivery of health services in rural and remote areas and as an expansion of the clinical career opportunities for nurses.

85 *Committee Hansard*, 22.3.02, p.520 (NSW Nurses Registration Board).

86 *Submission 927*, p.12 (RCNA). See also *Submission 477*, p.4 (NNOs); *Submission 800*, p.49 (NRHA).

87 *Submission 960*, p.16 (Victorian Government).

88 *Submission 960*, Supplementary Information, 13.5.02, p.1 (Victorian Department of Human Services).

89 *Submission 960*, p.16 (Victorian Government).

90 *Submission 800*, p.49 (NRHA).

91 *Submission 962*, p.36 (ANF).

The Committee also considers that there should be national consistency in standards and competencies for Nurse Practitioners.

Recommendation 34: That Commonwealth and State Governments promote and support the development and introduction of Nurse Practitioners across Australia as a viable component of healthcare services.

Recommendation 35: That the Royal College of Nursing and the NSW College of Nursing, in conjunction with the Commonwealth Department of Health and Ageing, the States and key stakeholders, develop a framework for nationally consistent standards and competencies for Nurse Practitioners.

Credentiailling for advanced practice nursing

4.69 Some submissions argued that there was a need for a national approach to the credentialling of advanced practice nurses and the accreditation of related education programs.⁹² Credentialling is a form of self-regulation by the profession by which an individual nurse is designated as having met established professional practice standards by an agent or body generally recognised as qualified to do so.⁹³ Credentialling of advanced practitioner and accreditation of related education programs occurs in nursing in the United States, the UK and Canada, as well as throughout the world in most other health professions.

4.70 A number of speciality nursing groups, such as independent midwifery practice, critical care and mental health specialities, have implemented credentialling processes as a means of self regulation for their particular speciality areas, so that nurses may demonstrate their competence and be publicly accountable for the services they provide. Nursing specialties have produced practice standards, and/or competencies, guidelines for curricula development and continuing professional development programs as a means of self-governance and quality improvement for their members.

4.71 The RCNA stated that a national accreditation and credentialling system needs to be introduced for advanced practice nurses and for specialist nurses to ensure that nursing graduates demonstrate agreed professional standards.⁹⁴ The RCNA study into the credentialling of Advanced Practice Nurses identified a number of benefits associated with credentialling. It was argued that credentialling formally demonstrates nurses' skills and knowledge; indicates a preparedness to be accountable to the profession; provides a means for identifying nurses' achievements and competencies; provides greater assurance of high quality care; and allows the profession to demonstrate its commitment to developing, maintaining and promoting high

92 *Submission 927*, p.11 (RCNA). See also *Submission 409*, p.4 (La Trobe University School of Nursing).

93 RCNA study, pp.73-74.

94 *Submission 927*, p.11 (RCNA); *Committee Hansard*, 22.3.02, pp.536-37 (RCNA).

standards.⁹⁵ The College pointed to research in the United States which examined the effect of nurse credentialling on health outcomes. The reported benefits included fewer adverse incidents in patient care; increased satisfaction, personal growth, skill competence and confidence in practice; and increased patient satisfaction.⁹⁶

4.72 The RCNA recently completed a project which examined the feasibility of implementing a national approach to the credentialling of Advanced Practice Nurses. The report argued that a national framework for the credentialling of these nurses and the accreditation of related education programs should be introduced.⁹⁷

4.73 Arguments against the concept of credentialling point out that nurses are already bound by the ANCI codes of ethics and professional conduct and are accountable to the public through State nurse regulatory authorities. These processes are designed to protect consumers from unsafe practitioners. The public also has remedy at common law. Credentialling is therefore not seen as necessary.⁹⁸

Conclusion

4.74 The Committee notes the arguments for and against the notion of credentialling of Advanced Practice Nurses. The Committee believes that credentialling of Advanced Practice Nurses is an important aspect of professional development which could be used as part of a career path for many nurses. The Committee considers that the Royal College of Nursing and the NSW College of Nursing should further examine the feasibility of introducing such a system in conjunction with the Commonwealth and other key stakeholders.

Recommendation 36: That the Royal College of Nursing and the NSW College of Nursing, in conjunction with the Department of Health and Ageing and other key stakeholders, such as nurse regulatory bodies, examine the feasibility of establishing a national approach to the credentialling of Advanced Practice Nurses.

