SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

THE PATIENT PROFESSION: TIME FOR ACTION

Report on the Inquiry into Nursing

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TABLE OF CONTENTS

LIST OF ACRONYMS

ACCCN	Australian College of Critical Care Nurses
ACDON	Australian Council of Deans of Nursing
ACMI	Australian College of Midwives Incorporated
ACORN	Australian College of Operating Room Nurses
ACPCHN	Australian Confederation of Paediatric and Child Health Nurses
AHA	Australian Healthcare Association
AHMAC	Australian Health Ministers' Advisory Council
AHWAC	Australian Health Workforce Advisory Committee
AHWOC	Australian Health Workforce Officials Committee
AIHW	Australian Institute of Health and Welfare
AMAP	Australian Midwifery Action Project
ANCI	Australian Nursing Council Incorporated
ANF	Australian Nursing Federation
ANHECA	Australian Nursing Homes and Extended Care Association
ANNA	Australian Neonatal Nurses Association
ANZCMHN	Australian and New Zealand College of Mental Health Nurses
APHA	Australian Private Hospitals Association Limited
AQF	Australian Qualifications Framework
ATSI	Aboriginal and Torres Strait Islander
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CFHNA	Child and Family Health Nurses Association
CPNRP	Centre for Psychiatric Nursing Research and Practice
DEST	Department of Education, Science and Training
DETYA	Department of Education, Training and Youth Affairs
DEU	Dedicated Education Unit
DEWR	Department of Employment and Workplace Relations
DHAC	Department of Health and Aged Care
DIMA	Department of Immigration and Multicultural Affairs
EFTSU	Equivalent Full-Time Student Unit
EN	Enrolled Nurse
HACSU	Health and Community Services Union
HECS	Higher Education Contribution Scheme
MODL	Migration Occupations in Demand List
NENA	National Enrolled Nurse Association
NHMRC	National Health and Medical Research Council
NNOs	National Nursing Organisations

NRHA	National Rural Health Alliance Incorporated
PELS	Postgraduate Education Loans Scheme
QNU	Queensland Nurses' Union
RCNA	Royal College of Nursing, Australia
RCS	Resident Classification Scale
RFM	Relative Funding Model
RN	Registered Nurse
TORN	Tasmanian Operating Room Nurses
VCPNO	Victorian Council of Peak Nursing Organisations
VET	Vocational Education and Training

OVERVIEW

Nursing is a great profession, established over 150 years ago and now providing the largest group of employees in the health care sector.

Yet nursing in Australia is still significantly overlooked in health policy development and in workforce calculations. The shortages of nursing staff, especially in hospitals and aged care that has been threatening for years, have now reached crisis point.

The Committee received evidence of critical shortages of nurses in all areas of health care services. In some areas, particularly aged care and mental health nursing, the problems due to nurse shortages are acute.

Issues associated with nursing including nurse recruitment and retention, workforce planning, education and specialised fields of nursing practice have been the subject of many inquiries, reviews, research projects and commissioned studies in recent years. While the Commonwealth, States and Territories have been implementing recommendations and strategies from these various reviews, concerns were expressed to the Committee that structural changes and reforms to overcome the major issues were slow in occurring.

Nursing has traditionally been a patient profession. Nurses are extremely dedicated and passionate about the health care they provide and the work they perform. However, nurses' frustration at perceived inaction has led to a growing militancy among their ranks. The Committee considers that there have been enough reviews. It is now time for leadership and action.

Nursing as a profession involves many stakeholders and contains many complexities and inter-relationships.

The Committee has made many recommendations, acknowledging that a range of jurisdictions have roles and responsibilities in relation to nursing including the Commonwealth, States and Territories, the Australian Nursing Council and State registration boards, professional nursing bodies including the Nursing Colleges, the Unions, the Universities and TAFEs, and the providers of health and aged care services that employ nurses in the public and private sectors.

The Committee considers that the need for a national nursing workforce planning strategy is fundamental and urgent. There is a requirement for a strong national leadership and coordination role, which should be undertaken by the Commonwealth due to the crucial role that it plays in the funding and delivery of health, education and aged care services.

To assist with national nursing policy, workforce planning and coordination, and to advise the Commonwealth government on nursing issues, the Committee has recommended the establishment of a Commonwealth Chief Nurse position in the

Department of Health and Ageing. The position would be equivalent to the Principal Nursing Adviser/Chief Nurse positions in the States and Territories.

The Committee supports the continuation of the current university-based system for the undergraduate education of registered nurses.

Evidence to the Committee highlighted that increasing the numbers of nursing graduates is a critical part of addressing the shortage problem. The Committee has addressed a range of issues in relation to undergraduate and postgraduate education and made many recommendations the area of nurse education including:

- the need for additional funded undergraduate places in nursing courses,
- enhanced clinical training and assistance with clinical placements as part of undergraduate courses, and
- additional scholarships to assist in attracting students into nursing as well as undertaking postgraduate study.

The Committee believes that like other university disciplines nursing research needs to be encouraged to continue and further develop and has made recommendations for increased research funding.

The Committee has also made a number of recommendations to improve the interface between the education sector and health system including partnership initiatives and arrangements, joint curriculum development and joint appointments, and sharing of facilities.

One area of significant loss of nurses is in the first year after graduation. The Committee has recommended that greater coordination and financial support be provided in programs for the transition of new graduates into the healthcare system. The Committee considers that there needs to be a formalisation of the graduate nurse programs and of the training and payment of nurses chosen to be preceptors.

Inadequate pay and unsympathetic and inflexible working conditions are major contributing factors to nurses leaving the profession. Improving the recruitment and retention of nurses is largely about addressing these issues.

The Committee has made recommendations which are applicable to all categories of nurses to address issues of recruitment and retention including:

- promotion of a positive image for nursing and the highly skilled work of nurses;
- extending professional development and continued education opportunities;
- development of improved career pathways and opportunity with professional recognition and remuneration of knowledge, skills and education;
- increasing remuneration;
- improving working conditions, especially workload, double shifts and flexibility in rostering and working hours;
- expanding refresher and return to nursing programs;

- the introduction of more family friendly practices to meet nurse expectations;
- providing more effective nursing leadership and management, including greater nurse involvement in decision making; and
- provision of a safe working environment that ensures nurses are free of fear, intimidation and violence.

Aged care nursing was singled-out as the sector of nursing in greatest crisis. Qualified nurses are leaving in large numbers and not being replaced. Salary rates for aged care nurses are significantly lower than for equivalent nurses in all other areas of nursing.

The Committee considers that there needs to be a concerted effort to ensure that all those in the aged care sector receive the quality of care that the Australian community expects. The Committee believes that aged care nurses should have access to working conditions, and receive remuneration and recognition, commensurate with their training and professionalism and comparable to similarly qualified nurses in other health areas.

The Committee has made a number of recommendations in aged care including reducing the burden of paperwork required under RCS funding, the need for pay parity, the increasing use of unqualified workers in aged care, introducing measures to reduce occupational injuries to nurses working in aged care, and to improve educational opportunity in aged care at both undergraduate and postgraduate levels.

Mental health nursing shortages made it another area requiring urgent action, to ensure that those already working in mental health are supported and provided with opportunities for further education, and improved career pathways; to ensure that there is an adequate take-up of postgraduate places in mental health nursing courses; and that postgraduate education for mental health nurses is rationalised and reformed.

Attracting and retaining nurses in rural and remote areas is increasingly difficult. Experienced nurses find moving to non-metropolitan areas unattractive due to the expense of moving, inadequate accommodation, lack of remuneration commensurate to qualifications and the degree of isolation or remoteness. Nursing staff already employed in rural and remote areas are leaving because of workload, lack of recognition of their skills, poor educational opportunities and pressures of providing care that may be outside their scope of practice.

The Committee strongly believes that it is important to encourage more Indigenous nurses into the general nursing workforce. Increasing the number of Indigenous people in the nursing workforce will improve the accessibility, quality and cultural appropriateness of health care for Indigenous communities. Increased participation in nursing will also extend an improved cultural awareness among non-indigenous members of the health workforce.

Specialised areas of nursing practice are also confronted with a range of recruitment and retention problems. The health care system needs experienced specialist nurses. With health care becoming more complex, nurses are seeking to undertake additional education to increase their knowledge and skills.

Nurses endeavouring to further their education in specialised areas face difficulties due to the cost of post graduate education, lack of suitable courses, lack of support from employers and lack of recognition and remuneration of their enhanced skills. This is contributing to nurse shortages in many areas including midwifery, paediatrics, community care, critical care and emergency nursing, as well as aged care and mental health.

The Committee recognises that these areas of health care could not now function without specialist nursing support. With the ageing nurse workforce and insufficient numbers of new graduates moving into specialist areas, there is little prospect of the situation improving without immediate action being taken.

The nursing profession has undergone a massive transformation in the previous 10-15 years. Nurses have won the struggle to move nursing education into the higher education sector, they have had to adjust to new medical health technologies, developments in information technology, and dramatic shifts in the approach to patient care in hospitals and the community.

Nurses have had to cope with the effects on patient care of increasing demands being placed on health services through constantly contracting budgets. Yet nurses have little opportunity to participate in the formulation of policies to deal with or address these changes.

It is time for the nursing profession to be recognised as an equal player in Australia's health care system.

It is time for the voice of nurses to be heard.

The patient profession is running out of patience!

It is time for action.

RECOMMENDATIONS

Chapter 1

Recommendation 1: That standard nomenclature be adopted throughout Australia to describe level of nurse and their qualifications, and including unregulated nursing and personal care assistants.

Chapter 2

Recommendation 2: That the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs streamline visa arrangements and simplify the process of recognising overseas qualifications for nurses wishing to migrate to Australia on a permanent or temporary basis, and to publicise the capacity to extend and to change visa arrangements.

Recommendation 3: The Committee recommends that the Minister for Health and Ageing undertake an urgent national review of the charges and practices of nursing agencies, including their impact on costs to public and private providers of health services and their impact on the shortage of nurses in Australia.

Recommendation 4: The Committee recommends that the Australian Competition and Consumer Commission conduct a review of the practices of nursing agencies in the healthcare sector.

Recommendation 5: That the Commonwealth in cooperation with the States and Territories facilitate and expedite the development of a national nursing workforce planning strategy.

Recommendation 6: That the Commonwealth provide the Australian Institute of Health and Welfare with the resources required to establish a consistent, national approach to current data collection on the nursing workforce in Australia.

Recommendation 7: That research be undertaken to examine the relationship between health care needs, nursing workforce skill mix and patient outcomes in various general and specialist areas of care, with a view to providing “best practice” guidelines for allocating staff and for reviewing quality of care and awarding accreditation to institutions.

Recommendation 8: That the Commonwealth, as a matter of urgency, establish the position of Chief Nursing Officer within the Department of Health and Ageing.

Recommendation 9: That national registration be implemented for registered and enrolled nurses.

Chapter 3

Recommendation 10: That the current university-based system for the undergraduate education of Registered Nurses be continued.

Recommendation 11: That the Commonwealth, in conjunction with the States and universities, implement improved mechanisms to determine the supply and demand for nursing places at universities and in determining how these targets are set.

Recommendation 12: That the Commonwealth Government provide funding for additional undergraduate nursing places to universities offering nurse education courses to meet the workforce requirements set by the States.

Recommendation 13: That, while maintaining a balance between theoretical and practical training, undergraduate courses be structured to provide for more clinical exposure in the early years of the course and that clinical placements be of longer duration.

Recommendation 14: That hospitals and other healthcare agencies be encouraged to provide part-time paid employment for student nurses from the second year of undergraduate courses.

Recommendation 15: That universities, as far as practicable, operate their clinical education programs across the entire year.

Recommendation 16: That undergraduate courses provide additional theory and clinical experience in mental health, aged care and cross-cultural nursing.

Recommendation 17: That the Commonwealth Government provide specific funding to support the clinical education component of undergraduate nursing courses; and that this funding provide that the clinical teacher/student be maintained at a ratio of 1:4.

Recommendation 18: That the Commonwealth and State Governments provide additional targeted scholarships for undergraduate nursing students based on merit directed at students from economically and socially disadvantaged backgrounds, NESB and ATSI backgrounds, and from rural and regional areas.

Recommendation 19: That the Commonwealth Government provide general scholarships for undergraduate nursing students based on merit.

Recommendation 20: That formal mentoring and preceptorship programs be developed nationally, with enhanced training and the payment of allowances for nurses chosen to become preceptors.

Recommendation 21: That graduate nurse programs be available for all nursing graduates and that these programs:

- concentrate on skills consolidation through a structured program to enable professional development;
- be provided with appropriate supervision and support; and
- be jointly funded by Commonwealth and State Governments.

Recommendation 22: That formal articulation arrangements and recognition of prior learning between enrolled nurse courses and registered nurse courses by

universities and enrolled nurse education providers be further developed nationally.

Recommendation 23: That formal articulation arrangements and recognition of prior learning be developed between Certificate III courses for unregulated healthcare workers and enrolled nurse courses, and between courses for ATSI health workers and enrolled nurse courses.

Recommendation 24: That the Australian Nursing Council, in conjunction with key stakeholders, including State regulatory bodies, the universities, professional nursing bodies and nursing unions, develop a national curriculum framework or guidelines for undergraduate nursing courses to ensure greater consistency in the interpretation of the ANCI competencies.

Chapter 4

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.

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.

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.

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.

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.

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.

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).

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.

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.

Chapter 5

Recommendation 44: That partnership arrangements be further developed between the public and private health sectors and universities and the vocational education sectors to facilitate the clinical education and training of nurses.

Recommendation 45: That partnerships be developed between universities to facilitate the sharing of resources and expertise; and facilitate undergraduate

student clinical placements in a range of metropolitan and regional clinical settings.

Recommendation 46: That improved partnership arrangements be established between the universities and the health sector in relation to curriculum development, including the appointment of clinicians to university curriculum committees.

Recommendation 47: That the Commonwealth provide funding for the establishment of more joint appointments between universities and health services.

Recommendation 48: That the Commonwealth provide funding for the establishment of additional clinical chairs of nursing.

Chapter 6

Recommendation 49: That the Commonwealth Government support the proposal by the Royal College of Nursing to conduct a pilot project in Australia on the Magnet Hospital Recognition Program.

Recommendation 50: That the Commonwealth and States fund regular, sustained campaigns conducted on a nationally coordinated basis to promote the status and positive image of nursing.

Recommendation 51: That a national nursing recruitment strategy be developed by the Commonwealth in consultation with the States and relevant nursing and employer bodies, with recruitment targets established through national workforce planning.

Recommendation 52: That any recruitment strategy and marketing campaigns specifically include encouragement for more males to adopt nursing as a career.

Recommendation 53: That the current career structure be reviewed and revised to provide career pathways that include continued clinical practice, enhanced opportunities for postgraduate study and accelerated pathways through which nurses can move to an advanced practitioner status. The career structure needs to recognise the skills obtained through postgraduate study and remunerate them accordingly.

Recommendation 54: That governments and professional nursing bodies provide detailed information to nurses on career pathways.

Recommendation 55: That the Commonwealth and States encourage providers of health care services to promote multidisciplinary team approaches to patient care which recognise all members of the team as valued and valuable.

Recommendation 56: That experienced, skilled and educated nurses be recognised and rewarded, both financially and through promotional opportunity, for the work they perform in decision making and the management and coordination of patient care across the continuum of care.

Recommendation 57: That the Commonwealth and States encourage providers of health care services to support nursing leadership by integrating nurses into the organisational hierarchy through their appointment to and meaningful participation in management; and by promoting nurse involvement in decision-making relating to nursing practice and clinical patient care.

Recommendation 58: That the Commonwealth and States ensure that nursing leaders are provided with the necessary in-service training and development to support them in their constantly evolving roles.

Recommendation 59: That the Commonwealth and States fund re-entry and refresher programs in all States and Territories, including the employment and payment of salaries for nurses undertaking such programs.

Recommendation 60: That there be greater coordination of re-entry and refresher programs provided through hospitals and tertiary institutions and of the content of these programs.

Recommendation 61: That the following 'family friendly' practices be advocated by all levels of government as best practice for all providers of health care services and nurse employers:

- That flexible rostering be introduced or where appropriate developed further, together with the encouragement of greater use of part-time and job-share options.
- That paid maternity and paternity leave be available to all nurses.
- That adequate, affordable, quality childcare be provided over extended hours at the workplace, or through other forms of direct childcare assistance such as the procurement of places at nearby childcare centres.
- That adequate facilities to meet breastfeeding requirements be provided in the workplace.
- That work practices be established to encourage experienced older nurses to remain in the profession.

Recommendation 62: That governments ensure that providers of health care services guarantee that education and other support measures for managing and responding appropriately to aggressive and violent behaviour are available to, and routinely provided for, nurses as continuing education in the workplace.

Recommendation 63: That the Commonwealth introduce a national reporting system for violence and aggression toward nurses and other health workers in order to understand the factors which give rise to violent incidents, the extent of the problem, and to inform the development of strategies to prevent future violent incidents involving nurses and other health workers.

Recommendation 64: That the National Occupational Health and Safety Commission urgently develop model uniform OH&S legislation and regulations for the Commonwealth, States and Territories relating to the use of safe needle technologies in Australian hospitals and other health workplaces, and work cooperatively with the States and Territories to improve associated safety education and training programs for health care workers.

Recommendation 65: That governments ensure that all nurse education curricula include occupational health and safety theory and practice covering aggression management training, use of safety equipment and devices, manual handling training, and competency assessment.

Recommendation 66: That the following 'occupational health and safety' practices be advocated by all levels of government as best practice for all providers of health care services and nurse employers:

- That all health and aged care facilities provide nurses with access to peer support, appropriate counselling, post-incident defusing and debriefing, and grievance handling.
- That providers of health care services support their nursing staff in the prosecution of violent offenders.
- That providers of health care services be required to ensure that nurses do not work alone in areas of high risk or where the level of risk is unknown. Where this is not possible, personal duress alarms or similar communications devices should be provided for personnel.
- That staff car parking should be accessible, well secured and well lit for access at all hours. In recurring problem areas, dedicated 24-hour a day security presence should be provided.
- That sufficient funding be available to ensure that hospital equipment, including safe lifting devices, are up to date, readily available for staff use and regularly maintained.
- That research be commissioned into the long-term effects of exposure to glutaraldehyde and that a process be put in place to eliminate the use of glutaraldehyde in health and aged care sectors.
- That alternative equipment be provided for those who are allergic to latex, with a view to eventually replacing the use of latex products by health care workers.

Recommendation 67: That governments ensure that all managers in health services receive training in:

- Management styles that promote leadership and consultation;
- Management skills to include conflict resolution and grievance management, improved human resource management, understanding industrial relations and awards, and information technology skills; and
- Occupational health and safety responsibilities and risk management.

Chapter 7

Recommendation 68: That the Commonwealth review the level of documentation required under the RCS tool to relieve the paperwork burden on aged care nurses.

Recommendation 69: That the outcomes of reviews and research be used to establish appropriate benchmarks for resources and skills mix in aged care nursing so as to support improved care for residents, workforce management, organisational outcomes and best practice and that Commonwealth funding guidelines be reviewed in light of this research.

Recommendation 70: That universities review the content and quality of clinical placements and experiences of students in aged care in their undergraduate courses and that clinical placements include a range of aged care settings.

Recommendation 71: That universities review and develop postgraduate programs and courses, including the provision of courses by distance education, appropriate for the aged care sector.

Recommendation 72: That the Commonwealth fund the expansion of re-entry/refresher programs specifically targeted at aged care nurses.

Recommendation 73: That the Commonwealth provide additional funding to implement wage parity between aged care and acute care nurses in each State and Territory.

Recommendation 74: That strategies be implemented to improve the image of aged care nursing.

Recommendation 75: That the Commonwealth take measures to reduce occupational injuries to nurses working in aged care, including the introduction of 'no lift' programs across the aged care sector in conjunction with the provision of up to date safe lifting devices that are readily available for staff use and are regularly maintained.

Chapter 8

Recommendation 76: That the Commonwealth fund scholarships for psychiatric/mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course.

Recommendation 77: That a targeted campaign be undertaken to improve the status and image of psychiatric/mental health nursing.

Recommendation 78: That funding be provided for the development of advanced practice courses in mental health nursing.

Recommendation 79: The Commonwealth provide additional funds to universities to extend clinical education in rural and remote regional hospitals.

Recommendation 80: That the Commonwealth increase the amount of funding of rural and remote nursing programs, including scholarship programs, in line with funding of medical programs.

Recommendation 81: That the Commonwealth and States provide funding for nursing relief programs such as 'circuit nurse' programs in rural and remote Australia.

Recommendation 82: That all rural and remote area health services with the assistance of State governments offer additional incentives to nursing staff through employment packages including accommodation assistance, additional recreation and professional development leave, and appointment and transfer expenses to encourage nurse recruitment.

Recommendation 83: That the Commonwealth increase the number of scholarships for Aboriginal and Torres Strait Islander nursing students and health workers to increase their numbers and upgrade their qualifications.

Recommendation 84: The strategies for the Aboriginal and Torres Strait Islander nursing workforce proposed in the Health Workforce National Strategic Framework be implemented as a matter of urgency.

Recommendation 85: That the Commonwealth while examining medical insurance issues also consider the issue of professional indemnity insurance for nurses, including midwives and allied health workers.

CHAPTER 1

INTRODUCTION

Terms of Reference

1.1 The Senate referred the matter to the Committee on 5 April 2001 for inquiry and report by 25 October 2001. Due to the Committee completing its inquiry into child migration and the intervention of the federal election this reporting date could not be met. At the commencement of the new Parliament, the Senate agreed to the readoption of the reference on 14 February 2002 with a reporting date of 27 June 2002.

1.2 The complete terms of reference for the inquiry are:

(a) The shortage of nurses in Australia and the impact that this is having on the delivery of health and aged care services; and

(b) Opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses.

That the Committee specifically make recommendations on:

(i) nurse education and training to meet future labour force needs,

(ii) the interface between universities and the health system,

(iii) strategies to retain nurses in the workforce and to attract nurses back into the profession including the aged care sector and regional areas,

(iv) options to make a nursing career more family friendly, and

(v) strategies to improve occupational health and safety.

1.3 In considering the broad range of issues associated with nursing it was difficult to attribute many to only one of the terms of reference. For example, the issue of nurse recruitment and retention, while primarily a workforce issue, is affected by a number of factors including the adequacy of educational preparation of nurses, models of nursing practice and clinical leadership. The Committee was cognisant of the interrelatedness of issues involved with the inquiry and their importance in drafting the report and recommendations.

Conduct of the Inquiry

1.4 The inquiry was advertised in *The Weekend Australian* on 14 April 2001 and through the Internet. Invitations to submit were also sent to Commonwealth and State governments and many organisations and individuals within the nursing profession. The closing date for submissions was originally 29 June 2001, although the Committee continued to receive submissions throughout the course of the inquiry.

1.5 The inquiry attracted wide interest throughout Australia with the Committee receiving 975 public submissions and 13 confidential submissions. Submissions came from every State and Territory with many representing regional and remote areas of Australia and were broadly representative of the entire nursing profession. Many organisations and individuals also provided additional written information to develop the issues raised in their submissions or oral evidence. The list of submissions and other written material received by the Committee and for which publication was authorised is at Appendix 1. Submissions that were received electronically may be accessed through the Committee's website at www.aph.gov.au/senate_ca

1.6 The Australian Nursing Federation circulated a questionnaire based on the Committee's terms of reference to its members in some States for completion and submission to the Committee. 658 responses were received by the Committee from individual nurses in response to this questionnaire, with 624 accepted as public submissions. A summary is at Appendix 3.

1.7 The Committee held a public hearing in Canberra on 28 August 2001 before the federal election was called. Further public hearings were held in Perth – 27 February 2002, Melbourne – 28 February, Hobart – 15 March, Canberra – 21 March, Sydney – 22 March, Brisbane – 26 March, and Adelaide – 27 March. A list of witnesses who appeared at the public hearings is included in Appendix 2.

1.8 Having received over 1 000 submissions, the Committee was again confronted with the difficulty of attempting to give as many groups and individuals an opportunity to speak directly to the Committee. The schedule for most hearing days was especially tight, and with many witnesses being heard in a panel format a few received only a short time to put their point of view. The Committee apologises to people who may have been inconvenienced by these procedures or were unable to be accommodated within the hearing schedule. The arrangements that are required to balance available time with maximum opportunity for individual witnesses is an especially complicated exercise in an inquiry that generates such interest.

1.9 The Committee places great value on submissions it receives as primary sources of information. Many of the submissions made to this inquiry, representing a wide range of organisations and individuals, emphasised the same or similar arguments. In preparing this report, it has not been possible to refer to all these submissions in footnotes. Thus, in many instances, footnotes acknowledge submission/s which are representative only of the point or argument being advanced. This in no way downgrades the importance placed on the many other submissions that have reinforced the same or similar point without being specifically identified.

1.10 The Committee found the range of titles and variation of nomenclature used in nursing throughout Australia to be most confusing. In this report the Committee has used titles and expressions as described in the Glossary at the end of the report. The titles of some Commonwealth and State departments have altered during the course of the inquiry. The references in the report are to the title at the time a submission was lodged or evidence presented.

1.11 The Committee considers that the range of titles currently used in nursing across Australia, particularly to describe level of nurse and qualification, need to be standardised to ensure uniformity and consistency.

Recommendation 1: That standard nomenclature be adopted throughout Australia to describe level of nurse and their qualifications, and including unregulated nursing and personal care assistants.

Previous inquiries and reviews into nursing

1.12 Nursing has been the subject of many reviews, inquiries and research projects in recent years, canvassing all areas of nursing, including recruitment and retention, workforce planning, education, and aged care and other specialised fields of nursing practice. Issues relevant to the Committee's terms of reference were discussed, strategies to address them identified and recommendations proposed.

1.13 Reference to this material was included in many of the submissions received by the Committee, often with the submitters having been involved in or having contributed to the work of an inquiry. Examples of these reviews are referred to below with a more comprehensive list provided at Appendix 4.

- *Nursing Recruitment and Retention Taskforce, Final Report*, New South Wales Health Department 1996.
- *Nursing Recruitment and Retention Ministerial Taskforce, Final Report*, Queensland Health, September 1999.
- *Nurse Recruitment and Retention Committee, Final Report*, Department of Human Services Victoria, May 2001.
- *New Vision, New Direction: Report of the West Australian Study of Nursing and Midwifery*, WA Department of Health, 2001.
- *Rethinking Nursing, Report of the National Nursing Workforce Forum,* Department of Health and Aged Care, 2000.
- *NSW Nursing Workforce – the Way Forward*, NSW Department of Health, 2000.
- *Recruitment and Retention of Nurses in Residential Aged Care: Final Report*, commissioned study, Department of Health and Ageing, 2002.
- *Scoping study of the Australian mental health nursing workforce: Final report*, M. Clinton, Department of Health and Aged Care, 2001.
- *Rural and Remote Nursing Summit: Report*, NSW Department of Health, 1998.
- *Nursing Education in Australian Universities: Report of the National Review into Nurse Education in the Higher Education Sector – 1994 and beyond*, Canberra, 1994, Chair: Janice Reid.
- *National Review of Specialist Nurse Education*, L.Russell, L.Gething, and P.Convery, Department of Employment, Education, Training and Youth Affairs, 1997.

1.14 Implementation by the Commonwealth and States of the strategies and recommendations from these reviews has varied across jurisdictions.[1] The attitude of nurses to the degree of implementation was powerfully conveyed:

> The nursing profession (and in this case – particularly the ranks of rural nurses) is heartily sick of the number of inquiries which are held but from which governments rarely implement any innovative recommendations and strategies. There is a perception that inquiries are conducted, they are shelved for a few years until the problems rise to the surface again, then a further range of inquiries are conducted – but nothing substantial happens.[2]

1.15 Shortly after the reference of this matter to the Committee the Commonwealth established on 30 April 2001 a National Review of Nursing Education. This Review is examining the effectiveness of current arrangements for the education and training of nurses encompassing enrolled, registered and specialist nurses; factors in the labour market that affect the employment of nurses and the choice of nursing as an occupation; and the key factors governing the demand for and supply of nursing education and training. The Review has commissioned research projects on a range of nursing issues, released a discussion paper in December 2001 and is due to complete its final report by the end of July 2002.

1.16 The information available from these reviews, inquiries and other research projects is simply voluminous. Strategies to address issues have been identified and recommendations made. The Committee believes that it is now time for concerted action.

Acknowledgments

1.17 The Committee expresses its appreciation to the individuals and organisations who made submissions to the Committee or gave evidence to the inquiry. As noted above, the Committee places great value on the submissions it receives as primary sources of information. Many witnesses provided additional written information and copies of articles or other published material. This information was most helpful to the Committee during its deliberations on the inquiry.

1.18 The Committee would also like to thank the staff of the King Edward Memorial Hospital for Women in Perth, the Freemasons Hospital in Melbourne and the Mater Misericordiae Hospital in Brisbane for their assistance in enabling the Committee to hold public hearings at their facilities. In particular, the Committee would like to thank Jim Swindon, Ro Hogan and the group of nurse unit managers from the Freemasons Hospital with whom it was able to meet and informally discuss nursing issues.

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1 See for example Recruitment and Retention of Nurses Progress Report: Overview, updated June 2001, *Submission* 867, Attachment 3 (NSW Health); Nurse Recruitment and Retention Committee: Government Response, June 2001, *Submission* 960 Attachment (Victorian Government); New Vision, New Direction: 2002 Status Plan, WA Department of Health

2 *Submission* 800, p.7 (NRHA).

CHAPTER 2

NURSE SHORTAGES AND THE IMPACT ON HEALTH SERVICES

Workforce planning and education has been sporadic, poorly integrated and inadequate. Nurses today however continue to provide high quality care despite these issues. It is apparent however that the impact of nurses continually providing more health care with fewer resources and lesser recognition, is that we cannot retain the nurses we have and cannot attract potential recruits.[1]

2.1 The shortage of nurses is being experienced worldwide. The International Council of Nurses reported that the majority of states of the World Health Organisation experienced 'shortage, maldistribution and misutilisation of nurses'.[2] In Australia, difficulties in recruiting and retaining skilled experienced nurses are currently occurring in both the public and private sectors and it is anticipated that the situation will not improve in the foreseeable future. According to anecdotal evidence, 75 per cent of nurses in hospital wards are now talking about leaving. Some hospitals reported that they experience a 30 per cent turnover of nurses each year. Submissions indicated that the real shortage of nurses is hidden as nursing data is incomplete and inadequate, nurses are working greater amounts of overtime, there has been an increased use of agency nurses and hospital beds have closed.[3]

2.2 Many witnesses indicated that while there were shortages across the board, some specialist areas, notably critical care, midwifery, aged care and mental health, faced acute shortages of nursing staff.[4] Witnesses described the current situation as a 'crisis' which is having, and will continue to have, an adverse impact on the quality of care provided to patients. The School of Nursing, Queensland University of Technology, stated that if the crisis was not stopped and reversed, it 'will lead to a serious reduction in the Australian community's ability to access a range of hospital and residential aged care services. If healthcare agencies continue to treat the same number of patients, despite these shortages, patient care will be compromised'.[5]

2.3 This chapter looks at the current level of employment in the nurse workforce, the estimated shortage, even crisis, projected demands for nurses, nurse workforce planning needs and the impact on health service delivery of shortages. The data used is drawn from the Australian Institute of Health and Welfare (AIHW), State and

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1 *Submission* 814, p.4 (ACCCN).

2 *Submission* 887, p.8 (Queensland Nursing Council).

3 See for example *Submission* 835, p.15 (APHA); *Submission* 937, p. 3 (ACT Government).

4 See for example *Submission* 736, p.5 (QUT).

5 *Submission* 736, p.5 (QUT).

Territory sources and from the evidence provided during the inquiry. In this chapter, the use of the term 'nurse' refers to both registered nurses (RNs) and enrolled nurses (ENs). RN and EN are used when appropriate to differentiate between the two groups.

Nursing in context

2.4 In the past, discussions of the nurse workforce focused on nursing within the acute hospital sector, particularly acute public hospitals. However, as noted in the Committee's report on public hospital funding, while public hospitals play an important role in health care provision, 'their services form part of the continuum of care, an increasing amount of which is provided outside of hospitals'.[6] As a consequence of this trend, there has been a shift of nursing staff into the provision of care in the community. With the ageing population there is increasing demand for nursing in the aged care sector. This sector is now the next largest employer of nurses after the acute care sector. Nurses are also playing a critical role in health promotion and health prevention in the primary healthcare model. In rural and remote Australia, nurses form the basis of healthcare services and may, in more remote areas, provide the only health care to the communities in which they work.

2.5 At the same time, the working environment of nurses and the characteristics of those they care for, whether in the acute hospital sector, the aged care sector or the community, have changed particularly over the last decade. The following is a brief overview of major trends in healthcare in Australia, based on information contained in the National Review of Nursing Education (the Education Review) Discussion Paper.

- ageing population: in 1999, 12.3% of the population were aged 65 years and over. Age is a significant predictor of poor health and disability, with many chronic diseases and conditions highly prevalent in the older population;
- Indigenous population: life expectancy in the Indigenous population at 65 years is significantly lower than for the non-Indigenous population (68% of Indigenous males can expect to live beyond 65 years compared to 84% for all males and 80% of Indigenous females can expect to live beyond 65 years compared to 91% of all females). Less than one third of the Indigenous population live in capital cities with easy access to mainstream health services and one in five reside in remote settings;
- enhanced primary care: there is increased use of general practitioner services in metropolitan areas, however, in rural and remote areas there is a much lower provision of health professionals and a greater reliance on nurses for healthcare services;
- high tech short stays in acute hospitals: there has been a decrease in the number of acute hospital beds (from 5.2 beds per 1 000 population in 1987-88 to 4.0 beds in 1998-99) and in the average length of stays in hospitals (from 4.6 days in

6 Senate Community Affairs References Committee, *Healing our Hospitals, Report on Public Hospital Funding,* December 2000, p.6.

1993-94 to 3.7 days in 1998-99); acute hospital separations grew from 257 per 1 000 population in 1993-94 to 294 in 1998-99;

- de-institutionalisation and community care: there has been a move to the integration of services in the community and de-institutionalisation of mental health services. Between 1991 and 1996 there was a 47% decrease in the number of psychiatric hospitals and an 80% increase in the number of community healthcare centres;
- new technologies: scientific developments in relation to disease management and control, and technological advances in fields such as communications (for example, Telemedicine) impact on the education and the scope of practice for nurses;
- healthcare expenditure: there has been an average increase of 4.0% in healthcare expenditure for the ten years to 1999-00. Labour costs are the largest item, although, while significant, available information does not enable the proportion of health expenditure spent on nurses to be calculated;
- aged care: major restructuring of residential aged care occurred in 1997, with the move to 'ageing in place'. In 2000, there were 84 residential aged care places per 1 000 population aged 70 years and over (a decrease from 89.3 places per 1 000 in 1997) and 11 community aged care packages per 1 000 population aged 70 years and over (an increase from 3.9 packages per 1 000 in 1994); and
- consumer input: consumers of health services have become more knowledgeable and have higher expectations of health services, both qualitatively and quantitatively.[7]

2.6 These changes have impacted on the skill level and expertise required of all nurses. In the acute sector, changes to care and improvements in technology has led to the increasing need for a highly specialised workforce. Indeed, some specialties would not be able to function efficiently without an appropriate specialist nurse workforce. Changes in the aged care sector has seen a move away from what has been described as 'custodial care' to the provision of more complex and intensive levels of care, such as palliative and post-operative care.

2.7 In the community sector, nurses are dealing with much sicker clients due to shorter hospital stays. The care of those suffering from drug problems, increased incidence of mental illness and depression and the emergence of social problems such as child and elder abuse and violence, have added to the complexity of the community sector working environment. As a result, a more highly skilled generalist workforce is emerging in the community sector. This trend is exemplified in rural and remote areas where the nurse workforce is the major provider of health services.

2.8 Changes to the healthcare system, the way in which services are delivered and changes to the skills required of those working within the system, are significantly

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7 National Review of Nursing Education, *Discussion Paper*, December 2001, pp.60-65; see also *Submission* 937, p.2 (ACT Government).

affecting the nurse workforce at a time when there is a severe shortage of experienced nurses and there are acute problems in retaining those still in the nurse workforce.

The nursing workforce

2.9 Queensland Health's submission stated that no one knows exactly how many nurses there are in Australia.[8] Data on the nursing workforce is available from a number of sources: statistics on registration and enrolments are available from nursing boards in each State and Territory and data on the nurse workforce is available from the Census, the AIHW's annual nursing labour force survey (conducted in conjunction with renewals of registration) and the Australian Bureau of Statistics quarterly labour force sample survey.

2.10 A major problem with the data arises from variations between the data sets. Variations arise as a result of double counting of nurses with registration in more than one jurisdiction, differences in nomenclature and differences in the purpose for which the data is collected. There are also delays in the processing of data and reporting the findings. The limitations of the data on the nurse workforce are discussed later in the chapter. The following information provides an overview of the latest available data.

Nursing Labour Force 1999

2.11 The AIHW's *Nursing Labour Force 1999* presents statistics from the 1997 Nursing Workforce Survey. The results of the 1999 survey will be available later this year. The AIHW's findings were cited in many submissions as evidence of the change to the nursing environment. *Nursing Labour Force 1999* showed the following:

- after allowing for multiple registrations, nursing registrations and enrolments fell from 270 720 in 1993 to 257 662 in 1999, a decrease of 4.8%; for the period 1994 to 1997, there was a decrease of 5.6%;[9]
- in 1999 it was estimated that there were 233 096 in the nursing labour force with 221 988 nurses employed mainly in nursing; in 1994 the numbers were 242 225 and 225 110 respectively;[10]
- in 1999, an estimated 24 571 registered and enrolled nurses were not in the nursing labour force (that is, they were not looking for work in nursing as they were either employed elsewhere or not employed, or were overseas) an increase from 23 659 in 1997;
- from 1994 to 1997, the number of employed enrolled nurses decreased by 12.2% from 52 676 to 46 276, mainly on account of a 22.0% decrease in those employed in nursing homes; and

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8 *Submission* 942, p.5 (Queensland Health).

9 Figures for 1999 estimated, based on applying the average of 1996 and 1997 data to total registrations and enrolments for 1998 and 1999.

10 Nursing labour force figures include total employed in nursing, those on extended leave and those looking for work in nursing. AIHW, *Nursing Labour Force 1999*, p.34.

- nurse employment per 100 000 population fell from 1 171.1 in 1989 to 1 032.7 in 1999.[11]

2.12 The AIHW noted that raw counts of the number of people in an occupation do not, by themselves, give an accurate indication of the labour supply, particularly in occupations where there are large numbers of part-time workers. Nursing numbers adjusted to full-time equivalent (FTE) nurses take account of hours worked. The AIHW also provided indicators of changes in the workload of nurses in hospitals which is related to the number of occupied beds, patient throughput (ie separations) and the average length of stay in hospital for both the public and private sectors.

2.13 The trends identified included that between 1995-96 and 1998-99 there was a marginal increase of 0.5% in the number of FTE nursing staff in hospitals (public and private acute and psychiatric and private free-standing day hospitals). Between 1995-96 and 1998-99 in public hospitals there was an increase of separations per FTE nurse – from 44.6 to 49.3. This reflects the 4.9% decline of FTE staffing (a decline of 2.8% in nursing staff and a 53.3% decline in other personal care staff) and the 7.4% increase in patient separations (to 20.3 FTE per 1 000 separations). There was also an 8.5% decrease in patient average stay day. This means that patient numbers per FTE nurse increased.

2.14 In private hospitals (acute and psychiatric hospitals) between 1995-96 and 1998-99, there was an increase of 10.1% in overall FTE staffing (an increase of 11.0% in FTE nursing staff and an increase of 8.9% for other staff). At the same time there was an increase of 4.5% in separations per FTE nurse (to 15.2 FTE per 1 000 separations) and 6.8% decline in patient days per FTE nurse. In private free-standing day hospitals, FTE nurses and other staff increased 50.1% and 45.8% respectively between 1995-96 and 1998-99 although the numbers of staff remain small. AIHW noted that the difference between public and private hospitals FTE per 1 000 separations is largely associated with wide differences in the nursing care requirements of the patients treated in each sector.[12]

National Review of Nursing Education published information

2.15 The National Review of Nursing Education provides a further source of information on the nursing workforce in its published material, including the December 2001 Discussion Paper and a commissioned research study that investigated job growth and turnover in nursing occupations in the period 1987-2001.[13] The trends identified in the research study included:

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11 AIHW, *Nursing Labour Force 1999*, p.31.

12 *Nursing Labour Force 1999*, pp.18-19; pp.80-82.

13 Shah, C & G Burke, *Job Growth and Replacement Needs in Nursing Occupations,* Report 01/18 to the Evaluations and Investigations Programme, Higher Education Division, Department of Education, Science and Training, Canberra, 2001. http://www.dest.gov.au/highered/eippubs/eip01_18/2.htm

- employment of nursing workers (personal care assistants; assistants in nursing; directors of nursing; nursing professionals; and enrolled nurses) grew at an average annual rate of 0.8%, half the rate of all occupations; employment contracted in some States (South Australia and Tasmania) while in Queensland the growth rate was 2.7 per cent per year;
- between 1987 and 2001, employment of nursing professionals (nurse managers, nurse educators and researchers; registered nurses; registered midwives; registered mental health nurses; registered developmental disability nurses) increased by 30% to 183 900 in 2001, an annual growth rate of 1.4%;
- registered nurses numbers grew between 1987 and 2001 to 163 500, an increase of 29.3% during the period;
- the employment of enrolled nurses declined 20.6% between 1987 and 2001 to 22 500 (partly due to restructuring of the nursing workforce in the early 1990s);
- projected annual growth of employment in nursing occupations is expected to be 0.4% (compared to 1.5% for all occupations) over the next five years with large growth in managerial positions and registered midwives and contraction in employment for enrolled nurses and registered mental health nurses; and
- projected net job openings for new entrants to the nursing profession (RNs and ENs) are expected to be about 27 000 over the next five years, with 80% due to replacement and 20% due to growth with the highest rate of job openings in managerial positions and for registered midwives.[14]

2.16 The Education Review noted that caution should be used in interpreting the numbers provided as, for example, changes in classification categories can impact on trend data; data is collected from different sources which may not ask the same questions; and, much of the data relies on self reporting which requires individual interpretation of categories and labels. The Education Review concluded 'however, it is possible to gain a picture of the trends from the information supplied'.[15]

State and Territory nursing data

2.17 The Committee also received statistics on nurse registrations and enrolments in States and Territories. In South Australia in 2000, there were 16 742 RNs (a decrease of 5.8% from 17 779 in 1992) and an estimated 5 000 ENs (a decrease of 26% from 6 774 in 1992) with active registration with the Nurses Board of South Australia. Of these, an estimated 1 846 RNs and 353 ENs were not in the workforce.[16]

2.18 In Victoria, from 1996 to 2000 there was a 2.4% decline in the total number of nurses registered from 71 813 to 70 075. In 1998, some 13 461 nurses were registered but not employed as nurses. In 2001, 71 079 nurses were registered in

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14 Education Review, pp.75-79, 96-101; see also Shah & Burke, sections 2.5.3, 2.6.

15 Education Review, p.75.

16 *Submission* 940, p.14 (SA Department of Human Services); *Nurse Labourforce*, Feb 2002.

Victoria, an increase of 1.5% over the previous year.[17] Significant growth is also expected in 2002, however, the number of graduates becoming registered accounted for less than half the growth in registrations in 2000 and 2001. The growth was attributed to an extensive recruitment campaign, including advertising and cost-free refresher/re-entry courses, conducted by the Victorian Government. As a result, the public sector workforce increased by over 2 300 FTE nurses (an increase of 10%) with 1 300 of these introduced into the public health system to improve nurse-patient ratios, while 1 000 were recruited to meet growth in demand. It was suggested in evidence that some of these nurses had been attracted from the aged care sector.[18]

2.19 In NSW in 2000, there were 76 188 RNs and 16 136 ENs. Since 1996 there has been a 2.8% increase in the number of RNs and a 2.7% decline in ENs.[19] In January 2002, the Nursing Re-Connect campaign was launched to attract nurses who have been out of the nursing workforce for some time back into nursing. By March 2002, some 300 nurses had re-entered nursing or were about to do so.[20]

2.20 In Queensland, in 2001 there were 36 817 RNs, an increase of 5.4% since 1996 and 7 095 ENs, a decrease of 11.7%.[21] Queensland's total public sector nursing workforce FTE increased approximately 9% between 1995 and 1999, with the registered nurse workforce increasing about 12% and the assistant in nursing and enrolled nurse workforces both decreasing about 2%.[22]

2.21 In Tasmania, the number of nurses holding current annual practicing certificates (inclusive of ENs and RNs) has declined by 11% since 1997. Tasmania has advertised nurse vacancies extensively – locally, nationally and internationally – but with only limited success.[23]

2.22 In the ACT, separation rates of nurses in the public sector have exceeded commencement rates by nearly 25% over the past three years. During this time the largest reductions have been in enrolled nurses and level 1 registered nurses. At present there are approximately 4 000 nurses registered and about 2 100 practicing.[24]

2.23 The Northern Territory has experienced a decline in nursing staff. There are now about 1 700 nurses employed in the public health sector, comprising 36% of the

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17 Nurse Recruitment and Retention Committee (Victoria), *Final Report*, May 2001, p.34; Nurses Board of Victoria*, Annual Report 2001*, p.7.

18 *Committee Hansard* 28.2.02, pp.179,182 (Department of Human Services Victoria).

19 *Submission* 296, p.2 (Nurses Registration Board of NSW).

20 *Committee Hansard* 22.3.02, p.500 (NSW Health Department).

21 Queensland Nursing Council, *Annual Report 2001*, p.61.

22 *Submission* 942, Supplementary Information, 17.4.02, Queensland Health, *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues,* Sept 2000, pp.4,8; Queensland Nursing Council, *Annual Report 2001*, p.61.

23 *Submission* 923, p.4 (Department of Health and Human Services Tas).

24 *Committee Hansard* 21.3.02, pp.375, 378 (ACT Department of Health and Community Care).

total workforce.[25] Turnover in many areas is also significant and the Australian Nursing Federation (ANF) (NT Branch) stated 'these turnover rates are considerably more excessive than the eastern seaboard statistics'.[26]

Factors impacting on demand for nurses

2.24 There are many factors impacting on the demand for nurses. Two main areas are employment trends in the nursing workforce including ageing of the workforce and the move to part-time work; and changes in the healthcare sector.