Unregulated healthcare workers

4.75 While RNs and ENs operate within a regulatory framework, there are unregulated healthcare workers, variously referred to as assistants in nursing (AINs) or personal care assistants/attendants, nursing assistants or people off the street, where strict standards do not apply. While there are training programs for these workers in the Vocational Education and Training (VET) system, there are no formal requirements for training set down by Governments or employers before these workers can be employed.⁹⁹ These workers may have a qualification from a VET

95 RCNA study, p.23.

96 *Submission 927*, p.12 (RCNA).

97 RCNA study, p.11.

98 See discussion in RCNA study, p.23.

99 *Committee Hansard*, 27.3.02, p.726 (ANF).

institution, some in-service training or no training at all.¹⁰⁰ The ANF referred to unregulated workers as ‘part of the nursing family’.¹⁰¹

4.76 Unregulated workers are employed predominantly in the aged care sector. Evidence indicated that some employers, especially in the aged care sector, are substituting qualified nurses with these unqualified personnel both as a cost-saving measure and to remove nurses with the skills and expertise to comment critically on management in these health facilities.¹⁰² This issue is discussed further in chapter 7.

4.77 The Committee received conflicting evidence on the proportion of unregulated workers with Level III qualifications. The ANF (SA Branch) stated that in South Australia, unlike some States, some 70 per cent of personal care assistants are trained to Certificate III level.¹⁰³ The ANF stated that a similar proportion are covered in NSW.¹⁰⁴ However, the NSW Nurses Association stated that the ‘majority’ of personal care assistants in NSW employed in the aged care sector do not have Certificate III level qualifications.¹⁰⁵

4.78 The ANF stated that unregulated workers, who provide assistance and support in the delivery of nursing care, must work under the supervision and direction of RNs. This supervision may be direct or indirect.¹⁰⁶ The Nurses Board of Victoria stated that to ensure quality of care, the RN must only delegate nursing activities when it is considered that the person to whom such tasks are delegated has the necessary skills and knowledge to undertake them safely. It is the responsibility of the RN to assume accountability for delegation.¹⁰⁷ The supervision of increasing numbers of unregulated workers in many healthcare facilities can add to the already heavy workloads of RNs.

4.79 The ANCI stated that whilst there is potential for unregulated workers to be used to ‘support’ nursing practice ‘they should not be used as substitutes for qualified nurses and their contribution to care should be carefully evaluated’.¹⁰⁸ The Council state that debate and consultation about which settings are appropriate for ‘suitably educated care workers’ to work, and their overall role, is needed.¹⁰⁹

100 *Submission 765*, pp.4-5 (NBV); Education Review, p.7. See also *Submission 899*, p.6 (NSW Nurses’ Association).

101 *Submission 962*, p.39 (ANF).

102 *Submission 457*, pp.9-10 (QNU). See also *Submission 899*, p.7 (NSW Nurses’ Association).

103 *Committee Hansard*, 27.3.02, p.726 (ANF/ANF (SA Branch)).

104 *Committee Hansard*, 27.3.02, p.726 (ANF).

105 *Committee Hansard*, 2.3.02, p.528 (NSW Nurses’ Association).

106 *Submission 962*, p.40 (ANF).

107 *Submission 765*, p.5 (NBV).

108 *Submission 926*, p.7 (ANCI).

109 *Submission 926*, p.7 (ANCI).

4.80 The Nurses Board of Victoria posed the question of unregulated workers with little or no education delivering what is, in effect, nursing care – ‘is it acceptable that those who have little or no education and are not subject to the public protection that comes from registration or licensure should provide nursing care to residents of aged care facilities?’.¹¹⁰

4.81 Concerns were also expressed that these workers routinely administer medications. One witness noted that in NSW ‘there are people at this level, and without qualifications, being asked to give medication, including injections, and make judgement calls about pain medication which is under a schedule’.¹¹¹ The ANF stated that this is a problem in most States with low care residential aged care facilities. They are classified as hostels under State Acts and ‘are not bound by the health facilities legislation’. The ANF added that:

Unlicensed workers routinely assist with medication administration at those sites. This is very concerning because with ageing-in-place many low care facilities have very high care residents. You can be sick, very frail and aged or demented but you may not receive regular nursing care if you stay in your hostel and an unlicensed worker may be administering your medications with very little or no education.¹¹²

4.82 In NSW, the *Poisons and Therapeutic Goods Act 1966* specifies that RNs are authorised to administer medications in healthcare facilities, such as hospitals and nursing homes. However, unregulated care workers are not specifically mentioned in the Act. As the Act only applies to specific healthcare facilities there is no regulation of medication administration in non-healthcare facilities, such as hostels or boarding houses. This means that in these facilities unlicensed healthcare workers are unregulated in relation to administering medications.

4.83 In South Australia, only RNs or ENs can administer medications in hospitals. In hostels unregulated care workers can administer medications to patients, with these medications usually pre-packed by a pharmacist. The care worker is considered to be assisting the patient take their medication rather than administering it. Under the *Controlled Substances Act 1984* the supply and administration of prescription drugs is restricted to medical practitioners and other prescribed professions or to a person administering to another person a prescription drug that has been lawfully prescribed for that person. Unregulated care workers are not explicitly excluded from administering medications. In Queensland, assistants in nursing are not permitted to administer medications.¹¹³

110 *Submission 765*, p.5 (NBV). See also *Committee Hansard*, 28.2.02, p.203 (NNOs).

111 *Committee Hansard*, 22.3.02, p.528 (NSW Nurses’ Association). See also *Committee Hansard*, 26.3.02, p.587 (Queensland Health).

112 *Submission 962*, Additional Information, 23.5.02, p.1 (ANF).

113 *Submission 942*, Additional Information, 17.4.02, p.1; 14.5.02, p.1 (Queensland Health).

4.84 Some evidence suggested that unlicensed health workers should be regulated. The Nursing Board of Tasmania argued that a regulatory process should be developed for unlicensed health workers ‘in a nationally consistent approach to ensure that they have the relevant knowledge, skills and competence to undertake the care activities that they are being required to perform...As the activities associated with this level of worker are an adjunct to nursing care, the board believes it is appropriate for the nurse regulatory authorities in each state and territory to undertake this role’.¹¹⁴ The Nurses Board of Victoria’s view is that there should be some licensing arrangement put in place by the State Government for unregulated workers.¹¹⁵

4.85 The Queensland Nursing Council, however, cautioned that if this class of worker were regulated, the form the regulation should take would need to be carefully considered – ‘regulating by title – that is, if you are going to be an assistant in nursing, you have to have X,Y and Z – would probably mean that some unscrupulous employers would start calling them something else’.¹¹⁶

4.86 The ANF, RCNA and other groups stated that the minimum entry level qualification for unregulated healthcare workers should be equivalent to Level III of the Australian Qualifications Framework.¹¹⁷ The ANF stated that the educational qualifications should be provided in the vocational education sector, be available in a variety of modes, including part time study and distance education and from a variety of education providers, TAFE colleges, employers, and private registered training organisations.¹¹⁸

4.87 The ANF and other groups further argued that formal articulation and recognition of prior learning arrangements should be developed between Certificate III courses for unregulated workers and enrolled nurse courses to facilitate professional development and a career path.¹¹⁹

Conclusion

4.88 The Committee shares the concerns of many witnesses during the inquiry that unregulated healthcare workers, many with little or no formal training are performing nursing care tasks. The Committee believes that unlicensed healthcare workers should be regulated by nursing regulatory authorities. The Committee also believes that such workers should not be permitted to administer medications. The Committee further

114 *Committee Hansard*, 15.3.02, p.267 (Nursing Board of Tasmania). See also *Submission* 838, Additional Information, 31.5.02, p.2 (Nursing Board of Tasmania); *Submission* 838, p.1 (Nursing Board of Tasmania).

115 *Committee Hansard*, 26.3.02, p.624 (ANCI).

116 *Committee Hansard*, 26.3.02, p.623 (QNC).

117 *Submission* 962, p.40 (ANF); *Committee Hansard*, 22.3.02, p.540 (RCNA); *Committee Hansard*, 28.2.02, p.203 (NNOs).

118 *Submission* 962, p.40 (ANF).

119 *Submission* 962, p.40 (ANF); *Committee Hansard*, 28.2.02, p.203 (NNOs).

considers that there should be a standard minimum level of training required for unregulated workers and that this should be equivalent to Certificate III level qualifications.

4.89 The Committee also believes that the plethora of titles currently used to refer to unregulated workers needs to be standardised and that a uniform title should be applied to these workers across Australia (see chapter 1).

Recommendation 37: That State and Territory nursing regulatory authorities develop a framework for the regulation of unregulated healthcare workers.

Recommendation 38: That the relevant State and Territory legislation be amended to provide that unregulated healthcare workers not be permitted to administer medications.

Recommendation 39: That the standard minimum level of training required for unregulated workers before they can be employed in healthcare facilities be equivalent to Level III of the Australian Qualifications Framework (Certificate Level III).