2.25 The nursing workforce has a large number of part-time employees and this is increasing. The proportion in part-time work (that is, less than 35 hours per week) increased from 41.2% to 44.1% between 1990 and 1999, and in 1999 enrolled nurses were much more likely to work part-time (60%) than registered nurses (52.5%).[27]

2.26 With the shift to part-time work, greater numbers of nurses are needed to provide the same level of services. The impact of this shift is illustrated by information from Queensland. In 1995 the average FTE per registered nurse was 0.86, which fell to 0.84 in 1999. It was noted that 'although the changes in average FTE appear to be subtle, they do have an important impact on the number of nurses Queensland Health employs'. The number of registered nurses employed by Queensland Health increased by 16% between 1995 and 1999 as compared with an increase of 12% in FTE.[28]

2.27 The AIHW reported that since the mid 1980s, the age structure of the nurse workforce has undergone a major change. At the 1986 census, 23.3% of nurses were aged under 25 years with 17.5% aged over 45 years. By the 1996 census, 7.7% of nurses were under 25 years and 30.3% were over 45 years. This reflects the move to university-based training as well as the decline in the number of students undertaking nursing education. The average age of nurses increased from 39.1 years to 40.4 years between 1994 and 1997.[29] In some areas the average age is higher, for example, on the Tasmanian North-West Coast and in the Swan Health Service WA, the average age in 2000 was 51 years.[30] In some specialist areas the average age is also greater, for example, in South Australia the average age of midwives is 44 years while in Tasmania the average age of midwives is 54 years.[31]

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25 Territory Health Services, *Annual Report 2000-2001*, p.19.

26 *Submission* 919, p.3 (ANF, NT Branch).

27 *Nursing Labour Force 1999*, p.13.

28 *Submission* 942, Supplementary Information, 17.4.02, p.6.

29 *Nursing Labour Force 1999*, p.12.

30 *Submission* 923, p.4 (Department of Health and Human Services Tasmania); *Committee Hansard* 27.2.02, p.66 (Swan Health Service).

31 *Submission* 940, p.12 (SA Department of Human Services); *Committee Hansard* 15.3.02, p.265 (Nursing Board of Tasmania).

2.28 The Australian Nursing Council Inc (ANCI) noted that the ageing workforce reflected the expansion of the nursing workforce which had occurred during the 1970s and 1980s. Those nurses are now in their 40s and 50s. Over the next 10 to 15 years, 30% of the workforce will be contemplating retirement. Nurses approaching retirement may also switch to part-time work, further exacerbating the nurse shortage. At the same time, the average age of nursing students has increased. In 1997 it was found that 25% of NSW entrants to nursing study were aged 23 years or older. The consequences are a reduced working life for up to 25% of all new graduates.[32]

2.29 Some witnesses did not see the ageing of the workforce as the main problem, rather the concern is the failure to graduate sufficient nurses to replace older nurses as they reach retirement. (This is discussed further below.) Older, experienced nurses are also essential to provide mentoring for inexperienced nurses coming into the workforce.[33]

2.30 Nursing remains a predominantly female profession. There has been little change in the number of males employed in nursing – enrolled male nurses increased from 6.2% to 6.3% of total ENs from 1994 to 1997 and in the same period the number of employed male registered nurses increased from 7.6% to 8.0% of total RNs.[34]

2.31 The nursing workforce is also highly mobile with nurses readily able to move between employment settings, be that intrastate, interstate or overseas. For example, in the Northern Territory, many nurses are attracted to short-term contracts during the peak tourist season from approximately April to September. In the Northern Territory, the ANF also indicated that the overall turnover of junior registered nurses is around 100%. In Central Australia, at Alice Springs Hospital the rate of turnover is higher at 137% per annum.[35] The Tasmanian Government noted that since 1991 approximately 10% of the Tasmanian School of Nursing graduates have gone overseas, the majority to the United Kingdom.[36] Womens and Childrens Health, Victoria stated 'Nursing Agencies in the UK are recruiting Australian nurses with offers of free return flights to the UK, onsite accommodation, 7 weeks annual leave, full orientation and support on arrival, and an excellent salary package; all this is difficult to compete against!'.[37]

2.32 An overview of changes in healthcare was outlined above. These changes have impacted on the demand for nursing staff, particularly experienced staff. Changes in patient acuity and shorter hospital stays were cited most often in evidence as impacting on the demand for experienced nursing staff.

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32 *Submission* 926, p.6 (ANCI); ANF, 2002-2003, Federal Government Pre Budget Submission, February 2002, p.4; *Submission* 962, p.19 (ANF).

33 *Committee Hansard* 28.2.02, p.188 (Department Human Services, Vic); see also *Submission* 919, p.6 (ANF NT Branch).

34 *Nursing Labour Force 1999*, Table 37, p.66 and Table 38, p.67.

35 *Submission* 919, pp.2,3 (ANF NT Branch).

36 *Submission* 923, p.4 (Department of Health and Human Services Tasmania).

37 *Submission* 780, p.11 (WCH Vic).

2.33 Patient acuity in both the hospital and the community health sectors has been rising. This is due, in part, to the ageing population and with it, an increase in chronic illnesses and disabilities. Demand for health services has grown and advances in technology mean that more complex interventions are available. It was argued that hospitals are increasingly becoming large intensive care units, with cardiac monitoring and respiratory assistance and treatment a growing part of the average patient's plan of care.

2.34 New technology allows rapid assessment, treatment and discharge from hospitals. For example, there has been an increase of day surgery procedures. Shorter hospital stays have resulted in patients moving back into the community with more complex healthcare needs. Thus, the community sector is also experiencing an increase in patient acuity and an increase in the number of treatments provided to patients in the home. This has led to an increased demand for nursing staff outside hospital facilities. The shortage of other health professionals, such as occupational therapists, increases the burden on nursing staff in both hospitals and the community.

2.35 Over the last decade there has been a particular government focus on reducing hospital budgets. As the nursing workforce constitutes the largest group in the healthcare system – over 55% of the entire health workforce – it has often been the most affected by fiscal constraint. Women's Hospitals Australasia & Children's Hospitals Australasia (WHA&CHA) argued that this is reflected in the comparison of percentage growth rates across health professions: the nursing workforce between 1986 and 1991 increased 3.2% (medical practitioners increased 18.3%) while in 1991-96 the increase was 0.5% (medical practitioners increased 13.4%).[38]

The shortage of nurses

2.36 The Committee received evidence of critical shortages of nurses in all areas of healthcare services. However, establishing the numerical extent of the shortage is problematic. The ACT Government stated 'with no clear, rigorous and nationally agreed methodology available, there is widespread concern that it is not possible to accurately determine and report on the actual number of nursing vacancies either locally and nationally'.[39] It was argued that the task has been made more difficult as nursing staff have taken on extra duties and are working more overtime in response to staff shortages, services have closed hospital beds and data is incomplete and/or inadequate. In addition, shortages may be more prevalent in a specialist area or locality such as remote and regional areas. As a consequence, 'only few studies have attempted to quantify shortages and fewer have done it rigorously'.[40]

2.37 The Commonwealth Department of Employment and Workplace Relations (DEWR) maintains the National Skills Shortage (NSS) List which indicates the

38 *Submission* 936, p.10 (WHA & CHA).

39 *Submission* 937, p.1 (ACT Government).

40 Shah & Burke, Executive Summary, p.5.

occupations experiencing shortages nationally and by State and Territory.[41] These lists are based on market intelligence undertaken by DEWR and only indicate the areas of shortage and not a numerical measure of the extent of the shortage. The NSS for February 2002, which is based on data for the second half of 2001, identified a national shortage of registered nurses as well as shortages in 16 specialist areas.

Table 2.1: National Skills Shortage List – February 2002

	AUST	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Registered nurse (general)	**N**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Accident/ Emergency	**N**	S	S	S	S	S	S		
Aged Care	**N**	S	S	S	S	S	S		S
Cardiothoracic	**N**	S	S	S	S	S	S		
Community	**N**	S		S	S	S	S	S	
Critical/ Intensive Care	**N**	S	S	S	S	S	S		S
Indigenous Health	**N**			R	S	S		S	
Neo-Natal Intensive Care	**N**	S	S	S	S	S	S		
Neurology	**N**	S	S	S	S	S			
Oncology	**N**	S	S	S	S	S	S		S
Operating theatre	**N**	S	S	S	S	S	S	S	S
Orthopaedics	**N**	S		S	S	S	S		
Paediatric	**N**	S	S	S	S	S	S		
Palliative Care	**N**	D	S	S	S	S			
Perioperative	**N**	S	S	S	S	S			
Rehabilitation	**N**	S		S	S	S	S		
Renal/Dialysis	**N**	D	S	S	S	S	S	S	
Respiratory	**N**	S		S	S	S	S		
RegisteredMidwife	**N**	S	S	S	S	S	S		
Registered Mental Health	**N**	S	S	S	R	S	S		S
Enrolled Nurse	**N**	S	S	S	S	S	S		

N = National shortage *R = Shortage in regional areas*
S = State-wide shortage *D = Recruitment difficulties*

Source: Department of Employment and Workplace Relations

2.38 The Department of Immigration and Multicultural Affairs maintains the Migration Occupations in Demand List (MODL).[42] As at May 2001, the list contained six nursing categories: nurse managers; nurse educators and researchers; registered

41 Shortages exist where employers are unable to fill or have considerable difficulty in filling vacancies for an occupation or specialised skill needs within that occupation at current levels of remuneration and conditions of employment, and reasonably accessible location. See www.workplace.gov.au

42 People seeking to migrate to Australia on the basis of their work skills receive points if their nominated occupation is on the Migration Occupations in Demand List.

nurses; registered midwives; registered mental health nurses; and registered developmental disability nurses. Queensland Nurses Union (QNU) stated:

> This list is significant given that employers are exempt from local labour market testing if the occupation appears on the MODL and they are therefore able to recruit suitably qualified overseas workers to fill vacancies. Inclusion of an occupation on the MODL is therefore recognition by the government that a significant skills shortage exists in that particular occupation.[43]

2.39 In evidence, some specific examples of shortages were provided to the Committee:

- the NSW Department of Health Reporting System indicate that in May 2001 the public sector was 'actively recruiting' approximately 1 486 FTE positions. At the same time it was using approximately 2 775 FTE casual staff including 692 agency nursing staff;[44]
- in Victoria, public hospitals estimated vacancies of 600 to 800 in early 2002;[45]
- a survey of Directors of Nursing in Victoria in 1999 found that almost 60% of hospitals and nursing homes needed more nurses;[46]
- the ANF (SA Branch) indicated that South Australia was between 500 and 700 registered nurses short of nursing requirements;[47] and
- in the ACT there are vacant funded positions in both public hospitals (a vacancy rate of 4% at Canberra Hospital and 6% at Calvary) and the community care sector with the number of vacancies increasing over time.[48]

2.40 In addition, some States have published nurse labour force projections:

- South Australia: To maintain the RN workforce in South Australia at its current size, between 650 and 1 350 new graduates per year are required. In 2000, 389 nursing students graduated and 430 were predicted to do so at the end of 2001. There needs to be 226 to 468 ENs graduating to maintain the EN workforce with 239 graduating in 2000. The SA Department of Human Services is carrying out a full review of the labour force model, as there are some concerns about the projections made.[49]

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43 *Submission* 457, p.8 (QNU).

44 *Submission* 867, Attachment 3, p.3 (NSW Health); see also *Submission* 962, p.4 (ANF).

45 *Committee Hansard* 28.2.02, p.183 (Department of Human Services Victoria).

46 *Submission* 379, Appendix 5, *The Hidden Costs of Understaffing*, p.2 (ANF Vic Branch).

47 *Committee Hansard* 27.3.02, p.709 (ANF SA Branch).

48 *Submission* 375, Supplementary Information, 22.4.02 (ACT Government).

49 *Submission* 940, pp.16-17 (Department of Human Services SA); *Committee Hansard* 27.3.02, p.776.

- Victoria: Labour force projections in 1999 estimated that with the current level of demand, Victoria would face a shortfall of 5 500 registered nurses by 2008. Preliminary findings of a study into the aged care workforce anticipates a shortfall of 7 000 nurses by 2004 in residential and sub acute services.[50]
- Queensland Health indicated that based on current service delivery models, the demand for nursing services in the public sector will increase by at least 30% over the next ten years. However, this estimation is subject to the influence of factors such as the take up of private health insurance etc.[51]
- Tasmania: to maintain the RN workforce at its current level, preliminary estimates indicate the need to recruit a minimum of 260 nurses annually to account for attrition. Currently the Tasmanian School of Nursing graduates 130-140 students annually.[52]

2.41 Projections of nurse labour force needs are discussed in more detail later in this chapter. Issues related to the specialist areas of nursing, including aged care, Indigenous nursing, midwifery, mental health nursing and critical care are discussed in chapters 7 and 8 of this report.

Supply of nurses

2.42 A broad range of factors influence the supply of both registered and enrolled nurses. These factors including the number of new nurse graduates; the number of overseas nurses entering the Australian workforce; retention and workplace issues; and recruitment and the image of nursing.

Nurse education

2.43 The Commonwealth Department of Education, Training and Youth Affairs (DETYA) and the National Review of Nursing Education provided statistics on nurse students and graduates. The Education Review stated that the data on supply was not easy to interpret, with differences in the pattern of commencements and completions in Bachelor of Nursing courses across the States and Territories. The following general trends were identified:

- commencements of domestic students in all nursing courses (undergraduate, post graduate and research students) decreased over the period 1994 to 2000;
- commencements of domestic students in bachelor courses decreased from 11 653 in 1994 to 8 423 in 2000;
- total enrolments of domestic nursing students declined between 1994 and 2000 by 5 893;

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50 *Submission* 960, p.9 (Victorian Government).

51 *Submission* 942, Supplementary Information, 17.4.02, p.12 (Queensland Health).

52 Department of Health and Human Services, *Final report of the Tasmanian Nurse Workforce Planning Project*, November 2001, Report 1, pp.29, 58.

- the decline in domestic nursing students in bachelor courses declined between 1994 and 2000 but the decline has been less marked since 1997;
- there has been a steady decrease in the number of domestic undergraduate students completing nursing courses, from a high of 9 525 in 1994 to 5 844 in 1999; and
- completions of domestic higher degree research have remained at about 30 per year, while course work degree completions and other postgraduate completions (postgraduate diplomas and certificates) have risen.

The Education Review indicated that some 2000 and 2001 data showed increases in completions for all States and Territories accept Tasmania and the ACT.[53]

2.44 The funding of student places is determined at the unit level and is converted to equivalent full-time student units (EFTSU). The allocation of total EFTSU allocated to universities for domestic nursing students has dropped by about 2 000 between 1994 and 2000. The number of EFTSUs attracting HECS has declined from 23 121 in 1994 to 19 494 in 2000. Fee-paying courses are largely in postgraduate certificates and diplomas areas with about 20% in the higher degree category.[54]

2.45 In evidence the number of students dropping out of nursing studies was discussed. Attrition rates in the first year of nursing studies ranged from 15% to 20% with smaller attrition rates in subsequent years. Research has indicated that the nursing student retention rate in university courses of 78% is the third highest of all courses. It was noted that in hospital-based courses the attrition rate had been 50% in some States.[55] Issues contributing to withdrawal from courses included:

- wrong choice of course;
- students using nursing as an entry point to university and then switching to the course that they initially wished to pursue; and
- pressure from other commitments outside study, such as the demands of full-time or part-time employment, and health and family issues.[56]

2.46 The problem of retaining new graduates when they first enter the nursing workforce was highlighted with witnesses noting the high rate of attrition in the first years following graduation.[57] New graduates leave because of problems with transition from study to work. Those who leave following completion of their graduate year may do so for personal reasons or to travel overseas although it was argued that many leave because they are disillusioned and the remuneration is

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53 Education Review, pp.87-89; see also *Submission* 928, pp.13-15 (DETYA).

54 *Submission* 928, p.16 (DETYA).

55 *Committee Hansard* 28.2.02, p.136 (Australian Council of Deans of Nursing).

56 See for example, *Committee Hansard* 27.2.02, p.82 (ANZCMHN WA Branch); *Submission* 940, p.23 (Department of Human Services SA).

57 *Committee Hansard* 28.2.02, p.187 (Department of Human Services Victoria).

inadequate leading them to seek a career change.[58] The issues of transition to practice are discussed further in chapters 3 and 6.

2.47 Attrition rates both during study and in the years immediately following completion of study are important for workforce planning. Research is this area has been commissioned by the Australian Council of Deans of Nursing and will be available later in 2002.[59]

Overseas nurses

2.48 Australia has always attracted many overseas nurses, particularly those from the United Kingdom. Nurses migrate permanently to Australia and large numbers come to Australia on working holidays. Nurses have been actively recruited from overseas and this is undertaken primarily on an individual health service or hospital basis and with varying levels of intensity.[60] Government bodies are reticent to become directly responsible for overseas recruiting campaigns.

2.49 The Department of Immigration and Multicultural Affairs (DIMA) indicated that in 2000-01, 580 nurses permanently entered Australia and 4 830 nurses entered on a temporary basis. There was a net gain in nursing professionals in Australia over the period 1997-98 to 1999-2000 of 1 200 nurses.[61]

2.50 Balancing the intake of nurses is the loss to Australia of qualified nurses who travel overseas. The enticement of travel is a positive for attracting people to nursing as a career. Nursing qualifications gained in Australia are favourably regarded in overseas countries meaning that Australian nurses wishing to travel can easily gain employment whilst on a working holiday.

2.51 The Department's submission provides an overview of the arrangements to allow overseas qualified nurses to enter Australia:

- permanent entry: nurses entering permanently may do so under a range of schemes including the Employer Nomination Scheme, Labour Agreements, the Regional Sponsored Migration Scheme and General Skilled Migration. Nurses doing so have been assessed by ANCI as being at the required Australian standard and are immediately eligible for registration in this country.

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58 *Committee Hansard* 27.2.02, p.75 (Peak Nursing Council of WA); see also *Committee Hansard* 22.2.02, p.473 (UTS).

59 *Committee Hansard* 28.2.02 p.137 (Australian Council of Deans of Nursing).

60 As an example, the Sir Charles Gairdner Hospital advised that overseas recruitment in 2001 was 26.63FTE through formal programs and 49.71FTE through informal programs, *Submission* 730, Additional Information 12.3.02. In Victoria there was 1105 overseas additions to the Victorian Nursing Register in 2000-01 (21% of the total). Of these 819 (74%) were from the UK/Ireland and New Zealand - *Submission* 960, Additional Information 8.5.02 (Vic DHS).

61 *Submission* 952, p.1 (DIMA).

- temporary entry: temporary entry may occur through Business (Long Stay), Occupational Trainee, Labour Agreements or Working Holiday Maker visas. Some nurses whose qualifications do not meet Australian standards are able to enter under Student, Occupational Trainee or Short Stay Business visas to undertake migrant nurse bridging programs in order to gain registration for work purposes. Some 3 200 Working Holiday Maker visas and 1 110 Business (Long Stay) visas were granted to nurses in 2000-01.

2.52 The Department concluded that 'in recent years, the Government has sponsored legislative and policy changes which have increased opportunities for various employers in the Australian health industry to recruit highly skilled overseas nurses. The Department will continue to work closely with the Australian Nursing Council Incorporated and, through them, the various State and Territory nurse registration bodies to assist them to address the shortage of nurses in Australia.'[62]

2.53 Some submissions argued that the processes for nurses entering Australia are complex and could be simplified. Women's and Children's Health Victoria (WCH) stated that 'by networking with our international colleagues, we know that nurses are travelling to Australia, but that the visa restrictions in place at present prevent them from working as nurses, and many are barmaids or fruit pickers'. WCH commented that 'the process of gaining registration with the Australian nursing registration authorities needs to be streamlined' and that 'due to the bureaucratic processes surrounding visa applications for entry into Australia, nurses are pursuing other avenues, such as UK-based Nursing Agencies'.[63] A Victorian nursing review indicated that the costs of business sponsorship and migration agents have led many healthcare facilities to view overseas recruitment as an option of last resort.[64]

2.54 The majority of overseas nurses enter Australia on the Working Holiday Maker visa. However, the conditions of the Working Holiday Maker visa require that the working holiday maker must not be employed in Australia by any one employer for more than three months without the written permission of the Secretary of DIMIA. NSW Health argued that a three-month period was too short a time in nursing as nurses are only just becoming familiar with the service and environment by the end of this time. It was suggested that the employment period be extended to six months.[65] An extension of time would not only assist with the nursing shortage, but would also enhance the skilled migration program as many of these nurses may apply to return to Australia as migrants at a later date.

2.55 However, not all witnesses supported more extensive immigration. Local, national and international health agencies are each competing worldwide for a limited number of qualified nurses. RMIT described the situation:

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62 *Submission* 952, 6 (DIMA).

63 *Submission* 780, pp.11-12 (WCH Vic).

64 Nurse Recruitment and Retention Committee, p.33.

65 *Submission* 867, p.5 (NSW Health Department). See also *Committee Hansard* 22.3.02 p.505.

> Countries are "stealing" from each other and it is not really addressing the problem of getting new nurses or nurses who have left the profession into the system. It is a redistribution of nurses throughout the world not an answer to the nursing shortage.[66]

2.56 The ANF did not support mechanisms to overcome Australian workforce shortages that may adversely affect health care in another country, especially that of a developing country. The ANF stated that 'an advanced country such as Australia should not use strategies that negatively affect other countries to solve local problems'. The ANF did support the voluntary flow of nurses between countries.[67] The Victorian Government indicated its support for the recently-signed protocol which discourages Australian public institutions from, in particular, recruiting nurses from English-speaking less developed countries, such as India and Pakistan.[68]

2.57 The Commonwealth has recently announced that it will introduce incentives to fast-track applications of nursing staff from abroad, particularly those who will work in regional areas. Overseas nurses will be able to participate in bridging courses held in Australia so that they meet Australian standards and then make an application for a long-term temporary resident visa while already in the country. There is also capacity to change visa arrangements, such as move to a Business Long Stay visa.

2.58 The Committee supports the fast-tracking of applications for overseas nurses. Onerous visa application processes should not hamper overseas nurses who wish to work in Australia. However, the Committee does not consider that the employment of overseas nurses is an appropriate mechanism to overcome the long-term shortage of nurses in Australia. While overseas nurses are currently employed in our hospitals and health services they are in the large part merely replacing Australians who have travelled overseas to work. Addressing the shortage of nurses will only be achieved through workforce planning and implementation of appropriate domestic recruitment and retention measures.

Recommendation 2: That the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs streamline visa arrangements and simplify the process of recognising overseas qualifications for nurses wishing to migrate to Australia on a permanent or temporary basis, and to publicise the capacity to extend and to change visa arrangements.

Retention and workplace issues

2.59 There have been numerous studies on the issue of the retention of nurses and why nurses leave the profession. These studies, as well as evidence to the Committee, pointed to working conditions as a fundamental reason for nurses leaving. These included conditions of pay, particularly in the aged care sector, safety issues,

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66 *Submission* 914, p.17 (RMIT).

67 *Submission* 962, pp.6-7 (ANF).

68 *Submission* 960, Supplementary Information 8.5.02 (Department of Human Services Victoria).

increased workload leading to stress and burnout, inappropriate and insufficient nursing skills mix, lack of recognition of individual skills and knowledge, occupational health hazards, and lack of accommodation and childcare. Issues of recruitment and retention noted in this section are also considered in chapter 6.

2.60 Information about the number of nurses leaving the workforce is difficult to obtain. However, some indication of the trends may be gained by looking at the number of persons with nursing qualifications not employed as nurses. The AIHW's *Nursing Labour Force 1999*, indicated that in 1999 there were 15 056 registered and enrolled nurses looking for work in nursing (both employed elsewhere or not employed) and 24 571 nurses not in the nursing labour force (not looking for work in nursing or overseas).[69]

2.61 Evidence was also received that in New South Wales in 1998, it was estimated some 16 000 registered nurses were not in the nursing workforce.[70] In South Australia in 2000, 1 846 registered nurses and 353 enrolled nurses were not in the workforce.[71] In Queensland, it was estimated that the number of qualified nurses not working in nursing could exceed 9 000.[72] In Victoria, it was estimated that some 13 000 were registered but not employed in nursing.[73] In the ACT there are nearly 4 000 nurses registered but only approximately 2 000 practicing.[74]

2.62 The estimates above are indicative only. The pool of qualified nurses not in the workforce is difficult to establish. For example, the QNU argued that the AIHW's data was an under-estimation of the number, as it did not include those who had allowed their registrations or enrolment to lapse. Changes in registration requirements in some States, such as currency of practice requirements, and increases in costs of registration may have influenced some not to maintain their registration when working in non-nursing occupations. However, it does appear that there are significant numbers of qualified nurses not in the nursing workforce, which the Nurses Board of Victoria noted 'underscores a substantial problem, not in actual number of nurses, but those willing to work under current conditions'.[75] In such a case, mechanisms to encourage re-entry are important.

2.63 It has been argued that retention is a key issue in ensuring that there are adequate numbers in the nursing workforce to meet demand in the future. As noted by the National Review of Nursing Education 'the small proportion of the workforce in

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69 *Nursing Labour Force 1999,* Table 13, p.34. See footnote 9 concerning 1999 labour force data.

70 *Submission* 867, Attachment, *NSW Nursing Workforce Research Project*, Sept 2000, pp.9,45 (NSW Health).

71 *Submission* 940, p.14 (Department of Human Services SA).

72 *Submission* 457, p.6 (QNU).

73 Nurse Recruitment and Retention Committee, *Final Report*, p.34.

74 *Submission* 444, p.2 (Nurses Board of the ACT).

75 *Submission* 765, p.2 (Nurses Board of Victoria).

the less than 30 years of age category means that those who might be interested in a long term career will be sourced from fewer nurses than in the past'.[76]

Recruitment and the image of nursing

2.64 Nursing was, in the past, seen as a traditional employment option for young women. Nursing has lost some of its attractiveness as greater career options have become available for young women and they become more aware of appropriate remuneration, conditions and career opportunities.[77] Many nurses would not recommend nursing as a career choice.

2.65 Nursing has also suffered from a poor image, particularly in the media. This exacerbates problems in recruiting school-leavers to enter nursing studies. The need to improve the image of nursing is discussed further in chapter 6.

Implications of the nurse shortage

> We must not slip into a minimalist agenda where a person's entitlement to essential care is comprised of basic services stretched by inadequate funding and overworked staff. If quality is to mean anything, it must be the driving force not just of service delivery but of basic funding allocation decisions, in the first instance, adopted by government budget making levels.[78]

Use of agency nurses and casualisation of nursing workforce

2.66 Many witnesses noted that there was an increase in the use of agency and casual nurses across all sectors of healthcare. Two factors have contributed to this increase: the shortage of nurses resulting in dependence on agency staff to fill gaps; and a perception that by working through an agency, nursing staff can obtain more attractive working conditions including pay and 'family friendliness'. Young nurses are also attracted to agency and casual employment because of the increased flexibility, increased leisure time and a decreased need for job security.

2.67 The Royal College of Nursing (RCN) noted that employment through agencies had become prevalent in the 1980s in metropolitan acute hospitals. This had continued and 'intensified' in recent years. The RCN indicated that critical care nurses and others are currently able to demand high salary rates and this has exacerbated utilisation rates of agency nurses. The Victorian Government also stated that competition between agencies for specialist staff has led to above-award wages, bonus payments and loyalty programs being offered as inducements, with the costs being passed on to hospitals in both the private and public sectors.[79]

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76 Education Review, p.86.

77 *Submission* 927, p.4 (RCN).

78 *Committee Hansard*, 21.3.02, p.396 (CHA).

79 *Submission* 960, p.15 (Victorian Government).

2.68 The ANF (NT Branch) stated that in the Northern Territory, 'health and aged care facilities are forced to rely heavily on agency staff to fill the void'. However, unlike other States a large proportion of agency staff were permanent staff who sought extra work to cover the increased costs of living in the Northern Territory.[80]

2.69 Witnesses noted that concerns have been expressed about the impact on quality of care through the use of agency staff.[81] It was noted that it is not always possible to know the calibre and skills of agency staff members until they have started work. There were also problems with continuity of care and the maintenance of clinical competency. Use of agency nurses also increased the administrative workload of permanent staff, adding to staff stress:

> It is also very stressful for nurses who work in an area–whether full-time or part-time–to have people walking in and out from an agency or from somewhere else. These nurses have to orientate those people, get them up to speed and supervise them. This happens quite a bit, and it is a significant stressor.[82]

2.70 The financial impact of the use of agency nurses may be great, with agencies charging a premium to place staff in specialist areas. Evidence was received that hospitals were paying as much as $265 per hour for staff. In some instances the agency retains more than 30% of the amount charged to the hospital.[83] It was reported that nursing staff from Western Australia were flying to Victoria for four or five days work with an agency.[84] One rural aged care facility indicated that its agency staff are paid casual rates, are provided with free accommodation and free flights from and to Brisbane.[85] UnitingCare advised that one of its facilities in Western Sydney spends $45 000 each month on agency nurses.[86]

2.71 In the private sector, the Australian Private Hospitals Association (APHA) also indicated that the inflated prices charged, agency practices and the onerous contractual conditions of agency staff 'further restrict the ability of the hospital to recruit permanent staff'. APHA estimated that the increasing reliance on agency staff added about 11% to total private hospital costs and indicated that agencies are enticing staff with pay and conditions which cannot be matched in the private sector. Agencies also levy a recruitment fee on hospitals offering a permanent position to an agency nurse who may have worked a shift at the hospital in the previous three months. The

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80 *Submission* 191, p.2 (ANF NT Branch).

81 See for example, *Committee Hansard* 15.3.02, p.267 (Nursing Board of Tasmania); *Submission* 960, p.15 (Victorian Government).

82 *Committee Hansard* 28.2.02, p.186 (Department of Human Services, Vic).

83 *Submission* 835, Supplementary Information, p.3 (APHA).

84 *Committee Hansard* 27.2.02, p.81 (ANZCMHN WA Branch).

85 *Submission* 746, p.2 (Pioneer Homes).

86 *Submission* 871, Supplementary Information 21.3.02 and *Committee Hansard* 21.3.02, p.397 (UnitingCare).

fee is payable even if the hospital recruited the nurse through its own recruitment processes such as a newspaper advertisement. APHA also argued that unlike genuine recruitment agencies, nursing agencies do not generally focus on finding permanent employment for their clients. APHA stated, 'on the contrary it is in the interests of nursing agencies for their clients to continue indefinitely as casual workers'.

2.72 APHA indicated that it had forwarded submissions to the Australian Competition and Consumer Commission providing details of charges and practices by nursing agencies that in its view 'amount to an abuse of market power'. APHA has also written to the Minister for Health and Ageing proposing a national inquiry into nursing agencies.[87]

2.73 In April 2002, the Victorian Government banned the use of agency staff in public hospitals because of the high costs involved. It was estimated that approximately 7% of FTE nurses were agency staff and that reducing reliance on agency nurses could result in savings of up to $20 million per year. At the same time, increased use of the Government's public nurse banks by hospitals is being encouraged. Almost 5 000 nurses are registered with the public nurse banks which operate across a couple of hospitals or a network of hospitals. The Victorian Department of Health Services indicated that nurse banks offered flexible work to nurses in the public sector. There are also better outcomes for quality care because the nurses listed in the banks are loyal to that organisation and they understand the process and protocol of the organisation.[88]

2.74 The Committee considers that the increase in the use of agency nursing staff has ramifications for the efficient delivery of quality healthcare. The Committee considers that at the present time nursing agencies are acting in a largely unregulated manner and that the charges they impose and the practices they engage in are a matter of concern.

Recommendation 3: The Committee recommends that the Minister for Health and Ageing undertake an urgent national review of the charges and practices of nursing agencies, including their impact on costs to public and private providers of health services and their impact on the shortage of nurses in Australia.

Recommendation 4: The Committee recommends that the Australian Competition and Consumer Commission conduct a review of the practices of nursing agencies in the healthcare sector.

87 *Submission* 835, Supplementary Information, p.5, (APHA).

88 *Submission* 960, p.15 (Victorian Government); *Committee Hansard* 28.2.02, p.186 (Department of Human Services Victoria).

Quality of care

> There is very little to feel happy about when you have been responsible for up to twenty patients on the ward and thus have not been able to care for any of them in a manner you feel is adequate.[89]

2.75 Many witnesses indicated that the shortage of nurses in the workforce was impacting adversely on the quality of patient care provided by the nurse workforce. Coupled with shortages, changes in service delivery have also acted to exacerbate workplace concerns. In-patients are now being cared for in their most acute and vulnerable periods and the nurse workforce must meet the challenges of high need, high technology and rapid admission and discharge flow of patients. In the community, nurses are also facing increased numbers and acuity of patients and the coordination problems of sharing care with family and other support people.

2.76 It was argued that if the ratio of appropriately qualified nurses to patients is not adequate, patient care is at risk. This may result from longer waiting periods before patients are attended by a nurse, a greater risk from clinical errors and nurses being asked to undertake duties beyond their skill level or knowledge. It was stated that employers are responding to shortfalls in specialties by allocating more duties to unqualified or non-nurses especially in the acute, renal, aged and peri-operative fields. There are also some concerns that in both the specialist and general nursing workforce, there are shortages of nurses with practical experience who can work without the need for ongoing supervision.[90]

2.77 Nursing staff also indicated that quality of care is affected adversely as time pressures do not allow nurses to undertake regular and on-going training and professional development.

Professional development of new nurses

2.78 The shortage of experienced nurses affects not only quality of care provided but also the development of new and inexperienced nurses in the workforce. The Nurses Board of Victoria noted:

> A vicious cycle has been established whereby, with heavy workloads and inflexible working conditions, more experienced nurses leave the profession. Those who are left have to carry heavier loads and do not have the time to work with the new and inexperienced nurses. They too leave the workforce, as they become frustrated with the lack of support for their development; hence those that remain have to work harder.[91]

2.79 Evidence also pointed to situations where newly graduated nurses may be the only permanent staff employed in a particular area. The new graduate may find

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89 *Submission* No 448, p.2 (Wollongong Hospital ICU Nursing Staff).

90 See for example, *Submission* 937, p. 4 (ACT Government); *Rethinking Nursing,* p.7.

91 *Submission* 765, p.4 (Nurses Board of Victoria).

themselves in the position of supervising agency or casual staff who may be better qualified and have more experience. This adds to the stress of new graduates.

Skills mix

2.80 The increased use of unqualified workers in nursing has raised issues about the overall state of health provision and public safety. The NSW College of Nursing noted that studies have shown a direct correlation between adequate numbers of registered nurses and quality of patient outcomes. Where the nursing workforce is either reduced in numbers or skills mix (that is, there is an increase in the use of unqualified workers), the quality of care is reduced, patients and nurses are dissatisfied and nurses leave the workforce.[92] There are also diminished opportunities for experienced nurses to provide direct, expert patient care as the role of the registered nurse becomes more managerial. This leads to decreasing job satisfaction, alienation from their nursing work and burnout.

2.81 The Nurses Board of the ACT commented that unsafe practices due to lack of qualified staff are a major issue for the Nurses Board. If nurses are unable to meet the practice standards established by the Nurses Board because of the low number of nurses rostered on duty, the legislation only permits action against the nurse who has not met the standards rather than the employing agency that cannot or does not adequately staff the facility. Nurses become embroiled in a dilemma between maintaining professional standards of care and fulfilling their obligations to employers with a significant risk to safe patient care. The Nurses Board viewed this situation with great concern.[93]

2.82 The ANCI stated that there is potential for unregulated workers to be used to support nursing practice, however it argued that they should not be used as substitutes for qualified nurses and their contribution to care should be carefully evaluated. The ANCI noted that research has indicated that care by skilled nurses rather than unskilled and unregulated workers, results in a significant reduction of adverse events. Furthermore, debate and consultation about which settings are appropriate for suitably educated care workers to work in and their role is needed.[94]

Workforce planning

> Australia has no mechanisms in place for assessing future nursing labour force needs, and subsequently, there is no nursing workforce planning occurring at a national level.[95]

2.83 Shortages in the nursing workforce are not new and some witnesses stated that in the nursing workforce, under and over supply was cyclical. However, the present

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92 *Submission* 480, p.3 (NSW College of Nursing).

93 *Submission* 444, p.2 (Nurses Board of the ACT).

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

95 *Submission* 962, p.18 (ANF).

situation was described by many witnesses as reaching crisis point and if it were to continue would seriously undermine the quality of care provided to users of the Australian healthcare system.

2.84 Mechanisms which will decrease the rate of attrition from the current workforce and encourage the re-entry to nursing of those qualified nurses who are no longer working in the healthcare sector provide possible solutions to the current shortage. Evidence from Victoria and NSW suggests that programs which make nursing more attractive and support re-entry have a positive impact on the number of nurses returning to the system.

2.85 However, drawing on the pool of nurses not currently working is only a short-term solution: the pool of qualified nurses is not limitless and that pool appears to be shrinking and is ageing.[96] Increasing the number of graduates is a medium to long term solution given the lead time for nursing students to come into the workplace. There is also a need to ensure that there is an appropriate skills mix in graduates so that long term needs of specialist areas are met. In addition, there is a need to ensure an adequate supply of suitably qualified nurses by locality, for example, in rural and remote Australia. In order to address these issues, adequate workforce planning is essential.

2.86 As noted in chapter 1, many reviews and research projects have been undertaken on nursing issues in recent years. The report on recruitment and retention of nurses in residential aged care presents reviews of current Australian nursing workforce studies.[97] A review commissioned by the Department of Education, Training and Youth Affairs (DETYA) provides a more detailed source of information on nursing labour force studies.[98]

2.87 Workforce planning is undertaken by States and Territories. The ANF commented that current strategies are 'based on the *ad hoc* responses of the States and Territories and these rarely involve the primary inputs to the equation needed to produce an accurate or meaningful result'. The ANF also added that it is apparent that 'some States and Territory Government decisions are made without reference to other jurisdictions'.[99] Commentators and witnesses argued that workforce planning is hampered by a lack of success in influencing policy issues identified in reports, lack of a national approach, lack of coordination with the tertiary education sector, inconsistencies of approach and inadequacies of the data and often does not take into account the needs of the private sector and aged care sector.

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96 *Submission* 942, p.6 (Queensland Health).

97 DHA, *Recruitment and Retention of Nurses in Residential Aged Care, Final Report,* 2001, pp.17-21.

98 Johnson, D & B Preston, *An Overview of Issues in Nursing Education*, October 2001, Sec 1.6, http://www.detya.gov.au/highered/eippubs/eip01_12/fullreport.htm

99 *Submission* 962, p.18 (ANF).

2.88 The review of labour force studies indicated that the lack of success in influencing policy may arise as there was often a range of options provided in the studies with no clear indications of which one is preferred for practical policy. The conclusions and recommendations of the studies may also be very different from current practice or the common sense judgement of the stakeholders. In addition, there may not be a strong strategic policy connection between those responsible for commissioning and receiving the report (for example, State departments of health) and those who are responsible for implementing the recommendations (universities).[100]

2.89 The lack of mechanisms to ensure workforce needs are taken up by the tertiary sector and the need for a more coordinated approach were raised. One commentator, while noting that university decisions have 'critical consequences for the health and community service sectors in terms of registered nurses', stated that 'there are no mechanisms at national level and few mechanisms at state level to ensure that these university decisions impact positively on future workforce requirements'.[101] In evidence it was also noted that the tertiary education sector is Commonwealth funded while the planning and responsibility of the public health sector, the largest employer of nurses, is a State matter. (See also chapter 5.) The Commonwealth funding of the aged care sector, a very large employer of nurses, adds to the complex division of responsibilities.

2.90 The fragmented nature of the health system and the split roles and responsibilities between various levels of government has led to calls for greater coordination in workforce planning. Many stakeholders, including nursing unions, APHA and State Governments supported a national approach. For example, Queensland Health recommended a national nursing supply management strategy to address shortages and to maintain an adequate long-term supply of nurses.[102]

2.91 The need for a national approach to nurse workforce planning was addressed by the National Nursing Workforce Forum which recommended the establishment of a national nursing workforce advisory committee; the development of a national nursing workforce strategy; and the establishment of the position of Commonwealth chief nursing officer.[103]

2.92 The Department of Health and Aged Care indicated that the Commonwealth reported the Forum's outcomes and recommendations to the Australian Health Ministers' Advisory Council (AHMAC), 'with recommendations for national approaches to broader health workforce planning with emphasis on nursing issues'.[104]

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100 Johnson & Preston, Sec. 1.6.

101 Duckett, S, 'The Australian health workforce: facts and futures', *Australian Health Review,* Vol 23, No 4, 2000, p.67.

102 *Submission* 942, p.6 (Queensland Health); see also *Submission* 937, p.1 (ACT Government); *Submission* 960, p.10 (Victorian Government); *Committee Hansard* 27.2.02, p.778 (Department of Human Services SA); *Committee Hansard* 22.2.02, p.500 (NSW Health).

103 *Rethinking Nursing*, p.3.

104 *Submission* 944 p.2 (DHAC).

In response, the Australian Health Workforce Advisory Committee (AHWAC) was established in December 2000 to provide advice to AHMAC on national health workforce planning and analysis of information and identification of data needs.

2.93 AHMAC requested that AHWAC examine the specialised nursing workforce as a first priority and in particular the areas of critical care, midwifery, mental health, aged care and emergency medicine. AHWAC is currently undertaking reviews of midwifery and critical care nursing. These reviews are expected to be completed by late 2002.

2.94 Witnesses conceded that AHWAC had been established in response to the recommendations from the National Nursing Workforce Forum, however they maintained that its program falls far short of what was envisaged by the Forum's recommendations. The ANF stated:

> The nursing workforce in the postgraduate areas of midwifery and critical care are currently under review. The model to be used will provide recommendations for the number of nurses required in these specialty areas but the essential context will be missing. The recommendations will be made in isolation from the broader labour force issues that affect entry to nursing practice and exit from the profession. And there is little point in considering postgraduate areas of nursing specialisation without first considering whether there will be a sufficient intake of undergraduate students to meet future specialist nursing needs.[105]

2.95 The ANF concluded 'our current shortage is the result of piecemeal and shortsighted approaches to health workforce planning and change is urgently required'.[106]

2.96 Many witnesses supported the need for a long-term view of nursing requirements and the development of a national, intersectorial approach.[107] WHA & CHA argued that all aspects of the health workforce – medical, nursing, midwifery, allied health and healthcare providers – must be considered together and not in isolation.[108] The Department of Human Services Victoria expressed similar concerns that the review being undertaken was focussing on component parts of the nursing workforce rather than the overall picture.[109]

2.97 Other evidence echoed these points. The NSW College of Nursing stated:

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105 *Submission* 962, p.20 (ANF).

106 *Submission* 962, p.18 (ANF); see also *Committee Hansard,* 27.3.02, p.696 (University of Adelaide).

107 See for example, *Submission* 962, p.18 (ANF); *Committee Hansard* 27.3.02, p.778 (Department of Human Services, SA); *Submission* 888, p.2 (Australian College of Health Service Executives).

108 *Submission* 936, p.11 (WHA & CHA).

109 *Committee Hansard* 28.2.02, pp.181-2 (Department of Human Services Victoria).

> Future labour force needs can only be effectively predicted by utilising a national approach with a multidisciplinary focus. Nurses do not work in isolation in the majority of health care contexts but with teams of doctors and allied health personnel. Patients are important partners in such teams. As in the UK, labour force needs in health require scoping through a multi focal lens encompassing all contexts and all workers.[110]

2.98 The ACT Department of Health and Community Care added that it:

> …believes strongly that a strategic intersectorial solution must be implemented if a way forward is to be found and recommends the following. The first of these recommendations includes that the Commonwealth undertakes extensive strategic planning related to the nursing work force and its unique characteristics based on solid ongoing research.[111]

2.99 APHA argued for the inclusion of the private sector in workforce planning because there is a need for 'strategic workforce planning responsive to demands of the health system as a whole'. APHA stated that the private sector needs to be engaged at a State and Commonwealth level in the planning for and creation of training places.[112] APHA also urged improved reporting on workforce targets:

> We also believe that monitoring of performance and accountabilities of each of the stakeholders – that is, government, training authorities and professions – in meeting the work force planning recommendations of AHWAC could be strengthened.[113]

2.100 At its hearing in August 2001, the Department of Health and Aged Care informed the Committee that health ministers had recently discussed the need for a mechanism to provide broad long-term advice regarding health workforce strategies to meet future health system needs. An expanded role for AHWAC was considered, however, 'discussion has now focused on setting up a new body to undertake long-term broad strategic advice'. The Department went on to state:

> The States are the major employers of nurses and the ones that can do most to deal with the problem. But it is a national problem and it needs a national approach. We believe that is best done through those intergovernmental mechanisms that I have described, the various committees. The new, if you like, overarching strategic committee which health ministers are in the process of setting up will assist us to take a more strategic view of the work force as a whole. It will look not just at doctors or nurses or physiotherapists

110 *Submission* 480, p.3 (NSW College of Nursing).

111 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care).

112 *Submission* 835, p.16 (APHA).

113 *Committee Hansard* 21.3.02, p.394 (APHA).

> or whatever but at what are the overall work force needs to deliver health care as we perceive it.[114]

2.101 The health ministers agreed that the new body would be established as an officials committee to be known as the Australian Health Workforce Officials Committee (AHWOC). Its purpose is to provide a forum for reaching agreement on key health workforce issues requiring collaborative action and to advise on health workforce requirements, as a basis for assisting AHMAC to fulfil its roles. Details of the role of AHWOC are provided in the glossary to this report.

Adequacy of existing nurse workforce data

2.102 In addition to calls for a national approach to workforce planning, concerns were raised about the adequacy of data currently available on the nurse workforce and the models used for workforce planning.

2.103 At the present time, State and Territory Governments conduct their own analyses of needs. The ANF noted that the quality of the projections is variable.[115] The review commissioned by DETYA concluded that the studies were hampered by inconsistencies of approach and inadequacies in the data. For example, some major methodological and data problems identified with some workforce studies include:

- a range of problems related to estimating or projecting future values for attrition (or separation) rates, including: not taking account of age profiles; and not consistently determining values for both separations and re-entry;
- problems of not adequately accounting for graduates' availability or suitability; and not accounting adequately in subsequent periods for graduates unable to gain desired positions in an initial period; and
- projected future workforce size is very difficult to estimate, and judgements must be made regarding appropriate (or likely) mixes of staff with different qualifications and work roles, work intensity, industry structure and work organisation, and other matters.[116]

2.104 Witnesses also noted shortcomings in labour force analyses. For example, among factors not routinely considered in the models are: the number of students enrolled in nursing courses in the tertiary education sector; changes in healthcare delivery such as case payments; the latest Commonwealth initiatives in health and aged care, for example ageing in place, or health service changes being proposed by State and Territory Governments for example, multipurpose centres, hospital in the home or the deinstitutionalisation of mental health services.[117]

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114 *Committee Hansard* 28.8.01, p.9 (DHAC).

115 *Submission* 962, p.18 (ANF).

116 Johnson & Preston, Sec 1.6.

117 *Submission* 960, p.9 (Victorian Government) *Submission* 962, p.18 (ANF).

2.105 Reviews of some of the models are being conducted, for example, South Australia is conducting a full review of its labour force model.[118] Queensland Health stated that it 'is committed to the development of a work force planning methodology that, rather than addressing professional groups in isolation, plans workforce requirements around streams of care…it is a new approach to planning which has the potential to take into account things like shifting professional boundaries and changing roles'.[119] The Victorian Government recommended that research into workforce predictors and planning models be encouraged.[120]

2.106 The major source of nursing data currently is from the AIHW's biennial survey of the nursing labour force. The survey is sent to all nurses renewing their registration with the registration board of each State and Territory. The survey seeks information on a range of demographic, work setting and educational information relating to the registered nurse labour force. The response rate to the survey varies between States and, as noted by the ANF, each jurisdiction modifies the data collection tool to meet local needs. Data is not collected over a consistent period (some jurisdictions collect data on an annual basis, some biennially) or at a consistent point in time as some jurisdictions undertake the collection over a twelve month period and others on a particular date.[121] The interpretation of the information is hampered by the fact that the survey is self-reported which requires assumptions to be made for the non-responding cohort.[122]

2.107 There have been significant delays in the publication of AIHW data, in part due to delays in obtaining data from some States. While the AIHW is to shortly publish data based on the 1999 survey, the most current data available is from 1997. The data is out of date for workforce planning purposes.

2.108 Many submissions noted that the lack of data limited the ability of stakeholders to undertake adequate workforce planning and other research into the nursing workforce.[123] The Victorian Department of Human Services noted 'there is concern in Victoria that [AIHW] data alone is insufficient for workforce planning both locally and nationally' and 'workforce planning is limited by the paucity of available data on forecasted nursing demand, vacancies, bed closures and workforce attrition.'[124] In the Western Australian report, *New Vision, New Directions,* it was stated that 'in the absence of comprehensive and reliable data, accurate projection models cannot be developed'. In response to these problems, the WA Department of Health has redesigned its labour force survey form to enhance data collection and

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118 *Committee Hansard* 27.3.02, p.776 (Department of Human Services SA).

119 *Committee Hansard* 26.3.02, p.574 (Queensland Health).

120 *Submission* 960, p.10 (Victorian Government).

121 *Submission* 962, p.21 (ANF).

122 Nurse Recruitment and Retention Committee*,* p.34.

123 See for example, *Submission* 962, p.4 (ANF); *Submission* 926, p.8 (ANCI).

124 *Submission* 960, pp.9-10 (Department of Human Services Victoria).

management.[125] Queensland Health also stated 'one of the key issues for us is having a national data set on the nursing work force that will enable us to actually plan for the future'.[126]

2.109 The Australian Midwifery Action Project (AMAP) stated that 'the availability of data on the midwifery labour force is one of the most pressing issues. The capacity to draw meaningful conclusions is compromised because of the use of non-standardised terminology and the incompatibility of databases and data domains'.[127]

2.110 In the private sector, the lack of data is also impacting adversely on planning. APHA noted that private hospitals were unable to plan for the increase in patient numbers, and were not able to assess the market availability of nursing staff because published nursing workforce data for the private sector was inaccurate, spasmodic or out of date. APHA also noted that the state-based system of workforce data collection is also variable and open to interpretation.[128]

2.111 Stakeholders called for improved data collection and dissemination. The ACT Department of Health and Community Care stated that research should also include the determination of a national information management system that will allow for accurate monitoring of the nursing work force.[129]

2.112 AHWAC has identified the need to improve existing nursing workforce data collection and has indicated that this is being pursued as a priority. AHWAC stated that the initial work in this area would focus on improvements to the AIHW's national nursing registration survey including increasing the response rate to the survey and improving the timeliness of data processing.[130]

Conclusion

2.113 Evidence received by the Committee clearly indicates that the need for national coordination of nursing workforce issues has been well established. Many reviews and reports have also identified this need, however little progress has been made to implement a national approach.

2.114 The Committee considers that many of the problems in nurse workforce planning can only be addressed on a national basis encompassing all sectors where nurses are employed. There has been a tendency for workforce planning to address

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125 West Australian Study of Nursing and Midwifery, Steering Committee, *New Vision, New Direction: report of the West Australian Study of Nursing and Midwifery,* WA Department of Health, 2001*,* p.18.

126 *Committee Hansard* 26.3.02, p.577 (Queensland Health).

127 *Submission* 912, p.3 (AMAP).

128 *Submission* 835, p.4 (APHA).

129 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care); see also *Submission* 960, p.10 (Victorian Government).

130 *Submission* 822, p.2 (AHWAC).

different groups of health professionals in isolation. The health workforces do not operate in isolation and there are interdependencies and pressures on professional boundaries as a result of organisational change which must be recognised.

2.115 A national approach is also needed to develop an improved workforce planning model to better predict future needs. There is an urgent need to improve the quality of the data available on the nurse workforce and its timeliness.

2.116 The Committee considers that the leadership role to advance work on these matters belongs to the Commonwealth. The Commonwealth already has direct responsibilities for the nurse workforce through its funding of the tertiary education sector and thereby funding for nurse training. The Commonwealth also directly funds the aged care sector which is a large employer of nurses. The Commonwealth also has a national perspective on health policy and funds specific programs such as Indigenous health and rural and remote health.

2.117 The Committee recognises that workforce matters are already being considered by AHWAC and further consideration will be given to workforce matters 'requiring collaborative action' by the newly formed AHWOC. However, the Committee considers that little progress will be made without strong leadership by the Commonwealth and without significant, direct involvement by all stakeholders. The Committee is not suggesting that the Commonwealth should take over the sole responsibility for nursing workforce issues. Rather, there is a need for a collaborative effort between all levels of government and stakeholders in the nursing system.

Recommendation 5: That the Commonwealth in cooperation with the States and Territories facilitate and expedite the development of a national nursing workforce planning strategy.

Recommendation 6: That the Commonwealth provide the Australian Institute of Health and Welfare with the resources required to establish a consistent, national approach to current data collection on the nursing workforce in Australia.

Recommendation 7: That research be undertaken to examine the relationship between health care needs, nursing workforce skill mix and patient outcomes in various general and specialist areas of care, with a view to providing "best practice" guidelines for allocating staff and for reviewing quality of care and awarding accreditation to institutions.

Chief Nursing Officer

2.118 Many witnesses called for the establishment of a position of principal nursing adviser at the Commonwealth level and pointed to the National Nursing Forum's

recommendation that nursing units and chief nursing officers should operate at Commonwealth and State levels.[131] The ANCI considered that:

> …the contribution of a national nursing perspective to the health policy process is integral to effective health outcomes for the community. Nursing leadership advice and contribution to Commonwealth government policy and initiatives would not only enhance policy decision making in areas such as health work force and education but also assist in and coordinate implementation of relevant policy.[132]

2.119 The ANF and other witnesses noted that the Commonwealth has a major responsibility for the nursing workforce as it sets national health priorities; it funds service provision, including nurses, through its funding agreements with the States and Territories; it has primary responsibility for Indigenous health and the aged care sector; and it sets the standards for service provision in other sectors such as home and community care and care for veterans. The Commonwealth is also responsible for the tertiary education sector in which nurses are educated and for the aged care sector in which the Commonwealth pays for the employment of nurses.[133]

2.120 The ANF saw the role of the principal nursing adviser as providing the Commonwealth with advice on general nursing issues; contributing to decisions affecting the nursing workforce; liaising with State and Territory chief nursing officers and the nursing profession generally; representing the Government at national and international forums; coordinating national activities that impact on nursing; and tracking nursing initiatives initiated by other government departments (for example, mental health, aged care, general practice, veterans' affairs, education).[134]

2.121 The Queensland Nursing Council considered that a principal nursing adviser would act as a focal point for existing bodies and informal networks and provide a significant resource to provide for a timely and effective advisory and policy role. It would also provide greater cohesion in a sector which is fragmented between specialist groups and where there are differing perceptions of an 'employee' model compared with a 'professional' model.[135]

2.122 The ACT Government went further than recommending a single position and stated that the Commonwealth should make 'a dedicated investment in addressing long-term planning by the funding of a chief nurse directorate – and by this we mean a directorate, a group of people, not a single individual – who will have responsibility

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131 See for example, *Submission* 867, Attachment 1, p.10 (NSW Health Department); *Submission* 962, p.20 (ANF); *Submission* 480, p.4 (NSW College of Nursing); *Submission* 942, p.17 (Queensland Health).

132 *Committee Hansard* 26.3.02, p.617 (ANCI), see also ANCI Position on the Establishment of a Nursing Directorate headed by a Chief Nurse in the Commonwealth Government, Feb 2002.

133 *Submission* 962, pp.21-22 (ANF).

134 ANF, 2002-2003 Federal Government Pre-Budget Submission, February 2002, p.10.

135 *Submission* 887, p.13 (QNC).

for workforce, education and other professional issues and will work in collaboration with State and Territory branches'.[136]

2.123 The Commonwealth Department of Health and Ageing currently has the full-time equivalent of 12.15 staff working on nursing workforce issues. Five of these staff are in the Aged Care Division.[137]

Conclusion

2.124 The Committee considers that much is to be gained through the establishment of a position of Chief Nursing Officer. The gains include greater coordination of national programs and policy impacting on nursing such as the education, supply and role of nurses; improved liaison with State and Territory Governments, overseas nursing counterparts and other sectors including the private and aged care sectors; and greater recognition that improved healthcare can only come through a nationally coordinated health workforce.

Recommendation 8: That the Commonwealth, as a matter of urgency, establish the position of Chief Nursing Officer within the Department of Health and Ageing.

National Registration

2.125 At the present time, nurses working in each State and Territory are registered or enrolled by the relevant regulatory authority. Under Mutual Recognition requirements, regulatory authorities are obligated to register or enrol applicants under conditions that are not more onerous than those imposed by the regulatory authority in the State or Territory of origin of the applicant.

2.126 Many witnesses recommended the introduction of a national registration scheme for nurses. The WHA, for example, argued that differences in nursing practice, curriculum development and quality that exist across Australia are due to the lack of one registration board, standard registration processes and commonality with educational curriculum development. This is hampering workforce planning and the provision of an appropriately educated and flexible nursing and midwifery workforce.[138] Catholic Health Australia also supported the notion of a national registration process and stated 'when it comes to aged care in particular, there needs to be nationally consistent approaches to medication, distribution and the interface with state governments' poisons legislation'.[139]

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136 *Committee Hansard* 21.3.02, p.370 (ACT Department of Health and Community Care).

137 *Submission* 944, Supplementary Information, 24.9.01, p.5 (DHAC).

138 *Submission* 936, p.12 (WHA).

139 *Committee Hansard* 21.3.02, p.397 (CHA).

2.127 National registration is supported by many nurses, in part due to the mobility of the nurse workforce and the problems of obtaining registration in different jurisdictions.[140] One nurse outlined concerns nurses have with separate registration:

> In Queensland, registration for a mental health nurse is not separate from registration as a general nurse but in other states…they are separated. My concern is: how come some nurses are able to practise in one field in one state without the same qualification as in another state or recognition that it is a separate field?
>
> …we need to have professional standards that go across all of the states as well. In my own mind, I cannot come to a conclusion about why it should be that nursing in different states within Australia means different things to different people.
>
> Also, the process of registering in different states is really quite difficult for nurses. Each state asks for a different set of documents and they are large and voluminous. Also, the registration fees for nurses within each state are vastly different. Victorian nurses pay…a small amount. In South Australia it is almost double that amount. In Queensland it is somewhere in between.[141]

2.128 Other witnesses pointed to time delays in acquiring registration in another State or Territory, with delays of six to eight weeks reported.[142]

2.129 National registration was not supported by all witnesses. Some pointed to the lack of problems with the present system. The Nurses Board of South Australia stated:

> There is very little inconvenience, if I could put it that way, for people to move from state to state. The Mutual Recognition Act supports health professionals crossing state and territory borders. We ask for a fee to be paid; we ask for identification of the licence where they were practising in the previous state and also that they identify their competency within the particular area. It is a very streamlined process. Once that is undertaken, the person is free to practise within the state. I think that the mutual recognition certainly supports that free movement.[143]

2.130 The New South Wales Nurses Registration Board stated:

> Essentially, regulation requirements for becoming a registered nurse in New South Wales are very similar across Australia. We have cross-accreditation, so somebody registered in New South Wales will be registered in Queensland should they simply apply for that, with mutual recognition. That

140 See for example, *Committee Hansard* 26.3.02, p.565 (QNU).

141 *Committee Hansard* 26.3.02, p.660 (Mater Hospital).

142 *Committee Hansard* 28.2.02, p.161 (Mercy Hospital for Women).

143 *Committee Hansard* 27.3.02, p.782 (Nurses Board of South Australia).

> works very effectively. We are unaware of delays in people gaining registration. We do not have a waiting list.[144]

2.131 A number of potential problems with national registration were outlined. The ANCI noted that people supporting national registration argued that Nursing Acts vary significantly between jurisdictions and that the barriers are the authorities which administer the Acts. ANCI countered that currently, there are more commonalities than differences between each of the Nursing Acts and what is not often taken into consideration by those pointing to differences are the objectives of the Acts and the policies that can be developed from the powers of the Acts.

2.132 The ANCI went on to note that, more importantly, there are significant differences between jurisdictions in other relevant legislation for example, legislation related to drugs and poisons. ANCI stated that:

> Any attempt to establish a national system of regulation requires that all legislation which impacts on nurses' practice be considered. In addition, any differences in legislation or policies have not generated difficulties in moving between jurisdictions under mutual recognition legislation. The processes involved provide for an almost instant recognition of nurses moving from one jurisdiction to another.[145]

2.133 The ANCI also indicated that issues involved in cross-border practice had been addressed. While mutual recognition provided for nurses registered in one State or Territory to be registered in other States or Territories, registration fees still had to be paid in all the jurisdictions where the nurse was working. In order to reduce the financial burden on those nurses who are required to register in more than one jurisdiction, all nurse regulatory authorities in Australia now have the ability in certain circumstances to consider waiving the fees or to exempt an individual from the requirement to pay a fee.[146]

2.134 The Victorian Department of Human Services also commented that nursing boards investigate complaints against nurses and that a single board would be required to do this task under national registration. It was suggested that there may be problems of a single board being able to do this across the nation. In addition, problems with State legislation may arise. The Department concluded 'we do not have a strong view on it, but would it really address any of the issues that are of importance to the system? We say not really.'[147]

2.135 Some witnesses did not support national registration because of problems experienced with mutual recognition requirements. The Nurses Board of the ACT stated that under mutual recognition, jurisdictions must register nurses that they may

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144 *Committee Hansard* 22.3.02, p.512 (NSW Nurses Registration Board).

145 *Committee Hansard* 26.3.02, p.617 (ANCI).

146 ANCI, *Position Statement Cross Border Nursing Practice: Waiver of Fees*, May 2000.

147 *Committee Hansard* 28.2.02, p.191 (Department of Human Services, Vic).

not have otherwise accepted, for example, the nurse may be required to retrain in one jurisdiction and not the other. The Board concluded that 'the mutual recognition is enough of a problem without national registration, if we go for the lowest common denominator, and not for the public safety aspect, just to address a shortage'.[148] The Nursing Board of Tasmania also pointed to difference in currency of practice requirements for registration that are standard in some States and not in others, for example, New South Wales.[149]

Conclusion

2.136 The Committee supports the need for national registration of nurses. The Committee considers that major advantages accrue from such as proposal. National registration would assist in the development of national consistency of registration requirements.

2.137 The Committee has noted the comments by those with concerns about mutual recognition and its implication for automatic registration notwithstanding that standards vary across jurisdictions. In the Committee's view this is a strong argument for national registration so that there is alignment of registration requirements acceptable across all jurisdictions. However, national registration should be implemented though each State and Territory regulatory agency. This would enable State and Territory regulatory bodies to maintain their State and Territory functions including the investigation of complaints related to unprofessional conduct and incompetence.

2.138 The Committee considers that national registration should be developed under the auspices of the ANCI as it already develops and maintains national competency standards for both registered nurses and enrolled nurses. National registration would also provide an improved mechanism for data collection for workforce planning. As has already been stated, the inadequacy of nursing workforce data is a major impediment to improving workforce planning. Through national registration there would be increased mobility opportunities for nurses to move between States and Territories. This would be welcomed by nurses.

Recommendation 9: That national registration be implemented for registered and enrolled nurses.

148 *Committee Hansard* 21.3.02, p.389 (Nurses Board of the ACT).

149 *Committee Hansard* 15.3.02, pp.269-70 (Nursing Board of Tasmania).

CHAPTER 3

UNDERGRADUATE EDUCATION

The demand for intelligent, imaginative nurses capable of navigating and delivering a complex course of care cannot be overstated. Nurses are the largest part of the professional health workforce, and for them to do what is required of them today and in the future will take tremendous practical, political, organisational and technical abilities – skills of the highest order.[1]

Introduction

3.1 The ability of nurse education programs to produce nurses capable of operating in an increasingly complex health system is one of the most important issues facing the profession, the healthcare system and the community generally. The delivery of healthcare in Australia continues to undergo rapid transformation. Nurses practice in this highly complex system, characterised by increased demands for healthcare services, high levels of technology, increased patient acuity, shorter length of stay and increased levels of consumer knowledge and expectations. These processes impact on how healthcare is delivered and the role of healthcare professionals in this system.[2]

3.2 The Australian Nursing Council (ANCI) stated that to provide realistic expectations of the nursing role, the most important principles underlying a program of nurse education should include:

- linkages between theory and practice;
- collaboration between education and service providers;
- flexible delivery of content; and
- consistency between content of education and ANCI competencies.[3]

3.3 The Australian Council of Deans of Nursing (ACDON) stated that the nurse of the future will become a 'knowledge worker', rather than 'knowledge holder', acting in partnership with the healthcare system, clients and the community – 'the skill development and experience for this life-long work are...very different from those of the traditional hospital-type curriculum. The "new" work necessitates new relationships between theory and practice and new understandings of the term

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1 *Submission* 914, p.10 (RMIT University, Department of Nursing & Midwifery).

2 *Submission* 936, p.15 (WHA & CHA); *Submission* 192, pp.1-3 (ACDON).

3 *Submission* 926, p.9 (ANCI).

"competency" given that nursing is a practice-based discipline regulated through demonstration of competencies to State authorities'.[4]

3.4 This chapter and chapter 4 discusses the Inquiry's terms of reference (b) relating to opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses and makes recommendations on nurse education and training to meet future labour force needs. This chapter specifically focuses on issues related to the undergraduate education of RNs. The terms of reference relating to the interface between universities and the health system are discussed in chapter 5.

3.5 The Committee notes that there is some cross-over in these terms of reference with the current National Review of Nursing Education (the Education Review) which was jointly announced by the Commonwealth Ministers for Education, Training and Youth Affairs and for Health and Aged Care in April 2001. The Education Review, which is expected to report in July 2002 is, *inter alia*, examining the effectiveness of current arrangements for the education and training of nurses encompassing enrolled, registered and specialist nurses.[5]

3.6 There are two levels of licensed nurse in Australia – registered nurses (RNs) (Division 1 in Victoria), who undertake a minimum of three years undergraduate preparation in the higher education sector at a Bachelor degree level, and enrolled nurses (ENs) (Division 2 in Victoria), who generally undertake their education in the vocational education/TAFE sector at a Certificate IV or Diploma level. Both levels are regulated by State regulatory bodies. Australia is one of the few countries whose RNs are all prepared to the same educational standard – the Bachelor degree level. Of the total number of employed licensed nurses, 78.7 per cent are RNs and 21.3 per cent are ENs.[6]

3.7 Within Australia, each State and Territory has its own nursing legislation (Nurses Act or Nursing Act), which provides for the accreditation of courses, registration, professional conduct and practice standards. Acknowledging the differences between the various Australian State/Territory nursing legislation and practice standards, the ANCI has developed ANCI National Competency Standards for the Registered Nurse and the Enrolled Nurse. They identify the minimum competency standards for nurses to practice in Australia and have been adopted by all the nurse regulatory authorities.[7]

3.8 Submissions and other evidence to the inquiry indicated comprehensive and widespread support for the retention of RN education in the university sector at the

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4 *Submission* 192, p.2 (ACDON).

5 National Review of Nursing Education, *Discussion Paper*, December 2001, pp.1-2.

6 *Submission* 962, p.3 (ANF). See also *Submission* No.928, p.4 (DETYA).

7 *Submission* 926, p.11 (ANCI).

Bachelor level.[8] The Australian Nursing Federation (ANF), reflecting much of the evidence, stated that:

> Entry to practice as a registered nurse should continue at the Australian Qualifications Framework level of Bachelor degree, offered in the higher education sector. We cite the increasing complexity of health care; the higher acuity and greater dependency of patients/clients accessing health services; the need for evidence based nursing and health care; the increasing use of complex technology; the increased expectations of patients/clients; and the expansion of advanced nursing role, as reasons for this position.[9]

3.9 The Committee strongly supports the current university based system for the training of RNs. The Committee notes that the National Review of Nursing Education also indicated their support for this position.[10] The Committee, however, believes that there are aspects of the current education and training programs for RNs and ENs that could be improved and these issues are discussed in this chapter and in chapter 4.

Recommendation 10: That the current university-based system for the undergraduate education of Registered Nurses be continued.

Current models of nurse education and training

3.10 The table below provides a summary of the current arrangements for nurse education and training in Australia and their links to the Australian Qualifications Framework (AQF).

3.11 The AQF establishes a framework for nationally consistent recognition of educational qualifications from the school, vocational education and training (VET) and university sectors. The AQF is a nationally agreed framework which identifies the qualifications available in these three educational sectors. Currently, ENs complete Certificate IV or a Diploma in the VET sector and RNs gain Bachelor degrees and other qualifications from universities.[11]

3.12 Certificate I courses teach introductory skills for certain occupations. Certificate II courses include traineeships with an on-the-job component. Certificate III courses provide a range of well developed skills in a variety of occupational areas. In the area of aged care, Certificate III courses provide the skills and knowledge required by workers who support and assist people with their daily living and personal care in community or residential settings. Certificate IV courses teach supervisory skills and advanced technical skills.[12]

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8 See, for example, *Submission* 927, p.10 (RCNA); *Submission* 890, p.4 (AHA); *Submission* 962, p.25 (ANF).

9 *Submission* 962, p.25 (ANF).

10 Education Review, p.16.

11 www.aqf.edu.au/aboutaqf.htm

12 www.tafensw.edu.au

Table 3.1: Overview of models of education and training related to nursing and midwifery

Australian Qualifications Framework	Title	Models of Education and Training
Doctorate Doctor of Philosophy/Professional Doctorate	• Doctor of Philosophy • Doctor of Nursing	• Research
Postgraduate • Masters • Diploma • Certificate	• Registered Midwife (on completion of Diploma or Masters)	• Masters by research or course work • Courses embedded - Cert/Diploma/Masters with exit points at each level if desired • Free standing courses at each level
Bachelor	• Registered Nurse/Division 1 Nurse • Registered Midwife (program commenced in 2002)	• Double degrees (nursing plus another degree) • Six semester courses (2-3 years) • Eight semester courses (with or without honours) • Graduate entry programs • Enrolled Nurse entry programs • One year entry for registered hospital trained nurses with lapsed registration • Hospital-trained (1 year) • Diploma upgrade (1 semester)
Diploma	Enrolled Nurse (Queensland)	• Employment contract with TAFE course (eg NSW traineeship) • VET Course with clinical placement (TAFE or private provider) • New Apprenticeship - on and off job training
Level V Certificate (Advanced Certificate)	Enrolled Nurse (Advanced Certificate)	
Level IV Certificate	Enrolled Nurse/Division 2 Nurse	
Level III Certificate	• Healthcare worker • Assistant in nursing • Personal care worker • Aged carers • Disability carers	• Traineeships for school students • Traineeships post-school • On the job training • Course with clinical placement (full or part-time)

Source: National Review of Nursing Education, *Discussion Paper*, December 2001, p.113.

Registered nurses

3.13 As noted above, RNs undertake a minimum of three years undergraduate preparation in the higher education sector at the Bachelor degree level.

3.14 Pre-registration programs comprise the following undergraduate nursing courses:

- Three-year Bachelor degrees in nursing.
- Four to five-year combined degrees, which either consist of a Bachelor degree in Nursing with a Bachelor degree in another field of study such as Psychology, Commerce or Arts, or a Bachelor degree in Nursing with a Bachelor degree in another nursing discipline, such as Midwifery or Rural Health.
- Two-year Bachelor degrees in Nursing for graduates from another discipline or students with previous nursing studies, such as Enrolled Nurse (Division 2) nurses. (These students are usually admitted into the three-year pre-registration Bachelor of Nursing program and are given credit equivalent to one year's full-time study).
- One-year re-entry programs (Bachelor degree or Certificate in Nursing) for nurses whose registration had lapsed.
- One-year conversion programs for overseas-qualified nurses seeking registration in Australia.[13]

3.15 Undergraduate nursing programs are offered at 28 universities as well as Avondale College.[14] In total, full or part nursing programs are delivered at 58 campuses across Australia.[15]

Midwifery

3.16 Under present arrangements midwifery registration usually follows registration as a nurse and study is at the postgraduate level. Midwifery courses are available in all States and Territories. A new four year double degree program integrates preparation to become a RN and undergraduate midwife as part of an undergraduate program. In addition, direct entry midwifery courses were introduced in 2002 in Victoria and South Australia.[16]

Specialist nurses

3.17 Specialist nursing courses may range from Graduate Certificates through to Masters degrees in any given specialisation. Courses preparing for specialisation can

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13 Education Review, p.116.

14 Avondale College is a non-profit, multidisciplinary private institution administered by the Seventh-day Adventist Church. See *Submission* 440, p.1 (Avondale College).

15 Education Review, pp.116-17.

16 Education Review, p.117.

attract the same level of qualification but show considerable variation in length, the mix of clinical and theory and the level of involvement of the health sector in their delivery.[17] Table 3.2 shows a profile of university courses by speciality and the number of graduates expected in 2001. This profile includes Postgraduate Certificate, Diplomas and Masters Degrees by coursework. Graduate Certificate courses are usually equivalent to six months of full-time study, while courses offered at the Graduate Diploma level are equivalent to one year of full-time study. Masters courses range from one to two years of full-time study, and Doctorate courses range from two to three years of full-time study.

Table 3.2: Number of postgraduate courses and expected domestic graduates in 2001 by nursing speciality across Australia

Speciality	Number of courses	Percentage of total number of courses	Total number of graduates
Family and child	34	6	282
Generic	84	14.7	743
Research	69	12.1	146
Functional	20	3.5	100
Community health	52	9.1	329
Midwifery	56	9.8	772
High dependency	114	20	1 036
Mental health	37	6.5	428
Rehabilitation/habilitation	37	6.5	128
Medical/surgical	67	11.8	294

Note: Does not include non-university sector (NSW College of Nursing)
Source: National Review of Nursing Education, *Discussion Paper,* December 2001, p.119.

3.18 Postgraduate courses are predominantly offered part-time, using flexible modes of delivery and are both up-front fee-paying and HECS funded. Postgraduate nursing data displays a trend toward courses within the specialties of midwifery and high dependency. States varied in the number of specialties that they offered, and the number of students projected to complete these courses in 2001. The Education Review noted that while there appears to be a trend toward an overall increase in postgraduate student enrolments into specialty courses, this trend may reflect the tail end of the transfer of postgraduate nurse education into the tertiary sector.[18]

Enrolled nurses

3.19 In most cases, EN courses are determined through the agreements of TAFE institutes and nurse registering authorities. The development of courses within the

17 Education Review, pp.118-19.

18 Education Review, p.119.

various States and Territories has resulted in considerable variation in the educational programs. Courses are offered through 22 capital city and 32 regional providers.

3.20 Table 3.3 shows details of courses offered for Enrolled Nurses across the States and Territories. Most courses are offered at AQF Level IV, except in the case of Queensland. The Level IV courses are predominantly offered over 12 months or equivalent full-time study, except in the case of Western Australia where the course is offered over 18 months.

Table 3.3: Enrolled Nurse courses by State or Territory

State/Territory	Course Title	Course length (months)	AQF level
Australian Capital Territory	Certificate IV in Health (Nursing)	12	4
Northern Territory	Certificate IV in Community Services (Enrolled Nurse)	12	4
New South Wales	Certificate IV in Nursing (Enrolled Nurse)	12	4
Queensland	Diploma in Enrolled Nursing	18	5
South Australia	Certificate IV in Health (Nursing)	12	4
Tasmania	Certificate IV in Health (Enrolled Nursing)	12	4
Victoria	Certificate IV in Health (Nursing)	12	4
Western Australia	Certificate IV in Enrolled Nursing	18	4

Source: National Review of Nursing Education, *Discussion Paper,* December 2001, p.115.

3.21 The flexibility of EN courses varies considerably around Australia. In New South Wales all students undertake a full-time employment model. Currently, there is no option available for part-time studies in that State. Western Australia also offers only full-time programs. In a hospital-based program to be offered in South Australia in 2002, students will undertake an employment-based program, available by full-time mode only. Within the other States and Territories, there is greater flexibility for students to study either full-time or part-time.

3.22 Hours of course contact are determined within the curricula set at State and Territory levels. Variations exist in the various States and Territories in relation to the amount of contact hours in courses, with total course contact hours varying between 756 hours (Northern Territory) and 1 200 hours (Western Australia). 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. Within the majority of courses students spend four full days per week on campus engaged in classroom learning.

3.23 Enrolled nurse students usually undertake block placements in health and community settings throughout their courses. The emphasis in courses on clinical

practice experiences vary from State and Territory. This is discussed further in chapter 4. All courses expose students to significant amounts of aged care and rehabilitation nursing. Furthermore, all courses provide students with exposure to acute care areas, mainly medical surgical nursing.[19]

Unregulated care workers

3.24 Unregulated healthcare workers are employed predominantly in the aged care sector. While there is no requirement for these workers to have formal training, industry training packages provide the framework for competencies for the Level II and III Certificates. The Community Services and Health Industry Training Advisory Body, has developed two training packages that provide skills training in related fields of health. While this level of qualification does not encompass nurses, it does prepare a range of workers whose work involves care and is often done under the supervision of a nurse.[20] The Committee has made recommendations relating to the regulation of these workers in chapter 4.

Improving undergraduate education and training programs

3.25 Evidence received during the inquiry indicated that there is a need to improve the education and training available to RNs. Issues related to the education and training needs of these nurses are discussed below.

Provision and funding of additional undergraduate places

3.26 The level of Commonwealth funding is fundamental to the viability of public universities – it determines the number of HECS-liable places for domestic students and provides the overwhelming majority of the resources available for teaching and research.

3.27 Commonwealth operating and research grants form a large part of universities' revenue. Universities, however, also generate a large proportion of their revenue from fees, particularly from postgraduate courses and overseas students, consultancies, donations and investments.

3.28 The main features of the current funding framework are:

- provision of operating resources as a single block operating grant;
- allocation of resources in the context of a rolling triennium which ensures that institutions have a secure level of funding on which to base their planning for at least three years;
- allocation of research funding primarily on a competitive basis ($460.8 million in 2001);
- special capital funding ($40.3 million in 2001); and

19 Education Review, pp.114-15, 142.

20 Education Review, p.114.

- an accountability framework provided essentially by the yearly submission of educational profiles.[21]

3.29 While the Commonwealth provides the bulk of university funds ($5.86 billion, including HECS, in 2001), higher education institutions are essentially autonomous organisations that are responsible for the distribution of funds between faculties and schools based on their own assessment of priorities and needs. Universities are responsible for the allocation of places across various fields, although the allocations are discussed with the Department of Education, Science and Training (DEST) during the annual profiles consultations. Universities are expected to take into account the extent of student demand, and the needs of the labour market.

3.30 Operating grants consist of four components:

- a teaching related component;
- Indigenous Support Funding;
- a research component; and
- a capital component.

The teaching related component forms the largest part of the operating grant. It provides funds for the general operating purposes of the institution. This includes academic and non-academic staff salaries, minor works and equipment, etc. The teaching related component is primarily determined by the agreed number of fully subsidised places measured in Equivalent Full-Time Student Units (EFTSUs) for a given year in the triennium and specified undergraduate fully subsidised minimum places for the year.[22]

3.31 Submissions argued that there is a shortage of Commonwealth funded undergraduate positions.[23] The Victorian Government, reflecting much of the evidence from State Governments/Departments, commented that:

> Efforts to increase the number of HECS funded places in nursing are being severely hampered by the inadequate level of Commonwealth funding provided.[24]

3.32 Evidence from State Governments and Departments indicated the seriousness of the problem. The Victorian Government stated that despite an increase of over 12 per cent in the first preference for university nursing places, the total number of

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21 *Submission* 928, p.19 (DETYA).

22 *Submission* 928, pp.18-20 (DETYA).

23 *Submission* 942, p.6 (Queensland Health); *Submission* 960, p.11 (Victorian Government); *Submission* 937, p.1 (ACT Government).

24 *Submission* 960, p.11 (Victorian Government).

nursing places available in 2001 actually declined by 250 places from the previous year.[25]

3.33 The NSW Health Department noted that, based on workforce requirements, the State requires a steady state of 2 490 EFTSU undergraduate first year enrolments per annum. The Department noted that the universities have consistently been unable to meet this target of 2 490 enrolments. The Department indicated that a problem is that the universities emphasise their autonomous status and 'determine numbers' on a year to year basis without reference to State workforce requirements.[26]

3.34 The South Australian Department of Human Services noted that current forecasting indicates that to maintain the South Australian RN workforce at its current size, the number of new graduates completing undergraduate nursing programs each year need to be between 650 and 1 350. A total of 389 students graduated at the end of 2000 and 430 graduated at the end of 2001. The Department stated that these numbers are 'significantly below' the range required to balance and meet current and future requirements.[27]

3.35 The Western Australian Department of Health stated that Western Australia requires more HECS funded positions for undergraduate nurses because the State's population is increasing. The Department noted that 1 669 students listed nursing as their first preference in 2002. As there were only 558 places available to students in Western Australian universities, 668 applicants failed to get into a nursing program.[28]

3.36 Queensland Health stated that over the last eight years, the number of pre-registration nursing commencements in the State has averaged approximately 1 200 per annum, and rose to 1 500 in 2001. The Department indicated that this number needs to rise to 1 700 within the next two years to maintain an adequate long term supply of nurses in Queensland.[29]

3.37 The Deans of Nursing stated that in 2000 and 2001 each State had more applicants for the undergraduate nursing degree courses than they had places available in the universities.[30]

3.38 The Deans of Nursing also emphasised that the number of nurses produced by universities is directly related to the funding of universities. The Council noted that:

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25 *Submission* 960, p.11 (Victorian Government).

26 *Submission* 867, Attachment 2, p.3 (NSW Health Department).

27 *Submission* 940, p.4 (SA Department of Human Services).

28 *Committee Hansard*, 27.02.02, pp.89-90 (WA Department of Health).

29 *Submission* 942, p.6 (Queensland Health) and Additional Information, 17.4.02. See also *Committee Hansard*, 26.3.02, pp.588-89 (Queensland Health).

30 *Submission* 192, p.6 (ACDON).

> Within each university funds are distributed to the various faculties and schools in accordance with the broad policies and priorities of the university. However, nursing is in competition with every other component of the university for funding, and in a situation where the Government itself has recognised that funding for universities is inadequate, it is not surprising that faculties/schools of nursing are constrained in the numbers they can take in. Indeed, most faculties and schools of nursing are over-enrolled, taking more students than they are funded for, in recognition of their social responsibilities.[31]

3.39 The Committee questioned the Department of Education, Training and Youth Affairs (DETYA) as to whether the Department has mechanisms in place to determine the adequacy of undergraduate nursing places in universities. DETYA responded that:

> We have an annual discussion with each university around what we call the profile of their enrolments. When nursing was transferred to the university sector, numbers were notionally agreed. Often there is pressure from the state health authorities to see where those numbers are trending. I think it is fair to say that some universities have within their mission retained a strong emphasis on nursing as part of the range of their offerings and have given attention to quality of provision. Others have responded more to student demand in other areas, as a result of which there has been variable performance in the total number of places that are around.[32]

3.40 The Committee further questioned the Department as to whether the lack of funding was due to Government funding decisions or the choice of universities not to provide places in nursing. The Departmental representative conceded that 'one can argue either way, I suppose. But I think there are discretions that the universities have within the funding that is made available to them, and some have exercised that discretion in favour of nursing and others in favour of other fields'.[33]

3.41 Witnesses argued that there needs to be more effective mechanisms in place between the Commonwealth, States and the universities so that funding issues and the question of university places can be assessed, especially as there is a common perception of a nursing 'shortage' yet courses continue to be oversubscribed. One witness noted that 'there absolutely has to be some kind of better dialogue that enables that funding to flow more effectively and be used more effectively'.[34]

3.42 Funding issues for undergraduate places are also related to the question of national nursing workforce planning and the mechanisms in place for assessing future nursing labour force needs. These issues are discussed in chapter 2.

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31 *Submission* 192, pp.5-6 (ACDON).

32 *Committee Hansard*, 28.8.01, p.28 (DETYA).

33 *Committee Hansard*, 28.8.01, p.28 (DETYA).

34 *Committee Hansard*, 27.3.02, p.685 (University of SA).

Conclusion

3.43 The Committee considers that improved mechanisms need to be put in place, in consultation with the States and universities, to determine the numbers of nurses needed – both in the short and longer term – and effective allocation of places between the States. The Committee believes that issues of supply and demand need to be considered in conjunction with improved mechanisms for assessing future nurse labour force needs.

3.44 The Committee also believes that there is an urgent need for the Commonwealth to increase the number of undergraduate university places for nurses and that consultations with State Governments, nursing organisations, unions and other key stakeholders in relation to this issue needs to be given priority. As discussed in chapter 2, there is a serious shortage of nurses in Australia and increasingly that shortage is now threatening the maintenance of our hospitals and health services.

Recommendation 11: That the Commonwealth, in conjunction with the States and universities, implement improved mechanisms to determine the supply and demand for nursing places at universities and in determining how these targets are set.

Recommendation 12: That the Commonwealth Government provide funding for additional undergraduate nursing places to universities offering nurse education courses to meet the workforce requirements set by the States.

Clinical component of undergraduate courses

3.45 During the inquiry the Committee received a considerable amount of evidence, especially from the healthcare sector, suggesting that the clinical education component of university courses is not sufficient to prepare new graduate nurses for work as nurses.[35] The Australian Healthcare Association (AHA), summarising much of the evidence, stated that:

> The level of practical preparation of graduates for entry-level practice is variable across universities and across graduates, and in many instances, insufficient to meet organisational requirements.[36]

3.46 Women's Hospitals Australasia & Children's Hospitals Australasia (WHA & CHA) also argued that:

> The clinical component of education programs needs to be increased so that, in addition to developing clinical skills, the students gain a real appreciation of what working as a nurse entails.[37]

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35 See, for example, *Submission* 936, p.17 (WHA & CHA); *Submission* 706, p.4 (Royal Perth Hospital Nursing Executive Council).

36 *Submission* 890, p.4 (AHA).

37 *Submission* 936, p.17 (WHA & CHA).

3.47 The universities and others argued, however, that it was an unrealistic expectation to expect new graduate nurses to have this level of skill and therefore to be able to 'hit the ground running'. The Deans of Nursing stated that 'in no other profession is the newly qualified graduate expected to perform to the standard of the experienced professional'.[38] The Committee notes, however, that this was the expectation for hospital-trained nurses.

3.48 Table 3.4 shows the clinical component of undergraduate courses in selected universities. The table indicates considerable variation in the clinical component of courses both in duration and clinical time allocated over the length of courses.

Table 3.4: Clinical Component in Undergraduate Courses - Selected Universities

	1st Year	2nd Year	3rd Year
Flinders University[1]	2 days per week for 13 weeks	2 days per week for 13 weeks	3 days per week for 15 weeks (+ practicum in area of choice)
University of Adelaide[2] (proposed undergraduate course)	2 days per week for 42 weeks	3 days per week for 42 weeks	5 blocks of 6 weeks at a time
University of Western Sydney - Macarthur campus[3]	4 weeks	6 weeks	6 weeks + 4 week block elective
University of Tasmania[4]	None, 2 weeks in 2003	3 weeks	Predominantly clinical placements (+ units taught at clinical sites)
Queensland University of Technology[5]	50 per cent off-campus clinical placements: • small proportion in 1st year; • increases in 2nd year; • in 3rd year - last semester - 8 weeks out of 13 in direct clinical placements		
Griffith University[6]	50 per cent clinical placements - clinical hours reduced from 1 200 to 900 hours in current curriculum		
University of Southern Queensland[7]	45 per cent clinical placements		

Source: [1] *Committee Hansard,* p.682.
[2] *Committee Hansard,* p.698.
[3] *Committee Hansard*, p.482.
[4] *Committee Hansard,* pp.290-293.
[5] *Committee Hansard,* p.595.
[6] *Committee Hansard,* p.595.
[7] *Committee Hansard*, p.595.

38 *Submission* 192, p.7 (ACDON). See also *Committee Hansard*, 28.2.02, p.123 (ACDON).

3.49 The Deans of Nursing stated that for most courses, approximately 40-50 per cent of the degree program is comprised of clinical practice that is undertaken in healthcare agencies.[39] However, as the above table indicates, for some courses the clinical component is less than this average.

3.50 The Committee received evidence that the total clinical component varied considerably between States. The WA Department of Health indicated that in that State there are 1 000 hours of clinical practice provided in undergraduate degrees, while other States have between 500 and 900 hours.[40] One hospital noted that in Victoria, undergraduates have between 600-700 hours of clinical practice over their three-year courses.[41]

3.51 The National Review of Nursing Education (the Education Review) noted that the issue of adequate clinical preparation 'is clearly a complex, multifaceted and difficult issue partly because it involves different perceptions of what is important and because its resolution involves very different players with different agendas'.[42] The Education Review noted that placements for students are not always easy to obtain even when educators recognise the value of exposure to particular clinical settings; there is a high level of competition for placements; and the costs of delivering adequately supervised programs are high.[43]

3.52 Evidence to the Committee indicated that there needs to be earlier placement of students in hospitals and other healthcare settings.[44] One witness noted that 'there could be improvements to the practical clinical preparedness of newly graduating staff by increased opportunities for clinical training placements [and] exposure to practice at an earlier stage in the registered nurse education program'.[45] Another submission noted the need for 'some improvements in the current tertiary preparation of students including the establishment of a clinical focus early in the training'.[46]

3.53 Evidence also indicated a need for longer blocks of clinical placements and better coordination and planning in these placements. The Austin and Repatriation Medical Centre stated that:

> Many of the university students we deal with at the moment, who have three-year degrees, have very limited clinical experience. They often have 600 or 700 hours in their total three-year degree. They often come for

39 *Submission* 192, p.6 (ACDON). See also *Submission* 736, p.8 (QUT, School of Nursing).

40 *Committee Hansard*, 27.2.02, p.91 (WA Department of Health).

41 *Committee Hansard*, 28.2.02, p.155 (Austin and Repatriation Medical Centre).

42 Education Review, p.127.

43 Education Review, pp.127-28.

44 *Committee Hansard*, 21.3.02, p.392 (APHA).

45 *Committee Hansard,* 21.3.02, p.395 (AHA).

46 *Submission* 730, p.1 (Sir Charles Gairdner Hospital).

> clinical placements to our hospital for one or two weeks at a time. We feel those clinical experiences are fairly meaningless because they never get really socialised or accepted into the work force…We believe that clinical experiences need to be more like six or eight weeks long. There needs so be some sort of continuity with them as well and they need to be planned and involve our staff.[47]

3.54 A number of universities have developed new and innovative ways of approaching clinical placements, such as those operating at Flinders University in South Australia and the University of Notre Dame in Western Australia.

Flinders University, South Australia

In an effort to ensure that students are oriented to the realities of nursing and equipped with the necessary clinical skills the School of Nursing and Midwifery at Flinders University, in partnership with several hospitals and with other health agencies, has developed an innovative model for clinical placement called the Dedicated Education Unit (DEU). The philosophy underpinning a DEU is one of collaboration between service and education based on mutual respect and trust. In summary, a DEU is an area which may be a ward in an acute or aged care institution, a mental health facility or a community site such as Royal District Nursing Service which is set up collaboratively to provide a consistent learning environment for students. The establishment of a DEU is a negotiated enterprise between the health care site and the University and ensures that both parties are keen for students to be placed at that institution. Students spend protracted periods of time (ie. 2-3 days per week per semester) in the DEU and clinicians and academics work together in fostering the provision of quality student teaching and learning.

Collaboration between academics and clinicians in clinical teaching means that the differing foci of each sector are brought together for the benefit of students. Clinicians, students and academics receive specific preparation prior to the DEU placement so that all are clear about the expectations for student achievement. A clinical liaison position is attached to the DEU and allows for a Level 1 Registered Nurse to be upgraded to Clinical Registered Nurse level. The clinical liaison Registered Nurse works closely with the academic assigned to the DEU to monitor the students' progress and generally facilitate and foster student learning and problem solve any issues that may arise. Students in the DEU are involved in an active exploration of experience and are encouraged to reflect on their experiences in critical ways. Peer teaching is encouraged and students are 'buddied' with more senior students as well as experienced Registered Nurse clinicians who have been fully briefed about the program and its intent. At present the university funds this model with 'in kind' support from the clinical agency.

Source: Submission No.740, pp.6-7 (Flinders University of SA, School of Nursing and Midwifery).

47 *Committee Hansard*, 28.2.02, p.155 (Austin and Repatriation Medical Centre).

University of Notre Dame, Western Australia

The model of clinical placement at Notre Dame University emphasises partnerships with hospitals so that students can undertake their placements at the same facility for the length of their course. This allows students to familiarise themselves and be comfortable with the uniqueness of a particular hospital or healthcare setting. It also gives the student a sense of belonging and for the assigned Hospital or healthcare group a sense of ownership of the student. Placements are also made with either hospitals or healthcare agencies close by so that the amount of travelling time for students is limited.

The university uses the whole of the academic year, with a summer term in January (4 weeks), first semester (14 weeks), a winter term (7 weeks), and then second semester (14 weeks). Nursing students use the 7 weeks of winter term for practicum and the last 6 weeks of second semester. Students commence clinical placements are the end of their first semester. Clinical placements are 'reality based', with students working the same shift across the week as their mentor, for a minimum of 32 hours a week in preparation for the reality of shift work during their working life as a nurse. It is expected that students undertake a patient case load of up to three patients by the end of their clinical placements. Also students are mentored by a Registered Nurse from the area in which they are assigned, and where possible have the same mentor for the whole of their clinical placement. The university seeks mentors voluntarily from each work place and provides them with an education program that not only identifies the level of competency they can expect from the student but gives them skills in teaching at the bedside.

Source: National Review of Nursing Education, Discussion Paper, December 2001, p.143.