Information technology

4.90 Evidence indicated that training programs for nurses need to integrate computer/IT skills more comprehensively throughout university/TAFE courses and clinical programs. Nursing practice continues to be revolutionised by the impact of technology. The increasing introduction of electronic patient health records makes it imperative that nurses are IT literate as the old style manual patient records system are no longer appropriate or adequate. In addition, ward data management systems are now computer-based. One submission noted that:

For nurses to take advantage of the new technologies considerable time and effort needs to be focused to ensure that computer literacy for nurses is a priority in nursing education. Within hospitals, information technology has become a must have in the delivery of efficient health care.¹²⁰

4.91 Witnesses raised a number of issues regarding the IT needs of undergraduates and other nurses.¹²¹ The ANF stated that while most younger undergraduates have good computer proficiency, the more mature aged undergraduates – which one witness suggested may constitute about 30 per cent of undergraduates – are much less computer/ IT literate. The ANF stated that:

What we have coming through into the hospital are two groups, but there is an assumption that because they have been through university they understand the Internet, they understand how to use the library resources

120 *Submission 780*, p.8 (WCH). See also *Submission 954*, pp.1-21 (Ms Anthony).

121 *Submission 926*, p.15 (ANCI); *Submission 409*, p.3 (La Trobe University School of Nursing).

and so on. One group finds anything about IT in hospital incredibly pedantic...and the other group is terrified of it.¹²²

4.92 The ANCI told the Committee that computer literacy standards are not specifically identified in the accreditation standards for nurse education courses.¹²³

4.93 The ANF also noted that long-term staff who are not used to computers/IT need access to education in the new technologies.¹²⁴ The Committee believes that in-service training is essential to address these needs. Witnesses noted how inadequate the present training facilities are at present in many States. One witness noted that Royal Adelaide Hospital ‘has two eight-seat training rooms and 5,000 staff’.¹²⁵

4.94 Technologies are being used to assist in the education of nurses, including distance education and advanced technologies such as online presentations and learning experiences via the Internet. One witness gave the example of where medical officers can do simulation exercises, such as simulated suturing and surgery – ‘that sort of area needs to be investigated, particularly for nursing and midwifery in the future, so that our students can get a chance to experience real life [situations]’.¹²⁶

4.95 Evidence indicated that there needs to be improved access to IT and computer technologies for nurses, especially in rural areas where computer and Internet access is often limited. The ANF noted that some community nursing organisations provide their community nurses with IT to take to the home so that patient information can be downloaded directly – ‘but that is the exception rather than the rule’.¹²⁷

4.96 The NSW Health Department stated that an electronic health records system is being developed in that State and that it will be implemented by 2010. In addition, the Clinical Information Access Program is operating, which is an Internet base clinical information system that provides up-to-date clinical information at point of care. The Department stated that this system ‘has been particularly successful across NSW, particularly in our rural areas...and now is providing nurses, in particular, with access to immediate up-to-date clinical information on a whole variety of different clinical situations’. Nurses access the computers at the area health services and community health nurses in the field access the system via palm pilots.¹²⁸

122 *Committee Hansard*, 27.3.02, p.736 (ANF).

123 *Committee Hansard*, 26.3.02, p.633 (ANCI). See also *Committee Hansard*, 26.3.02, pp.633-34 (QNC).

124 *Committee Hansard*, 27.2.02, p.736 (ANF).

125 *Committee Hansard*, 27.3.02, p.736 (ANF).

126 *Committee Hansard*, 2.3.02, p.517 (NSW Nurses Registration Board).

127 *Committee Hansard*, 27.3.02, p.736 (ANF).

128 *Committee Hansard*, 22.3.02, pp.517-18 (NSW Health Department).

4.97 Access to computers is vital for nurses. The Committee notes that while Commonwealth grants of \$3 000 were available to each GP to purchase computers, similar assistance has not been extended to nurses.¹²⁹

Conclusion

4.98 The Committee supports the continued use and development of new technologies in nurse education and training. It also believes that the computer/IT needs of undergraduates need to be addressed, especially for more mature aged undergraduates that may lack the IT literacy skills of their younger colleagues.

4.99 The Committee also believes that IT needs to be supported in practice settings. The Committee considers that in-service training needs to be more widely available for graduate nurses. The Committee also believes that the Commonwealth should extend assistance to enable nurses to access computers. The Committee notes that the Commonwealth Government has provided substantial assistance to GPs to purchase computers.

Recommendation 40: That universities continue to promote and develop IT in undergraduate nursing courses, in particular the training needs of mature aged undergraduates.

Recommendation 41: That in-service training in IT skills be widely developed and promoted for graduate nurses.