3.55 As noted above, Flinders University has developed an innovative model for clinical placements called the Dedicated Education Unit (DEU). A DEU is an area such as a ward in an acute or aged care institution which is set up collaboratively to provide a consistent learning environment for students. The model provides for students to spend protracted periods of time – 2-3 days per week per semester – in the DEU and clinicians and academics work together to provide quality student teaching and learning.[48]

3.56 An evaluation of Flinders University DEU model has shown it to be extremely effective in producing graduates with beginning competence in clinical settings. The evaluation report concluded that the major strength of the DEU was that it enhanced the transfer of theory into practice for students more effectively than previous models of clinical placement used by the university.[49] One witness commented that the DEU is a 'very sound model' with the hospital receiving 'good feedback' from clinicians regarding its operation.[50]

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48 *Submission* 740, p.6 (Flinders University, School of Nursing & Midwifery).

49 J. Gonda et. al, 'Dedicated Education Units: An Evaluation', *Contemporary Nurse*, vol.8, no.4, December 1999, p.176. See also Education Review, p.144.

50 *Committee Hansard*, 27.3.02, p.791 (Royal Adelaide Hospital).

3.57 As indicated above, the University of Notre Dame uses the whole of the academic year for teaching and students commence clinical placements early in their courses – at the end of their first semester. Several witnesses cited this model of nurse preparation as being particularly effective. One witness noted that Notre Dame was a 'best practice example' – 'it is able to solve the problem…which is lack of clinical preparedness in undergraduates and also provide some opportunities for earlier entry into the work force'.[51] Another witness noted that University of Technology, Sydney (UTS) and a number of other universities in Victoria are examining the Notre Dame model.[52]

3.58 Another witness, however, cautioned that that it was 'far too early' to assess the effectiveness of the model offered at Notre Dame –'it is also a very selective school of a very small size – a "boutique" school of nursing if you like – where they can obviously try different approaches in a very much less structured fashion than a school of nursing which has to accommodate up to a thousand students'.[53] The Education Review found that the model at Notre Dame University 'appears to be working well with students', although the first small group of nursing students were only enrolled in the program in February 2000.[54]

3.59 Other models, such as courses at the University of Wollongong were also referred to in evidence as best practice examples in relation to clinical placements.[55] The University of Western Sydney (UWS) has also developed a new, innovative, and 'industry responsive' undergraduate program which was introduced from 2002. It has a strong emphasis on clinical application in response to changes that have occurred in the clinical service area, for example, in models of care and staffing levels. The university has developed close liaison with health service providers in planning, implementing and evaluating clinical learning experiences and curricula.[56] The UTS referred to the use of clinical development units in the third year of their undergraduate degree – 'where almost all of the third year of our program is now spent in the clinical facilities'. The university noted the positive response of the area health service to this development.[57]

3.60 Some witnesses saw merit in students undertaking their placements at the same facility for the duration of their course, such as occurs at the University of Notre Dame. This was seen as important as it builds in students a sense of attachment and

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51 *Committee Hansard*, 21.3.02, p.404 (AHA).

52 *Committee Hansard*, 27.3.02, p.792 (Royal Adelaide Hospital).

53 *Committee Hansard*, 27.2.02, p.116 (Royal Perth Hospital).

54 Education Review, p.143.

55 *Submission* 923, p.9 (Tasmanian Department of Health & Human Services).

56 *Submission* 784, p.11 (UWS).

57 *Committee Hansard*, 22.3.02, p.468 (UTS).

loyalty to the healthcare facility.[58] Other witnesses did not, however, support this concept arguing that it is not always possible to obtain all types of placements within the one facility and that a diversity of clinical placements was important for students. One witness noted that this diversity is a 'plus' – 'our students are actually placed in a variety of venues…I do not think there is an identification with one particular area'.[59]

Conclusion

3.61 The Committee considers that there should be greater clinical exposure earlier in courses and that it should be of a longer duration than that which is available in many courses at present. Evidence indicates that greater clinical exposure is better than less exposure. The Committee notes that there have been significant improvements in many university courses over recent years that have led to an increase in the duration of clinical placements. This demonstrates an acknowledgment by universities of the need to increase the clinical exposure of students during undergraduate courses and a recognition that this will lead to improved retention of nurses once in the workforce.

Recommendation 13: That, while maintaining a balance between theoretical and practical training, undergraduate courses be structured to provide for more clinical exposure in the early years of the course and that clinical placements be of longer duration.

Clinical placements in undergraduate courses

3.62 Concerns were raised in relation to the availability and cost of clinical placements available to undergraduates. It was emphasised during the inquiry that quality clinical placements in a variety of health services are vital to the achievement of fitness to practice as a professional nurse.[60]

3.63 Evidence indicated that placements in clinical settings are increasingly difficult to obtain. The Deans of Nursing indicated that each dean or head of school has to find hospitals and other healthcare facilities which are able and willing to accept students and offer them supervised practice – 'it is becoming increasingly difficult to make such arrangements because hospitals and other organisations are themselves short of resources; they are less and less able to spare the time of hard-pressed nurses to assist in the training of students, and some clinical nurses…resent this extra load'.[61]

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58 *Committee Hansard*, 21.3.02, p.365 (Focus Group of Specialist Nurses); *Committee Hansard*, 27.3.02, p.704 (University of SA).

59 *Committee Hansard*, 27.3.02, p.704 (Flinders University).

60 *Submission* 192, p.3 (ACDON).

61 *Submission* 192, p.6 (ACDON).

3.64 One witness graphically illustrated the problem faced by the UWS:

> We have a lot of trouble finding enough adequate and quality clinical places. It is very hard to find clinical places in the drug and alcohol area in our region of Sydney. It is very hard to find in-hospital placements in mental health…It is hard to find opportunities to give students experience in working with community mental health nurses, because they are thin on the ground and we have a large number of students. Some facilities have very good intentions. They might be small private surgical hospitals or small private psychiatric hospitals, but they limit the number of students they can take over time…because they have restructured and downsized.[62]

3.65 It was emphasised in evidence that the cost of undergraduate clinical education is high because hospitals, and other healthcare providers, charge for providing this service, or the universities have to employ clinical teachers to supervise students.[63]

3.66 A number of options were suggested to address the problem of the availability of placements.

3.67 Some witnesses suggested that 'sandwich' courses should be piloted. These programs would provide that a large part of the undergraduate course – up to half of each year of the course – would be spent in the clinical environment as a salaried member of the workforce. It was recognised that quality clinical teachers would need to be available in the healthcare settings and industrial relations issues related to pay and conditions would need to be negotiated.[64]

3.68 Some evidence suggested that part-time employment for nursing students should be provided, especially during student vacations so that they are exposed to hospital settings and get a 'feel' for nursing and the 'culture' of the hospital environment.

3.69 Some hospitals already provide employment for second year student nurses with pay rates equivalent to assistants in nursing rates.[65] Evidence suggests that this approach has positive results. One witness noted that:

> While there have been some teething problems with it, the actual undergraduate students who are working at this post-second year level of their program are anecdotally saying that they are starting to feel part of

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62 *Committee Hansard*, 22.3.02, pp.482-83 (UWS, School of Nursing, Family & Community Health). See also *Committee Hansard*, 15.3.02 (Tasmanian School of Nursing); *Committee Hansard,* 26.3.02*,* p.609 (QUT, School of Nursing).

63 *Submission* 914, p.11 (RMIT University, Department of Nursing & Midwifery).

64 *Committee Hansard*, 22.3.02, pp.488-89 (UWS, School of Nursing, Family & Community Health).

65 *Committee Hansard*, 28.2.02, p.172 (Latrobe Regional Hospital); *Committee Hansard*, 21.3.02, p.412 (Catholic Health Australia/UnitingCare Australia).

> what is going on; they know what the hospital is like; they know who these people are.[66]

3.70 A difficulty with this approach is that the pay rates offered by hospitals are lower than equivalent pay that can be obtained with outside casual employment. One witness noted that the pay rates for assistants in nursing is about $11.50 an hour, and $13-14 hour in the acute sector, compared with approximately $20 an hour for casual work with outside employers, such as KFC or McDonalds.[67]

3.71 Other witnesses suggested that clinical education should be available across the entire year. Currently, most universities run their clinical education programs within two narrow 14-15 week semesters each year. Invariably this means that clinical agencies are 'overloaded' with students at certain times of year. Access to agencies therefore has to be rationed and not all students have access to the widest range of clinical experiences. Submissions suggested that universities should use the entire year for clinical education thus affording more students the opportunity to access a range of clinical placements.[68] This would, however, increase the costs of clinical education.

3.72 Other witnesses suggested that the quality of the clinical placements, and not necessarily the duration of the placements needed to be maximised but that this would require additional resources – 'resourcing into units, adequate staffing of units, would be an enormous step forward to having a better clinical environment for the students to learn in'.[69]

3.73 Other witnesses suggested that a fourth year of supervised clinical practice was a better option than trying to find extra undergraduate placements given the difficulties in obtaining placements in the current environment.[70] This issue is discussed later in the chapter.

Conclusion

3.74 The Committee believes that issues related to the availability of clinical placements need to be addressed. As previously discussed, the Committee believes that students should have more clinical exposure during courses. Questions related to clinical placements are also bound up with issues related to the duration of undergraduate courses and the cost of clinical education. These issues are discussed later in the chapter.

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66 *Committee Hansard*, 27.3.02, p.681 (University of Adelaide).

67 *Committee Hansard*, 2.3.02, p.412 (UnitingCare Australia/Catholic Health Australia).

68 *Submission* 812, p.12 (ACU, Faculty of Health Sciences); *Submission* 725, p.7 (ACU, School of Nursing (Victoria)). See also *Committee Hansard*, 28.2.02, p.223 (ANF – Victorian Branch).

69 *Committee Hansard* , 22.3.02, p.488 (University of Technology, Sydney, Faculty of Nursing).

70 *Committee Hansard*, 27.2.02, p.117 (Royal Perth Hospital).

3.75 The Committee believes that students need to spend more time in clinical practice under the supervision of experienced clinicians so that they are exposed to work in hospitals and related settings. The Committee considers that hospitals should be encouraged to provide for paid, part-time employment for nursing students during their undergraduate courses, which from evidence has proved to be a good learning experience for the students. The Committee also believes that clinical education programs in universities should be available across the entire year rather than within two narrow 14-15 week semesters per year as occurs in most courses at present.

Recommendation 14: That hospitals and other healthcare agencies be encouraged to provide part-time paid employment for student nurses from the second year of undergraduate courses.

Recommendation 15: That universities, as far as practicable, operate their clinical education programs across the entire year.

Content of undergraduate courses

3.76 Evidence to the inquiry indicated that the theoretical aspects of undergraduate courses were generally satisfactory. The ANF cited the results of a survey undertaken by the ANF (SA Branch) which indicated that newly graduated nurses, experienced nurses and Directors of Nursing considered that the undergraduate programs were providing a sound theoretical base for students to enter the nursing workforce.[71] The Education Review also noted that there is general satisfaction with the theoretical background of new graduates.[72]

3.77 Concerns were, however, raised that some areas such as mental health, aged care and cross-cultural nursing are not adequately covered in existing undergraduate programs.[73] Other areas identified as requiring more attention were leadership, negotiation skills, research, information technology, and pharmacology.[74]

3.78 The ANF stated that:

> The curriculae…must prepare nurses for practice in the current environment in which health services are provided eg mental health, aged care, community and primary health care, and not just focus on preparation for practice in the acute care sector.[75]

3.79 In relation to mental health, the WA Branch of the Australian & New Zealand College of Mental Health Nurses noted the relatively small amount of teaching time

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71 *Submission* 962, p.26 (ANF).

72 Education Review, p.19.

73 *Submission* 409, p.3 (La Trobe University School of Nursing); *Submission* 942, p.15 (Queensland Health).

74 *Submission* 409, p.3 (La Trobe University School of Nursing).

75 *Submission* 962, p.25 (ANF). See also *Submission* 942, p.15 (Queensland Health).

devoted to mental health in undergraduate courses in Western Australia, especially compared to the previous hospital-based courses. The College noted that more teaching time needed to be devoted to mental health nursing in courses and also more time spent in clinical areas.[76]

3.80 Research commissioned for the Education Review found that in relation to mental health nursing, current programs preparing general nurses 'contain too little, and inadequate, preparation for mental health nursing practice. Specialist preparation, of higher quality, and of greater intensity in both theory and clinical practice, is therefore needed to meet workforce demands of quality and quantity of the mental health nursing workforce'.[77]

3.81 The table below provides information on the number of hours of classroom instruction and of clinical experience in undergraduate mental health nursing courses offered by Australian universities. The table shows that both classroom hours and clinical experience varied markedly across States.

Table 3.5: Average number of hours of classroom instruction and clinical experience in mental health nursing in Australian universities - 1999

State/Territory	Classroom Instruction (hours)	Clinical Experience (hours)
New South Wales	63	86
Victoria	69.75	140
Queensland	71.6	106
Western Australia	116	260
South Australia	35	95
Tasmania	18	116
Australian Capital Territory	78	120
Northern Territory	24	40
Australia	59.4	120

NB: Clinical experience hours exclude elective clinical placements.

Source: M. Clinton, *Scoping Study of the Australian Mental Health Nursing Workforce 1999*, Canberra: Department of Health and Aged Care, 2001, p.32.

3.82 The research report for the Education Review reviewed a variety of possible models for mental health nursing education. These focus on undergraduate programs including generalist programs which provide initial exposure to mental health nursing, and programs offering an initial period of specialist training within a three or four year degree. On the basis of the models reviewed, it was found that there were advantages

76 *Submission* 479, pp.13-15 (ANZCMHN). See also *Submission* 914, p.12 (RMIT University, Department of Nursing & Midwifery); *Committee Hansard*, 28.02.02, p.206 (HACSU).

77 Education Review, pp.124-125.

in adopting a four-year model, based on generalist preparation in the first two years, followed by specialist theoretical and clinical placement components in at least the last year. Initial registration as a nurse would be possible after the third year, but specialist registration as a mental health nurse would not occur until after the fourth year.[78]

3.83 With regard to aged care, some submissions suggested that that there was insufficient time devoted in undergraduate programs to issues on ageing and insufficient clinical placements in aged care facilities.[79]

3.84 Commissioned research for the Education Review found that undergraduate nursing programs currently offer 'too little specialised theoretical work and clinical practice in aged care. As a consequence, newly Registered Nurses are often inadequately prepared for work in the area'.[80] The researchers suggest that undergraduate courses be extended from three to four years. They argue that the current three years does not allow sufficient time for the development of general knowledge and clinical competencies and for the development of specific knowledge and skills for clinical practice in a particular area of specialisation – whether in aged care or other settings. The fourth year would allow students to develop the particular knowledge and clinical skills for work in different specialised settings.[81]

3.85 Submissions also noted that courses need to promote culturally sensitive programs. Such programs 'will assist nurses maximise health outcomes and provide appropriate care within Australia's multicultural society'.[82]

Conclusion

3.86 The Committee notes that evidence to the inquiry indicated that the theoretical aspects of undergraduate courses were generally satisfactory. However, concerns were raised during the inquiry that certain areas, such as mental health, aged care and cross-cultural nursing are not adequately covered in many undergraduate programs. The Committee believes that more attention should be devoted to these areas in relation to both theory and clinical practice in undergraduate courses.

Recommendation 16: That undergraduate courses provide additional theory and clinical experience in mental health, aged care and cross-cultural nursing.

Duration of undergraduate courses

3.87 Several submissions argued that the current three-year undergraduate degree course is too short and should be increased to a four-year degree program.[83] As noted

78 Education Review, p.125.

79 *Submission* 775, p.1 (Aged & Community Services Tasmania).

80 Education Review, p.124.

81 Education Review, p.124.

82 *Submission* 942, p.15 (Queensland Health).

above, it was argued that the current three-year course does not allow adequate time to be devoted to certain areas of nursing such as mental health and aged care.

3.88 Submissions argued that a four-year course is necessary to ensure that students are sufficiently exposed to the burgeoning knowledge base required for professional nursing practice.[84]

3.89 Submissions also pointed out that nurses are the only health care professionals who receive a three-year degree: all others require a 4-year degree, including physiotherapists and occupational therapists – 'this makes nursing unattractive to many potential applicants as its status is automatically reduced'.[85]

Options for a fourth year

3.90 Some submissions argued that a three year degree program could be followed by a fourth year as an intern year with full registration at the end of the fourth year. The student would be paid during the internship at special student award rates.[86]

3.91 Royal Perth Hospital, in arguing that the fourth year of the undergraduate nursing course should be spent in the practice setting as paid employees –'students of nursing' – noted that 'this would help alleviate the staff shortage issue as well as reduce the reality shock that currently confronts new graduate nurses'.[87] Royal Perth Hospital added that:

> I would draw a parallel with those in the medical system, whereby five years of their time is spent largely in academic preparation and then they have a compulsory internship year if they are going to practice clinically…Unfortunately, at this stage the graduate year placements are not compulsory…our preferred position now from an industry perspective, is to see a compulsory fourth year offered and for there to be sufficient positions to accommodate all newly graduating nurses in that.[88]

3.92 A number of submissions argued that a system of paid employment for both student ENs and student RNs would increase the exposure of student nurses to the healthcare system.[89] Queensland Health suggested that the trial of paid employment

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83 *Submission* 812, p.9 (ACU, Faculty of Health Sciences); *Submission* 409, p.3 (La Trobe University School of Nursing); *Submission* 449, p.10 (Tasmanian School of Nursing).

84 *Submission* 725, p.5 (ACU, School of Nursing); *Committee Hansard*, 27.3.02, p.676 (University of SA).

85 *Submission* 725, p.5 (ACU, School of Nursing).

86 *Submission* 736, p.9 (QUT, School of Nursing); *Submission* 755, p.2 (University of SA, School of Nursing & Midwifery).

87 *Submission* 706, p.6 (Royal Perth Hospital).

88 *Committee Hansard*, 27.2.02, pp.115-16 (Royal Perth Hospital). See also *Submission* 706, Additional Information, 13.5.02, p.1 (Royal Perth Hospital).

89 *Submission* 890, p.9 (AHA); *Submission* 942, p.14 (Queensland Health); *Submission* 937, p.5 (ACT Government).

for undergraduate nurses 'could assist transition to the clinical environment'.[90] The Education Review stated that individual arrangements already exist and some other formal arrangements for both RNs and ENs are being developed or are in place in some States.[91]

3.93 The Education Review noted that while such arrangements may increase the exposure of nursing students to the healthcare system, employers are often too inflexible to use the students to best advantage and often the student nurse will not carry out any 'real' nursing tasks.[92]

3.94 One witness noted that the graduate nurse program – a one-year supervised clinical program in a health facility – is similar to the concept of an intern year and nurses have the advantage under the program of being paid as RNs.[93]

3.95 The University of South Australia also suggested that the Bachelor of Nursing degree should be awarded after four years, that is, at the conclusion of the 3-year undergraduate nursing course and after the one year graduate nurse program – as the majority of nurses undertake a fourth year in the form of a graduate nurse program.[94] The University proposed that an undergraduate nursing program of four years duration could include an exit point at which a student would be eligible for enrolment as a nurse as well as inclusion of the graduate program or internship as the fourth year, after which the student would gain a degree and be eligible for registration.[95]

3.96 The Tasmanian School of Nursing argued that a four-year undergraduate program is preferable to the option of an internship because 'it allows a better blend of clinical practice and the fostering of higher level conceptual development necessary for practice in contemporary healthcare settings. It also enables the preparation of nurses who are exposed to clinical practice in a variety of clinical settings'.[96]

Conclusion

3.97 The Committee is not persuaded that the undergraduate degree program should be increased from three to four years. The Committee considers that the cost to the Commonwealth Government of this change would be substantial. The Committee believes that the focus of reform in this area should be on improving the structure of the current three-year undergraduate program, especially in relation to greater clinical

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90 *Submission* 942, p.14 (Queensland Health).

91 Education Review, p.128.

92 Education Review, pp.128-29.

93 *Committee Hansard*, 21.3.02, p.411 (APHA).

94 *Submission* 755, pp.1-2 (University of SA, School of Nursing & Midwifery); *Committee Hansard*, 27.3.02, p.676 (University of SA).

95 *Submission* 755, Supplementary Information, 10.5.02, p.2 (University of SA, School of Nursing & Midwifery).

96 *Submission* 449, p.10 (Tasmanian School of Nursing).

exposure of undergraduates and support for first year graduate nurses in their workplaces.

3.98 The Committee also believes that a four-year program would not address the problem of the retention of nurses, indeed lengthening of the undergraduate degree program may act as a disincentive to many students contemplating a nursing career. The Committee further believes that resources in the area of nurse education would be better directed towards support for first year graduate nurses in the workplace by improving education outcomes through the graduate nurse transition programs, and by encouraging continuing education and the provision of additional postgraduate places for specialist nurse education. These issues are discussed later in this chapter and in chapter 4.

Funding of the clinical education component of courses

3.99 Submissions and other evidence argued that the current funding model does not adequately support the clinical practice requirements of undergraduate nursing programs.[97]

3.100 As noted previously, the universities receive the bulk of their funds as a one line operating grant. The funding rate per student received by each university depends on the distribution of students across levels and fields of study. The funding rate is based on the Relative Funding Model (RFM). The model comprises a teaching related component designed to reflect the relative costs of teaching in different discipline cost clusters at different levels, and a research related component to support research activities.

3.101 A relative teaching costs index was developed to distribute the teaching component of the model's allocations on the basis of an institution's particular mix of disciplines and levels. Nursing is placed in cost cluster 3 (out of five possible clusters). This means that the notional funding for undergraduate nursing is 1.6 times the funding of the base cost cluster (undergraduate accounting/economics/law/other humanities). For a postgraduate coursework award it is 1.8 times the base cost cluster funding.[98]

3.102 Several submissions argued that the weightings in the RFM do not reflect actual teaching costs. One submission noted that in the model nursing was allocated a weight of 1.6 for the undergraduate program, 1.8 for the postgraduate program, and

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97 *Committee Hansard*, 28.2.02, pp. 123-24 (ACDON); *Committee Hansard,* 28.2.02, p.200 (ANF-Vic Branch)*; Submission* 960, p.11 (Victorian Government); *Submission* 962, p.27 (ANF); *Submission* 914, p.12 (RMIT University, Department of Nursing & Midwifery).

98 Since the relative funding model adjustments were made, the amount of operating grant each institution receives in any given year has been based on the level of funds it receives in the previous year, plus or minus any growth or downward adjustment in its Commonwealth funded load. The growth places provided to universities in recent years have been funded at the system average funding rate for undergraduate places and universities are free to allocate these places to high cost or low cost disciplines. See *Submission* 928, pp.20-22 (DETYA).

2.0 for research degrees which was very low in comparison with other healthcare disciplines. For example, medicine and dentistry are allocated weights of 2.7 for undergraduate programs, 3.0 for postgraduate programs, and 4.7 for research degrees.[99] It was argued that universities were therefore not being adequately compensated for the costs associated with courses, resulting in further cost pressures, or a failure to provide appropriate standards of training, or both.

3.103 The cost of undergraduate clinical education is high. RMIT University stated that it employed clinical teachers at approximately $35 an hour, and the Education Review noted that the costs of supervision are as high as $50 an hour.[100] One submission noted that many Schools of Nursing are required to meet annual clinical budgets of $1 million.[101] QUT indicated that its projected clinical costs will be $1.3 million for 2002.[102]

3.104 Submissions argued that additional funding specifically earmarked for improving the programs of clinical placement for student nurses should be provided by the Commonwealth.[103] The funding for undergraduate nursing courses does not at present include particular funding to accommodate for the costs of clinical education. The Education Review stated that these costs are high due to the need for the clinical supervision of students.[104] The Education Review further argued that 'it is obvious that dedicated funding of clinical education is needed, outside the operating grant model'.[105]

3.105 One university stated that funding should be increased to a level that would allow the clinical teacher/student ratio to be decreased from the current ratio of 1:8 to a ratio of 1:4 or 1:6 at the maximum.[106] Submissions argued that improved teacher/student ratios enhance the learning opportunities of undergraduate students.[107]

3.106 The ANF commented that the inadequate funding for the clinical preparation of nurses 'means that the quality of their clinical preparation is compromised and they

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99 *Submission* 914, p.12 (RMIT University, Department of Nursing & Midwifery).

100 *Submission* 914, p.11 (RMIT University, Department of Nursing & Midwifery); Education Review, p.129. See also *Committee Hansard*, 2.3.02, p.495 (UWS, College of Social & Health Sciences).

101 *Submission* 736, p.8 (QUT, School of Nursing).

102 This figure includes the cost of the clinical program of 20 weeks per student over 3 years plus the costs of the on-campus program. See *Committee Hansard*, 26.3.02, pp.596-97 (QUT, School of Nursing).

103 *Submission* 192, p.6 (ACDON); *Submission* 812, p.9 (ACU, Faculty of Health Sciences).

104 Education Review, pp.18,129.

105 Education Review, p.18.

106 *Submission* 812, p.9 (ACU, Faculty of Health Sciences).

107 *Submission* 812, p.10 (ACU, Faculty of Health Sciences).

have less opportunity to develop the clinical skills for a confident entry to practice'.[108] The Federation argued that there should be a review of the real costs of the clinical preparation of RNs and that funding should be allocated accordingly.

Conclusion

3.107 The Committee believes that the current funding arrangements fail to adequately support the clinical education requirements of undergraduate courses. The Committee considers that the Commonwealth should provide additional funding specifically directed to the undergraduate clinical education component of nursing courses.

Recommendation 17: That the Commonwealth Government provide specific funding to support the clinical education component of undergraduate nursing courses; and that this funding provide that the clinical teacher/student be maintained at a ratio of 1:4.

Cost of undergraduate courses for students

3.108 Students generally pay a Higher Education Contribution Scheme (HECS) contribution for their nursing courses.[109] The HECS debt will depend on the length of the course and the combination of subjects within the course. Most nursing courses are in HECS Band 1 (contribution of $3 521 per year in 2001), which is the lowest level of contribution, although some components of the course are in Band 2 ($5 015 in 2001). This means that nursing students will pay HECS at a higher level than that defined for Band 1 courses.[110] Student ENs pay course fees in most States and Territories, except in NSW where the Area Health Services meet these costs. Course fees vary between the States – from no fees payable in the case of NSW to between $3 000-$4 500 in the case of Tasmania. Added to HECS payments or fees for ENs are the costs of travel to clinical placements, uniforms and accommodation (often both for their usual residence and the one near the clinical site). Many also have childcare costs.[111]

3.109 While there are some scholarships available, most target Indigenous students and students from rural and remote areas.[112] The Commonwealth Government in the 2001-02 Budget introduced the Commonwealth Undergraduate Remote and Rural Nursing Scholarship Scheme. The scheme provides funding for 110 annual

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108 *Submission* 962, p.27 (ANF). See also *Committee Hansard*, 15.3.2, p.279 (Tasmanian School of Nursing).

109 Fees are not normally charged, except in the case of Avondale College and the University of Notre Dame, both of which are private institutions. In 2000, fee-paying undergraduate domestic nursing students comprised only 0.05 per cent of nursing students. See Education Review, pp.131-32.

110 *Submission* 928, p.23 (DETYA).

111 Education Review, pp.18,131.

112 Education Review, p.131.

undergraduate rural nursing scholarships at a cost of $10.9 million over four years. Funding is provided for 100 scholarships valued at $10 000 per annum for undergraduate nursing students from rural and remote areas and 10 scholarships valued at $10 000 per year for ATSI nursing students undertaking a full-time undergraduate nursing degree. Financial assistance of up to $5 000 is also available for scholarship recipients suffering exceptional financial hardship.[113] Rural nursing scholarships are also available through some State Governments, universities and nursing organisations.[114]

HECS exemptions

3.110 Many submissions argued that undergraduate nursing courses should be HECS exempt as the cost of such courses provide a disincentive to students undertaking these courses.[115] The ANF suggested that nursing should be HECS exempt in the immediate short term.[116]

3.111 Other submissions suggested that HECS contributions should be waived for certain nursing students, for example, from rural and remote backgrounds or ATSI students or that the HECS debt should be waived for nursing students who undertake a specified period of nursing in rural or remote areas upon completion of their studies.[117] Some submissions recognised, however, that providing special HECS arrangements for nursing students would create precedents for the Commonwealth regarding other fields of study.[118]

3.112 DEST advised the Committee that an average HECS liability for a full time undergraduate nursing degree completed in 2002 would be $10 582 and the Department estimated that it would take 8.5 years to repay this HECS debt.[119]

3.113 The Education Review stated that HECS does not appear to be a disincentive to students from lower socioeconomic (SES) backgrounds undertaking nursing courses, and that it is unlikely that the removal of HECS would encourage more students into nursing.[120] Data on the SES backgrounds of nursing students in

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113 *Submission* 944, Supplementary Information, 24.9.01, p.1 (DHAC).

114 *Submission* 800, p.5 (NRHA).

115 *Submission* 755, p.3 (University of SA, School of Nursing & Midwifery); *Submission* 867, p.3 (NSW Health Department).

116 *Submission* 962, p.24 (ANF).

117 *Submission* 800, p.31 (NRHA); *Submission* No.31, p.1 (CATSIN).

118 *Submission* 800, p.31 (NRHA).

119 Based on an average annual starting salary for a nurse of $31 390 and assuming a student defers 100 per cent of their HECS contribution for the course, and no voluntary repayments are made. See *Submission* 928, Additional Information, 22.2.02, p.4 (DEST).

120 Education Review, p.18.

undergraduate courses from 1994 to 2000, indicate that those from low-and middle-SES backgrounds increased marginally over the period.[121]

3.114 Reports on the impact of HECS on participation in higher education generally found that HECS is not a major factor influencing the higher education participation of students from low SES backgrounds. Reports by the Higher Education Council on the impact of HECS concluded that HECS was not deterring students from participating in higher education. A Higher Education Council 1991 attitudinal survey, which specifically targeted disadvantaged groups, found that for school leavers, HECS was a low ranking factor in their decision not to go onto higher education, while for those intending to undertake higher education or those undecided about whether to do so, HECS ranked behind academic factors and more pressing economic factors in their decision making. Another report on this issue by DETYA concluded that HECS is a very minor factor in the low participation rates in higher education by students from lower SES backgrounds.[122]

Scholarships

3.115 Other submissions argued that scholarships should be available.[123] There are no general Commonwealth Government scholarships currently available for undergraduate nursing students except, as noted above, for Indigenous students and students from rural and remote areas. Some groups argued that these scholarships should particularly target students from disadvantaged backgrounds, non-English speaking backgrounds, ATSI students and students from rural and remote areas or students who undertake to practice in areas of need or shortage after graduation.[124]

3.116 The ANF, while welcoming the recent allocation of scholarships for undergraduate rural and remote nursing students noted that there is a significant disparity between the nursing scholarship allocation and the medical scholarship scheme (with 500 medical scholarships for 1 200 commencing students, compared to 100 nursing scholarships for more than 7 000 nursing students commencements each year).[125] One submission suggested that the number of nursing scholarships should be available on a pro-rata equivalent basis to the number of Commonwealth-funded scholarships available to medical students.[126]

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121 Education Review, p.58.

122 Cited in Senate Employment, Workplace Relations, Small Business and Education References Committee, *Universities in Crisis*, September 2001, pp.277-28. See also Parliamentary Library, *The Higher Education Contribution Scheme*, 2001, p.9.

123 *Submission* 812, p.16 (ACU, Faculty of Health Sciences); *Submission* 725, p.9 (ACU, School of Nursing (Victoria)).

124 *Submission* 749, p.8 (Griffith University, School of Nursing); *Submission* 936, p.16 (WHA & CHA); *Submission* 800, p.31 (NRHA); *Submission* 31, p.1 (CATSIN).

125 *Submission* 962, p.23 (ANF).

126 *Submission* 800 p.32 (NRHA).

3.117 The ANF argued that there should be additional scholarships provided for nursing students as well as the inclusion of a 'support component' to assist students in completing their courses, such as the provision of bridging courses, mentoring and extra tutorials.[127]

3.118 The National Rural Health Alliance (NRHA) argued that the Commonwealth should establish a scholarship scheme for student nurses similar to the John Flynn Scholarship Scheme for medical undergraduates. The Alliance argued that this Scheme when fully operational should provide at least 300 nursing scholarships per year. This would be in addition to the undergraduate rural nursing scholarship scheme. The Alliance stated that the John Flynn Scheme has proved a popular way to enable medical undergraduates to gain some experience of working in rural and remote communities The scholarships provide medical undergraduates with a two-week placement once a year for four consecutive years during their medical training. This is in addition to any rural placement that occurs as part of their clinical education.[128]

Other support measures

3.119 Submissions suggested that measures that assist students with the costs associated with clinical placements should be a priority. Submissions noted that the cost of undergraduate education, including accommodation and travel to clinical placements, is an increasing burden on students.[129]

3.120 Submissions commented especially on the high cost of clinical placements for students who choose to undertake clinical experience in rural or remote areas. Submissions argued that the housing and travel costs for these students should be subsidised.[130] Submissions noted that students who are exposed to rural nursing/midwifery during their undergraduate education are more likely to return to work in rural areas after graduation.[131] An example cited in evidence was the situation in Tasmania where the School of Nursing is located outside the capital city in Launceston which means that students coming from elsewhere in the State may incur considerable accommodation and travel costs in completing their studies.[132]

3.121 One submission noted that problems with encouraging nursing students to take up rural and remote clinical placements will continue until there is a sustainable

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127 *Submission* 962, pp.23-24 (ANF). See also *Submission* 800, pp.6,31-32 (NRHA).

128 *Submission* 800, p.43 (NRHA); *Committee Hansard*, 21.3.02, p.425 (NRHA).

129 *Submission* 867, p.3 (NSW Health Department).

130 *Submission* 409, p.5 (La Trobe University School of Nursing); *Submission* 940, p.22 (SA Department of Human Services).

131 *Submission* 409, p.5 (La Trobe University School of Nursing).

132 *Committee Hansard*, 15.3.02, p.291 (Tasmanian School of Nursing); *Committee Hansard,*15.3.02, pp.323,338 (Tasmanian Department of Health & Human Services).

funding source similar to that available for medical students undertaking rural placements through the RUSC funding from the Commonwealth.[133]

3.122 The Education Review also noted that the provision of some support during the undergraduate course may be a better incentive to retain those students who are struggling to meet living costs than HECS exemptions. This could take the form of scholarships or allowances to meet daily living expenses, especially the costs associated with clinical placements.[134]

Conclusion

3.123 The Committee does not consider that undergraduate nursing courses should be HECS exempt. The Committee believes that as nurse education properly belongs in the university sector and that undergraduate courses generally require a HECS contribution from students, nursing undergraduates should be treated no differently than other undergraduates in relation to the payment of HECS. Apart from such a practice creating a precedent for other courses, evidence indicates that HECS does not appear to be deterring students from selecting nursing courses. The Committee notes that nursing courses continue to be oversubscribed.

3.124 The Committee believes that support measures such as scholarships are a more practical approach to assist with the costs students face in undertaking undergraduate courses, rather than HECS exemptions. The Committee believes that general scholarships as well as specific targeted scholarships should be provided by the Commonwealth and State Governments.

Recommendation 18: That the Commonwealth and State Governments provide additional targeted scholarships for undergraduate nursing students based on merit directed at students from economically and socially disadvantaged backgrounds, NESB and ATSI backgrounds, and from rural and regional areas.

Recommendation 19: That the Commonwealth Government provide general scholarships for undergraduate nursing students based on merit.

Transition from university to practice

3.125 A large percentage of new graduates leave nursing within twelve months of graduation. Many submissions argued that programs of support for new graduates during this transitional year need to be improved.[135] A number of persistent transition issues from university to workplace have been identified that include: preparedness for practice; skill mix in clinical settings; new graduates practicing without support

133 *Submission* 940, p.22 (SA Department of Human Services).

134 Education Review, p.18.

135 *Submission* 192, p.7 (ACDON); *Submission* 367, p.9 (VCPNO).

and beyond their level of expertise; and conflict between the demands of the situation and the skills of the beginning practitioner.[136]

3.126 Evidence to the inquiry indicated that adjusting to the transition from university to the practice setting, from student to nurse, is difficult and stressful for many graduates. The Committee was told that new graduates entering the workforce suffer a serious reality shock when faced with working expectations and conditions, and the usual stresses associated with hospital and other healthcare work environments. There is a strong expectation that new graduates should 'hit the decks running'. The transition process from student, with little responsibility and accountability, to RN with full responsibility and accountability, is difficult enough without this expectation.

3.127 In many hospitals a hierarchy operates based on the old 'apprentice' system. The reality shock is compounded for some graduates who believe they are highly trained and should not be required to perform many of the 'traditional' routine or manual nursing duties.

3.128 From the hospitals' perspective there are reports that graduates lack practical key clinical and supervisory skills to easily survive the daily demands of a busy acute hospital with patients with high levels of acuity and short length of stays. Tensions arise when overworked senior nurses regard themselves as having to carry the extra work of their inexperienced new colleagues. The education sector is then criticised for producing graduates with insufficient clinical training and expertise.

Graduate nurse programs

3.129 The main mechanisms for facilitating the transition from university to nursing work for new graduates are graduate nurse programs, orientation programs and periods of preceptorship/mentorship or other forms of supervision or assistance by an experienced nurse. Graduate nurse programs provide a broad framework in which activities such as orientation programs, preceptorships and other forms of assistance may be provided. The graduate programs vary considerably in scope and may consist of, for example, placements in three or four wards or units or the provision of an educator and an education program with the provision of time off for study.[137]

3.130 Orientation programs and preceptorships may also be used outside the framework of a formal graduate nurse program, as new graduates require preceptorship and orientation to specific work environments. Some undergraduate courses include a form of preceptorship during clinical placements, in which students work on a one-to-one basis with an experienced RN as preceptor. Students often return as graduates to clinical areas that had provided good learning environments. Transition to practice programs are affected by the shortage of nurses, especially RNs.

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136 National Nursing Workforce Forum 2000, p.8.

137 *Submission* 962, Supplementary Information, 6.6.02, p.1 (ANF).

3.131 The inadequacies of current graduate nurse programs were summarised:

> The programs offered to support new graduates into their first year of practice are inconsistent from one health care organisation to another. There is no consistent amount of funding in Australia to hospitals for these programs. These programs may consist of formal and informal preceptorship, mentoring and orientation that vary in quality and length of time. There have been increasing instances of graduates who have been employed on a casual basis with an agency or an emergency 'pool' where they are expected to practice in a range of clinical settings without having any appropriate orientation process.[138]

3.132 Graduate nurse programs are not compulsory in the States and Territories. Evidence also indicated that some graduates do not get into these programs and there are few programs in the private and aged care sectors. While most State governments contribute some funds to the program there are different levels of funding between the States and Territories. The Victorian Government provides $10-11 000 per graduate under its graduate nurse program. In 2001, 223 graduates were funded under this program.[139] In Western Australia, one witness stated that hospitals only get 'a few hundred dollars per student' under the program.[140] The hospitals have positions for graduate nurses and their employment costs are paid for in their budget allocations. [141]

3.133 The ANF argued that graduate nurse programs should be offered in all environments where nursing is provided – 'these should be tailored to the needs of the individual and incorporate the use of mentors or preceptors'.[142] One witness noted that 'I certainly feel that nurses are ready to work in practice at the end of three years, but they need continued support in that transition to practice. Not all nurses are offered that opportunity or are able to take that opportunity up. Those that do not maybe practice in areas outside of their level of expertise'.[143] Another witness emphasised the need to support nurses' transition into the workforce 'with some well-structured programs that are effectively managed and are monitored on the outcomes that they are able to achieve…in the first six months graduates are essentially finding their feet, and in the second six months they are consolidating their experience as a new registered nurse and they begin to fly'.[144]

3.134 The Committee also received some evidence that the funds allocated by State Governments for graduate nurse programs are not being spent for the purposes for

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138 *Submission* 914, p.15 (RMIT University, Department of Nursing & Midwifery).

139 *Committee Hansard*, 28.2.02, pp.187, 190 (Victorian Government).

140 *Committee Hansard*, 27.2.02, p.117 (Royal Perth Hospital).

141 Education Review, pp.19,129; *Submission* 962, Additional Information, 23.5.02, p.1 (ANF).

142 *Submission* 962, p.28 (ANF).

143 *Committee Hansard* , 27.2.02, p.118 (Royal Perth Hospital).

144 *Committee Hansard*, 26.3.02, p.604 (QUT).

which they are intended. The Deans of Nursing suggested that State Governments should carefully audit these programs.[145]

Preceptorship programs

3.135 Much evidence referred to the need to develop nationally formal mentoring and preceptorship programs and that such programs should include competency and individualised development plans for all nurses. There is a need to expand the provision of training and payment for those nurses chosen to become preceptors to compensate them for providing supervision to new graduates and nurses returning to the profession. As examples, Queensland Health has developed Preceptor Training Modules designed to assist trainers when providing preceptors with the preparatory knowledge and skills necessary to fulfil their role.[146] In respect of payment, Tasmania's recently negotiated Nurses Enterprise Bargaining Agreement includes the introduction of a preceptor allowance.[147]

Recommendation 20: That formal mentoring and preceptorship programs be developed nationally, with enhanced training and the payment of allowances for nurses chosen to become preceptors.

The role of nurse educators

3.136 Submissions noted that the role and functions of nurse educators in both educational and clinical settings had been abolished or absorbed. Nurse educators can be clinical educators – teaching and working in a ward or they may have a wider role in education and they may be organising new graduate education, including short courses and working with students.[148]

3.137 In universities, positions for clinical teachers are predominantly sessional positions – for many competent clinicians the seasonal nature of these positions are therefore unattractive, as they offer little financial security and few opportunities for career advancement.[149] The Education Review also noted that in universities, staff find that the time and effort required to remain current and clinically competent competes with other academic priorities.[150]

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145 *Submission* 192, p.7 (ACDON). See also *Submission* 367, p.9 (VCPNO).

146 Queensland Health Preceptor Program for Nursing Transition Support: Training Modules and Framework, March 2001, *Submission* 942, Additional Information, 26.3.02 (Queensland Health).

147 *Submission* 923, p.7 (Department of Health and Human Services Tasmania).

148 *Submission* 962, Additional Information, 6.6.02, p.1 (ANF).

149 *Submission* 725, p.8 (ACU, School of Nursing (Victoria)); *Submission* 812, p.13 (ACU, Faculty of Health Sciences).

150 Education Review, p.130.

3.138 In healthcare settings, the ANF argued that the demise of nurse educator positions or their absorption into the nursing care delivery workforce in times of shortage is adversely impacting on new graduates – 'these positions provide an enormous amount of support and have an important role in continuing education, competency assessment, managing change etc'.[151] The ANF argued that clinical nurse educator positions should be widely re-introduced.

3.139 The ANF also noted that nurses are constantly engaged in supervising, supporting and educating new staff, both new graduates and other employees new to the workplace, in addition to their normal workloads, without any acknowledgment or monetary reward.[152]

Enrolled nurses

3.140 Transition to practice is also an issue for ENs and many of the same support programs are required. The ANF argued that similar strategies to those for RNs are needed for ENs, that is, peer support, mentorship and clinical educators.[153] The National Enrolled Nurse Association (NENA) argued that there should be a fully funded post registration/graduation year program in line with the current RN graduate year program.[154]

3.141 The Association pointed to the need for quality preceptorship and orientation programs for newly graduated ENs.[155] NENA noted that there are no formal graduate or preceptorship programs in the States or Territories for ENs. In the Northern Territory a graduate program for ENs is being introduced. Some States have hospital based preceptorship programs for ENs.[156]

Conclusion

3.142 The Committee notes the concerns expressed in evidence that support programs for new graduates – both RNs and ENs – need to be improved to address difficulties that these graduates may face in adjusting to the hospital environment.

3.143 The Committee believes that graduate nurse programs should be available for all nursing graduates and that the emphasis of the programs needs to focus on the provision of a period of supervised practice to consolidate clinical and decision-making skills and to provide orientation to the workforce.

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151 *Submission* 962, p.29 (ANF).

152 *Submission* 962, p.29 (ANF).

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

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

155 *Submission* 728, p.5 (NENA).

156 *Submission* 728, Supplementary Information, 10.5.02, pp.1-2 (NENA).

Recommendation 21: That graduate nurse programs be available for all nursing graduates and that these programs:

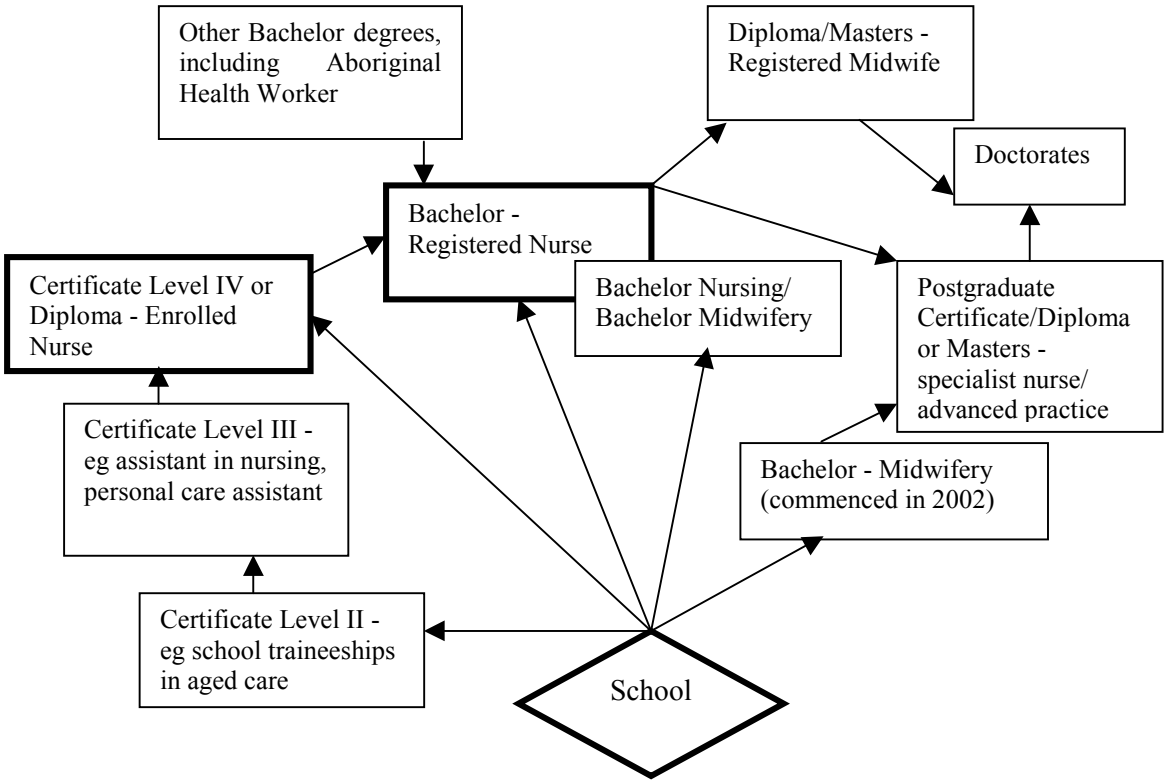
- **concentrate on skills consolidation through a structured program to enable professional development,**
- **be provided with appropriate supervision and support, and**
- **be jointly funded by Commonwealth and State Governments.**

Articulation between nursing levels

3.144 A number of different articulation pathways between different nursing education levels operate at present. Evidence indicated the need for innovative, flexible and multiple models of enrolled nurse, registered nurse and postgraduate education within an articulated framework that enables multiple entry and exit points, all of which should include competency based outcomes.[157]

3.145 The types of articulation pathways currently available are illustrated in the figure below.

Figure 3.1:Articulation pathways for those currently involved in nursing work



Source: National Review of Nursing Education, *Discussion Paper,* December 2001, p.121.

157 See *Committee Hansard*, 27.3.02, p.676 (University of SA).

3.146 The Education Review noted that currently students are undertaking Certificate III courses with a view to going onto Enrolled Nursing – in some places, agreements with employers exist to support this arrangement. Student ENs are beginning Certificate IV intending to use it to move into an undergraduate nursing course. Bridging courses exist or are being developed in various forms to assist students to make this transition. There are also EN programs that are designed to lead directly into undergraduate entry programs. Graduate entry programs also operate in universities. These allow students who graduate with a degree from another discipline to accelerate their completion of a nursing degree.[158]

3.147 Submissions generally supported the need for a range of academic pathways for entry to, and exit from, various courses.[159] One witness noted that multiple entry and exit points are important to ensure that 'if for some reason somebody cannot complete a training program, the training is not wasted and they can perform a useful role within the profession'.[160] Some submissions stated that students should be able to exit at one, two or three years with a specific qualification that will enable them to work in the health sector, instead of having to undertake a standard three or four year university program.[161]

3.148 Some universities are developing flexible programs. La Trobe University stated that it has developed a flexible EN/RN conversion course to be offered to experienced ENs and a flexible midwifery education course.[162] Charles Sturt University offers ENs with an Advanced EN Certificate from TAFE admission to their Bachelor of Nursing degree courses. The University also provides nursing studies through distance education to some 470 students – out of a total of 650 students enrolled in the nursing undergraduate course. Most of the distance education students are ENs who are converting their current qualifications to RN status. Some 70 per cent of the distance education students live in rural or remote areas. Although most live in NSW, a significant number reside in Victoria and Queensland. The University stated that there is a 'very high demand' for the course.[163] UTS stated that it has multiple entry programs – 'possibilities into the Bachelor of Nursing program. ENs can come in with a certificate IV…It is a special program designed to the same exit point as the other [programs], but to meet the needs of enrolled nurses'.[164]

3.149 During the inquiry issues were raised in relation to articulation pathways for ENs, nursing and personal care assistants, ATSI health workers and midwives.

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158 Education Review, p.20.

159 *Submission* 890, p.9 (AHA); *Submission* 936, p.17 (WHA & CHA); *Submission* 409, p.2 (La Trobe University School of Nursing).

160 *Committee Hansard*, 27.3.02, p.787 (ACHA).

161 *Submission* 900, p.6 (ACHA).

162 *Submission* 409, p.4 (La Trobe University).

163 *Submission* 410, p.1 (CSU, School of Nursing & Health Sciences, Bathurst).

164 *Committee Hansard*, 22.3.02, p.472 (UTS).

3.150 In relation to ENs, NENA argued that there needs to be national consensus in recognising prior learning and experience for those ENs wishing to articulate to registered nurse.[165] The NSW Health Department stated that 'we believe very strongly that there needs to be articulation through all educational pathways and that an institution needs to recognise the prior learning that a nurse has received in a previous course'.[166]

3.151 The Education Review noted, however, that there are difficulties in establishing a system that gives standard credit for education and experience for ENs seeking a university place. These factors are:

- standards and qualification requirements for ENs vary across Australia and standards vary within States. Without a common standard it is not possible to identify an appropriate level of credit.
- university courses also vary in approach and the order in which materials are covered, so topics an EN has previously completed may be distributed anywhere/widely throughout in the standard university course.
- there is no framework that demonstrates that EN competencies are an identifiable subset of those for RNs, or that the theoretical foundations required for a university course are established as part of the EN program. Without this overlap it is difficult to establish a system of credits for ENs at university.[167]

3.152 The Education Review noted that the current situation means that in States like NSW which has a centralised EN curriculum, the development of conversion and bridging courses at TAFE allows students to gain credit at university as well as overcomes some of the problems that automatic credit arrangements might cause.[168]

3.153 The ANF argued that the formal articulation and recognition of prior learning arrangements which have developed between EN courses and RN courses by some universities and EN education providers should be consolidated and extended so that all ENs have access to undergraduate programs if that is their career path choice.[169]

3.154 The TAFE NSW Nursing Unit proposed a single model educational pathway for ENs and RNs. Under this proposal, students would enter the program at the Diploma level and have two optional exit points – exit after 12 months as an EN – after completion of a Diploma in Nursing – or exit after 3 years as a RN after completion of a Bachelor of Nursing degree.[170] TAFE NSW argued that the EN

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165 *Submission* 728, p.2 (NENA).

166 *Committee Hansard*, 22.3.02, p.510 (NSW Health Department).

167 Education Review, p.121.

168 Education Review, p.121.

169 *Submission* 962, pp.37-38 (ANF). See also *Submission* 942, p.16 (Queensland Health); *Submission* 736, p.9 (QUT, School of Nursing).

170 *Submission* 772, pp.2-4 (TAFE NSW); *Committee Hansard*, 22.3.02, pp.471-72, 487, 492 (TAFE NSW).

education program 'needs to be embedded into the first year of the undergraduate nursing program and provide exit points…either exiting as an enrolled nurse or moving into the second year of the program'.[171]

3.155 The ANF argued that formal articulation and recognition of prior leaning arrangements should be developed between Certificate III courses for unlicensed nursing and personal care assistants (however titled) and enrolled nurse courses, and between courses for ATSI health workers and enrolled nurse courses.[172] One submission stated that a possible pathway could include the opportunity for students to enter as personal care assistants through the TAFE sector. These students would then be offered the opportunity to progress into an EN program and from then to a Licensed Practical Nurse program (based on the US model where these nurses have a specific role which is different from that of the RN), and then onto completion of the program as a RN.[173]

3.156 In relation to midwifery, the Australian College of Midwives (ACMI) advocates separate, direct entry undergraduate programs for the preparation of midwives, as a complementary mode of entry to existing programs. On the basis of a cooperative effort between midwifery educators in a number of States, a three year Bachelor of Midwifery has been developed for implementation in 2002. At present, courses are offered in Melbourne and Adelaide.[174] Currently, entry to practice as a midwife requires completion of a postgraduate course, following initial registration as a nurse.

3.157 Some groups expressed concerns that while direct entry midwifery programs may satisfy those who only want to practice as midwives, they may limit the career choices of those who undertake them and reduce their employment potential, particularly in rural, regional and remote areas.[175]

Conclusion

3.158 The Committee notes progress made in the development of articulation and recognition of prior learning between different levels of nursing. The Committee believes that formal articulation and recognition of prior learning should be further extended for ENs, unregulated healthcare workers and ATSI health workers.

Recommendation 22: That formal articulation arrangements and recognition of prior learning between enrolled nurse courses and registered nurse courses by

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171 *Committee Hansard*, 22.3.02, p.470 (TAFE NSW).

172 *Submission* 962, p.38 (ANF). See also *Submission* 942, p.16 (Queensland Health).

173 *Submission* 900, p.5 (ACHA).

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

175 *Submission* 962, p.32 (ANF); *Submission* 936, p.18 (WHA & CHA).

universities and enrolled nurse education providers be further developed nationally.

Recommendation 23: That formal articulation arrangements and recognition of prior learning be developed between Certificate III courses for unregulated healthcare workers and enrolled nurse courses, and between courses for ATSI health workers and enrolled nurse courses.

National nursing curriculum

3.159 Several witnesses argued for the development of a national nursing curriculum to ensure consistency with competency standards. One witness stated that in relation to national consistency in the delivery and development of undergraduate courses –'I do not think we have articulated our expectations clearly at the national level of what we expect of students who have completed the three-year degree course'.[176] The Education Review noted that there were views expressed during its consultations that a core nursing curriculum that allows for local variation should be developed and applied nationally.[177]

3.160 While all nurse education programs incorporate the ANCI competencies and all graduates are assessed to meet those competencies in order to be registered, there appears to be considerable variation in their interpretation.[178]

3.161 There was some diversity of views as to what a national curriculum would or should entail. One witness noted that 'for me, when they say, standardised national curriculum, I have the vision of just one type of course. But I think there should be some diversity within the core curriculum'.[179]

3.162 Some witnesses did not support the introduction of a national curriculum emphasising the need to maintain diversity in course structure.[180] The Faculty of Nursing at the University of Technology, Sydney stated that:

> The AUTC review clearly says that there is no evidence of the need for a national curriculum. We have ANCI competencies. They are expressed in different ways in different curricula, but they meet the appropriate nursing registration authority standards and there is a real need for university curricula to be able to have local flavour.[181]

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176 *Committee Hansard*, 28.02.02, p.160 (Mercy Hospital for Women).

177 Education Review, p.16.

178 Education Review, p.16.

179 *Committee Hansard,* 15.3.02, p.343 (Tasmanian Department of Health & Human Services).

180 *Committee Hansard,* 26.3.02, p.621 (Queensland Nursing Council); *Committee Hansard* 15.03.02, p.265 (Nursing Board of Tasmania).

181 *Committee Hansard*, 22.3.02, p.497 (University of Technology, Faculty of Nursing). See also *Committee Hansard*, 22.3.02, p.550 (RCNA/NSW College of Nursing).

3.163 An alternative approach to a national curriculum proposed by some witnesses was the development of a national accreditation system of all education programs for nurses to ensure national consistency in standards. Currently, each nurse regulatory authority is responsible for the accreditation of nursing courses in their jurisdictions. The ANCI stated that when nursing courses are accredited, competency standards are used to identify that the particular course would be able to produce a graduate who would in fact demonstrate those competencies – 'so, in essence, national standards exist for the development of courses, standards which everybody has adopted for that purpose'.[182] One witness noted that 'we do have national competency standards to which all universities work. That is a better way [than a national curriculum] because they can be creative, but they have the same outcome standards to meet'.[183]

3.164 The ANCI informed the Committee that it is currently examining the issue of the development of a national system of accreditation. The ANCI stated that a national system 'would bring a better sense of standards being set across the country'.[184] The Nurses Board of Victoria in supporting a national system of accreditation of nursing courses also argued that the ANCI should examine the establishment of a national accreditation system. The Board suggested that the system could be modelled on the current system in place for accreditation of medical courses conducted by the Australian Medical Council.[185]

Conclusion

3.165 The Committee believes that a national curriculum framework or guidelines for undergraduate nursing courses should be developed and applied across Australia to overcome current variations in the interpretation of ANCI competencies. The Committee believes that this core nursing curriculum should, however, allow for local variation in course design. The Committee does not propose the introduction of the same nursing curriculum nationwide, only that there be consistency in course structure with defined competency standards.

Recommendation 24: That the Australian Nursing Council, in conjunction with key stakeholders, including State regulatory bodies, the universities, professional nursing bodies and nursing unions, develop a national curriculum framework or guidelines for undergraduate nursing courses to ensure greater consistency in the interpretation of the ANCI competencies.

182 *Committee Hansard,* 26.3.02, p.620 (ANCI). See also Supplementary Information, 15.5.02, p.1 (ANCI).

183 *Committee Hansard,* 22.3.02, p.550 (NSW College of Nursing).

184 *Committee Hansard*, 26.3.02, p.620 (ANCI).

185 *Submission* 765, p.7 (NBV).

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 eduction 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]

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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]

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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

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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

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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

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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

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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

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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]

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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:

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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]

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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

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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

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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

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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

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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

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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.

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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.

Credentialling 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]

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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]

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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

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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 Anthoney).

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]

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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]

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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).

CHAPTER 5

INTERFACE BETWEEN THE EDUCATION SECTOR AND THE HEALTH SYSTEM

> *Universities are making independent decisions about curriculum development, the states and territories are making independent decisions about the structure of the nursing workforce with relatively weak national coordination of policies…The need for national coordination in this area is self-evident but sadly lacking.*[1]

Introduction

5.1 Evidence to the inquiry indicated the need for a much more coordinated approach between the Commonwealth and the States and between the education and the health sectors in relation to the education and training of nurses. The complex division of responsibilities for the education and training of nurses, the registration of nurses and the responsibility for nursing workforce issues and the lack of coordination at the national level in relation to these matters is a continuing problem that needs to be addressed. One commentator highlighted the urgent need for national coordination in these areas:

> Responsibility for initial preparation of nurses rests with the universities, loosely coordinated by the Commonwealth government. Each university makes an independent decision about course design, number of entering students, postgraduate course offerings and so on. University decisions have critical consequences for the health and community service sectors in terms of the numbers of entering registered nurses and yet there are no mechanisms at national level and few mechanisms at state level to ensure that these university decisions impact positively on future workforce requirements.[2]

5.2 The Commonwealth Department of Health and Aged Care also alluded to the problem in the following terms:

> The Commonwealth Government has an overall interest in the supply, distribution and quality of the health workforce, including nurses. It also provides funding for Registered Nurse education through the Department of Education, Training and Youth Affairs. However, State responsibility for health practitioner registration and the split of responsibility for health

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1 S. Duckett, 'The Australian health workforce: facts and futures', *Australian Health Review*, vol.23, no.4, 2000, pp.65, 67.

2 Duckett paper, p.67.

> service funding and provision in Australia gives the Commonwealth little direct responsibility for the nursing workforce.[3]

5.3 As noted previously, the education and training of nurses is delivered through separate parts of the education and training system – RNs are prepared through the universities which are largely funded by the Commonwealth Government and ENs are prepared in the vocational education and training sector which is largely funded by the States. The Victorian Department of Human Services commented that these funding arrangements can lead to unusual outcomes:

> There is something ironic about this. We [the States] are responsible for the training of the work force for aged care facilities and the Commonwealth is responsible for the training of the work force for public hospitals.[4]

5.4 The National Review of Nursing Education (the Education Review) also commented on the effects of the complex interaction of Commonwealth and State Government responsibilities in the areas of education, health and workforce planning and their impact on nurse education. The Education Review stated that:

> The initial education of and training of registered and specialist nurses is primarily the responsibility of universities, primarily funded by the Commonwealth education portfolio. The training of Enrolled Nurses…occurs in the Technical and Further Education institutions of the States. State Governments have a direct interest in their role as the dominant employers of nurses. Nursing workforce issues are matters for both the Commonwealth and State health portfolios. These various responsibilities in relation to education policy, funding and employment all impact on nursing education.[5]

5.5 As discussed in previous chapters, the inquiry highlighted the need for better linkages between the workforce requirements of the healthcare sector and the places and programs provided by the education sector; more effective mechanisms for assessing future labour force needs and a nationally coordinated approach to nursing workforce planning; and improved coordination between education and health departments at the Commonwealth and State level. These issues are further discussed in chapter 2.

Improving the interface between the education and health sectors

5.6 As noted previously, evidence to the inquiry emphasised the need for strong links between the education and health sectors in the education and training of nurses. It was noted in evidence that formal, collaborative and effective partnerships between education and healthcare service providers are required to enable nurses to access an appropriate range of experiences to facilitate comprehensive development of nursing

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3 *Submission* 944, p.1 (DHAC).

4 *Committee Hansard*, 28.2.02, p.190 (Victorian Department of Human Services).

5 National Review of Nursing Education, *Discussion Paper*, December 2001, p.1.

skills; produce graduates able to provide competent nursing in an environment of continuing change; and enable cost-effective and appropriate teaching and learning models to be developed for nursing programs.[6]

5.7 Concerns were expressed during the inquiry about the relationship between the education and health sectors both in preparing students and in assisting them to make the transition from the university environment to the workplace.[7] One university noted that:

> The move to the higher education sector decoupled the curriculum from service needs allowing Registered Nurses to be educated rather than trained as apprentices. While this has been beneficial in terms of providing Registered Nurses with the theoretical input necessary for a career in modern health care there has been some argument that it has distanced nursing from service priorities.[8]

5.8 Another university also commented that:

> Nursing can be strengthened by greater collaboration between clinical practice settings and universities. In Australia the shift of nursing education to the tertiary sector widened the gap between theory and practice. What we are now seeing is a shift back to industry working more closely with nursing-education institutions.[9]

5.9 The 1994 Reid Report into nursing education stated that 'the outstanding issue' during that review was the need to encourage closer and more effective relations between the university schools of nursing and the various stakeholders, especially health industry employers, and the profession and the registering authorities, but also consumers of both health services and education services.[10]

5.10 The report commented that:

> It is not a question of "restoring" the old health-education relationship that was disrupted by the transfer to higher education. It is a matter of building a new relationship in which education will be more responsive to the needs of the workplace but the relationship with the workplace will take into account educational imperatives…In the emerging environment, education and research will play a more universal, dynamic and higher quality role than

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6 *Submission* 926, p.13 (ANCI); *Submission* 411, p.3 (Royal Adelaide Hospital).

7 *Submission* 962, p.42 (ANF); *Submission* 936, p.19 (WHA & CHA); *Submission* 890, p.4 (AHA).

8 *Submission* 740, p.14 (Flinders University, School of Nursing & Midwifery).

9 *Submission* 914, p.17 (RMIT University, Department of Nursing & Midwifery).

10 National Review of Nurse Education in the Higher Education Sector, *Nursing Education in Australian Universities*, AGPS, Canberra, 1994 (Chair: Professor J. Reid), p.340.

> before, while at the same time depending for their effectiveness on their relationship with the health sector.[11]

5.11 Evidence to the Committee indicated that while there have been improvements in the linkages between the education and health sectors, they are inconsistent and underdeveloped in many instances.[12] One submission noted that 'whilst there have been some moves in this direction this remains an area where there is still room for improvement'.[13]

5.12 Evidence suggested an overwhelming degree of support for the development of closer collaboration between educational institutions and health providers.[14]

5.13 A range of measures were suggested in evidence to improve the interface of the education and health sectors, including:

- partnership initiatives;
- joint curriculum development;
- joint appointments/clinical chairs; and
- use of shared facilities.

These measures are discussed below.

Partnership initiatives

5.14 Submissions argued that there should be more partnership models developed between the health sector – both public and private – and the universities and TAFE sectors to facilitate the clinical education and training of nurses.[15]

5.15 Submissions argued that there needs to be better arrangements between the universities and the health sector in clinical planning arrangements, especially to improve the coordination of clinical placements and issues related to the duration and cost of placements. These issues are further discussed in chapter 3.

5.16 A number of successful partnership initiatives were highlighted during the inquiry.[16] As noted previously in chapter 3, Flinders University, in partnership with several hospitals and other health agencies has developed an innovative model for

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11 Reid report, p.340.

12 *Submission* 411, p.2 (Royal Adelaide Hospital); *Submission* 962, p.42 (ANF).

13 *Submission* 411, p.2 (Royal Adelaide Hospital).

14 *Submission* 926, p.13 (ANCI); *Submission* 962, p.42 (ANF); *Submission* 936, pp.19-20 (WHA & CHA).

15 *Submission* 480, p.5 (NSW College of Nursing); *Submission* 449, p.13 (Tasmanian School of Nursing); *Submission* 740, p.15 (Flinders University)*; Submission* 900, p.9 (ACHA); *Submission* 962, p.43 (ANF).

16 *Submission* 192, p.8 (ACDON).

clinical placements through the introduction of Dedicated Education Units.[17] The University of Notre Dame, as previously discussed in chapter 3, has a model of clinical placement that emphasises partnerships with hospitals to enable students to undertake their placements at the same facility for the length of their course.[18] The University of Western Sydney has developed a new 'industry-responsive' undergraduate degree program, beginning in 2002, which was developed in close cooperation with clinical service providers in Greater Western Sydney. The University stated that it has developed close liaison with health service provides in planning, implementing and evaluating clinical learning experiences and curricula.[19]

5.17 The University of Technology, Sydney has clinical partnerships with approximately 100 clinical facilities. The University has a large number of partnerships with the public sector and also has strong private sector partnerships, especially in the postgraduate area.[20] UnitingCare noted that agencies had an affiliation agreement with Southern Cross University to provide undergraduate students with practical clinical experience and an effective collaborative partnership with the Queensland University of Technology to develop post-graduate level courses in aged care nursing.[21]

5.18 Submissions argued that private healthcare providers should be encouraged to contribute to the undergraduate and postgraduate education of nurses.[22] The Australian Council of Deans of Nursing (ACDON) noted that the Adelaide Community Health Alliance (the Alliance), a group of five private hospitals, in partnership with several universities 'is basing its successful recruitment policies on support for continuing education'.[23] The Alliance, has established strong links with Flinders University and the University of South Australia as well as with the Douglas Mawson Institute of TAFE. The Alliance stated that the placement of students in clinical settings over extended periods in its member hospitals has led to the successful recruitment of graduates to work in its hospitals. [24] One submission noted that in Tasmania, a private mental health hospital, in partnership with public sector hospitals, offers paid clinical rotation for students undertaking postgraduate courses in mental health nursing.[25]

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17 *Submission* 740, p.6 (Flinders University, School of Nursing & Midwifery).

18 Education Review, p.143. See also *Committee Hansard,* 21.3.02, p.404 (AHA).

19 *Submission* 784, p.11 (UWS).

20 *Submission* 824, p.1 (University of Technology, Sydney).

21 *Submission* 871, Supplementary Information 21.3.02 (UnitingCare).

22 *Submission* 449, p.13 (Tasmanian School of Nursing).

23 *Submission* 192, p.8 (ACDON).

24 *Submission* 900, p.3 (ACHA); *Committee Hansard*, 27.3.02, pp.788-89 (ACHA).

25 *Submission* 449, p.13 (Tasmanian School of Nursing).

5.19 Submissions also noted that partnerships between EN course providers, especially TAFE colleges, and the health system need to be more clearly defined.[26] The National Enrolled Nurse Association (NENA) argued that there was a need to create a more collaborative approach between the education and health sectors and advocated the inclusion of hospital education staff in the teaching process and adequate funding for clinical placements.[27] UnitingCare Australia stated that a number of its organisations at a local facility level 'do develop relationships with TAFEs to provide on-site training and opportunities for practical experience'.[28]

Recommendation 44: That partnership arrangements be further developed between the public and private health sectors and universities and the vocational education sectors to facilitate the clinical education and training of nurses.

Partnerships between universities

5.20 Submissions also commented on the need for greater collaboration between universities. Monash University stated that it has consortium type arrangements in areas such as community health and development (linked with Deakin University), midwifery (ACU, RMIT and VUT Universities) and emergency nursing (RMIT University). Monash stated that further development and evaluation of such models should result in a more rational use of resources and also meet local industry needs through the use of shared/common course materials and expertise.[29]

5.21 Submissions noted that partnerships should be developed between metropolitan and regional universities to enable students from city campuses to undertake clinical placements in regional hospitals and vice versa. Submissions noted that this was important as the clinical experiences in the two settings are quite different.[30]

5.22 The Australian Catholic University (Sydney) has a partnership arrangement in place that enables students from its regional campus to undertake clinical placements in metropolitan hospitals as well as in regional and rural hospitals. The University is now planning to offer its metropolitan-based students the opportunity of regional placements.[31]

Recommendation 45: That partnerships be developed between universities to facilitate the sharing of resources and expertise; and facilitate undergraduate

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26 *Submission* 728, p.4 (NENA); *Committee Hansard*, 28.2.02, p.203 (NENA).

27 *Submission* 728, p.4 (NENA).

28 *Committee Hansard*, 21.3.02, p.403 (UnitingCare Australia).

29 *Submission* 458, p.5 (Monash University, School of Nursing).

30 *Submission* 812, p.11 (ACU, Faculty of Health Sciences); *Submission* 725, p.7 (ACU, School of Nursing (Victoria)).

31 *Submission* 812, p.11 (ACU, Faculty of Health Sciences).

student clinical placements in a range of metropolitan and regional clinical settings.

Other partnership arrangements

5.23 The Committee received evidence of the involvement of State Governments and Departments in facilitating the interface between universities and the health system. Queensland Health stated that it had implemented strategies identified by the Ministerial Taskforce on the recruitment and retention of nurses to improve this interface. An education standing committee has been established to facilitate the development of partnerships, match postgraduate and enrolment courses to industry needs and address ongoing issues.[32]

5.24 In Tasmania, the *Partners in Health* initiative between the Tasmanian Department of Health & Human Services and the Faculty of Health Sciences at the University of Tasmania is aimed at developing and maintaining collaborative teaching, research and clinical service delivery activities. The Tasmanian School of Nursing stated that one of the benefits of this program is the establishment of joint appointments that assist in developing linkages between the health and education sectors.[33]

Joint curriculum development

5.25 Submissions argued that there needs to be structured healthcare industry input into curriculum development to ensure that graduates are well prepared for employment in the various practice settings.[34] One submission noted that curricula must not be developed without input from healthcare industry stakeholders.[35] Queensland Health stated that:

> Better partnerships between the higher education sector and the health sector in curriculum development and clinical experience planning would reduce gaps between industry needs, improve relevance of curricula content and improve coordination of clinical placement.[36]

5.26 Another submission commented that:

> Universities and TAFEs need to develop programs in close consultation with the heath sector agencies so that the programs address both current and emerging health care demands. Currently such programs are developed almost in splendid isolation, or in consultation with the professional bodies only. Hospitals in particular are in a good position to know what the likely

32 *Submission* 942, p.17 (Queensland Health).

33 *Submission* 449, p.13 (Tasmanian School of Nursing).

34 *Submission* 936, pp.19-20 (WHA & CHA); *Submission* 942, p.17 (Queensland Health).

35 *Submission* 942, p.16 (Queensland Health).

36 *Submission* 942, p.17 (Queensland Health).

> needs of their future workforce are to be and thus must be integral to curriculum development as well as implementation.[37]

5.27 The Education Review noted that in some universities clinicians have been appointed to curriculum committees.[38] The Australian Nursing Federation (ANF) stated that more cross membership of key committees such as university curriculum development and health facility education committees would strengthen the relationship between the two sectors.[39] The Australian Healthcare Association suggested that a national industry training authority should be established to ensure a balance of education/training provider, professional and industry input into course content at all levels of nurse education.[40]

Recommendation 46: That improved partnership arrangements be established between the universities and the health sector in relation to curriculum development, including the appointment of clinicians to university curriculum committees.

Joint appointments/clinical chairs

5.28 Many submissions argued that there should be more joint appointments to clinical chairs between universities and health services.[41] Submissions noted that a number of successful initiatives in the area of joint appointments have already been undertaken.[42]

5.29 One submission noted that to enhance partnerships between the universities and the health industry, senior nursing appointments in the health sector could be joint appointments where the incumbent has a university clinical title – similar to that which occurs in the medical field. In addition, a number of joint appointments could be established where salary costs are shared between the sectors.[43] One submission commented on the benefits of joint appointments in the following terms:

> This will facilitate cooperative arrangements for organising and sharing the responsibility for clinical supervision and ongoing nursing education at both undergraduate and post-graduate levels. The other obvious benefit, given

37 *Submission* 936, p.19 (WHA & CHA).

38 Education Review, p.127.

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

40 *Submission* 890, p.9 (AHA).

41 *Submission* 962, p.42 (ANF); *Submission* 477, p.7 (NNOs); *Submission* 936, p.19 (WHA & CHA); *Submission* 926, p.13 (ANCI).

42 *Submission* 960, p.12 (Victorian Government).

43 *Submission* 449, p.13 (Tasmanian School of Nursing). See also *Committee Hansard*, 15.3.02, p.337 (Tasmanian Department of Health & Human Services).

> that nursing is a practice-based discipline, is that it allows academics to engage with the clinical setting and thus maintain their clinical currency.[44]

5.30 The ANF argued that joint appointments could be extended to include all levels, for example, clinical nurses as tutors or mentors, clinical nurse educators as clinical teachers; and professorships. The Federation noted, however, that issues of professional accountability and responsibility can cause dilemmas for nurses who work across the two environments and these issues would need to be addressed.[45] Submissions also argued that joint appointments should be promoted with both public and private sector facilities.[46]

5.31 Submissions also argued that funding should be provided to enable more clinical chairs of nursing at major hospitals to be established.[47] One submission noted that the advent of clinical chairs 'has done much to cement the relationship between industry and academia. Clinical chairs and joint appointments provide leadership and facilitate collaborative practices between the two parties'.[48] One witness noted that:

> Clinical chairs are extremely important and very successful in raising the profile and status of nurses and nursing, facilitating nurses' contribution to policy development, improving the collaboration between the service and education providers, promoting research in nursing and providing role models for the profession.[49]

5.32 For example, Flinders University stated that the Clinical Chair in Nursing funded by both the School of Nursing and Flinders Medical Centre is 'highly effective' in developing that partnership.[50]

Recommendation 47: That the Commonwealth provide funding for the establishment of more joint appointments between universities and health services.

Recommendation 48: That the Commonwealth provide funding for the establishment of additional clinical chairs of nursing.

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44 *Submission* 449, p.13 (Tasmanian School of Nursing).

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

46 *Submission* 740, p.15 (Flinders University, School of Nursing & Midwifery).

47 *Committee Hansard*, 27.3.02, p.679 (Flinders University); *Submission* 936, p.19 (WHA & CHA); *Submission* 801, p.7 (Mercy Hospital for Women); *Submission* 740, p.14 (Flinders University, School of Nursing & Midwifery); *Submission* 960, p.13 (Victorian Government).

48 *Submission* 740, p.14 (Flinders University, School of Nursing & Midwifery).

49 *Committee Hansard*, 27.3.02, p.679 (Flinders University).

50 *Submission* 740, p.14 (Flinders University, School of Nursing & Midwifery); *Committee Hansard*, 27.3.02, p.679 (Flinders University). See also *Committee Hansard*, 21.3.02, p.404 (Catholic Health Australia).

Shared facilities

5.33 The ANF argued that health facilities should host university nursing campuses on their sites, including tutorial rooms and offices, and encourage staff to be more involved in educational activities. The shared arrangements could cover all levels of education, from formal programs to continuing education programs. The arrangements should also include rural health facilities.[51]

Conclusion

5.34 Evidence to the inquiry indicates a need for a more coordinated approach between the Commonwealth and the States and between the education and health sectors in the education of training of nurses. This requires a national approach and national leadership with more effective interaction between the different levels of government, the universities and healthcare service providers. As the Commonwealth and the States each have a role in the education of nurses and in workforce planning issues, a nationally coordinated approach is required to ensure that the supply of nurses meets current and future needs.

5.35 The Committee notes that while there have been improvements in the linkages between the education and health sectors in relation to the education and training of nurses there are still areas where improvements could be made. The Committee believes that closer and more effective links could be developed through the implementation of partnership initiatives between the health sector and the universities and the TAFE sector, such as in the area of clinical placements, to facilitate the training of nurses. Other areas highlighted during the inquiry to improve the interface between the two sectors were the need for greater healthcare industry input into curriculum development, more joint appointments to clinical chairs between universities and health services, and the establishment of more clinical chairs of nursing at major hospitals.

51 *Submission* 962, p.42 (ANF). See also *Submission* 837, p.2 (Directors of Nursing Association Qld).

CHAPTER 6

RECRUITMENT, RETENTION AND RETURN TO NURSING

6.1 The nurse of the 21st century is required to provide high quality care to a discerning consumer whilst dealing with increasingly complex work issues that demand s/he make astute clinical judgements premised on higher-order thinking.[1]

Introduction

6.2 Recruitment and retention of skilled experienced nurses are fundamental issues not only for the future of the Australian nursing workforce but also for the delivery of health care. Catholic Health Australia emphasised the importance of this issue by indicating that 'for those managing nursing services across both the acute and aged care sector the difficultly in recruiting and retaining these skilled nurses in metropolitan and rural acute and aged care facilities has seriously threatened the provision and level of care given'.[2]

6.3 As noted earlier these issues have been the subject of many reviews in recent years. In the words of one submission 'the literature on the factors influencing the retention of nurses is robust and extensive with Australian findings echoing the international work'.[3] The reviews have constantly raised a number of major problems and canvassed a range of strategies to address these problems. The recommended strategies have been implemented to differing degrees across jurisdictions.

6.4 The continuation of these major problems has been reinforced through the submissions and evidence received by the Committee from a broad range of groups and individuals involved in the nursing profession. They overwhelmingly express a view that a considerable amount of work is still required to address the issues in a meaningful manner.

6.5 The strategies for nursing recruitment and retention in the workforce simply require these issues of concern to be addressed. They generally fall within the following major problem areas: education - including attrition from undergraduate courses, level of clinical undergraduate training and continuing educational opportunity; adequate remuneration; conditions of employment - including staffing and skill mix, working hours and making nursing a more family friendly profession; and providing a safe, healthy and enjoyable working environment.

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1 *Submission* 470, p.3 (Flinders University Partnership).

2 *Submission* 897, p.4 (CHA).

3 *Submission* 824, p.3 (UTS).

6.6 While these problems for nurse recruitment and retention have been identified in the large number of reviews and studies referred to in chapter 1, criticism is often levelled at individual components of the system. For example universities are criticised concerning the educational preparations of nurses, transition from university to nursing practice is a difficulty for many graduates, employers of health care workers provide inadequate career structure and poor working conditions.

6.7 The Committee considers that strategies to address the major problem areas and multiplicity of issues contained within can best be implemented in a holistic manner. All parties involved in the nursing profession must implement strategies in a coordinated manner if long term change and benefit is to be achieved. A band aid approach of addressing issues haphazardly will only prolong the crisis in nursing and lead to further deterioration of the system in the future. Current solutions to nursing shortages such as the increasing use of double-shifts, casual staff, and agency nurses, can only be stopgaps that are not sustainable in the long-term. Such measures must be supported with the introduction of national and State strategies.

6.8 The issues confronting nursing are not unique to any one sector - public, private and aged care are all affected. As noted in the workforce planning section, coordination across all sectors is required to address the issues. The Australian Private Hospitals Association described the situation facing private hospitals:

> There has been a lack of an integrated public/private approach to nursing recruitment and retention to date, and a lack of reliable state and national statistics on the current nursing workforce, vacancies, retention rates and numbers of undergraduates training for an acute nursing career. This has left private hospitals with little option but to rely on their own endeavours to recruit and sponsor undergraduates and postgraduates undertaking speciality training. Many hospitals have also had an increasing reliance on agency nurses to fill vacancies and to undertake night and weekend shifts.[4]

6.9 The issues are multi-sectorial, require more than one level of government to address them, and the problem is not just restricted to funding. The need for a broader national approach to improve coordination and planning of nursing policy and workforce issues has been discussed earlier. Issues involving education, including clinical education, transition to practice, continuing education and development, and postgraduate study have also been considered in earlier chapters

6.10 Many witnesses and submissions argued that fundamental to discussion on recruitment and retention was the need for a satisfied nursing workforce that was able to take pride in their work and who could readily encourage others to join the profession. For a range of reasons this fundamental point is not being met with nurses expressing a high level of dissatisfaction with their profession.

6.11 A number of submissions drew attention to the activities of magnet hospitals in the United States as an example of how to successfully provide job satisfaction to

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4 *Submission* 835, p.2 (APHA).

the nursing workforce. Magnet hospitals are a group of health care facilities in the USA which have successfully identified and addressed key factors in the recruitment and retention of their nursing staff. They are facilities that are viewed as great places to work where nurses want to work and remain. Their research, that has been extensively documented in nursing literature, has shown that autonomy, status, and collaboration in a professional environment by truly valuing staff views is crucial to a high level of nursing staff job satisfaction.

6.12 Magnet hospitals have demonstrated that the provision of organisational support to enable nurses to fully use their knowledge and expertise leads to high level patient care and staff who remain in the job. Their characteristics include participative and other quality management and human resource practices, employment opportunities through a clinical career ladder, provision of continuing education and training, and flexible working practices.[5]

6.13 Clearly such practices can be successfully implemented in health care facilities if the resolve is present. The University of Technology Sydney commented that many of these characteristics 'have appeared repeatedly in workforce reports but which are still to be put into common practice'.[6] The Royal College of Nursing has proposed the establishment of a pilot Magnet Recognition Program. The College has identified many of the principles within the Magnet program developed overseas that it believes would be highly beneficial for improving nursing services and client outcomes in Australia.[7]

Recommendation 49: That the Commonwealth Government support the proposal by the Royal College of Nursing to conduct a pilot project in Australia on the Magnet Hospital Recognition Program.

6.14 Evidence suggested that the recent figures that show many undergraduate courses are receiving more applicants than there are available places may understate the difficulties that nursing is encountering in attracting younger school leavers to a career in the profession. During the 1990s many students enrolling in nursing courses were mature age applicants. However, with the elapse of time since the introduction of undergraduate courses, expectations are that the pool of potential mature age applicants is likely to dry-up over the next 5 plus years.[8]

6.15 This scenario will place greater emphasis on the need to recruit young school leavers to nursing courses. The magnitude of this task was illustrated in Queensland

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5 For example *Submission* 470, p.17 (Flinders University Partnership); *Submission* 824, p.2 and attached article *When Care becomes a Burden*, CM Fagin, February 2001, pp.10-11, Milbank (UTS); *Submission* 871, p.7 (UnitingCare) and *Submission* 927, p.13 (RCN).

6 *Submission* 824, p.2 (UTS).

7 *Committee Hansard* 22.3.02, p.536 and *Submission* 927, Attachment A (RCN).

8 *Submission* 942, Supplementary information 17.4.02, Queensland Health Discussion Paper – *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010*, September 2000, p.14.

where it is estimated that if the number of RN graduates needs to be increased by 30 percent from 1999 to 2010, then the number of students entering nursing courses will need to be doubled from 1 200 to 2 400.[9] Similar increases are expected in other States.

6.16 Recruitment issues are important, linked as they are with the insufficient number of funded undergraduate places available and national nursing workforce planning. However, many submissions argued that as important as recruitment issues are, retention issues need more immediate attention – especially given the large numbers of experienced nurses who are registered and not practicing and the expertise being lost through trained nurses leaving the profession.

6.17 As nursing is principally administered at a State level, variations in pay and employment conditions, career structure, health service management and distribution of resources ensure that many nursing issues differ significantly across States. The Committee has already commented that it considers that all nursing issues need to be approached holistically, in a nationally coordinated and planned manner.

Recruitment

Status of nursing profession

6.18 Professional nursing is an essential resource to the health and well being of the Australian public, yet there is enormous failure on behalf of policy makers and decision takers to recognise the overall contribution that nurses make to health care. There is a lack of public awareness of the many vital services that nurses currently provide. The commonly perceived view of a caring nurse carrying out low level menial work is out dated. Nursing has changed.

6.19 Negative mass media images do not assist in conveying the true nature of current nursing and educating the wider public about the developments that have occurred in nursing.

6.20 To attract and retain new nurses to the profession it is crucial that the true value of nurses is made explicit. Nursing can no longer rely on attracting women to the profession almost by default due to the minimal choice of career opportunities that were previously available. Alternative career opportunities for women are now flourishing in a wide range of professions and are regarded as far more enticing options than nursing. Clinical nursing is and needs to be seen as a career worth pursuing and on a par with career opportunities in other fields.

6.21 Importantly nursing also needs to be seen as a viable career option for men. With less than 10 percent of employed registered nurses being male, recruitment to nursing strategies need to focus on enhancing the attractiveness of nursing as a career for men as they represent a relatively untapped source of recruitment.

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9 *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010*, p.15.

6.22 Addressing perceptions about nursing will involve a sustained attempt to alter how those in nursing reflect the profession to outsiders. A positive view is essential. Yet no campaign would be able to convince young people or school leavers that nursing is a worthwhile career option to pursue if the reality being experienced by nurses is not positive. Issues need to be addressed front–on so that nurses' levels of job satisfaction and confidence with the profession's future are restored and a truly positive image for nursing as a career can be conveyed.

6.23 The National Nursing Workforce Forum concluded that there needs to be a strategic response on the part of Federal and State governments in collaboration with the profession to implement and sustain a marketing effort that addresses the image of nursing both within the profession itself and to the community at large. The main aim of the strategy is to recruit quality students into nursing as a career and attract existing nurses back into the workforce and for the community to value the contribution of nursing.[10]

6.24 Nursing needs to be repositioned, with structures and supports that value its contribution, recognising it as a highly versatile profession with enormous diversity and opportunity where young people can learn science, technology, caring, critical thinking and decision making and that it is a profession with **equal status** to other practicing professions within the workplace.

Campaigns

6.25 In many jurisdictions there have been media campaigns to attract nurses with a focus on combining the positive image of nursing to the education levels required and career opportunities apparent in the profession post registration. The Committee received information about a number of positive campaigns being conducted, including:

- Nursing Career, Education and Employment Expos convened by the Royal College of Nursing and with exhibitors from universities, specialty nursing groups, hospitals and other health industry employers;[11]
- The Western Australian marketing program centred on the slogan 'Are you good enough to be a nurse';[12]
- 'Nurses: worth looking after' – A Queensland Nurses Union campaign directed to improving the pay and conditions of nurses;[13]
- Joint efforts between the NSW Department of Health and the NSW Nurses Association to attract school leavers to a career in nursing.[14]

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10 *Rethinking Nursing*, National Nursing Workforce Forum 2000, p.7.

11 *Committee Hansard* 22.3.02, p.442 (ANN) and p.548 (RCNA).

12 *Committee Hansard* 27.2.02, pp.85, 102 (WA Department of Health).

13 *Committee Hansard* 26.3.02, p.556 and *Submission* 457, Supplementary Information (QNU).

14 *Submission* 899, p.2 (NSWNA).

6.26 The Committee considers that such campaigns are constructive and would be enhanced by the development of a comprehensive national marketing program focussing upon nursing being a favourable career option.

6.27 The Committee was reminded that any marketing strategy 'must be complemented at the same time by strategies aimed at addressing retention issues if maximum benefit is to be gained from the marketing strategy'.[15] No amount of marketing will be successful if retention issues such a the following are not addressed:

- workload pressures,
- doctor, patient and patient family demands,
- staff shortages without relief,
- higher patient acuity levels,
- long hours and double shifts,
- lack of professional support of clinical nurse specialists and educators, and
- 'old fashioned' work practices.

6.28 Representatives of universities and the health care sector do attend 'career nights' and arrange displays at schools, though there is scope for greater opportunity of promoting nursing as a career through visits to high schools and colleges, arranging exhibitions and the production of promotional information emphasising the variety of nursing career choices available.

Recommendation 50: That the Commonwealth and States fund regular, sustained campaigns conducted on a nationally coordinated basis to promote the status and positive image of nursing.

Recommendation 51: That a national nursing recruitment strategy be developed by the Commonwealth in consultation with the States and relevant nursing and employer bodies, with recruitment targets established through national workforce planning.

Recommendation 52: That any recruitment strategy and marketing campaigns specifically include encouragement for more males to adopt nursing as a career.

6.29 Use of the Internet can prove to be a valuable medium for promoting and disseminating information about nursing. The Committee's attention was drawn to a new American website created as part of a national campaign 'Be a nurse. They dare to Care'. The site offers information about nursing salaries, nursing specialties, future nursing demand, individual nurse profiles, every nursing education program in the country and every scholarship available to nursing students – by region, size of

15 *Submission* 937, Supplementary information dated 22.4.02 (ACT Department of Health and Community Care).

program or scholarship, and types of degree offered.[16] A number of Australian websites are listed in Appendix 4.

Overseas recruitment

6.30 As noted in chapter 2, arrangements within Australia for recruiting nurses from overseas is undertaken primarily on an individual health service or hospital basis and with varying levels of intensity, though Government bodies are reticent to become directly responsible for overseas recruiting campaigns. While the recruitment of nurses can ameliorate the shortage of nurses in the short-term, the Committee does not consider that the employment of overseas nurses is an appropriate mechanism to overcome the long-term shortage of nurses in Australia.

Retention

6.31 Data has shown that a significant number of nurses depart nursing within 12 months of graduating, while the general turnover of experienced nurses is also unacceptably high. Strategies to retain nurses are cost-effective due to the funds and commitment that has already been expended in training nurses being lost, as well as the invaluable experience developed over years in nursing being lost.

6.32 Nurses report a range of reasons for leaving the profession including disillusionment through feeling unappreciated and undervalued for their contribution and commitment, perceived lack of support from their management and lack of respect from doctors, lack of career path for experienced nurses, being overworked and burnt out due often from staff shortages, suffering frustration and physical and emotional exhaustion, and receiving low pay compared with their responsibilities and/or compared with what they could receive in other professions.[17] Disaffected nurses leaving the profession serve only to compound the problems for those remaining.

6.33 The submissions received by the Committee from over 600 nurses in response to an Australian Nursing Federation (ANF) questionnaire provided a similar list of issues impacting on their working life and which are seen as important for them to remain in nursing. The most commonly identified issues were low morale through lack of recognition of their skills and work, low pay scales, large workloads and stress from staff shortages and cost cutting, lack of development and career opportunity, inflexible rosters and shiftwork. Information from these submissions is detailed in Appendix 3.

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16 www.discovernursing.com

17 These reasons are reported in most reviews; see also *Submission* 744 – a benchmarking study into the factors that determine nursing attraction and retention in Australian healthcare organisations by Best Practice Australia.

Nature of nursing

6.34 There is a growing complexity within the role of nursing. A combination of factors are leaving nurses dissatisfied and experiencing a sense of alienation from their work. Nurses are becoming an increasingly educated and experienced workforce, though their role in health care does not appear to be recognising their evolving situation. While the nursing workforce becomes more highly skilled, there is an increasing use of unqualified or semi-skilled persons undertaking nursing duties. This demeans the nurses' role, as a perception that the delivery of nursing care requires little or no specialist knowledge, skills or academic preparation is reinforced. The time expended by trained nurses constantly having to supervise unqualified health care workers combines with their sense of powerlessness within the health care system to foster the sense of alienation from their work.

6.35 The evolving role of nursing and responsibilities of nurses must be recognised in future planning. It is envisaged that the proportion of assistants in nursing and ENs will increase in coming years compared to RNs. Queensland Health has commented that this change in the composition of the nursing workforce would require a redistribution of the services provided by each component of the nursing workforce. In particular, the RN workforce would focus on the provision of high level nursing services while ENs and assistants in nursing would take over the lower level services currently undertaken by RNs.[18]

Career structure

6.36 The current career structure needs to be reviewed and revised in order to adapt to the evolving role of nursing and to more appropriately acknowledge advanced clinical practice by providing an incentive for clinicians to stay in practice. As the nursing executive at Sir Charles Gairdner Hospital commented:

> One of the most significant factors in influencing nurses to remain within the nursing profession is the ability to recognise a potential career path. There are currently limited opportunities within the clinical, research or education arenas at middle to senor levels of nursing and as a result nurses choose either to remain at the clinical level or leave the profession to seek satisfaction in other areas.[19]

6.37 The career pathways within nursing are currently ill defined. Often nurses progress within the health care system in an accidental manner, depending on how they are promoted and the pathways they may choose at the time. It was considered that certain career pathways could be streamlined and that significant incentives could induce people to enter particular career pathways, especially those where there are critical shortfalls within the workforce.