Nursing research

4.100 Evidence indicated that there is a need to increase funding for nursing research in Australia.¹³⁰ One witness stated that, for example, there is no research in the Australian context that analyses the impact that nursing workloads, staffing levels, patient acuity, and the different nursing skill mix and models of nursing care have on patient outcomes.¹³¹

4.101 The Education Review also noted that:

Research that underpins innovations in practice and education will need to be current and strong if Australia is to have a nurse workforce that can remain effective in a changing environment. The dearth of Australian research on nursing in relation to evolving models of healthcare, and the lack of evaluation of models of education and training is evidence for this need.¹³²

129 See *Committee Hansard*, 26.3.02, p.633; 27.3.02, p.735.

130 *Submission 192*, p.9 (ACDON); *Committee Hansard*, 27.3.02, p.679 (Flinders University).

131 *Committee Hansard*, 2.3.02, p.501 (NSW Health Department).

132 Education Review, p.134. See also *Committee Hansard*, 22.3.02, p.501 (NSW Health Department).

4.102 The present research funding environment is very competitive, and much nursing research does not easily fit the type usually supported by the medical model. Nursing is a clinically based discipline so it is difficult to establish an active research program. Funding tends to go more to the basic sciences and medicine. Consequently, nursing researchers have difficulty in gaining support for research projects in the context of large competitive grants applications. The lack of experience as a developing research discipline places nursing at a further disadvantage.¹³³ One witness noted that ‘for us to move to a very evidence based practice where we establish our standards appropriately there need to be dedicated funding support for research’.¹³⁴

4.103 The Deans of Nursing argued that the lack of research funding for nursing is partly due to the nursing professions’ ‘thin representation’ on the National Health and Medical Research Council (NHMRC) and especially the committee structure within the Council that approves grants.¹³⁵ The Tasmanian School of Nursing noted that while the NHMRC recognises nursing research for funding purposes ‘it is a token gesture and risks being subsumed within the competitiveness of established medical researchers for scarce resources’.¹³⁶ The School argued that a separate national funding scheme for nursing research should be established.

4.104 The lack of funding for nursing research is illustrated by the fact that of the 758 continuing project grants funded by the NHMRC in 2000 (with total funding of \$69.5 million) only five (for a total of \$283 970) were designated as being for nursing research.¹³⁷

4.105 The Tasmanian School of Nursing suggested that Key Centres of Clinical Nursing Research should be established. These centres would be based around identifying and developing clinical nursing research in response to identified needs/expertise within specific geographical contexts. For example, in areas of regional Australia, such as Tasmania, the area of interest might be rural/remote area nursing. The specific foci could include community, aged care, acute care and mental health nursing. In urban areas a Key Centre might have a broad area of interest in paediatric nursing. Specific foci might include adolescent health, and paediatric intensive care/neonatal nursing. The Centres could be affiliated with one or more university schools of nursing as well a specific healthcare organisation. The Centres would aim to develop strong multi disciplinary research partnerships with researchers across Australia; facilitate collaborative research between stakeholders in the three

133 *Committee Hansard*, 27.2.02, p.109 (Sir Charles Gairdner Hospital); *Submission* 192, p.9 (ACDON).

134 *Committee Hansard*, 27.2.02, p.109 (Sir Charles Gairdner Hospital).

135 *Submission* 192, p.9 (ACDON). See also *Submission* 804, p.2 (University of Southern Queensland).

136 *Submission* 449, pp.12-13 (Tasmanian School of Nursing).

137 Education Review, p.135.

sectors – universities, healthcare agencies and the community; and provide opportunities for research training/staff development for clinical staff.¹³⁸

4.106 Submissions noted that strengthening the contribution of nursing to health research would lead to improved health outcomes for Australians, and also have the effect, over time, of enhancing the status and reputation of nursing thereby making it more attractive in terms of recruitment.¹³⁹

Conclusion

4.107 The Committee believes that there should be a strong national commitment to nursing research to ensure best practice and improved health outcomes and that funding for nursing research should be increased.

4.108 The Committee also considers that funding for research provided by the Department of Education, Science and Training to universities needs to be increased to encourage more university-based nursing research.

Recommendation 42: That the Commonwealth Government, through the National Health and Medical Research Council, increase funding for nursing research as a matter of priority.

Recommendation 43: That the research funding provided by the Department of Education, Science and Training to universities be increased to facilitate additional university-based nursing research.



138 *Submission 449*, Supplementary Information, 22.3.02, p.1 (Tasmanian School of Nursing).

139 *Submission 192*, p.9 (ACDON); *Submission 804*, p.2 (University of Southern Queensland).