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18 *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010*, p.16.

19 *Submission* 730, p.4 (Sir Charles Gairdner Hospital).

6.38 Nurses lack advice on the career pathways available to them, both within hospitals and in the broader system. Packages need to be developed that provide assistance to workers within the health care system to provide appropriate advice regarding the many, varied career pathways that can be undertaken within nursing.

6.39 A number of suggestions for developing improved career paths were advanced in evidence:

- A nurse's progression in their career, through recognition and reward, should be based on increasing skills/competencies and qualifications rather than on years of service as is the current system. This should also include a strategy to link competence to salary to enable skilled nursing staff to be paid appropriate to their competence.
- A more structured pathway for nurses to remain within the clinical stream needs to be supported financially and politically. Currently nurses have to leave the clinical stream in order to advance their career. Career pathways, that recognise clinical expertise and enable practitioners to remain in the clinical setting but still pursue career progression, should be established. This would allow for appropriate recognition and time for mentoring and preceptorship as well as clinical expertise.
- There should be multiple entry and exit points into nursing to enable persons to select the level of training to enter nursing, or to upgrade from one level to another ie. an enrolled nurse to a registered nurse, or to transfer from one type of nursing to another. Multiple entry and exit points should be offered within the nursing programs. Multiple career pathways should be constructed that include the introduction of double degrees, accelerated pathways for Nurse Practitioners, and specific streamed processes through which people can gain advanced practitioner status.
- Opportunities for nurse practitioners in specialised nursing functions and rural/regional centres should be accelerated.
- The development of partnerships between the tertiary education and health care sectors - in particular, specialty areas such as mental health, critical care, ICU, perioperative, aged care and midwifery would prove advantageous.
- Governments and professional bodies should have a role in providing information to nurses on career pathways.

Recommendation 53: That the current career structure be reviewed and revised to provide career pathways that include continued clinical practice, enhanced opportunities for postgraduate study and accelerated pathways through which nurses can move to an advanced practitioner status. The career structure needs to recognise the skills obtained through postgraduate study and remunerate them accordingly.

Recommendation 54: That governments and professional nursing bodies provide detailed information to nurses on career pathways.

Transition to practice

6.40 Overcoming difficulties during the first twelve months spent adjusting from university to practice is crucial to retaining nurses. New graduates require support and the development of skills to manage the transitional problems they face. There are many issues in this area including the level of clinical preparation of new graduates, improved and better funded graduate nurse programs, more effective support for new graduates especially through mentorship and preceptorship programs, and enhanced training and remuneration for preceptors. Issues relating to transition to practice have been considered in chapter 3.

Workloads

6.41 Changes in the delivery of health care to reduce the time patients stay in hospitals with resultant greater acuity of patients leads to increased workloads for nurses. Nursing staff shortages, especially the inadequate number of nurses to meet desired nurse:patient ratios and the inappropriate skill mix to provide the necessary clinical support for junior nurses, exacerbate workload problems.

6.42 Workloads must be addressed in relation to their effect on burnout and stress. Burnout contributes to job dissatisfaction, absenteeism and turnover. Burnout is the consequence of specific social and situational factors that can be changed, if the will is there. Social support in the workplace is a critical tool for offsetting burnout in nurses.

6.43 Improved nurse:patient ratios is regarded as a primary mechanism for nurses to control workloads and to be able to properly look after patients. Victoria has introduced measures to improve nurse:patient ratios and reduce workload by adding extra nurses into the public health system.[20]

6.44 Apart from employing more nurses, a number of suggestions were made to address this issue. They included the development and implementation of a patient acuity system which accurately reflects the skill mix required to meet the care needs of patients with nurse working hours, increasing the number of ward clerks in order to increase the effective use of nursing time and to factor in time for communication and interaction by nurses with patients to increase staff job satisfaction.

6.45 The University of Western Sydney suggested that with the ageing of the nursing workforce, one option is to make nursing work more age-friendly to retain older workers.

> There are improving technologies which allow older workers to continue to work in care roles. This will not only allow older workers to work longer but it will make nursing work less exposed to risk of accident and injury. As well there are opportunities to develop new nursing specialties, for example case management/coordination, that may be attractive to older workers. This

20 *Submission* 960, p.14 (Victorian Government).

> is a quantum leap for the health system and it will need careful consideration and long-term planning to achieve the cultural change.[21]

Recommendation 55: That the Commonwealth and States encourage providers of health care services to promote multidisciplinary team approaches to patient care which recognise all members of the team as valued and valuable.

Remuneration

6.46 Issues of inadequate pay and working conditions are very important to nurses, as they have been fundamental concerns leading to increasing militancy in recent years. Nurse's work is often perceived as synonymous with 'women's work' and has been underpaid and under valued for far too long.

6.47 Queensland Health has noted that 'the typical starting salary of graduate nurses appears to be about the same as the typical starting salary of all university graduates. However, comparison of the salaries of all professionals, not just new graduates, shows that the typical salary of a registered nurse appears to be below the typical professional salary.'[22]

6.48 A recent study prepared for the NSW Nurses' Association (NSWNA) found that while the issue of pay rates relative to other professions and allied health workers is very important, there was much stronger sentiment that nursing rates of pay were quite unfair now compared with those which had prevailed in the past because of the changing nature of nursing work. Nurses are saying that they do not feel that they are financially rewarded for the level of responsibility that they are currently undertaken.[23] As one submission commented, 'Australia's health care system is not sustainable without remuneration which compensates for the skill and knowledge required to practice as a nurse'.[24]

6.49 A particular issue of concern for nurses who have undertaken professional development through obtaining postgraduate qualifications is the lack of recognition and appropriate remuneration to reward the skills attained as a result of their commitment to higher education and training.

6.50 Similar issues arise in the area of nursing leadership. The Committee was advised that nursing unit managers (Level 3) who assume advanced levels of responsibility in managing a unit are often getting paid less than their subordinate staff, due primarily to the loss of penalty pay through no longer working shifts or

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21 *Submission* 784, p.15 (UWS).

22 *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010*, p.13.

23 *Stop telling us to cope!* A report prepared for the NSW Nurses' Association by the Australian Centre for Industrial Relations Research and Training, May 2002, pp.39-42; see also *Committee Hansard* 22.3.02, p.522 (NSWNA).

24 *Submission* 783, p,5 (ACT Focus Group).

overtime and thus forfeiting penalty pay.[25] Women's and Children's Health Victoria noted the unit manager role is central to maintaining clinical practice standards and providing quality nursing services. The role needs to be remunerated accordingly.[26]

6.51 Other issues on remuneration included the salary differential across jurisdictions for the same level of nurse and the disparity between pay for nurses working in aged care. The issue of pay rates for aged care nurses is discussed in chapter 7.

6.52 Many nurses hold the view that the changes required to make nursing more attractive would take some time to achieve. Changes in pay could, however, be achieved almost instantly.

Recommendation 56: That experienced, skilled and educated nurses be recognised and rewarded, both financially and through promotional opportunity, for the work they perform in decision making and the management and coordination of patient care across the continuum of care.

Education

6.53 Health care in the Australian context is dynamic and challenging. Greater access to clinically relevant, vocationally oriented ongoing education and greater recognition for post-graduate study successfully undertaken are important points to encourage nurses to remain in the profession. Nurses need opportunities for continuing education to prepare for, and remain competent throughout their careers in the various scopes of practice.

6.54 Education is the foundation of professional development and the key to empowering the nursing profession. Barriers must be removed so as to ensure nurses reach their full potential. Education programs must be affordable and career structures and organisational structures must be developed that reward commitment to life long learning.[27]

6.55 The importance of continuing education is discussed earlier. However, access to ongoing, and especially postgraduate, education is often financially crippling, thereby depriving many nurses of the opportunity of further study. The provision of additional scholarships or financial assistance and permitting time off for study leave are regarded as necessary improvements to this area.

6.56 The development of close partnerships between academic institutions and the health care sector, as discussed in detail in chapter 5, will help address the nurse retention issue. Such developments are allied to strategies to retain nurses in the

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25 *Committee Hansard* 27.2.02, p.50; 15.3.02, p.315; 26.3.02, p.664.

26 *Submission* 780, p.11 (WCHV).

27 National Nursing Workforce Forum, p. 9; see also *Submission* 783, p.5 (ACT Focus Group).

workforce and to attract nurses back into the profession in the public, private and aged care sectors.

Unqualified workers

6.57 The increased numbers of workers with little or no formal training being introduced into the health care system as a replacement for qualified nurses or to cover nursing shortages is having an adverse effect on nursing practice and morale. These workers are generally unregulated and unlicensed. This unregulated section of the workforce is discussed in chapters 4 and 7 dealing with EN education and aged care.

Nursing leadership

6.58 Leadership in nursing is a critical issue that must be addressed. It is recognised that the Nurse Unit Manager role is critical in the organisation of care delivery. Nurse Unit Managers must be carefully selected, developed, mentored and rewarded. In many instances unit managers are given an onerous task to perform without being equipped with the skills necessary to lead and manage teams of professionals.

6.59 Nurses today are highly skilled, highly educated and articulate. Clinical nurses, given they ultimately implement decisions, eg new technology, policies, documentation, should be actively involved in high level clinical decision-making.

6.60 It is difficult for nurses to play significant roles in policy-making or communicate effectively with decision-makers because they are under-represented in institutional hierarchies. Thus they have limited power to influence change or make improvements. A broadening of access to senior roles will create opportunities for greater diversity and strength of leaders who wish to remain in their areas of expertise. Good nursing leaders can increase group cohesion and reduce stress. The magnet hospitals experience referred to earlier has shown that leadership which supports and empowers nurses through their involvement in decisions, planning and policy making, improves their motivation, retains their loyalty and reduces staff turnover.

Recommendation 57: That the Commonwealth and States encourage providers of health care services to support nursing leadership by integrating nurses into the organisational hierarchy through their appointment to and meaningful participation in management; and by promoting nurse involvement in decision-making relating to nursing practice and clinical patient care.

Recommendation 58: That the Commonwealth and States ensure that nursing leaders are provided with the necessary in-service training and development to support them in their constantly evolving roles.

Management support

6.61 Many nurses indicated in evidence that much greater support was required within the hospital setting from management, to facilitate a work place environment that encouraged nurses into, and to remain within, the health care system. Many of the

issues relating to retention particularly in regard to family friendly policies and occupational health and safety issues are within the control of nurse and hospital managers.

6.62 Evidence to the Committee repeatedly raised these and other points as contributing to reasons why nursing is losing its attractiveness:

- There needs to be support ranging from remuneration issues through to counselling services, education and incentive/reward systems;
- There needs to be appropriate time for nurses to be debriefed over the day's activities and processes established for mentorship;
- Improved role modelling by management to address particular concerns, such as behavioural issues, time management, patient focus and etiquette, needs to be pursued;
- There also needs to be support for nurses at the hospital level by managers and boards of management during legal issues arising from patient care or when nurses are subjected to aggressive and violent behaviour and harassment.

6.63 A greater number of senior nursing managers are needed in Area Health Services or their equivalent who possess and can apply best practice management standards and well developed risk-management strategies.

Return to nursing – Re-entry and refresher programs

6.64 Returning skilled and experienced nurses to the workforce is a critical aspect of nurse recruitment and retention. Strategies for retaining expensively educated nurses in the system and for returning trained nurses to health care after restoring their competency levels by updating knowledge and skills are cost effective measures. The recruitment and education of new nurses is a much more costly option. Recent research indicates that there is a sizeable pool of trained nurses, who would be willing to return to nursing, particularly in the surgical, midwifery and critical care areas.[28]

6.65 Re-entry and refresher programs are currently loosely arranged, may be offered within individual hospitals, universities or by health services, and with marked jurisdictional variations of form and content.

6.66 The re-entry programs are intended to provide a re-entry avenue for previously Registered or Enrolled Nurses who have allowed their registration to lapse, usually beyond a five-year period. Such programs provide the participants with the opportunities to update nursing knowledge and develop nursing skills to a level of competency that is required for registration within the State and therefore re-entry into the nursing workforce. Re-entry programs usually run for 12 to 18 weeks and may be offered through universities or health care facilities. However, the length, content and competency levels can vary widely between re-entry programs.

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28 *Submission* 867, Attachment 4 *New South Wales Nursing Workforce Research Project*, dated September 2000.

6.67 Refresher programs are generally intended for Registered or Enrolled Nurses who have maintained registration but have not worked for less than five years, and who wish to consider returning to nursing. Refresher programs usually take between 6 to 12 weeks to complete and may be provided by both public and private health care facilities. Content usually covers theoretical update on nursing issues and practice and supervised clinical practice.

6.68 Career advisory information needs to be developed in conjunction with return to nursing programs. The New South Wales College of Nursing commented that:

> There is a general lack of knowledge about retraining or refreshing in nursing after a period of absence. Many respondents do not know about refresher courses or how to find out about them. Others had sought careers advice but had been unable to find appropriate or adequate information.[29]

6.69 The financial aspects associated with re-entry programs are important. The Committee received evidence on costs that even if a program is provided free of charge, there is usually no income whilst retraining. Significant travel and relocation expenses and personal inconvenience provide added difficulties for those in rural or remote areas. The ANF commented that the cost of such courses may act as a barrier to nurses returning to the workforce and suggested that government and other employers should subsidise programs and offer re-entry program scholarships as recruitment and retention initiatives.[30]

6.70 NSW Health has introduced Nursing Re-Connect which offers a clinically focussed, individually tailored re-entry plan on a full or part time basis in general or specialty areas. Participants are employed and paid while undertaking the program which does not charge course fees.[31] Other jurisdictions also advised that work is in progress to develop consistent standards within re-entry and refresher programs, funding the programs and providing participants with a wage.[32]

6.71 The Australian Private Hospitals Association indicated that the private sector is willing to work with the public system in developing and supporting refresher and re-entry programs to encourage nurses to return to the workforce.[33] Programs in the aged care sector have been considered in the chapter on aged care nursing.

6.72 The Australian Catholic University suggested that funding should be provided to universities rather than hospitals for the education and updating of nurses returning to the workforce. The focus of education would be toward the returning nurse to

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29 *Submission* 480, p.6 (NSWCN).

30 *Submission* 962, p.50 (ANF).

31 *Committee Hansard* 22.3.02, p.500 (NSW Health).

32 *Submission* 867, Attachment 3 pp.7-9 (NSW Health); *Submission* 914, Additional Information 5.4.02 (RMIT); *Submission* 942, Additional Information 17.4.02 (Queensland Health); *Committee Hansard* 28.2.02, p.179 (DHS Vic); *Committee Hansard* 27.3.02, p.763 (DHS SA).

33 *Submission* 835, p.7 (APHA).

ensure they received the knowledge and skills that met their needs, by utilising the considerable educational resources available at all universities.[34]

6.73 Nurses returning to the workforce are often doing so after having started a family. They like to work near home and school, work part-time, choose their shifts and be able to work shorter or longer shifts as family commitments alter or their health dictates. These issues are all related to making nursing a more family friendly career.

Recommendation 59: That the Commonwealth and States fund re-entry and refresher programs in all States and Territories, including the employment and payment of salaries for nurses undertaking such programs.

Recommendation 60: That there be greater coordination of re-entry and refresher programs provided through hospitals and tertiary institutions and of the content of these programs.

Making a nursing career more family friendly

Working conditions

6.74 Difficulties with working conditions are conveyed as a most serious problem for the retention of nurses practicing in the profession. More family friendly working conditions are often expressed as the reason why some nurses move to work in the private sector or for agencies or leave the profession altogether. Overcoming issues in this area are at the heart of making nursing more family friendly and encouraging nurses to return to the profession, particularly in the public and aged care sectors.

6.75 The ANF has noted that nurses report that working conditions consisting of inadequate levels of appropriately qualified staff that result in unreasonable workloads lead to nurses returning home to families at the end of a shift too exhausted to undertake family responsibilities or participate fully in family and social activities.

6.76 Nurses report that not only does inadequate staffing levels and unreasonable workloads result in physical and mental levels of exhaustion, they are also the major aspects affecting their job satisfaction. This is due to the impact these aspects have on the level of care nurses are able to provide, in a health care environment characterised by such conditions. Satisfaction with work performed has a positive impact on feelings of self esteem and well being which extend beyond the workplace into family and social life. The job dissatisfaction experienced by many nurses is negatively affecting the way they interact with their families and in their social contacts.

6.77 Flexibility in rostering is a particular area requiring consideration. Long hours and rotating shifts are disruptive to family and social life, with rosters perceived by nurses to be structured to meet workplace needs without their needs being considered

34 *Submissions* 725, p.5 and 812, p.8 (ACU).

in the process. A number of submissions suggested a return to 8, 8, 10 rostering. Nurses at the workplace should have a greater say in the structuring of their rosters.

6.78 There is variance between State awards in relation to mix of shifts in roster periods and minimum breaks between shifts. Some submissions urged the benchmarking of award rostering conditions across the States, such as minimum breaks between shifts, number of consecutive shifts that may be rostered without consultation and the mix of shifts within a roster period.

6.79 Shiftwork remains an unattractive option for many nurses. The unsociable hours that are worked can no longer be accepted as just a part of working as a nurse. Suggestions to make shiftwork more palatable include increasing financial incentives for shiftwork, especially night duty, offering incentives to attract more permanent night staff and providing additional leave to compensate shiftwork.

6.80 Associated with flexible rostering there needs to be greater use of part-time and job-share options to enable registered nurses to work around family commitments whilst developing their careers. Such flexibility needs to be balanced so that full-time staff are not left to continually work unwanted shifts and are not otherwise penalised.

6.81 Reference has been made to the difficulties many nurses have in gaining time-off for study leave, especially for postgraduate studies. Flexible rostering arrangements can assist nurses to undertake further studies.

Parental leave

6.82 Paid maternity and paternity leave is provided within the public sector, yet nurses appear to struggle to receive consistent levels of paid leave across Australia. Paid maternity and paternity leave should be available for all nurses, including those working in the private and aged care sectors. The establishment of a benchmark of 14 weeks paid maternity leave was proposed by the ANF,[35] though a national campaign for 12 weeks covering the entire workforce is currently being undertaken. Any benchmark that is agreed should apply equally across all jurisdictions.

Childcare

6.83 With nursing having a predominantly female workforce many of who undertake the role of child rearing, childcare becomes an essential part of the workplace support infrastructure. Research has shown that many nurses leave nursing temporarily or permanently to have children and that there are inadequate incentives for them to return to nursing following career breaks.

6.84 The issue of childcare was constantly raised as an important aspect of encouraging nurses to remain in or return to the profession. While nurses face similar decisions about childcare as any other worker in respect of the child's best interests and the affordability of care, rostered working hours considerably reduce their

35 *Submission* 962, p.58 (ANF).

options. Nurses who often work long hours or shifts require extended hours childcare, access to before and after school care, and vacation care. Very few childcare centres offer the flexibility of hours of care to meet such a requirement. Many submissions argued that adequate, affordable, quality childcare must be provided over extended hours at the workplace or, alternatively, childcare assistance could be provided in the form of a direct subsidy.

6.85 A particular issue for women returning to work with babies who require feeding is permitting breast-feeding in the workplace through the provision of an appropriate environment to allow lactation breaks. The ANF and its branches strongly support this position and have a policy endorsing the practice.

Caring for relatives

6.86 As noted previously, nursing is an ageing profession with many nurses having an additional responsibility of caring for elderly parents or relatives. Being able to juggle work and caring for relatives require a delicate balancing of a nurse's time. This raises issues not just of caring for the elderly, often in a home environment, but also of flexibility of working arrangements. Many nurses will require access to affordable day care facilities that are responsive both to the needs of the elderly person and the needs of the nurse in that they are open for extended hours, as well as for occasional care.

6.87 The Committee considers that nurse employers have the responsibility to commit to 'family friendly' practices and introduce them into their workplace. While not directly relevant to Commonwealth responsibilities, the Committee was repeatedly told by nurses and nursing organisations that the need for more 'family friendly' practices in the workplace was a significant issue for the retention of nurses.

Recommendation 61: That the following 'family friendly' practices be advocated by all levels of government as best practice for all providers of health care services and nurse employers:

- **That flexible rostering be introduced or where appropriate developed further, together with the encouragement of greater use of part-time and job-share options.**
- **That paid maternity and paternity leave be available to all nurses.**
- **That adequate, affordable, quality childcare be provided over extended hours at the workplace, or through other forms of direct childcare assistance such as the procurement of places at nearby childcare centres.**
- **That adequate facilities to meet breastfeeding requirements be provided in the workplace.**
- **That work practices be established to encourage experienced older nurses to remain in the profession.**

Improving occupational health and safety

6.88 Providers of health care services have developed occupational health and safety policies in accordance with statutory requirements, though many areas struggle with OH&S issues due to staffing shortages. While monitoring of the work environment and staff behaviour regarding OH&S must be ongoing, the most effective way of improving OH&S performance is through ensuring staffing numbers remain consistent and reliable.

6.89 The work environment can have positive or negative physical, mental and social effects on nurses. Like all employees, nurses should be able to work in an environment that is safe and free from fear and intimidation. Much remains to be done to reduce the high rate of injuries to nurses and enhance their feelings of well-being by improving standards of work environments and through the provision of staff recreational amenities that provide opportunities for health and fitness activities.

Violence in the workplace

6.90 The level of aggression, violence and harassment encountered by nurses in their working environment is a major concern and an influential factor in many leaving their job. The issue has been well researched and documented, with some studies showing that nurses are physically assaulted, threatened and verbally abused at higher rates than other professionals.[36]

6.91 Violent or aggressive behaviour towards nurses is encountered in a number of forms and places. Emergency departments, mental health settings and community practice are particularly hazardous environments. The mainstreaming of mental health and an increase in drug and alcohol induced problems have led to more patients presenting to hospitals with behavioural difficulties that may result in recourse to violence. Nurses are in the frontline of health care and increasingly confronted with verbal or physical abuse from patients or relatives expressing raw emotions in response to the traumas of acute and chronic illness. Many nursing staff are not appropriately trained to manage patients and their relatives who display such an aggressive behavioural disposition. Nursing staff need to be assured that there is adequate security staff backup should they become involved in violent episodes.

6.92 The external environment also needs to be made safer. Shift workers have been violently attacked in car parks while returning to their transport especially in evenings. Car parking should be accessible, well secured and well lit for access at all

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36 Examples of studies and articles on the extent and impact of violence towards nurses include: *Violence: It's not part of the job*, Australian Nursing Journal, v.9 No.9 April 2002, pp.24-6; *Horizontal violence: a conundrum for nursing*, The Collegian, v.2 No.2 April 1995, pp.5-17; Taskforce on the Prevention and Management of Violence in the Health Workforce, UNSW Working Papers Series, Discussion Paper No.1 – *Occupational Violence: Types, Reporting Patterns, and Variations between Health Sectors*, August 2001, Discussion Paper No.2 – *Prevention of Occupational Violence in the Health Workforce*, October 2001, Discussion Paper No.3 – *'Internal' Violence (or Bullying) and the Health Workforce*, December 2001.

hours. The Committee heard of examples where hospitals that had experienced trouble within their grounds had introduced 24-hour a day security presence.

6.93 Exposure to danger is especially high in situations where nurses are working as sole practitioners, such as in community or rural nursing. It was strongly argued that nurses should not be placed in the situation of having to work on their own. Where this was not possible, nurses should be given access to communication devices to allow for immediate and effective monitoring of their location and well-being.

6.94 The other major source of concern in this area is horizontal violence or workplace bullying. This may involve a single physical act of violence resulting in a physical or emotional injury or some form of continuing harassment or bullying. Such behaviour includes any threatening statements or behaviour to victimise, threaten, undermine or generally give the worker cause to believe he or she is at some form of risk. This makes the workplace an unpleasant, intimidating or humiliating place to work. Within nursing, it is often reported as the younger nurses or students who encounter problems from hostile and unsupportive older nurses.

6.95 A major contributing factor to the problem of horizontal violence is that nurses need to feel better supported within the hospital system, which currently seems to perpetuate the problem. There needs to be more participative management so that nurses have a voice in the organisational decision making. Adequate role preparation for managers and clinical supervisors is seen as integral to reducing horizontal violence and other system sources of aggression.

Recommendation 62: That governments ensure that providers of health care services guarantee that education and other support measures for managing and responding appropriately to aggressive and violent behaviour are available to, and routinely provided for, nurses as continuing education in the workplace.

Recommendation 63: That the Commonwealth introduce a national reporting system for violence and aggression toward nurses and other health workers in order to understand the factors which give rise to violent incidents, the extent of the problem, and to inform the development of strategies to prevent future violent incidents involving nurses and other health workers.

Manual handling

6.96 Research has shown manual handling to be the major cause of injuries to nurses. Serious manual handling injury is a significant cause of wastage of experienced nurses from the profession. Management of this issue is occurring through the implementation of ‘no lift’ programs, advocated by the ANF, to reduce manual handling injuries resulting from the lifting of patients. ‘No lift’ programs, particularly those adopting a full risk management approach, have been very effective at reducing the number and severity of injuries. The Victorian Nurses’ Back Injury Prevention Project has had promising results with a reduction in patient handling

injury and lower back injury claims since the implementation of the no lifting program.[37]

6.97 The NSWNA noted that the management of manual handling risks not only reduces injuries, it provides a more supportive environment that leads to less physical exhaustion of nurses and improved accommodation of post injury rehabilitation programs. It also generates large cost savings through lower workers compensation and rehabilitation costs. Anecdotal reports of reduced staff turnover and absenteeism are commonplace in workplaces that have implemented manual handling risk management systems in consultation with their staff.[38]

6.98 Discussion in chapter 2 on nursing shortages has shown that most health service and aged care facilities are understaffed. Nurses are at greater risk of personal injury when they are stressed, tired and overworked. Nurses are also less likely to use safe manual handling practices including lifting devices when workloads are heavy because they cut corners with safety to save time. Adequate staffing levels and appropriate skills mix are integral to the elimination of manual handling injuries.

6.99 Hospital and nursing home equipment, including safe lifting devices, should be up to date, readily available and regularly maintained. All staff must have access to appropriate education and training on how to use equipment.

Needlestick injuries

6.100 Needlestick injuries are a recognised source of exposure to blood-borne diseases for workers in health care occupations, especially hepatitis B, hepatitis C and HIV. While most workers may not contract infection from such an injury, they all endure a lengthy and expensive process of diagnostic procedures of up to three months with the added psychological trauma of uncertainty during this period before it is known whether a serious disease has been contracted or not.

6.101 The exact level of needlestick injury is difficult to determine. While the Committee's attention was drawn to a number of studies conducted internationally, the number of published studies relating to Australia remains minimal. Figures provided to the Committee indicated that over 3000 needlestick injuries occurred in 1997 within 56 hospitals participating in an exposure prevention program and that at least 13 000 had occurred in Australian hospitals in 1998. The Committee also received individual statistics from a number of major hospitals. Research has indicated that the actual incidence of needlestick and sharps injuries could be much higher due to under-reporting, with some estimates that it may be by as much as 60 percent.[39]

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37 *Submission* 960, p.20 (Victorian Government); *Submission* 962, p.64 (ANF).

38 *Submission* 899, p.14 (NSWNA).

39 Information in this section has been drawn primarily from *National Surveillance of Healthcare Associated Infection in Australia*, A report to the Commonwealth Department of Health and Aged Care prepared by An Expert Working Group of the Australian Infection Control Association, April 2001, pp.61-65 www.health.gov.au/pubhlth/strateg/jetacar/pdf/scope.pdf

6.102 The economic implications of such injuries are substantial. The cost of testing and treating injured workers has been assessed internationally and theoretical calculations have also been undertaken in Australia. The cost of treatment for one uncomplicated injury (no transmission of infection) ranged from a 'conservative' $550 to over $1 500. Becton, Dickinson estimated that, based on 13 000 injuries and by using the lower cost figure, the economic cost of needlestick and other sharps injuries could be over $6 million per annum. Large compensation payments for those who may contract disease are likely to significantly inflate the economic cost.

6.103 Infection control experts agree that the number of injuries could be drastically reduced by the use of safety technology and education programs. In April 2001 the Federal Needlestick Safety and Prevention Law came into effect in the United States. In Australia action is currently left to individual hospitals or health services.

6.104 The Austin and Repatriation Medical Centre in Melbourne has introduced a needlestick prevention program using safety engineered technology combined with nursing and medical staff training. To pay for the program the hospital has had to prioritise its funding and divert funding from other programs. No additional funding is provided for the program, which is expected to cost about $400 000 per annum. Royal Perth Hospital has introduced a needleless intravenous injection system, with other initiatives including a retractable intravenous insertion needle and a vacu-container blood collection system. Some individual NSW Area Health Services are proactive in providing hospital products designed to reduce needlestick injuries. For example, the Illawarra and Hunter AHSs have mandated OH&S policy changes for the use of safety engineered sharps. These examples are very much a minority.[40]

6.105 The Australian Infection Control Association emphasised that:

> safety devices are only one component of the overall occupational health and safety management in terms of occupational exposures…Supplying of safety devices requires education and training in support of these as well as appropriate levels of staffing resources both in numbers or skill mix. The need to work quickly under staffing and other resource pressures all appears to contribute to higher occupational exposure injury rates.[41]

6.106 Becton, Dickinson considered that 'by delaying the implementation of safety technology, Australian hospitals and health care institutions are exposing themselves,

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and *Submission* 966 (Becton, Dickinson and Co). Examples of individual hospitals included: Royal Brisbane – 131 in 2001, *Submission* 457, Supplementary information 19.4.02 (QNU); Royal Perth – 620 from 1997 to 2000, *Submission* 706, Supplementary information 18.4.02; Sir Charles Gairdner, WA – 205 from 1999 to 2001, *Submission* 730, Supplementary information 12.3.02.

40 *Committee Hansard* 27.2.02, pp.112-4 (Royal Perth) and 28.2.02, p.170 (Austin); *Submission* 966, pp.7-8 (BD).

41 *Submission* 968, p.6 (AICA).

their Directors and taxpayers to expensive litigation under Occupational Health and Safety Acts'.[42]

6.107 The ANF expressed concern that decisions about products designed to reduce needlestick injuries are being made on the basis of cost. The cost of such products needs to be offset against the compensation costs for a nurse or other health worker contracting or fearing a blood borne illness. The ANF commented that while some employers have placed the health and welfare of nurses before cost and upgraded their products, the response is generally inadequate. The Federation argued that if this can not be achieved on a voluntary basis, then it should be made mandatory under occupational health and safety legislation.[43]

Recommendation 64: That the National Occupational Health and Safety Commission urgently develop model uniform OH&S legislation and regulations for the Commonwealth, States and Territories relating to the use of safe needle technologies in Australian hospitals and other health workplaces, and work cooperatively with the States and Territories to improve associated safety education and training programs for health care workers.

Glutaraldehyde and latex

6.108 The ANF has raised the issue of exposure to the disinfecting agent glutaraldehyde and the onset of hypersensitivity conditions. There have been successful British compensation claims for debilitating conditions such as asthma. The ANF notes that some improvements have been made in the Australian health system, such as stringent monitoring processes, better education, improved ventilation and other protective measures. However, the Federation does not consider the risk to nurses acceptable and proposes that glutaraldehyde use be eliminated and safer methods of disinfection used.[44]

6.109 Latex allergies or sensitivity is also seen as an escalating problem for health care workers in Australia. Reactions can range from allergic skin reaction to systemic hypersensitivity. While the use of latex gloves has grown markedly in recent decades, the prevalence of latex allergy/sensitivity is not known, although studies in the United States have estimated that between 5 and 17 percent of the health workforce are affected. Cost is acknowledged as an issue due to the significant differences between products containing latex and those without. However, the ANF notes that this must be weighed against the potential costs of lost productivity and workers' compensation payments for staff who develop latex sensitivity and allergy through exposure to latex allergens in the workplace.[45]

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42 *Submission* 966, p.3 (BD).

43 *Submission* 962, p.67 (ANF).

44 *Submission* 962, pp.65-6 (ANF).

45 *Submission* 962, pp.67-8 (ANF).

6.110 In general, all nursing staff should have ready access to appropriate equipment and apparatus and protective attire for use while handling and having exposure to chemicals and toxic substances and bodily fluids. Procedures for reporting hazards needs to be streamlined and readily understood by all nursing staff.

Recommendation 65: That governments ensure that all nurse education curricula include occupational health and safety theory and practice covering aggression management training, use of safety equipment and devices, manual handling training, and competency assessment.

Recommendation 66: That the following 'occupational health and safety' practices be advocated by all levels of government as best practice for all providers of health care services and nurse employers:

- **That all health and aged care facilities provide nurses with access to peer support, appropriate counselling, post-incident defusing and debriefing, and grievance handling.**
- **That providers of health care services support their nursing staff in the prosecution of violent offenders.**
- **That providers of health care services be required to ensure that nurses do not work alone in areas of high risk or where the level of risk is unknown. Where this is not possible, personal duress alarms or similar communications devices should be provided for personnel.**
- **That staff car parking should be accessible, well secured and well lit for access at all hours. In recurring problem areas, dedicated 24-hour a day security presence should be provided.**
- **That sufficient funding be available to ensure that hospital equipment, including safe lifting devices, are up to date, readily available for staff use and regularly maintained.**
- **That research be commissioned into the long-term effects of exposure to glutaraldehyde and that a process be put in place to eliminate the use of glutaraldehyde in health and aged care sectors.**
- **That alternative equipment be provided for those who are allergic to latex, with a view to eventually replacing the use of latex products by health care workers.**

Recommendation 67: That governments ensure that all managers in health services receive training in:

- **Management styles that promote leadership and consultation;**
- **Management skills to include conflict resolution and grievance management, improved human resource management, understanding industrial relations and awards, and information technology skills; and**
- **Occupational health and safety responsibilities and risk management.**

Conclusion

6.111 The Committee notes that recruitment and retention issues have been extensively canvassed in recent reviews, inquiries and research projects. Strategies to address the issues have been identified and recommendations proposed. Action has been undertaken to different degrees across the Commonwealth and States. However the Committee considers that all nursing issues and especially those affecting recruitment and retention, need to be approached holistically, in a nationally coordinated and planned manner.

6.112 The Committee has not attempted in this chapter to reproduce in detail the arguments and discussions from these reviews, a great deal of which was strongly reinforced in the submissions and evidence received by the Committee. Rather, the Committee has attempted to highlight many of the major issues that have been raised. The Committee believes that it is now time for decisive national action and has made recommendations accordingly.

6.113 The Committee considers that the following list identifies major issues requiring strategic action to expand the level of nurse recruitment and retention:

- Promotion of a positive image for nursing and promotion of nursing as a desirable career;
- Development of a skilled nursing workforce that is highly valued within the health care system and by the community generally;
- Introduction of programs to reinvigorate nurse job satisfaction and to bolster morale;
- Expansion of refresher and return to nursing programs;
- Improvement of working conditions, especially workloads and flexibility in rostering and working hours;
- Increasing remuneration;
- Extension of continued education opportunities for professional development;
- Development of improved career pathways and opportunities, with professional recognition of knowledge, skills and education;
- Advancement of effective nursing leadership and management, including greater nurse involvement in decision making both about their professional work and broader health policy;
- Application of more family friendly policies to meet the needs of nurses, including access to childcare;
- Provision of a safe working environment that ensures nurses are free of fear, intimidation and violence.

CHAPTER 7

AGED CARE NURSING

> *The Association is of the view that the aged care sector is in dire need of increased numbers of enrolled and registered nurses if they are to reach an adequate standard of nursing care. Recipients of that care would have the opportunity to experience health gains and as a consequence, the quality of life of those residents would also improve. No longer would we have to hear of elderly Australians dying from opportunistic infections because of neglect arising from care worker ignorance.*[1]

7.1 The Committee received much evidence detailing the acute shortage of nurses in the aged care sector. Concerns were voiced about the impact of the shortage on quality of care, particularly for residents of aged care facilities.

7.2 The aged care sector is the second largest employer of nursing staff after the acute care hospital sector. Approximately 20% of Australians aged over seventy use aged care services with more than half of this group accessing Home and Community Care Services. The remainder are cared for in nursing homes (5%), hostels (3.7%) or through Community Aged Care Packages (0.2%).[2]

7.3 The profile of residents in the aged care facilities has changed over the last few years with an increasing number of older clients with higher levels of dependency. The Australian Institute of Health and Welfare (AIHW) has provided an overview of the main characteristics of residential aged care:

- nearly half of those residents in aged care homes at 30 June 2000 were aged 85 or over;
- about 62% of residents fell into high-care categories (Resident Classification Scale (RCS) 1 to 4) and 38% into low-care categories (RCS 5 to 8);
- the lowest level of care (RCS 8) contained about 2% of residents on 30 June 2000;
- between 1998 and 2000 dependency levels increased with the proportion of residents classified as high care (RCS 1 to 4) rising from 57.8% to 61.8%, while those classified as low care (RCS 5 to 8) falling from 42.2% to 38.3%; and

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1 *Submission* 899, p.8 (NSW Nurses' Association).

2 Pearson, A, Nay, R, Koch, S, Ward, Andrews, C, & Tucker A, *Literature Review: Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, Commissioned Research Project, National Review of Nursing, 2001, p.1.

- newly admitted resident tended to have marginally higher dependency levels, overall, than did current residents.[3]

7.4 The Australian Nursing Homes and Extended Care Association (ANHECA) NSW also pointed to an increasing acuity of residents. It reported that at December 2001 there were 806 residents classified at category 1, the highest level of need in hostels and nursing homes, which 'was up from 620 some nine months earlier, and there were 23 153 in nursing homes, up from a previous figure of 20 890'.[4]

Aged care nursing staff

7.5 The rise in acuity levels of residents reflects government policy which focuses on allowing aged care residents, with increasingly high levels of need, to remain within the one facility. At the same time, a greater proportion of care for people, who would otherwise be eligible for low-care residential support, is being provided in their homes. The AIHW noted 'available residential care places have thus been targeted to a progressively more dependent group of people'.[5] Witnesses also noted that changes to hospital practices such as early discharge of patients back to residential facilities have added to rising resident acuity.

7.6 Nursing staff may now be caring for acutely ill residents requiring more intensive levels of care such as palliative care and post-operative care. Registered nursing staff may be administering Schedule 8 drugs and providing care for residents with tracheotomies and those in need of subcutaneous infusion or dialysis. In addition, early hospital discharge results in rising acuity of those cared for in the community and extends the length of time of care.[6]

7.7 Against this background of rising acuity levels of residents, evidence pointed to a number of major trends in the workforce employed in the aged care sector: there is an acute shortage of registered nurses; the number of enrolled nurses in the sector has decreased; and the number of unregulated workers has increased. The ANF (SA Branch) noted:

> …in aged care, we have an almost total conflict between the growth in patient requirements for care in that sector and a reduction, if anything, in terms of nurses involved. For example, in South Australia in low care, the number of people in hostels requiring a nursing home level of care has grown from 18 per cent of residents in March 2000 to 24 per cent in March 2001. In nursing homes, the top two categories of care have grown from

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3 AIHW, *Residential Aged Care in Australia 1999-00: A Statistical Overview*, pp 3,5,8 at www.aihw.gov.au/publications/age/racsa99-00/index.html; see also *Submission* 893, p.5 (ANHECA NSW).

4 *Committee Hansard* 22.3.02, p.432 (ANHECA NSW).

5 *Residential Aged Care in Australia 1999-00*, p.5.

6 *Submission* 893, p.6, (ANHECA NSW); *Committee Hansard* 27.3.02, p.715 (ANF); see also *Submission* 897, p.4 (CHA); *Submission* 913, p.2 (Aged & Community Services Australia).

> 65 per cent to 76 per cent of the resident population over that same year. But at the same time, we had actually a small reduction in registered nurses and enrolled nurses in employment in aged care facilities – a complete reversal of the actual trend.[7]

7.8 As with the nurse workforce generally, it is difficult to identify the extent of the shortages in the aged care sector. Employment statistics indicate trends in the aged care nursing workforce. AIHW data indicated that in 1997, a total of 35 294 nurses were employed in geriatric and gerontology nursing, 6 040 fewer than in 1994. Although the total numbers decreased, the proportion who were RNs increased from 54.8% in 1994 to 58.4% in 1997, reflecting a greater decrease in the number of ENs in aged care from 18 671 in 1994 to 14 632 in 1997. The AIHW also noted that the average age of RNs in aged care (43.5 years) is greater than nurses in general.[8]

7.9 Evidence from the QNU also pointed to a decrease in employment of both RNs and ENs in aged care in Queensland between 1997 and 1999. As with the national trend, the decrease was greater for ENs.

	ENs employed in aged care in Queensland	**RNs employed in aged care in Queensland**
1997	1 401 (22.7% of ENs)	3 419 (11.8% of RNs)
1999	1 142 (18.3% of ENs)	3 332 (11.2% of RNs)

Source: Queensland Nurses Council, Workforce Characteristics: Nurses Re-registered in Queensland 1996,1997, 1999.

7.10 Aged and Community Services Australia noted that in Victoria there were as many as 4 500 vacant shifts in residential care homes per fortnight.[9] The Victorian Department of Human Services has undertaken an analysis of the Victorian aged care workforce. The preliminary findings of this study anticipate a shortfall of 7 000 nurses by 2004 in residential and sub acute services.[10]

7.11 Other evidence also provided trends in employment in the aged care sector. The Tasmanian Branch of the HACSU stated that since the mid 1990s there had been a decline of over 26 per cent in the number of nurses employed in the aged care sector in that State.[11] The ANF (Victoria) stated that in Victoria 'for the most part we have an average of one division 1 nurse, a registered nurse, to 45 high-care patients. You would not want to try it. It is quite devastating'.[12] Australian Catholic University

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7 *Committee Hansard*, 27.2.02, p.712 (ANF (SA Branch)).

8 AIHW, *Nursing Labour Force 1999*, pp.14-15, Table 38, p.67.

9 *Submission* 913, p.1 (Aged & Community Services Australia).

10 *Submission* 960, p.9 (Victorian Government).

11 *Committee Hansard* 15.3.02, p.243 (HACSU).

12 *Committee Hansard* 28.2.02, p.213 (ANF Vic Branch).

indicated that it was not unusual for one registered nurse to be responsible for up to 100 residents.[13]

7.12 In some areas the shortage is more acute, for example, the ANF (NT Branch) described the situation in the Northern Territory as being at 'crisis point' with many registered nurses obliged to work considerable amounts of rostered overtime to keep nursing homes operational.[14]

7.13 The prevalence of the substitution of qualified nurses, in particular ENs, with unqualified personnel was of particular concern to many witnesses. Witnesses stated that it is difficult to obtain current data on the number of unqualified workers employed to perform nursing work in the aged care sector. This is due to the use of different nomenclature for unqualified workers performing nursing work, the variety of their work roles and the time lag in data collection and analysis.[15] However, some evidence was provided that indicated the extent of substitution in the aged care sector, for example, the NSW Nurses' Association stated that the ratio of unqualified workers to registered nurses is now 5:1.[16]

7.14 The ANF (SA Branch) also pointed to the increase of unqualified staff delivering aged care packages for people living at home:

> There are over 3,000 full-time equivalent personal care workers and 3,000 full-time equivalent nursing and personal care staff in aged care in the state, so a good 50 per cent of the work force falls into that unlicensed care worker category. Within community aged care packages, that proportion is significantly higher. So almost all the care packages are being delivered by unqualified or unlicensed personnel, mostly with completely inadequate supervision of their care by registered nurses, to the point where a number of the aged care providers in this state just will not get into the business of aged care packages, because they are not satisfied that they are actually able to give the quality of care program that would be required if they go into it with the current level of funding and with the current arrangements.[17]

7.15 The shortages of nursing staff in the aged care sector adversely affects the care provided to residents. The QNU stated that the nursing skill mix and staffing levels in many hostels are failing to match the acuity levels of residents.[18] With continued shortfalls in staffing requirements, precious resources are spent in constantly trying to recruit staff and orientate new staff. Organisations may have to engage expensive agency nurses to fill gaps. As a result, ageing residents have to cope with a constantly changing workforce and may be unable to develop relationships with

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13 *Committee Hansard* 28.2.02, p.149 (Australian Catholic University).

14 *Submission* 919, p.2 (ANF (NT Branch)).

15 *Submission* 457, p.9 (QNU); *Submission* 899, p.6 (NSW Nurses' Association).

16 *Submission* 899, p.6 (NSW Nurses' Association).

17 *Committee Hansard*, 27.3.02, p.733 (ANF (SA Branch)).

18 *Submission* 457, p.12 (QNU); see also *Committee Hansard* 22.3.02, p.432, (ANHECA NSW).

staff. This affects both resident care and resident satisfaction and quality of life.[19] The use of agency staff is also expensive. The ANF concluded that the growing nursing shortage has the potential to compromise government policy on nursing home accreditation and its legislative commitments to quality of care for residents.[20]

7.16 Evidence was received that recruitment and retention of nursing staff in the aged care sector reflected similar difficulties as nursing generally with a number of aged care specific problems which are related to:

- remuneration;
- increased workloads due to increases in dependency of clients in care;
- increased workloads related to increasing client numbers and demand in acute and community-based services;
- increased workloads related to documentation and external validation required by the Commonwealth Government relating to the Resident Classification Scale;
- increased use of unqualified workers;
- lack of career prospects;
- poor image of nursing in aged care;
- lack of re-entry programs in aged care; and
- the size of the residential care units.[21]

Implications of RCS funding

7.17 Submissions argued that funding for aged care needs to be sufficient to ensure that the appropriate number of qualified staff are employed in the aged care sector.[22] The Committee received many comments critical of present funding mechanisms through the Resident Classification Scale (RCS). It was argued that the RCS funding tool does not acknowledge the increased level of care required by residents who are chronically ill including those who have been discharged early from hospital with complex needs. The ANF stated that 'as a result, we cannot employ more qualified people because the money is not there'.[23]

7.18 Queensland Health stated that the Commonwealth funds aged care for outcomes and does not stipulate inputs. It is for individual facilities to determine the inputs that the facility requires to achieve the desired outcomes for it to reach the

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19 *Submission* 195, p.1 (Our Lady of Consolation Aged Care Services Ltd).

20 ANF, 2002-2003 Federal Government Pre-Budget Submission, February 2002, p.8.

21 *Submission* 899, p.6 (NSW Nurses' Association); *Submission* 942, p.9 (Queensland Health); *Submission* 452, p.1 (Lutheran Community Care); *Submission* 775, p.2 (Aged & Community Services, Tas); *Committee Hansard* 27.2.02, p.85 (WA Department of Health).

22 See for example, *Submission* 899, p.8 (NSW Nurses' Association); *Submission* 927, p.10 (RCN).

23 *Committee Hansard*, 27.3.02, p.715 (ANF).

standards set out in the Aged Care Act. Queensland Health noted that this 'has the potential for facilities to reduce RNs and/or employ more unregulated workers'.[24]

7.19 The NSW Nurses' Association argued that the funding model created a further problem: the RCS creates a financial disincentive for admitting residents with low care needs. This raises the aggregated acuity level of aged care residents 'to the point where they are more realistically regarded as patients because they are more ill or frail than they are well and require far more than hygiene, nutritional assistance and custodial supervision'.[25]

7.20 The level of documentation required by accreditation and the RCS model also drew considerable criticism. Witnesses frequently commented on the time required to complete documentation, with one suggesting that it was not uncommon for registered nurses to work for two hours per shift on documentation.[26] Nurses argued that this prevented staff from actual delivery of care which is their primary role.

7.21 The ANF stated that there was a large amount of repetitive documentation being required to validate a RCS claim. Further, that the RCS has been in use for some time and that the number of questions could be reduced: 'it is a funding tool and it has 20 questions. Statistically it should be possible to reduce the number of questions so that the RCS becomes a funding tool and does not become a pseudo care plan.'[27] The ANF also noted that the Department of Health and Aged Care had considered the level of documentation but indicated:

> They said, 'Yes, it is possible', but they were reluctant at that time to reduce the number of questions for two reasons: one was that they did not want to introduce more change into the system and, secondly, they thought they were collecting a lot of valuable data that they might want to use at some stage. I do not think those reasons are good enough now…
>
> You have a care plan. At the moment, because you are doing so much documentation for the RCS, it is almost being used as a pseudo care plan which it was never meant to be and it is not designed to be. It does not pick up all aspects of care. So it is your care plan which is your legal tool. The RCS is a funding tool and should be limited to that.[28]

7.22 Aged and Community Care Services Tasmania indicated that a survey of 25 per cent of aged care providers 'found that there was probably an extra $4 million of time spent completing just the RCS requirements in excess of normal documentation

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24 *Submission* 942, p.9 (Queensland Health).

25 *Submission* 899, p.5 (NSW Nurses' Association).

26 *Committee Hansard* 15.3.02, p.243 (HACSU).

27 *Committee Hansard* 27.3.02, p.719 (ANF); see also *Committee Hansard* 27.2.02, p.63 (Peak Nursing Council WA).

28 *Committee Hansard* 27.3.02, p.720 (ANF).

requirements. This time could have been better spent perhaps in providing direct resident care.'[29]

Remuneration in aged care sector

7.23 Disparity between rates of pay for aged care nurses and acute care nurses was raised frequently in evidence and was seen as a major reason for staff attrition in the aged care sector. Wage disparities also exist between the public and private sector and are causing nurses to leave private aged care facilities. The ANF noted that the disparity in some states is as high as a twenty per cent. This translates to a difference of between $65.00 and $155.00 per week between aged care and public sector wage rates.[30]

7.24 The difference in pay rates varies across the States and Territories. For example, in Tasmania aged care nurses are paid 15 per cent less than those in acute care.[31] In Western Australia, aged care nurses are about 28 per cent behind acute sector nurses.[32] In Victoria, the difference between the public and private sector for registered nurses division 2 (Enrolled Nurses) is now $4.74 per hour.[33]

7.25 The Victorian Council of Peak Nursing Organisations indicated that nurses in aged care in Victoria 'work under a separate award, an aged care award, which is negotiated on the basis of what those facilities are funded by the Commonwealth government.'[34] Some organisations paid above the award to keep staff, but others, particularly the for-profit sector did not.[35]

7.26 The need to provide wage parity was viewed as one of the most significant mechanisms to improve recruitment and retention in the aged care sector. The Nurses Board of Victoria stated that until the anomalies in wages are addressed 'other strategies will be less effective in drawing nurses to the area'.[36] The ANF proposed that the gap in wages between nurses working in the aged care sector and nurses working in the public sector be closed and mechanisms be developed to fund ongoing wage parity.[37]

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29 *Committee Hansard* 15.3.02, p.298 (Aged and Community Services Tasmania).

30 *Submission* 962, p.53 (ANF).

31 *Submission* 775, p.2 (Aged and Community Services Tasmania).

32 *Committee Hansard* 27.2.02, p.110 (Aegis Health Care Group).

33 *Submission* 941, p.1 (Nurses in Aged Care, North East Victoria).

34 *Committee Hansard* 28.2.02, p.212 (Victorian Council of Peak Nursing Organisations).

35 *Committee Hansard* 28.2.02, p.213 (ANF (Vic Branch)).

36 *Submission* 765, p.4 (Nurses Board of Victoria).

37 ANF, 2002-2003 Federal Government Pre-Budget Submission, February 2002, p.8.

Use of unregulated workers in aged care

7.27 The increased use of unqualified and unregulated workers in aged care was criticised in evidence. The ANF stated that in its view 'employers are substituting nursing positions with unlicensed workers citing current shortages as their rationale and yet they are doing little to reverse the exit of educated and experienced nurses from the aged care sector'.[38]

7.28 The impact of the use of unqualified workers on the skilled workforce was highlighted. With larger numbers of unqualified workers, there is a need to exert stringent supervision and control over employee activities through routines and procedures if the legal duty of care of the organisation is to be met. The NSW Nurses' Association stated that in such circumstances, routine can undermine the attractiveness of this type of nursing. RNs may also have to provide training to unqualified workers before work can be delegated.[39] This increases the workload of RNs and adds to the level of stress in the workplace. As UnitingCare stated:

> This is a self-perpetuating, downward spiral: non-registered staff are employed because registered staff are not available, increasing the pressures on the registered staff, which adds to the sector's general inability to recruit and retain nurses in aged care.[40]

7.29 Enrolled nurses also expressed concern about the use of unqualified workers, stating that they were made to feel a 'lesser being' as they were precluded from undertaking some duties by their enrolment provisions which unqualified workers are asked to do. The National Enrolled Nurses Association stated that they have become the 'lesser option when it comes to employment'.[41]

Specialist education

7.30 In order to recruit and retain nurses in aged care, specialised education was seen as essential. The Queensland Nursing Council indicated that only 2 per cent of Australian nursing students were attracted to aged care although it currently accounts for 28.5 per cent of nurse employment.[42] Witnesses argued that there is poor identification and valuing of aged care nursing in the undergraduate courses.[43] This reinforces the low status of aged care as a potential area of specialty and is exacerbated by the lack of clinical placements.

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38 *Submission* 962, p.54 (ANF).

39 *Submission* 899, p.5 (NSW Nurses' Association).

40 *Submission* 871, p.4 (UnitingCare).

41 *Committee Hansard* 28.2.02, p.227 (NENA).

42 *Submission* 887, p.21 (QNC).

43 See for example, *Submission* 838, p.3 (Nursing Board of Tasmania); *Submission* 942, p.10 (Queensland Health).

7.31 The ANF noted that aged care is a specialist area of nursing with its own discrete body of knowledge which is constantly growing. However, there is a lack of postgraduate courses, for example, it was stated that the University of Tasmania has not offered postgraduate gerontology studies for some time.[44] The ANF also pointed to a shortage of gerontic specific education courses at Graduate Certificate level in external and distance modes offered at a reasonable cost. The need for a review of educational and professional development needs was seen as particularly important because of the changing context of aged care health delivery and the need to ensure that quality care for older people using aged care services is maintained. ANHECA also noted that education and development opportunities are an enormous incentive for nurses to stay in the profession.[45]

7.32 Poor access to refresher/re-entry programs was also seen as a disincentive for nursing staff to move into the aged care sector. The Victorian Government has addressed this by offering refresher, re-entry and supervised practice programs for nurses through public sector facilities with a residential aged care focus. However, it was noted that there are limitations for the non-public residential aged care sector (ie. private and not-for-profit providers) to provide such programs due to their inability to offer all the components of the accredited course and a lack of approved clinical supervisors in the sector.[46] Queensland Health suggested that to overcome problems in this area, the Commonwealth fund re-entry and refresher programs in aged care.[47]

7.33 Other staffing issues raised included a lack of positive promotion of aged care nursing and a prevailing view that it is a low status occupation with unchallenging, unrewarding work and a place where nurses lose their clinical skills. It was argued that this is a major contributor to the difficulties experienced in recruiting and retaining nursing staff. Witnesses stated that the nursing profession was poorly articulating the value of aged care nursing. As a result, specialist aged care nursing is not being widely recognised and valued inside and outside the profession. Frontier Services noted that the Commonwealth had provided 'funding only for policing in aged care, reinforcing the notion that the industry is unprofessional and needs to be carefully monitored'.[48]

7.34 A further issue raised was the high rates of occupational injury, particularly in relation to manual handling injuries. Nursing homes still experience higher worker's compensation claims rates than hospitals, including psychiatric hospitals. The rate for nursing homes is 72 per cent higher than the all-industries average. Nursing homes average workers' compensation cost per occurrence is $8 330 per claim, which is

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44 *Submission* 775, p.1 (Aged and Community Services Tasmania).

45 *Committee Hansard* 22.3.02, p.442 (ANHECA NSW).

46 *Submission* 960, p.17 (Victorian Government); see also *Submission* 775 p.2 (Aged and Community Services Tasmania).

47 *Submission* 942, p.10 (Queensland Health).

48 *Submission* 826, p.1 (Frontier Services).

13 per cent higher than for hospitals and 37 per cent higher than for psychiatric hospitals. Claims are predominantly related to manual handling.[49]

Administration of medication

7.35 The issue of administration of medication, particularly by enrolled nurses, in aged care was raised in evidence. Many residents of nursing homes have complex needs with complex pharmacology requirements. The Working Group on Aged Care Worker Qualifications has undertaken a review of the current role of enrolled nurses in the aged care sector. As part of that review, the Working Group examined options for the administration of medications in aged care. It reported broad support for an enhanced scope of practice for enrolled nurses up to and including S4 medication administration provided there is appropriate education and supervision in a nationally consistent framework.[50] Stakeholders will consider the findings of the review later in the year.

7.36 ANHECA supported an expanded role for enrolled nurses, believing that they are under-utilised in the aged care sector largely because of limitations placed on their practice by current legislation. ANHECA supported post enrolment education and training for enrolled nurses to increase their scope of practice to administering up to and including Schedule 4 medications, under the indirect supervision of a registered nurse.[51] Catholic Care of the Aged voiced concern, stating that such a move may lead to the number of registered nurses working in nursing homes being further reduced and that there may not be enough enrolled nurses to take on this role.[52]

Commonwealth Government programs

7.37 The Department of Health and Aged Care stated that the Commonwealth 'is assisting and providing leadership to support the industry in a number of ways, and has committed resources for initiatives to help promote the aged care nursing workforce and lift its profile and professionalism, to assist with the retention of the existing workforce and to attract new entrants to that workforce'. The Commonwealth has introduced initiatives such as Awards for Excellence in staff development which the Department stated would enhance the professional profile and image of aged care as a discipline.

7.38 The Department commissioned a report on recruitment and retention of nurses in residential aged care on behalf of the Aged Care Workforce Committee.[53] The

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49 *Submission* 962, p.54 (ANF).

50 Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, *A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions*, 2001, p.40.

51 *Submission* 893, p.7 (ANHECA NSW).

52 *Submission* 380, p.3 (Catholic Care for the Aged).

53 DHA, *Recruitment and Retention of Nurses in Residential Aged Care, Final Report*, 2002.

report investigated reasons for nursing attrition in aged care; factors to encourage nurses to return to aged care; strategies the aged care sector might implement to attract nurses; and the influence appropriate re-entry courses might have on the sector's ability to attract nurses to the profession. Twenty recommendations were made in the report covering re-entry programs, wage parity, postgraduate programs, skills mix, national education and training, and improving the image of aged care nursing.

7.39 The Department noted that aged care workforce issues are monitored and considered by the Aged Care Workforce Committee, a high level advisory committee made up of representatives of the aged care industry, academia, nursing organisations and carer and consumer groups, and a representative of State and Territory Governments. This Committee is considering the link between quality care and an appropriate skilled workforce, including nursing staff.

7.40 Under the Minister for Aged Care's National Compliance and Accreditation Forum, two working groups are addressing workforce issues. One is looking at a *Code of Ethics and Guide to Ethical Conduct for Commonwealth Residential Aged Care.* This will be a voluntary and self-regulated code within the industry. The second group is the Aged Care Worker Qualifications Working Group which, as noted above, has reviewed the role of enrolled nurses in aged care.

7.41 In the 2002-03 Budget, the Commonwealth provided an additional $26.3 million over four years to fund up to 250 aged care scholarships, valued at up to $10 000 per year, for students in undergraduate, postgraduate or re-entry nursing studies at rural and regional university campuses. Universities will be responsible for marketing the scholarships and will be expected to make additional nursing places available. Funding of $21.2 million over four years is to be provided so that personal care staff in smaller, less viable aged care homes can undertake a range of accredited courses related to geriatric care. Upgrading the skills of personal care workers will enable facilities to free registered nurses to concentrate on clinical work rather than general personal care.[54]

7.42 The Budget also provided for increased subsidies for residential aged care of $211.1 million. The additional funding will allow providers of aged care to attract and retain more aged care nurses by offering them pay rates closer to those of nurses in the public hospital sector.[55]

Conclusion

7.43 In its submission, the Department of Health and Aged Care stated that in the aged care sector 'a strong, well-trained and qualified nursing workforce is essential for the delivery of quality aged care whether in residential or community settings'.[56] The

54 DHA, Budget 2002-2003, *Fact Sheet 5 Aged care taskforce*; Portfolio Budget Statements 2002-03, pp.105, 108.

55 DHA, Portfolio Budget Statements 2002-03, p.109.

56 *Submission* 944, p.3 (DHAC).

Committee agrees with the Department's view, however, evidence indicates that delivery of quality aged care is under threat. The Committee considers that the threat comes from the retreat of qualified nurses, both RNs and ENs, from aged care and the increased employment of unqualified staff. This results in staff with skills mix which is at best variable and in some instances not up to standard. The qualified nurses remaining in the aged care workforce are left to care for sicker clients and to supervise increased numbers of unqualified workers. Clients and their families also have expectations that there will be expanded use of new technology and greater levels of intervention. At the same time workloads have increased due to the massive amount of repetitive documentation required by government.

7.44 The Committee considers that the shortage of qualified staff has now reached a crisis point. The Committee's recommendations, together with those of the Final Report on Recruitment and Retention of Nurses in Residential Aged Care, provide strategies for resolving the crisis in the aged care sector. However, there will be no resolution without national leadership, without the involvement of all stakeholders including employers and without implementation of solutions already identified. There needs to be a concerted and sustained effort to act and ensure that all those in the aged care sector receive the quality of care that the Australian community expects to be available and that aged care nurses receive working conditions, remuneration and recognition commensurate with their training and professionalism.

Recommendation 68: That the Commonwealth review the level of documentation required under the RCS tool to relieve the paperwork burden on aged care nurses.

Recommendation 69: That the outcomes of reviews and research be used to establish appropriate benchmarks for resources and skills mix in aged care nursing so as to support improved care for residents, workforce management, organisational outcomes and best practice and that Commonwealth funding guidelines be reviewed in light of this research.

Recommendation 70: That universities review the content and quality of clinical placements and experiences of students in aged care in their undergraduate courses and that clinical placements include a range of aged care settings.

Recommendation 71: That universities review and develop postgraduate programs and courses, including the provision of courses by distance education, appropriate for the aged care sector.

Recommendation 72: That the Commonwealth fund the expansion of re-entry/refresher programs specifically targeted at aged care nurses.

Recommendation 73: That the Commonwealth provide additional funding to implement wage parity between aged care and acute care nurses in each State and Territory.

Recommendation 74: That strategies be implemented to improve the image of aged care nursing.

Recommendation 75: That the Commonwealth take measures to reduce occupational injuries to nurses working in aged care, including the introduction of 'no lift' programs across the aged care sector in conjunction with the provision of up to date safe lifting devices that are readily available for staff use and are regularly maintained.

CHAPTER 8

NEEDS IN SPECIALIST NURSING

8.1 In recent years there has been an expansion in the demand for specialist services, for example, intensive care units and mental health services. An important component of specialist service delivery is the availability of appropriately qualified nursing staff. Indeed, many areas of specialist medicine could not be maintained without specialist nurses. However, evidence indicated that there are nursing shortages in many specialist areas. This chapter provides an overview of the needs of some of these specialist areas including mental health nursing, rural and regional nursing, Indigenous nursing, midwifery, and community, neonatal, paediatric, critical care, operating theatre, emergency and oncology nursing.

Mental Health

> The future crisis that everyone speaks of is here now. Mental Health Nursing is in the grips of a national human resource crisis. Short term solutions need to be created along with more considered approaches that are medium and long term.[1]

8.2 In the last decade there have been significant changes to the delivery of mental health care and to the education of the mental health workforce. The national mental health reform process resulted in the deinstitutionalisation and mainstreaming of mental health services into general health services. Mental health management is focused on care in the community with support from acute care and short stay units in general hospitals:

> There has been a move away from the institutional care, particularly in the up to 70s age group, with a devolution of institutions into an explosion of community based services, to the point now where the acuity of patients now being managed in the community is far higher than it has ever been at any time in the past.[2]

8.3 Changes to mental health education have resulted in a move from direct entry psychiatric nursing courses to programs within undergraduate courses, combined with post registration specialist mental health courses from Graduate Certificate to Masters level.

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1 *Submission* 777, p.3 (ACT Mental Health Service).

2 *Committee Hansard* 27.2.02, p.67 (ANZCMHN (WA Branch)).

8.4 The shortage of mental health nurses is being felt in all States and Territories.[3] Submissions noted that this shortage is occurring at a time when there is increasing demand for mental health services by a larger proportion of the population.[4]

8.5 In 1997, there were 2 181 enrolled nurses employed in mental health areas and 10 113 registered nurses. 33.9 per cent of mental health nurses are males and 66.1 per cent female. In 1997, more than 55.7 per cent of mental health nurses were aged 40 years or older, an increase from 46.6 per cent in 1994. Only 12.7 per cent of mental health nurses are less than 30 years of age.[5] As a result many mental health nurses are approaching retirement. For example, in the ACT an estimated quarter of mental health nurses will retire by the year 2006 and half by the year 2011. However, there have been less than 400 mental health nurse graduates in the past three years across Australia to replace those retiring.[6]

8.6 Submissions pointed to the move to generic undergraduate nursing programs as a major reason for the decline in new entrants to mental health nursing. It was argued that student nurses in general undergraduate courses have inadequate exposure to mental health nursing during their studies and therefore do not consider a career in mental health nursing. The Health and Community Services Union (HACSU) (Victorian Branch) reported that the mental health content in Victorian undergraduate degrees varies from zero to 17.4 per cent.[7] The Australian and New Zealand College of Mental Health Nurses (ANZCMHN) (Victorian Branch) added that 'the quality and quantity of specialist content has been eroded to such an extent that clinical agencies sometimes question the relevance of nursing education to clinical practice'.[8] The Centre for Psychiatric Nursing Research and Practice (CPNRP) stated that the Victorian Department of Human Services had attempted to increase the mental health content of undergraduate nursing courses. It had convened a working party which reported in 1998. However, it 'failed to have any significant impact'.[9]

8.7 Although there is little emphasis on mental health nursing in undergraduate courses, witnesses pointed to the importance of these skills in the general nursing environment. The ANF stated 'most clinical nurses identify mental health education as a requirement for practice, as patients/clients with a mental illness are increasingly accessing other services such as acute care (particularly in emergency departments),

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3 A comprehensive review of workforce shortages in each State and Territory is provided in the *Scoping study of the Australian mental health nursing workforce 1999, Final report*, Canberra, 2001, pp.19-27.

4 See for example, *Submission* 960, p.17 (Victorian Government); *Committee Hansard* 27.2.02, p.70 (ANZCMHN WA Branch).

5 AIHW, *Nursing Labour Force 1999,* Table 61, p.94.

6 *Submission* 741, p.2 (ANZCMHN (Vic Branch)).

7 *Submission* 967, p.3 (HACSU (Vic No 2 Branch)).

8 *Submission* 741, p.3 (ANZCMHN); see also *Committee Hansard* 28.2.02, p.164 (Austin & Repatriation Medical Centre).

9 *Submission* 766, p.2 (CPNRP); see also Scoping Study, p.3.

community health and aged care'.[10] CPNRP also argued that generic mental health skills should be essential for nurses irrespective of the area in which they chose to practice.[11] The Department of Health and Aged Care (DHAC) similarly stated 'the expansive role of the primary care sector is an issue for the general nursing workforce and adequate mental health training needs to be included in the general nursing training at the undergraduate level'.[12]

8.8 Witnesses also voiced concern about the quality of clinical placements for students. Some health service providers are reluctant to host mental health placements for nursing students and prefer placements for allied health students such as psychologists and occupational therapists.[13]

8.9 Many nursing students have a negative view of the mental health sector, particularly concerning violence and danger and the stigma related to mental illness. The ANZCMHN also noted that the image of mental health nursing is not improved when graduates 'come into a culture in which there is a large degree of burnout…they will see insensitivity and indifference' and choose not to work in mental health.[14]

8.10 A lack of postgraduate education programs was also identified, for example, in Western Australia the last postgraduate program for community mental health nurses was offered several years ago and has not been continued. In addition, the majority of mental health nurses do not have university qualifications and so access to university, post basic education or graduate education in not easily available.[15] As with many other specialist nursing areas, the cost of postgraduate education is seen to be prohibitive for some of those wishing to specialise.

8.11 Submissions identified the main areas impacting on retention of mental health nurses. Working conditions are often poor, with heavy workloads and lack of resources which adds to the stress of nursing staff. There is a lack of pay parity with other health professions. There is a high level of workcover claims in the mental health sector. There is a lack of career pathways which has resulted in low morale, lack of job satisfaction, and poor status. Mental health nurses, as with other specialist nursing groups, lack professional development opportunities and employer educational assistance schemes. All of these issues undermine the attractiveness of mental health nursing for new graduates and encourage professional stagnation of those already practicing.

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10 *Submission* 962, p.34 (ANF).

11 *Submission* 766, p.3 (CPNRP).

12 *Submission* 944, p.4 (DHAC).

13 ANZCMHN, *Scoping study of the Australian mental health nursing workforce 1999, Final report*, National Mental Health Strategy, Canberra, 2001, p.3.

14 *Committee Hansard* 27.2.02, pp.42, 68 (ANZCMHN).

15 *Committee Hansard* 27.2.02, p.37 (ANZCMHN).

8.12 The shortage of mental health nurses is impacting adversely on patient care as well as the nurse workforce. Lack of staff has been reported as contributing to increased violence in the workplace.

8.13 The present crisis in staffing in the mental health sector has not had a sudden onset. Workforce matters were covered in the evaluation of the *National Mental Health Strategy, Final Report*, 1997 and again in 1999 in *Learning Together: Education and Training Partnerships in Mental Health - Final Report*. The latter report proposed guidelines and information for universities, professional associations and employers to implement so as to update mental health education and training. The report also recommended that it be considered as a source document informing the development of a national education and training framework under the Second Mental Health Plan; and proposed a number of detailed actions for a national education and training network.[16]

8.14 In 2000, the National Mental Health Education and Training Advisory Group was established to follow up on the education and training of the mental health workforce.[17] The Advisory Group has developed National Practice Standards for the Mental Health Workforce in consultation with five mental health disciplines of nursing, social work, occupational therapy, psychology and psychiatry. The Standards offer a strategic national framework for the education and training of the future mental health workforce. Draft Standards were circulated in late 2001.

8.15 In May 2001, a scoping study prepared by ANZCMHN, was published. The study had been initiated in 1998 by the Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group following concerns over the decline in numbers of suitably qualified and experienced mental health nurses. It focused on the problems of recruiting and retaining mental health nurses and the current challenges facing mental health education. The findings of the study included that the take-up rate of postgraduate places in mental health nursing courses is inadequate to meet the future needs of specialist mental health services; postgraduate education in mental health nursing is in need of rationalisation and reform; there is inadequate planning and development of the mental health nursing workforce to meet needs of mental health services; and mental health nurses are increasingly working under stress which is impacting adversely on recruitment and retention. The Scoping Study identified six areas for immediate action including the promotion and development of the mental health nursing workforce; and the urgent reform of undergraduate and postgraduate education in mental health nursing.[18]

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16 Deakin Human Services Australia, *Learning Together: Education and Training Partnerships in Mental Health Service, Final Report*, February 1999. Prepared by Deakin Human Services Australia with funding from the Commonwealth Department of Health and Aged Care under the National Mental Health Strategy.

17 *Submission* 944, p.4 (DHAC).

18 ANZCMHN, *Scoping study of the Australian mental health nursing workforce 1999, Final report*, National Mental Health Strategy, Canberra, 2001, pp.3-4.

8.16 The November 2001 mid-term review of the Second National Mental Health Strategy also raised concerns about the mental health workforce. It stated that 'the overall *nursing complement* is too limited to fill even current posts. The future is even more daunting as nursing is an ageing work force without sufficient new recruits', and further, 'the situation is serious with a high risk of insufficient numbers of trained nurses being available in the foreseeable future to sustain a viable mental health service'.[19] Ways forward for the mental health workforce were outlined in the review and those relating to nurses included:

- addressing the immediate and serious workforce issues at both Commonwealth and State and Territory levels including the extent of current and likely shortages of mental health professionals especially nurses; introducing measures to retain current staff; and making mental health career choices increasingly attractive in the future; and
- addressing educational needs and the content of training for mental health professionals, and standardising all new training models for mental health professionals with a set standard for core competencies for the mental health disciplines.[20]

Conclusion

8.17 The Committee notes the conclusions of the Mental Health Nursing Scoping Study: that mental health services are changing and becoming more complex; that the demands made on mental health nurses by clients in acute in-patient facilities are becoming increasingly challenging; and that experienced mental health nurses are required in community mental health services. At the same time, the Scoping Study found that there were major concerns about the future viability of the mental health nursing workforce.

8.18 The reports already completed into the needs of mental health nursing and the evidence received by the Committee provide ample indication of the underlying workforce problems facing the sector. These are not projections of potential problems, but problems which mental health services across the country are dealing with today.

8.19 The situation requires urgent action: action to ensure that those already working in the sector are supported and provided with opportunities for further education, career pathways and recognition of their contribution to the health sector generally; action to ensure that adequate take-up rates of postgraduate places in mental health nursing courses occurs; and action to rationalise and reform postgraduate education for mental health nurses. The Committee notes that the Scoping Study identified areas for immediate action. The Committee considers that work should be undertaken in these areas to improve recruitment and retention of mental health nurses so as to ensure the viability of mental health services in the future.

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19 Betts, V & G Thornicroft, *International Mid-Term Review of the Second National Mental Health Plan for Australia*, National Mental Health Strategy, November 2001, p.11.

20 Betts & Thornicoft, pp. 5-6.

8.20 The Committee received many suggestions for improving the educational opportunities for those wishing to enter mental health nursing and to retain those already in the sector and makes the following recommendations:

Recommendation 76: That the Commonwealth fund scholarships for psychiatric/mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course.

Recommendation 77: That a targeted campaign be undertaken to improve the status and image of psychiatric/mental health nursing.

Recommendation 78: That funding be provided for the development of advanced practice courses in mental health nursing.

Rural and remote nursing

> It is very serious and it is most serious in rural and remote areas. Nurses, as you well know, in some more remote areas are the highest trained and, perhaps with the exception of Aboriginal health workers, the only trained health professionals in more remote areas. So if we are short of them, we are short of the only people who can provide hands…health services.[21]

8.21 Nursing services constitute the largest group in the rural and remote health workforce and in most areas are the first line contact in healthcare services. Nurses provide a wide range of services, which in many smaller towns and communities, are only supported by on-call or part-time medical officers and allied health staff. In the more remote centres, nurses often are the sole primary healthcare provider and are frequently called upon to provide other health services due to community demand and lack of any other form of health personnel support.

8.22 Services are experiencing recruitment difficulties and shortages of appropriately skilled registered nurses and specialist nursing staff. There are particular difficulties in aged care services and midwifery. The Royal Flying Doctor Service indicated that it was experiencing difficulties recruiting midwives and nurses with other post basic/graduate nursing qualifications. This situation is becoming so critical that the RFDS Queensland Section has established a position where the nurse only undertakes the emergency component of her duties while completing an external course in early childhood.[22] In many small rural hospitals the Director of Nursing may be the only qualified midwife and is on call 24 hours a day to provide midwifery services. In 1999, around 30 per cent of nurses employed in small rural centres and other rural and remote areas (except for large centres) were enrolled nurses. In cities only 17.1 per cent are enrolled nurses.

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21 *Committee Hansard* 21.3.02, p.423 (NRHA).

22 *Submission* 455, p.3 (RFDS).

8.23 As with the general nursing workforce, the rural and remote workforce is ageing with an average age of 38 years and with 35 per cent of remote and rural nurses aged over 45 years. The turnover of nurses in rural and remote areas is high – the National Rural Health Alliance (NRHA) stated that in some areas it was 450 per cent.[23] The Rural Health Stocktake found that nurses in the small towns were either young and generally transient; or older, and mostly trained in the era before university training was available. The Stocktake stated that 'the consequence of the transfer of training of nursing to university is the transfer of training away from the local hospital, and hence from the rural environment. Therefore, there is an imminent nursing workforce problem which some predict will dwarf the lack of doctors in the bush'.[24]

8.24 The healthcare needs of rural and remote Australia have come under scrutiny in a number of reviews, inquiries and research projects. The Commonwealth has responded to the healthcare needs of rural and remote communities through mainstream programs[25] and through a number of targeted programs, including those aimed at the nursing workforce.

8.25 The Federal Budget 2001-02 provided $104.3 million over four years for general practices to employ more nurses in areas where patient access to medical services is limited, including rural and remote areas, and was aimed at providing general practices with nursing staff to assist in the management of chronic diseases, conduct health assessments and provide clinical support. Under this measure, $5.2 million over four years was allocated for re-entry training programs for rural nurses including approximately 400 scholarships each year, worth up to $3 000 each. The scholarships will benefit former rural nurses by removing some of the financial barriers to re-entry into the workforce. The scholarships are available to rural nurses who wish to update their skills or re-enter the workforce in non-acute settings such as aged care, general practice or community health centres. The Royal College of Nursing administers the program.[26]

8.26 The Department of Health and Ageing reported that soon after the Government announced this program, several State Governments announced very generous upskilling programs which affected the number of people who applied for the program. In light of the lower than expected uptake, it was decided to increase the scholarships from $3 000 to $6 000, aiming for half the number of participants but optimising the use of funds.[27]

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23 NRHA, *Action on Nursing in Rural and Remote Areas: Draft Issues Paper*, p.6.

24 Best, J, *Rural Health Stocktake Advisory Paper to the Commonwealth Department of Health and Aged Care*, March 2000, p.93.

25 Such as the Australian Health Care Agreements, Medicare Benefits Scheme, Pharmaceutical Benefits Scheme, Aged and Community Care, Private Health Insurance Incentives, Public Health Outcome Funding Agreements and other Specific Purpose Payments.

26 DHA, *Budget 2001-02, Health Fact Sheet 3*.

27 Senate Community Affairs Legislation Committee, *Committee Hansard* 5.6.02, p.202 (DHA).

8.27 The 2001-02 Budget also provided $13 million over four years to improve access to undergraduate nursing education for rural and regional nursing students. 100 scholarships were provided for rural students and ten scholarships were provided for Aboriginal and Torres Strait Islander nursing students or health workers who want to upgrade their qualifications at a cost of $10.9 million. Provision was made for 30 additional scholarships in December 2001.[28] Funding of $2.1 million was provided for support measures associated with the scholarships with a particular emphasis placed on Indigenous nursing students. Funding was also provided for culturally appropriate training for rural nurses to assist them in providing care for Indigenous Australians.

8.28 The Commonwealth also funds nursing scholarships for relevant postgraduate courses, short courses and programs and for attendance at conferences to improve the knowledge base and skills of rural and remote nurses and further their professional development.

8.29 The National Rural and Remote Midwifery Upskilling Program provides funding to the States and Territories for upskilling of midwives in rural and remote areas. The program is expected to provide for at least 1 575 midwives over the four years from 1999-2000 to 2003-2004 and is based on a payment of $3 000 per midwife to enable them to undertake a two-week upskilling or refresher course. The Department indicated that at June 2002, a total of 1 999 midwives had participated in the program.[29]

8.30 In the 2002-03 Budget, the Commonwealth provided an additional $26.3 million over four years to fund up to 250 scholarships for aged care nursing, valued at up to $10 000 per year, for students from regional areas to undertake undergraduate, postgraduate or re-entry nursing studies at rural and regional university campuses.

8.31 The Commonwealth also provides funding for University Departments of Rural Health. These Departments are designed to provide educational opportunities and professional support for rural health professionals and students, including nurses. In the future, all Departments will provide further education, training and upskilling courses for rural nurses and health care professionals. Some of these Departments are, or will be, providing placements and, or, components of courses for undergraduate nurses.[30]

8.32 In addition, State and Territory initiatives include Nurse Practitioners in NSW, South Australia and Victoria. Other initiatives include Isolated Practice endorsement in Queensland; Rural Health Policy Cadetships in Western Australia; and rural nursing scholarships available through some State Governments, universities and

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28 Minister for Health and Ageing, *Media Release*, 13.12.01.

29 Senate Community Affairs Legislation Committee, *Committee Hansard* 5.6.02, p.201 (DHA).

30 *Submission* 944, p.6 (DHAC).

nursing organisations.[31] For example, NSW provides scholarships to first year undergraduate nursing students with a rural background, rural placement grants and postgraduate scholarships.[32]

8.33 While these positive initiatives were welcomed, it was noted that:

- there has been a large number of nursing inquiries in which specific recommendations have been made about rural and remote nursing which have not been implemented;
- there has been a piecemeal approach to dealing with health issues in rural and remote areas without an overall 'blueprint' for rural and regional development;
- there is a tendency for the Commonwealth to fund initiatives for rural and remote nurses (and allied health practitioners) mainly through General Practice;
- there is a lack of an integrated, cohesive strategy for dealing with nursing (and allied health) workforce issues affecting remote and rural Australia;
- there is little prospect of attracting substantial numbers of practising nurses away from urban areas while there remain significant shortages of nurses overall; and
- the number of undergraduate nursing scholarships being funded by the Commonwealth represents a much smaller proportion of rural nursing students than the scholarships available to rural medical undergraduates relative to their overall numbers.[33]

8.34 NRHA provided the Committee with an overview of a range of inquiries and research projects which made recommendations in relation to rural and remote nursing. While these recommendations covered many key issues facing rural and remote nurses including education opportunities, the role of distance education, advanced nursing practice, and retention issues, NRHA stated that 'little has changed'. NRHA suggested that there were 'substantial barriers yet to be addressed hindering progress on nursing workforce issues in rural and remote Australia'. These barriers include:

- the lack of national leadership;
- the lack of clarity about which level of government is responsible for specific aspects of nursing workforce issues;
- the relatively low status and high numbers of nurses (and thus perceived overall costs of policy actions) compared with doctors where much greater efforts have gone in educating, attracting and retaining them in rural areas;
- resourcing issues;

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31 *Submission* 800, p.5 (NRHA).

32 *Submission* 921, p.2 (NSW Farmers' Association).

33 *Submission* 800, pp.5-6 (NRHA); *Submission* 962, p.52 (ANF).

- opposition from some influential medical organisations to some innovative approaches to nursing in rural and remote areas;
- the lack of effective structures for interaction and agreement and associated poor coordination between the key players in workforce planning and nurse education; and
- fragmentation of developments in education, training and new nursing models of practice.[34]

8.35 The Committee received many recommendations for the improvement in recruitment and retention rates for rural and remote nurses.

Attracting people to nursing who will practice in rural and remote areas

8.36 NRHA indicated that a high proportion of nurses working in rural and remote areas have strong rural backgrounds or connections. However, overall participation rates for students from rural and remote backgrounds in higher education are low. Leeton Shire Council noted that once students moved away from home to attend university, they often did not wish to return to rural areas to work. There have been moves to provide postgraduate courses through distance education, but the University of South Australia is the only university offering a full undergraduate course by distance education, supplemented by a short block of on-campus workshops every semester.[35]

8.37 In evidence a number of strategies for improving rural participation rates in nursing were suggested, these included:

- marketing campaigns in secondary schools;
- reducing the cost of courses or introducing a system to enable 'pay as you go';
- reducing HECS fees for every year worked in a designated rural community;
- waiving HECS fees for nursing students from remote and rural backgrounds;
- increasing scholarship or sponsorship arrangements through area health services in rural areas;
- introducing bonded scholarships;
- introducing a rural nursing certificate; and
- increasing educational opportunities in rural areas.[36]

The marketing of nursing in primary and secondary schools was seen as being essential if students from rural and remote areas are to be attracted into nursing.

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34 *Submission* 800, pp.11-12 (NRHA).

35 *Submission* 445, p.2 (Leeton Shire Council).

36 *Submission* 445, p.3 (Leeton Shire Council); *Submission* 921, p.8 (NSW Farmers' Association).

Improving education of rural and remote nurses

8.38 The importance of education and training for rural and remote practice was emphasised. Frontier Services stated that universities were 'failing to provide staff with the confidence they need to work with minimal supervision in remote areas, whether in aged care or in remote clinics. Younger staff appointed to these positions simply do not stay.'[37]

8.39 The NRHA considered that there was considerable room for improvement in undergraduate programs to prepare students for rural and remote practice. Issues of concern included limited or no rural or remote experience on the part of teaching staff; insufficient content on Indigenous health and rural and remote cultural sensitivity and cultural safety; inadequate funding for rural and remote placements; and lack of recognition of the extra load on rural and remote health services from accepting student nurses. Insufficient clinical experience was a particular concern as nurses in rural and remote areas have less support and back-up than their urban counterparts. NRHA recommended that universities urgently address problems in their courses to ensure that undergraduate nursing programs are suitable for those wishing to enter rural and remote practice.

8.40 Nursing students wishing to undertake clinical placements in rural and remote services often face problems in accessing places including high costs of travel and accommodation. The Victorian Government has implemented a program to provide financial assistance to both metropolitan and undergraduate nursing students taking up rural placements where accommodation and travel costs are incurred.[38] NRHA recommended that the Commonwealth establish a scholarship scheme for student nurses similar to the John Flynn Scholarship Scheme for medical students to allow for two-week placements each year while studying.

Further education and re-entry education

8.41 Witnesses pointed to the difficulties experienced by rural and remote nurses in accessing educational opportunities. Release for education may be difficult because of: lack of appropriate staff to fill vacant positions; the reduced funding to area health services; the reduced number of doctors in some areas leaving the nurse as the only professional available 24 hours a day; and the high level of experience and skill of these nurses who are often working as the primary provider in an area making them indispensable to a community. The ANF noted that further education costs significantly more for nurses based in rural and remote areas than it does for their metropolitan counterparts as travel and accommodation costs and living expenses away from home may be high. This acts as a disincentive to further education. The ANF argued that an extension of the current Federal Government scholarship scheme

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37 *Submission* 826, p.2 (Frontier Services); see also *Submission* 445, p.2 (Leeton Shire Council).

38 State Government Victoria, *Nurse Recruitment and Retention Committee, Government Response,* June 2001, p.xv.

for rural and remote nurses would enhance their practice and contribute to high quality nursing outcomes.

8.42 Maintaining skill levels for skills infrequently used, for example managing a major burn injury or delivering a premature baby, is also an issue for nurses working in rural and remote areas. The ANF recommended that a mechanism needs to be developed to allow nurses working in rural and remote areas to have access to appropriately funded and supported skills maintenance programs. These could be developed through partnership arrangements between metropolitan and rural facilities.[39]

8.43 Other factors acting as barriers to further education include time pressures, as many nurses work part-time, the dispersion and remoteness of the nursing workforce; the relatively high proportions of nurses whose qualification is a hospital Registered Nurse Certificate (that is, not university nursing courses); and, the age structure of the workforce.

8.44 Recommendations in this area made in evidence included the need for more flexible modes of learning. For example, NSW Farmers' Association noted the need for improved access to information technology and tele-health facilities for nurses to allow greater education and training opportunities.[40] It was also suggested that more training needs to be available in regional and rural centres, including the development of regional study centres located at regional hospitals. This would enable staff to undertake refresher and other courses at a facility close to home and thereby decrease costs and time taken. There was a need for paid study leave or scholarships. Currently, many nurses use long service leave and holiday entitlements to attend courses and greater financial support and scholarships were recommended.[41] However, the NSW College of Nursing noted that evidence suggested that where nurses are removed from their day-to-day responsibilities to attend education programs, both outcomes and retention rates of the programs are higher.[42]

8.45 The idea of a circuit nurse to provide relief for rural and remote nurses wishing to undertake educational opportunities was raised in evidence. The NSW College of Nursing noted that 'the majority of barriers may be overcome if there was an appropriate individual available to replace staff during release times'. A circuit nurse would travel from town to town to give care during times when the nurse needs to travel for educational purposes. While the College noted that many circuit nurses would be required, there would be advantages through increased retention rates in rural and remote areas, it would boost morale in areas where nurses feel ignored, undervalued and exhausted and provide opportunities for nurses who want to

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39 *Submission* 962, p.51 (ANF).

40 *Submission* 921, p.7 (NSW Farmers' Association).

41 *Submission* 355, p.1 (Network 9 Health Council).

42 *Submission* 480, Supplementary Information, 22.4.02, p.2 (NSW College of Nursing).

experience working in rural and remote areas but who are not willing to commit to moving and resettling.[43]

8.46 Queensland Health is also establishing a statewide system of rural and remote nursing relief. The program will provide a pool of relief nursing (registered and enrolled) staff for Queensland Health's rural and remote facilities. Relief nurses will be available for planned relief periods of up to four months duration.[44]

8.47 NRHA noted the importance of the role of ENs in rural and remote health services. Rural and remote ENs have less access to continuing education and they are often placed in positions where they are working outside their scope of practice. NRHA recommended that bridging programs be more widely available to ENs in rural and remote areas to achieve advanced standing in Bachelor of Nursing programs.

Improving retention rates

8.48 Retention rates in rural and remote areas vary with turnover rates in Central Australia being 110 per cent for nurses. Factors most commonly identified by rural nurses as essential in influencing their decision to take up and remain in rural nursing are both personal (lifestyle and family related) and job-related (experience, career development and diversity).[45]

8.49 In remote areas limited resources mean that nurses are often on call for extended periods of time or are involved in extended call-outs in demanding circumstances. In these circumstances, burnout becomes a problem and nurses leave the workforce. Rural nurses also suffer from lack of resources, particularly lack of additional staff in times of shortage or heavy workloads. Often this leads to excessive amounts of overtime being worked and adds to stress. These situations are difficult for experienced nurses and extremely unfavourable for new graduates. Many witnesses noted that new rural and remote nurses were not retained because of inadequate preparation and orientation and they were unprepared for the complexity of the task, the isolation and responsibility.

8.50 A further concern raised was the scope of practice of remote area nurses. Remote area nurses often work outside of their scope of practice because they are isolated from other healthcare providers and have to respond as best that they can to the health needs of the community. NRHA stated that this places nurses in an unacceptable position. NRHA also argued that more effective action is required by States and Territories to provide protection for nurses working outside their scope of practice in situations where more appropriate health care providers are not available.[46]

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43 *Submission* 480, Supplementary Information (NSW College of Nursing).

44 *Submission* 942, Supplementary Information (Queensland Health).

45 *Submission* 800, pp. 34-35 (NRHA).

46 *Submission* 800, p.55 (NRHA); see also *Submission* 867, Attachment 1, p.8 (NSW Health).

8.51 Remuneration of rural and remote nurses was raised by witnesses. While income is not seen as the major factor in influencing rural and remote area nurses' decisions to stay, NRHA stated that it is unlikely that major increases in recruitment of nurses can be achieved in rural and remote areas without an improvement in salaries.[47]

8.52 Employment conditions and the working environment were also important in decisions to remain in nursing. For example, there is a lack of funding for relief while staff are attending in-service training or on other leave. Centres with only one nurse are often forced to close down when that nurse is on annual or sick leave. This causes stress to both the nurse and the community. Even in larger centres such as Mt Isa, there is limited choice as to when leave can be taken as services must be adequately staffed at all times. It was suggested that single nurse posts should be converted to two person positions or to implement a locum system. NRHA stated that improved relief arrangements for rural and remote nurses would make a substantial contribution to improving the recruitment and retention of nurses as well as enhance quality of care.

8.53 Incentive packages are offered in some jurisdictions,[48] though many witnesses pointed to the differences in incentives offered to other health professionals and other occupations in rural and remote areas. For example, the QNF Mt Isa Branch reported that in Mt Isa, doctors are housed in flats or houses provided by Queensland Health, whereas the nurses quarters at the hospital contain cell-type rooms, have holes in the walls, communal toilets and showers, and leaking ceiling.[49]

8.54 Strategies suggested in evidence for increasing retention rates centred on conditions of service, remuneration and recognition of the unique nature of rural and remote nursing:

- remuneration commensurate with training and responsibility, to reflect that often nursing staff work alone and are the first point of contact with very little support;
- a rural component be factored into Nurses Awards;
- remuneration and allowances equal to other health workers employed in rural and remote areas;
- expansion of the Nurse Practitioner model to better reward expert skills and improve the level of health care to local communities;
- development of a rural incentive scheme including relocation expenses, housing subsidies and bonuses for length of service etc;
- provision of adequate and safe accommodation;

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47 NRHA, *Draft Issues Paper*, p.15.

48 For example Queensland Health provides a Remote Area Incentive Package for RNs and Accommodation Assistance as part of Rural and Remote Incentive, IRM 2.7-17 and IRM 2.2-12, *Submission* 942, Supplementary Information 26.3.02 Attachments.

49 *Submission* 704, p.1 (QNF (Mt Isa Branch)).

- provision of mobile phones in all work vehicles (an occupational health and safety issue);
- provision of relief staff for education and holiday entitlements;
- child minding; and
- opportunities for partners to be gainfully employed/occupied eg a package be available to families which includes job creation type funding for a spouse.[50]

8.55 Some initiatives have been developed to address the working conditions of rural and remote nurses. In Western Australia, the Department of Health is developing an implementation plan for the recommendations of the 2001 study of nursing and midwifery. Recommendations on rural and remote nursing included that accommodation facilities be reviewed; that accommodation be provided to attract nurses and midwives with families to practice in rural and remote settings and that there be a review of the use of and access to information technology.[51]

Conclusion

8.56 There are many issues facing the nursing workforce in rural and remote Australia. Some of the issues are similar to nursing as a whole, though exacerbated by distance and isolation. In rural and remote areas the situation is particularly challenging as the nursing workforce provides the backbone of skilled healthcare and in some areas the only healthcare.

8.57 Attracting and retaining nurses in rural and remote areas is increasingly difficult. New graduates may not have the experience or appropriate level of knowledge to meet and understand the challenges of nursing in rural and remote areas.

8.58 Experienced nurses find moving to non-metropolitan areas unattractive due to the expense of moving, inadequate accommodation, lack of remuneration commensurate to qualifications and the degree of isolation or remoteness. Nursing staff already employed in rural and remote areas are leaving because of workload, lack of recognition of their skills, poor educational opportunities and pressures of providing care that may be outside their scope of practice.

8.59 The Committee considers that urgent action is required if there is to be a nursing workforce of sufficient numbers and appropriate skill to meet the challenges of providing healthcare in rural and remote Australia.

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50 See for example, *Submission* 197, p.2 (Institute of Nursing Executives NSW & ACT); *Submission* 355, p.1 (Network 9 Health Council); *Submission* 445, p.3 (Leeton Shire Council); *Submission* 455, p.4 (RFDS); *Submission* 708, p.3 (Greater Murray Area Health Service); *Submission* 737, p.8 (Eyre Region Health Service); *Submission* 921, (NSW Farmers' Association).

51 Pinch, C & Della, P, *The West Australian study of nursing and midwifery: New Vision, New Direction*, Perth, Department of Health, 2001, p.54.

Recommendation 79: The Commonwealth provide additional funds to universities to extend clinical education in rural and remote regional hospitals.

Recommendation 80: That the Commonwealth increase the amount of funding of rural and remote nursing programs, including scholarship programs, in line with funding of medical programs.

Recommendation 81: That the Commonwealth and States provide funding for nursing relief programs such as 'circuit nurse' programs in rural and remote Australia.

Recommendation 82: That all rural and remote area health services with the assistance of State governments offer additional incentives to nursing staff through employment packages including accommodation assistance, additional recreation and professional development leave, and appointment and transfer expenses to encourage nurse recruitment.

The Indigenous nursing workforce

8.60 Indigenous nurses and Aboriginal Health Care Workers play an important part in the provision of healthcare services in rural and remote areas. Indigenous nurses account for 0.8 per cent of the nursing workforce, with a high proportion being enrolled nurses. In 1996, there were 693 Indigenous registered nurses and 564 Indigenous enrolled nurses.[52] In South Australia in 1999 it was estimated that there were approximately 64 registered and enrolled nurses of Aboriginal and Torres Strait Islander origin with active status.[53]

8.61 Increasing the number of Indigenous people entering the health workforce is 'essential to produce an effective health workforce capable of meeting the health needs of Australia's Indigenous people'. In addition to producing an effective health workforce, other benefits will be gained: improving the health and welfare of the individual student will have flow-on effects to their family and communities; Indigenous nurses will become role models for young Indigenous people; improved employment opportunities for people from Aboriginal and Torres Strait Islander communities; and increased understanding of Aboriginal and Torres Strait Islander cultural and health issues in the nursing workforce.[54] Increasing the number of Indigenous nurses will help to overcome shortages in the nursing workforce not only in rural and remote areas but also across Australia.

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52 *Indigenous health in core nursing curricula and the development of recruitment and retention strategies for Indigenous Australians in Nursing Education, Consultation Draft*, Nov 2001, p.15.

53 *Submission* 940, p.12 (Department of Human Services, SA).

54 *Consultation Draft*, Nov 2001, p.27.

8.62 Increasing the number of registered nurses can be achieved through attracting Indigenous young people into nursing careers and facilitating enrolled nurses and Aboriginal Health Workers to undertake education to upgrade to registered nurses.

8.63 A number of major issues have been identified as barriers to the success of Aboriginal and Torres Strait Islander nursing students. These included:

- cultural issues generally and in relation to curricula;
- lack of suitable bridging courses and acknowledgment of prior learning;
- inadequate educational preparation, particularly in the sciences;
- inappropriate selection criteria and interview processes;
- lack of acknowledgment of experience and knowledge in Indigenous health in career structures;
- insufficient support within universities for Aboriginal and Torres Strait Islander nursing students;
- lack of articulation between nursing and Aboriginal Health Worker qualifications; and
- lack of distance learning opportunities to enable students to remain in their communities while undertaking nursing programs.[55]

8.64 Inadequate educational preparation was raised in evidence. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) noted the difficulties of Indigenous students attaining education levels sufficient to undertake nursing studies.[56] The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) stated:

> You may or may not be aware of how many indigenous people complete grade 12. It is a very low number. Certainly some people who come in and undertake the undergraduate nursing program are from school…Many are mature age entry students, and they do not have the science background that is required. Many have literacy and numeracy skills that are not as advanced as they ought to be and so they are behind the eight ball right from the start. Even though the support may be there for them, it is extremely difficult.[57]

8.65 CATSIN provided the Committee with details of recommendations it has adopted to develop strategies for the recruitment and retention of Indigenous nurses. The recommendations cover cultural heritage and identity; professional nursing issues; recruitment and retention of Aboriginal and Torres Strait Islander nursing

55 *Submission* 800, p.33 (NRHA); *Consultation Draft,* p.14.

56 *Submission* 958, p.5 (AMSANT).

57 *Committee Hansard* 26.3.02, p.644 (CATSIN).

students; nursing education; and the relationship between the roles of Aboriginal Health Workers and the Aboriginal and Torres Strait Islander Registered Nurse.[58]

8.66 CATSIN provided the Committee with the consultation draft of the report for Indigenous health in nursing curricula.[59] The draft provides a detailed list of strategies to increase recruitment, retention and graduation of Indigenous students of nursing; to promote the integration of Indigenous health issues into core nursing curricula; and to improve nurses' health service delivery to Indigenous Australians. CATSIN reported that there had been a very good response from the Deans of Nursing and that they had accepted the recommendations contained in the consultation draft.

8.67 In January 2002, the Indigenous Nursing Education Workshop was held to discuss the future of Indigenous Nursing Education. Those taking part in the workshop included Deans and staff of schools of nursing, representatives of nursing associations, Commonwealth and State and Territory health department staff, representatives of Indigenous and rural health bodies, and staff of Indigenous student support bodies. Strategies identified to improve recruitment and retention included:

- promotion of nursing as a career to primary and secondary school students;
- employment of flexible learning strategies and multiple entry points into nursing;
- provide financial assistance through scholarships;
- educate teachers and clinical staff and recruit Indigenous staff;
- develop mentors and role models to provide support for students;
- work actively with Indigenous communities;
- address difficulties Indigenous nurses experience in the workplace; and
- deal with broader issues including racism.

Strategies were also identified to make Indigenous health and culture a part of the core curricula for all nursing students.[60]

8.68 AHMAC has endorsed the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.[61] It has been drafted as a framework for workforce reform and consolidation, requiring collaboration between Commonwealth, State and Territory Governments and the Aboriginal and Torres Strait Islander community controlled health sector.

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58 CATSIN, *Recommendations to Develop Strategies for the Recruitment and Retention of Indigenous Peoples in Nursing,* August 1998.

59 *Indigenous health in core nursing curricula and the development of recruitment and retention strategies for Indigenous Australians in Nursing Education, Consultation Draft*, Nov 2001.

60 *Submission* 31, Supplementary Information 26.3.02 (CATSIN).

61 Standing Committee on Aboriginal and Torres Strait Islander Health, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC, May 2002; see also Senate Community Affairs Legislation Committee, *Committee Hansard* 5.6.02, p.CA221.

8.69 The Workforce Strategic Framework sets out a range of strategies to achieve a competent health workforce for the broad Australian health system (all of which must be responsive to needs of Indigenous people and be culturally appropriate and accessible) and for the delivery of comprehensive primary healthcare services for Aboriginal and Torres Strait Islander people. Five objectives, including increasing the number of Aboriginal and Torres Strait Islander people working across all the health professions, were identified. These are supported by detailed strategies to achieve the objectives.

8.70 It is intended that the objectives and strategies in the framework will be incorporated in the broader National Strategic Framework for Aboriginal and Torres Strait Islander Health which is being drafted by the National Aboriginal and Torres Strait Islander Health Council for signature by all Health Ministers.

8.71 The Commonwealth provides funding for Indigenous nurse education. As noted above funding for ten nursing scholarships for Aboriginal and Torres Strait Islander nursing students or health workers who want to upgrade their qualifications was provided in the 2001-02 Budget. Funding of $2.1 million was provided for support measures associated with the scholarships with a particular emphasis placed on Indigenous nursing students. Funding was also provided for culturally appropriate training for rural nurses to assist them in providing care for Indigenous Australians.

Conclusion

8.72 The Committee strongly believes that it is important to encourage more Indigenous nurses into the general nursing workforce. Increasing Indigenous people's participation in nursing will improve the accessibility, quality and cultural appropriateness of healthcare for Indigenous communities. There needs to be a concerted effort by all stakeholders for this to occur. The Committee recognises the importance of Indigenous nurses in all health settings – Indigenous nurses should not be restricted to providing healthcare only for Indigenous communities.

8.73 The Committee considers that the recommendations made by CATSIN and the strategies proposed under the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework provide a sound basis for improving the recruitment and retention of Indigenous nurses. The Committee considers that they must be implemented as soon as possible, particularly those strategies aimed at the education and training sectors. As a first step, the Committee considers that the Commonwealth should increase the number of scholarships provided to Aboriginal and Torres Strait Islander nursing students and health workers who wish to upgrade their qualifications. The present number of ten scholarships provided by the Commonwealth is insufficient.

Recommendation 83: That the Commonwealth increase the number of scholarships for Aboriginal and Torres Strait Islander nursing students and health workers to increase their numbers and upgrade their qualifications.

Recommendation 84: The strategies for the Aboriginal and Torres Strait Islander nursing workforce proposed in the Health Workforce National Strategic Framework be implemented as a matter of urgency.

Midwifery

8.74 To practice as a midwife in Australia, a postgraduate course must be completed following initial registration as a nurse. In evidence, comments were made regarding the position of midwifery within the nursing profession. Midwives supported the view that midwifery should be recognised as an independent profession distinct from nursing.[62] The ANF held the position that midwifery is a specialist area of nursing practice. However, the ANF just as strongly supported the position that all nurses providing midwifery care should have midwifery qualifications.[63]

8.75 Witnesses pointed to a shortage of midwives, with the Australian College of Midwives stating that 'consumers are now being exposed to non-midwifery care and this must be addressed as a matter of urgency'.[64] Two specific areas of acute shortages were identified: rural and remote areas; and midwives attending to the needs of Indigenous women.

8.76 The midwifery workforce is also ageing. The average age of midwives ranged from 44 years in South Australia to 54 years in Tasmania. In 1995, 25 per cent of midwives were aged between 35 and 39 and over 65 per cent of midwives are aged over 35 years.

8.77 The Australian Midwifery Action Project (AMAP) provided the Committee with a rudimentary analysis of midwifery needs and concluded that some 940 student midwives were required to maintain the midwifery workforce. Current new graduates were estimated at 550 so that less than two-thirds of the numbers required are being educated. AMAP noted that NSW Health had stated that 'the pool of new graduate midwives supplying the midwifery workforce is considerably less than the predicted numbers required to adequately sustain the workforce'. In addition, NSW Health had found that 30 per cent of newly qualified midwives did not seek midwifery related employment on graduation.[65]

8.78 The NSW Midwives Association indicated that overseas trained midwives were unlikely to provide a source of midwives to overcome the shortage as current maternity care trends in Australia are incongruent with contemporary midwifery practices internationally. In addition, qualified midwives from overseas programs with

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

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

64 *Submission* 886, p.4 (ACM).

65 *Submission* 912, p.6 (AMAP).

a Bachelor of Midwifery qualification may have difficulties obtaining registration to practice midwifery in Australia.[66]

8.79 Evidence suggested that the lack of adequate graduates in midwifery is due to:

- costs of midwifery education as midwifery is classified as a postgraduate qualification and thus attracts full course fees;
- the requirement to be a registered nurse before entering midwifery studies, that is five to six years of study before qualifying to practice as a midwife;
- many women and students from Indigenous and/or rural and isolated backgrounds are already either not entering postgraduate study or facing financial hardship following further education; and
- high attrition rates with anecdotal reports suggesting rates as high as 50 per cent in some midwifery programs.[67]

8.80 It was also asserted that midwifery education lacks overall consistency in design, duration or level of award both nationally and within each State. At present there is no national monitoring system to guarantee comparability or an adequate baseline of competence. There is also inconsistency in the nature of clinical placements in hospitals.[68]

8.81 The introduction of three-year Bachelor of Midwifery or undergraduate midwifery degree programs without the pre-requisite three-year nursing registration was supported by midwives. Midwives commented that requirements for midwives to go through general undergraduate training was both a waste of scarce educational resources and acted as a disincentive to those who consider a career in midwifery. Midwifery education is discussed in more detail in chapter 4.

8.82 The Committee received suggestions to improve retention rates for midwives including:

- improved recognition of the skills of midwives;
- introduction of family friendly, flexible work practices;
- provision of opportunities for skill maintenance and development;
- provision of satisfying working experiences with new models of care;
- improved access to ongoing educational opportunities; and
- provision of access to refresher programs.

8.83 Evidence was received about programs to improve retention and recruitment of midwives. In Victoria, the Midwifery Re-entry Program is funded by the Victorian

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66 *Submission* 891, pp.3-4 (NSW Midwives Association).

67 *Submission* 912, pp.7-8 (AMAP); *Submission* 718, p.2 (Midwives, St George Hospital).

68 *Submission* 718, pp.3-4 (Midwives, St George Hospital).

Government and provides a 14 week program to encourage non-practising midwives to return to the midwifery workforce.[69] The Commonwealth provides funding for he National Rural and Remote Midwifery Upskilling Program. Under the program funding is provided to the States and Territories for upskilling of midwives in rural and remote areas.

8.84 Evidence was also received about the development of enhanced role midwives. In 1999, two recommendations of the National Health and Medical Research Council report on services provided by midwives were reviewed in Western Australia. The recommendations related to the initiation and administration of medications and the ordering and interpretation of routine tests by midwives. The review determined an operational framework for the implementation of the enhanced role midwife. The recommendations of the review covered the areas of employment, certification, education, legislative changes, Clinical Protocols, and future development of the enhanced role midwife.[70]

8.85 The Western Australian Department of Health indicated that the Department and the Minister had approved this project and tenders were being sought for an academic institution to write the curriculum to allow midwives to act in the enhanced role. Enhanced role midwives will be recognised as such on the register of nurses. The Department noted that one of the reasons for advancing the project was to provide protection to midwives, especially those working in country areas:

> …who are ordering tests, interpreting the results and giving medications without the legal protection of either the Nurses Act or the Poisons Act. What happens is that the doctor will actually write a pathology form and just leave it for the nurse to do what he or she wants to with it. The doctor will leave a whole stack there for them. So technically they are working outside the guidelines but, if they did not work outside the guidelines, their client base would not be getting the service that they require.[71]

8.86 The shortage of midwives in rural and remote areas was also highlighted in evidence. Women in rural and remote areas are more likely to have a higher rate of maternal and infant morbidity and mortality. Women are also being airlifted or transported many miles from their homes to seek care during the birth of their baby because of the lack of locally available midwifery care. The Australian College of Midwives stated that recruitment and retention of midwives in the rural and remote areas of Australia is problematic. Travel, geographical separation from family,

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69 *Submission* 886, p.4 (Australian College of Midwives).

70 Chief Nursing Officer's Office (WA), *Interim Report of Reference Committee to Recommendations from NHMRC 1998 Report 'Review of Services Offered by Midwives': Enhanced Role Midwife Project*, Nov 2001, p.3.

71 *Committee Hansard* 27.2.02, p.90 (Department of Health, WA).

absence of ongoing education or professional development results in midwives leaving these areas.[72]

8.87 There is also an acute shortage of midwives and inadequate numbers of Indigenous people training to become health workers and health professionals. The need for Indigenous workers in midwifery was particularly important as the differential in birth outcomes between Indigenous women and other Australians has not been eliminated. The number of low birth weight babies being born to Indigenous women is still two to three times the number of those born to non-Indigenous women. Stillbirths and the death rate for babies in the first 28 days are also higher for Indigenous babies. As well, nearly 30 per cent of Indigenous mothers from remote communities have to travel away from their home location to give birth. If cultural needs are not met, women feel the loneliness at being separated from their families, and find the strange surroundings overwhelming. Many Aboriginal people fear that if they give birth somewhere other than on their homeland they may relinquish rights of traditional ownership.[73] CATSIN indicated that it had been provided with funding for bursaries for Indigenous nurses to undertake postgraduate midwifery studies.[74]

8.88 The Australian Health Workforce Advisory Committee (AHWAC) is presently undertaking a review of midwifery. A workforce working party has been established to report to AHWAC on the number, composition, distribution and workforce characteristics of the current midwifery workforce and the optimal supply of midwives across Australia including projections of future requirements. It is expected to report to AHWAC later this year.[75]

Conclusion

8.89 The Committee has reviewed the education and regulation of midwifery in chapter 4 and recommended the development of a national curriculum framework to overcome inconsistencies in midwifery education. The Committee believes that a variety of midwifery educational models be available.

8.90 The Committee notes the evidence provided on the issue of insurance for midwives and recognises that independent midwives are primarily covered by professional indemnity insurance. However, the Committee understands that with professional indemnity insurance being withdrawn or becoming prohibitively expensive, many midwives have stopped practicing. The Committee is aware that negotiations are currently taking place between government and industry on insurance issues.

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72 *Submission* 886, p.5 (Australian College of Midwives)

73 *Submission* 912, p.6 (AMAP). See also Senate Community Affairs References Committee, *Rocking the Cradle: A Report into Childbirth Procedures*, December 1999, pp.75-7.

74 *Committee Hansard* 26.3.02, p.639 (CATSIN).

75 *Submission* 822, Attachment 2 (AHWAC).

Recommendation 85: That the Commonwealth while examining medical insurance issues also consider the issue of professional indemnity insurance for nurses, including midwives and allied health workers.

Community nurses

8.91 The role of the community health sector has expanded over the last decade. Community nurses play a major role in prevention and/or self-management of many chronic illnesses and disabilities. In addition, there has been an increasing emphasis on post acute care in the community as a result of early discharge of patients from hospital. With increasingly complex care requirements comes increased workloads and the need to maintain appropriate skill levels. Other factors leading to increased workloads include emerging social issues, for example, elder abuse, child abuse and violence. The Australian Council of Community Nursing Services stated:

> If we look at early discharge from hospitals, there are now far more people in the community with very high needs that we did not see before. I am the director of education within RDNS and I look at the skills our community nurses have to have and at what level; certainly, with people choosing to die at home under palliative care and the set-up in some homes…it is like running a mini hospital. It is getting more and more complex, and this is where education for registered nurses is essential to keep up to date – just with the equipment and so on that they have to deal with.[76]

8.92 Evidence pointed to three main areas of concern: lack of resources; lack of planning; and lack of recognition of community nursing as a speciality.

8.93 Witnesses noted that community nurses are at the forefront of providing services to the community. However, it was argued that the community sector is not being adequately funded to meet the emerging challenges of caring for patients, particularly those who have been discharged early – they are sicker and require more specialised care. In some areas, there are long waiting lists for community based health services resulting in adverse health outcomes. Resources to support nurses in the community are limited – for example there is limited administrative support, insufficient equipment, and lack of funding to meet workplace health and safety requirements.[77]

8.94 Brisbane South Community Nurses, QNU Branch stated that staffing numbers had not changed in response to the move to greater community care and increased patient acuity. Not only does this impact on the care delivered and the workload of nurses but it also impacts on the ability of services to provide adequate staff coverage for nurses on leave.

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76 *Committee Hansard*, 27.3.02, p.745 (Australian Council of Community Nursing Services).

77 *Submission* 369, p.1 (Child Youth and Family Health); *Submission* 331, p.3 (South Brisbane Community Nurses, QNU Branch).

8.95 Lack of planning was an issue raised in some submissions. At the more general level, the South Brisbane Community Nurses argued that 'there is mixed messages being given about the future of community health. No real understanding from the decision makers on the purpose of primary health care and community health services.'[78]

8.96 At the service delivery level, it was argued that there is a need for more comprehensive discharge planning to ensure continuity of care and ease of transition between hospital and home for the patient. Services are fragmented and there is little or no planning for future services to meet local needs. With the shift in emphasis to post acute care, rather than primary health care, there is increasingly little time for health promotion which would reduce future demand on health services.

8.97 The Royal District Nursing Service also argued that case mix funding provided incentives for the acute sector to redirect some of its funding back into the community with little regard for duplication of existing community services and the ability of acute care organisations to maintain a quality service. On the other hand, community services, funded through the HACC program, suffers from the limitations imposed on service development of output based funding/purchasing to meet pre-determined output measures. Service development initiatives that would attract nurses are not supported and therefore it becomes difficult to maintain appropriate career pathways.[79]

8.98 It was also argued that lack of planning extends to educational needs. Community nurses have little opportunity to undertake the further education that is crucial to maintaining and developing skills to meet the increasing demands created by changing health needs. The need for appropriate educational opportunities was highlighted by the Royal District Nursing Service which noted that there is a great need to provide in-service education, training, professional supervision and information support because:

> …knowledge is growing and changing too fast for nurses – as with general practitioners – to remain up to date. Casual workers are most at risk of losing skills, let alone extending them. For community nurses, the greatest imperative is for training to develop and hone capacity to provide assessment and case management services that embrace:
> - traditional health care options as well as complementary ones
> - a diversity of cultures and religious beliefs
> - a more deeply informed client population which is also becoming a more litigious one.[80]

78 *Submission* 331, p.3 (South Brisbane Community Nurses, QNU Branch); see also *Submission* 794, p.4 (Community Nurses Special Interest Group (ANF WA Branch)).

79 *Submission* 476, p.4 (Royal District Nursing Service).

80 *Submission* 476, p.3 (Royal District Nursing Service).

8.99 While the community health sector is playing an increasingly important part in the delivery of care, it was felt that health professionals working in fields other than community based health services have limited understanding of the pivotal role community nurses play in the overall health and wellbeing of the community through practicing within the primary healthcare framework.[81]

8.100 It was also stated that there are also very few postgraduate courses available for those wishing to enter the sector which further detracts from its standing as a specialty.[82] For example, the Western Australian Community Nurses Special Interest Group reported that a distance education course run at Curtin University has been discontinued and a previously discontinued course at Princess Margaret Hospital has been restarted for one 12-month course only. Curtin University will commence a Postgraduate Diploma for community health nursing in July 2002. This will cost $8 000 to $9 000 (the cost of the previous courses was less than $3 000). The Special Interest Group also stated that no refresher programs were available in Western Australia to assist these nurses into community child health or provide an easier transition into this field.[83] ACT Community Care also noted that there were very few distance education courses for community nursing.[84]

Neonatal nurses

8.101 Neonatal nurses care for small, sick and premature infants and their families. Care is provided in a variety of settings from acute care neonatal intensive care units to palliative care and chronic care in the community. As a result of improvements in technology, babies being cared for are smaller, sicker, have more complex illnesses, and have longer stays in neonatal intensive care units and special care nurseries. Care in the community can last for months, weeks or years.[85]

8.102 The ethical issues, technological advances and family dynamics encountered by neonatal nurses make their role very demanding. Ethical issues include resuscitation and continuing care of extremely premature infants; and continuation or withdrawal of life support. Technological advances, for example the use of high frequency ventilators and administration of nitric oxide, require continuing high level education and training. The Australian Neonatal Nurses Association (ANNA) stated that the use of new technology has not led to a decrease in the number of nurses

81 *Submission* 331, p.16 (South Brisbane Community Nurses, QNU Branch); see also *Submission* 476, p.4 (Royal District Nursing Service).

82 *Committee Hansard* 21.3.02, p.345 (ACT Community Care).

83 *Submission* 794, p.7 (Community Nurses Special Interest Group, WA); Supplementary Information, 21.3.02, p.2.

84 *Committee Hansard* 21.3.02, p.350 (ACT Community Care).

85 *Submission* 712, p.2 (Association of Neonatal Nurses of NSW).

required, rather the workload has increased because nurses are required to use the technology as well as troubleshoot problems as they arise.[86]

8.103 ANNA concluded that 'all these stresses push the nurses to their individual limits and without relief and support programs they leave the workforce'.[87] High turnover rates and wastage rates also place added stress on those nurses who remain to support new staff. Burnout due to the high stress working environment, limited career opportunities within the speciality, lack of flexible working conditions and employment of casual and agency staff to fill staff shortfalls contribute to the under supply of neonatal nurses.

8.104 ANNA identified national under supply of neonatal nurses in both intensive care and special care nurseries. Turnover rates range from 10 per cent to 15 per cent annually and vacancy rates in neonatal intensive care units are around 10.5 per cent. Wastage rates for new nurses entering the speciality are high and the average length of stay in the speciality is 3 to 5 years. Neonatal nurses are younger than the average of the registered nurse workforce (61 per cent are less than 40 years), most are female and a third are employed part-time.[88] The Association of Neonatal Nurses of NSW indicated that the higher proportion of females with a lower age, impacted on staffing in neonatal units. There is an increased demand for child care and part-time work. As a consequence difficulties arise in maintaining adequate cover for all shifts. Problems with adequate cover also arises because, unlike many areas, neonatal units generally require the same number of staff for each shift.[89]

8.105 ANNA indicated that States with more neonatal intensive care units and special care nurseries appear to have problems with staffing levels. Hospitals which are more isolated tend to have a better record at keeping staff, but there are problems with continuing education, access to formal education programs and currency of clinical practice at these hospitals. With the trend to establish special care cots in private hospitals, competition for staff has increased as the private sector tends to offer more flexible rostering, job sharing and set shifts.

8.106 Recruitment into the speciality of neonatal nursing comes from student graduates (general and midwifery) and re-entry of qualified staff. However, as with many other specialities, there is limited exposure to neonatal, paediatric or midwifery nursing in the undergraduate programs. Neonatal training is provided through university graduate courses and some hospital based 'speciality skills' programs. Some States provide specific funding to support students and some university programs are HECS funded. However, costs remain high and can act as a deterrent to those wishing to enter the specialty.

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86 *Submission* 439, p.1 (ANNA).

87 *Submission* 439, p.2 (ANNA).

88 *Submission* 439, p.5 (ANNA).

89 *Submission* 712, p.2 (ANNN).

8.107 ANNA also suggested that there needed to be collaboration between the universities, the profession and the industry in curriculum development, flexible learning modes, particularly for nurses practicing in rural areas, and clinical competency assessments. Masters degree programs for neonatal nurses were needed to ensure continued quality of care as well as providing a positive incentive for career development and retention within the speciality. ANNA also suggested that the nurse practitioner model would provide improved educational and research opportunities and an expanded career path.[90]

Paediatric nurses

8.108 Witnesses pointed to the changing context of children's health care: there has been an increase of psychosocial health problems and an increase in the survival rate of premature babies and children with chronic health conditions. In the community, nurses are caring for children still having treatments that were once carried out in hospital and working with families with complex social and health needs. There have also been changes to priorities in response to changing government policy. For example, in New South Wales, policy initiatives which focus on early childhood will rely heavily on child and family health nurses to undertake programs such as home visits. The emphasis on child protection has also added to workloads. These factors have increased the demand for qualified paediatric and child health nurses at a time when the speciality is facing a shortage of experienced nurses.[91] This has resulted in increased workloads and concerns about quality of care.

8.109 The Child and Family Health Nurses Association (NSW) (CAFHNA) raised the problem of the lack of consultation when policy initiatives are introduced and stated that:

> There appears to be an unspoken expectation that nurses will take up the burden incurred by staff shortages and extra workloads. In plain terms, our members complain that they 'get dumped with extra work and that it is often without consultation'. In our view this amounts to system abuse.[92]

8.110 The Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) voiced concern about the impact of the shortage of paediatric and child health nurses on the quality of health services being delivered. For example, where suitable staff are not available, the shift to early discharge has resulted in domiciliary nursing services taking on the care of sick children when these services have traditionally cared for the elderly. The Confederation also suggested that health services, in both metropolitan and non-metropolitan areas, were 'settling for who they can find' when employing staff, rather than choosing the best person for the position.

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90 *Submission* 439, p.3; *Committee Hansard* 22.3.02, p.448 (ANNA).

91 *Submission* 734, p.1 (Tresillian Family Care Centres).

92 *Submission* 889, p.2 (CAFHNA NSW).

It was argued that generalist nurses often do not have the skills in children's health care and the increasing use of agency nurses exacerbates this problem.[93]

8.111 Many of the factors impacting on the general nurse workforce are also causing shortages in specialist nursing areas. In paediatric nursing there are a number of additional factors identified in evidence which are contributing to retention difficulties:

- in smaller organisations, staff can be expected to work across both adult and children's health service which many nurses believe deskills them and reduces job satisfaction;
- new graduates experience significant barriers to entry into children's health including the cost of postgraduate education (the average cost of a postgraduate program is more than $6000); the view that child health nurses should be qualified midwives (the time, effort and cost of gaining three qualifications is prohibitive); and difficulties in obtaining positions in children's wards to gain experience as more nursing in the community means fewer hospital beds; and
- nurses leaving as they are unable to cope with the demands of specialised paediatric practice.[94]

8.112 The need to improve educational opportunities for paediatric and child health nurses was emphasised in evidence. ACPCHN's recommendations included that:

- ACPCHN standards and competency statements be used in developing curricula for both undergraduate and postgraduate education, to prepare nurses at generalist and beginning and advanced levels of specialist nursing practice in children's health services;
- undergraduate nursing education include sufficient content on children's health to enable graduates to meet ACPCHN minimum standards;
- postgraduate curricula recognise common knowledge areas related to children's health, to reduce the number of different units that need to be available;
- entry requirements for postgraduate courses be flexible and recognise clinical experience and informal education;
- financial support for specialist nurse education;
- in-service education programs to address the lack of educational and experiential background of nurses to care for children; and
- rationalisation of postgraduate education according to broad areas of clinical practice rather than nurses being required to undertake a series of postgraduate

93 *Submission* 763, p.2 (ACPCHN); see also *Submission* 753, p.3 (Association of Paediatric & Child Health Nurses WA); *Submission* 889 p.5 (CAFHNA NSW).

94 *Submission* 734, p.4 (Tresillian Family Care Centres); *Submission* 763, p.1 (ACPCHN); *Submission* 889, p.5 (CAFHNA NSW).

qualifications (eg midwifery and child health, midwifery and neonatal nursing, paediatric and child health nursing).[95]

8.113 The need for the expansion of child and family nurse practitioner's role was also raised. It was argued that the appointment of nurse practitioners would provide recognition for the highly advanced nursing role of those nurses who work independently in practice within the community or in an advanced role in the specialist acute care setting. The role would assist in the creation of a new career pathway for nurses and would support the retention and recruitment of highly skilled practitioners.[96] The need for the recognition of nurse specialist qualifications in both the nursing career structure and remuneration rates was also seen as essential to retain experienced staff and to promote the speciality.

Critical care nurses

> Australia has struggled to maintain an adequate number of nurses available to ICU's for much of the last 10 years. As a consequence many ICU beds and services have not been accessible to the community which can only suggest a potential for inappropriate care or harm when critically ill patients are denied such access to ICU. Access to available ICU beds in Australia is strongly correlated to the number of available nurses, and in particular qualified critical care nurses.[97]

8.114 There has been an enormous expansion in demand for intensive care units (ICUs) and intensive care beds. For example, in the last six years admissions to NSW Intensive Care Units have almost doubled, from 36 410 admissions in 1994-95 to 61 710 admissions in 1999-2000.[98] These units are experiencing a shortage of nurses.

8.115 The Australian College of Critical Care Nurses (ACCCN) indicated that the shortage was not only due to an increase in demand as a result of an expansion of ICU beds, but is also the result of advances in technology; the increasing acuity of patients; and poor retention of nursing staff in the speciality. The decline in the number of nurses, especially those with specialist qualifications, places significant workload pressure on those who remain.

8.116 In ICUs throughout Australia, minimum standards for ICU management have been established. However, the ACCCN suggested that these standards have tended to be seen as 'optimal' and the number of nursing staff have been reduced. As a result, nursing workloads have increased, patient access to intensive care has been restricted, there are high rates of major elective operation cancellations and refusal of ambulance admission to ICUs in more extreme cases.

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95 *Submission* 763, p.4 (ACPCHN).

96 *Submission* 753, p.6 (Association of Paediatric & Child Health Nurses WA).

97 *Submission* 814, p.10 (ACCCN).

98 *Submission* 814, p.1 (ACCCN).

8.117 The ACCCN noted that in the light of declining numbers of critical care nurses, State Governments, nursing organisations and employers have attempted to plan or suggest a wide range of strategies to ameliorate the situation. However, 'many of these have included strategies modelled on those in the United States that have largely been unsuccessful and/or more costly in the long term'. The ACCCN argued that 'consensus is needed on a clear, transparent and understandable methodology by which policy and decision makers in governments and health departments can agree on to measure, plan, fund and supply this scarce and needed resource: intensive care nurses'.[99]

8.118 The ACCCN noted that critical care nursing is a specialist area of nursing that requires a level of skill and knowledge that is beyond the scope of undergraduate nursing programs. In order to provide optimal nursing care in the area of critical care, nurses must have access to educational programs that reflect the established standards of the speciality. ACCCN put forward a large number of recommendations in relation to critical care nurse education including that :

- HECS for postgraduate courses be restored;
- scholarships be available for those wishing to undertake postgraduate critical care courses;
- the number of nurse educator positions in critical care areas be increased to support new staff and ongoing education programs in the workplace;
- structured refresher programs aimed at the return of intensive care nurses to the clinical workforce be implemented;
- Colleges of Nursing which conduct the Intensive Care Graduate Certificate be assisted to increase sponsored places and support for distance education programs be provided;
- health services develop an internal pool of registered nurses with appropriate orientation, willing to work in ICU;
- the nurse practitioner role in intensive/critical care be further investigated to build a clinical career structure that would retain experienced critical care nurses in the clinical setting;
- ACCCN be provided with resources to develop distance education programs for critical care nurses in rural and remote environments; and
- dedicated funding be made available to ensure a minimum of 1000 nurses can be qualified each year so that a consistent supply of such nurses is always available to ICU's. An additional proportional number would also need to be qualified to serve other critical care areas (emergency, cardiology, recovery room, etc).[100]

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99 *Submission* 814, p.2 (ACCCN).

100 *Submission* 814, p.2 (ACCN).

8.119 The Australian Health Workforce Advisory Committee has identified critical care nursing as one of the two initial areas for review. The reviews are expected to be completed before the end of 2002.

Operating room nursing

8.120 Operating room nursing is one of the key areas suffering the effects of the nursing shortage. The Tasmanian Operating Room Nurses (TORN) indicated that the majority of operating room nurses will retire over the next 10 years and they are not being replaced.[101]

8.121 Access to educational opportunities was emphasised in evidence. One problem noted by TORN was that those wishing to undertake a operating room nursing course in Tasmania had to do so by distance education. TORN stated 'that causes us quite a bit of concern because they are not getting the clinical experience that they need to be a good operating room nurse. Doing something that is so clinically based and practical by distance education is not the ideal way to run a course like this. We are not even formally training anybody any more.'[102]

8.122 The need for continuing education for operating room nurses was also seen as essential for the ongoing maintenance of professional expertise and therefore professional standards. With the rapid development of new technologies in the operating room environment, nurses need access to professional development programs on a regular basis.

8.123 The Australian College of Operating Room Nurses (ACORN) indicated that there was a need to appoint Clinical Nurses Educators. These positions need to be funded and supported. At present, the role of Clinical Nurse Educator is not particularly attractive to RNs as they often end up on a reduced salary from the loss of shift work.

8.124 A further matter raised by ACORN was the lack of remuneration for operating room nurses with higher levels of qualification. At the present time in some States and Territories, there is no recognition of specialty education in operating room nursing. ACORN stated that there should be recognition and remuneration for expertise similar to that currently being paid in other specialist areas of nursing.[103]

Emergency nurses

8.125 The Australian College of Emergency Nursing stated that there were shortages of experienced emergency nurses and those that remain are ageing: 'I think the average age of emergency nurses these days is in the 40s, which is really quite old

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101 *Committee Hansard* 15.3.02, p.304 (TORN).

102 *Committee Hansard* 15.3.02, p.304 (TORN).

103 *Submission* 747, p.5; *Committee Hansard* 27.3.02, p.752 (ACORN); *Submission* 327, p.4 (TORN).

when you consider the acuity that you are dealing with and the pace that you are going at'.[104]

8.126 Significant shortfalls in staffing numbers are being filled by casual and agency nurses. These nurses do not possess the specialist skills required to function at an advanced level in the Emergency Nursing setting. In other instances, shortages are filled by new graduates or nurses who have gained experience in other areas of nursing. This creates additional stress on the existing staff who are required to supervise inexperienced staff.

8.127 Emergency nurses are leaving the profession as 'the current working environment in Emergency departments is so difficult'. Emergency areas often experience long waiting times and there are periodic closures. As a consequence nurses are subject to increased abuse from members of the public. Another significant reason is the lack of professional recognition of knowledge, skills and educational qualifications leaving emergency nurses feeling devalued.[105]

8.128 Training in emergency nursing is provided through the Australian College of Emergency Nursing. The College runs programs throughout Australia and New Zealand. The College noted that while the courses are popular, very few nurses receive financial assistance or paid study leave to attend them. The College recommended the provision of interest free loans to assist in accessing continuing education. It was also recommended that recognition of prior learning for nurses entering postgraduate programs be considered as many of the nurses have over 10 years clinical experience and may not have an undergraduate nursing degree. In some instances, this leads to exclusion from postgraduate study.

Oncology nurses

8.129 The Oncology Nurses Group of the Queensland Cancer Fund provided the Committee with an overview of the work of oncology nurses. Nursing in the oncology area is demanding with cancer care nurses often caring for patients over long periods of time. Cancer patients are more dependent on nurses for emotional and physical support than in many other areas of nursing. There is a lack of acknowledgment of the uniqueness of the cancer nursing role. Lack of experienced staff and the need to continually provide orientation to new staff increases the workload of existing staff. Nurses with families pointed to increases in overtime as a problem with many preferring to finish on time rather than receive increased pay.

8.130 Other developments are also increasing demands on experienced cancer care staff. These include the introduction of 24 hour a day telephone support services. Allied health services have also been reduced in some units. Nurses indicated that this placed extra demands in terms of emotional support. The Oncology Nurses Group also noted that there has been a change in role with nurses now taking on some of the tasks

104 *Committee Hansard* 22.3.02, p.439 (Australian College of Emergency Nursing).

105 *Submission* 813, p.3 (Australian College of Emergency Nursing).

previously undertaken by doctors. In addition, patients are becoming more demanding with increased use of the Internet and increased knowledge. The demand for cancer care nurses has increased with the ageing population and increasing incidence of cancer.

8.131 Cancer care nurses acknowledged the need for continuing education, knowledge development and increasing their expertise. However, this was not always supported in the workplace, although it was expected by employers. Education also suffers because of workloads and lack of time.

8.132 The Oncology Nurses Group also identified problems for cancer care nurses in remote and rural areas. Nurses need to travel long distances to access education programs. They have difficulties maintaining skills particularly in relation to chemotherapy administration.

8.133 Recommendations received by the Committee in relation to oncology nursing included:

- provision of advanced skill development and support for further education;
- improving opportunities in rural and remote areas to increase skills; and
- the need for promotion of cancer nursing.

Conclusion

8.134 The healthcare system needs experienced specialist nurses. With healthcare becoming more complex, nurses are seeking to undertake additional education to increase their knowledge and skills. However, those endeavouring to further their education face difficulties due to the cost of postgraduate education, lack of suitable courses, lack of support from employers and lack of recognition of their enhanced skills. This is contributing to nurse shortages in areas such as mental health, aged care, critical care, midwifery and emergency nursing. However, these areas of healthcare could not now function without specialist nursing support. With the ageing nurse workforce and insufficient numbers of new graduates moving into specialist areas, there is little prospect of the situation improving without immediate action being taken.

8.135 The Committee was provided with a number of suggestions to overcome the shortage in specialist areas including:

- provision of postgraduate scholarships to encourage additional entry;
- cancellation of undergraduate HECS debt when postgraduate students enrol in clinical courses;
- that dedicated HECS places be allocated for postgraduate education;
- paid study leave during work time for specialist education;
- funding of in service education to provide opportunities for nurses to update their professional knowledge and clinical skills;

- funding of research and provision of opportunities for nurses to be involved in the promotion of new initiatives through evidence based practice; and
- provision of remuneration commensurate with postgraduate qualifications.

8.136 The Committee has made recommendations in chapter 4 to improve the access of nurses to specialist education through increased HECS funded postgraduate places and additional postgraduate scholarships.

8.137 Many of the recommendations made in relation to the nursing workforce in general apply to the specialist nurse workforce. The Committee also considers that employers must look to the conditions of work for specialist nurses to ensure that they are supported in furthering their education and maintaining their skills. As with all nurses there must be family friendly workplaces and acknowledgment of the particular demands of a predominantly female workforce.

8.138 Of particular concern to the Committee is the lack of recognition of the high level of skills and knowledge of the Australian specialist nurse workforce. This is especially important as professional boundaries in the health sector are blurring. The need for remuneration commensurate to the education and skills of specialist nurses was frequently raised in evidence. At the present time the attainment of higher education qualifications for specialist work is not always recognised. This acts as a significant disincentive to the recruitment of nurses wishing to enter a specialist area and to the retention of those already practicing. The Committee also considers that a comprehensive career path for specialist nurses needs to be developed.

8.139 In order to attract nurses into speciality areas, a more concerted effort is required to ensure adequate workforce planning. The Committee acknowledges the work currently being undertaken by the Australian Health Workforce Advisory Committee in relation to the critical care nursing and midwifery workforce. This is welcomed. However, all speciality areas face a crisis and this must be addressed.

8.140 The way ahead is clear. It has been identified in many reports and reviews. What is now required is leadership and action.

Senator the Hon Rosemary Crowley

Chair

GOVERNMENT MEMBERS MINORITY REPORT

There are a number of issues that have been raised and recommendations made by the Opposition Parties that are already the focus of the Commonwealth Government.

The Government Senators, prior to this matter being referred to the Committee, expressed reservations about the proposed (and subsequently accepted) Terms of Reference on the basis that the Commonwealth does not employ nurses in the acute sector. Therefore it follows that the Terms of Reference that refer particularly to remuneration, conditions and workplace issues are the province of the States.

The Government Senators however agree that matters revolving around the education of nurses, the university component and the delivery of aged care services were issues that could be usefully examined. They did however note, prior to the referral that the Government was soon to announce a National Review of Nursing Education. They believed the Review should be undertaken and completed prior to yet another inquiry.

The Review encompasses the preparation of enrolled, registered and specialist nurses, The Review has the support of the State Health Ministers. They were consulted on the Terms of Reference. The Review is to make recommendations on models of nursing education and training to meet future labour force needs and will have regard to regional needs and circumstances and financial arrangements.

At the commencement of the Review interested parties and organisations were asked to make a submission to the review of any information, opinions, arguments or recommendations on any issues relevant to the Terms of Reference of the Review. A total of 159 submissions were received.

Members of the Review Panel held meetings across Australia between August and October 2001. The Review Panel was diligent to ensure that they received input and advice from the key stakeholders concerned about the future needs of nursing education. Public Forums were held in each State and Territory along with focus groups targeting enrolled nurses, registered nurses, students and Directors of Nursing. State and Territory Health Departments, nursing registration boards, key unions, national representative bodies, universities and TAFE institutions have been consulted.

Following the release of the discussion paper at the end of December 2001 many comments were received and a second round of consultations were completed by the end of March 2002. The Review has commissioned 17 research studies into a wide range of nursing issues and areas including mental health nursing education, the health labour force, midwifery education, aged care nursing, nursing knowledge and skills required to meet changing workforce need, student expectations of nurse education, enrolled nurse education, nursing career pathways, education in a multicultural context and projected demand for nurses.

The question of nursing shortages is something for which the States and Territories are the major employers, not the Commonwealth. The States and Territories also have direct responsibility for the regulation and registration of nurses in the public and private sectors. It is pleasing to note that most State Governments have recently and progressively implemented nurse recruitment and retention initiatives.

It is also worth noting that there is a diverse mixture of groups that have responsibility for nurses and nursing. In addition to the Commonwealth, the States and Territories there are State Registration Boards, national and state-based bodies representing nurses including the colleges, Federations and Associations, the providers of health care services that employ nurses in both the public and private sectors, and the universities and TAFEs that provide nursing education.

Within this amalgamation of roles and responsibilities the Commonwealth has an overall interest in the supply, distribution and quality of the health workforce, including nurses. It also provides funding for Registered Nurse education through the Department of Education, Science and Training. The Commonwealth also has responsibility in the funding and delivery of aged care services, a major employer of nurses. The Commonwealth also administers HECS.

It is a recognised fact that nurses provide the major component of the delivery of health care services in Australia. They work in public and private hospitals, nursing homes, rural and regional areas, home and community care setting, and in a variety of specialised fields.

The comment was drawn by some witnesses that it would be desirable to have incentive funding for the recruitment and retention of nurses in rural and remote areas of Australia.

As the Report by the Opposition Parties recognises, issues associated with nurse recruitment and retention, workforce planning, education, and specialised fields of nursing practice have been the subject of a large number of inquiries, reviews, research projects and commissioned studies since the early 1990s. Many of these reports have been undertaken by, or as commissioned studies for, the Commonwealth Department of Health or the respective State Health Departments.

Over 50 reports of recent reviews, inquiries or commissioned studies that are considered to be major or influential are listed in Appendix 4 to this Report, indicating the breadth and volume of research work that has been undertaken into all aspects of nursing in Australia. The list is by no means exhaustive.

While it is impractical and undesirable to suggest that the Commonwealth should take control of the nursing workforce, the Commonwealth Government has introduced a number of important initiatives in an effort to address nurse shortages. Naturally, these are mainly focused on education and incorporate incentives to attract and retain nurses in aged care and in rural and remote areas, where the shortage is most acute. The prime example of this is the Australian Remote and Rural Scholarship Program that

offers incentives to nurses wishing to pursue or build on a career in rural or remote area nursing.

It is important to note that the first Commonwealth Undergraduate Remote and Rural Nursing Scholarship (CURRNS) scheme was fully implemented within eleven weeks of its announcement. A total of 1014 applications were received for the 110 scholarships.

The CURRNS scheme proved so popular that in December 2001 the Minister for Health and Ageing agreed to a one off expansion of 30 places in 2002 at an additional cost of $900,000 over three years.

Additionally, the Australian Remote and Rural Nursing Scholarship Program has four different scholarship programs.

Postgraduate – to support continuing nursing education

Conference – provides a contribution toward travel and registration fees

Undergraduate – to improve access to undergraduate nursing education for rural and remote students

Re-entry and Upskilling – to fund former nurses to undertake re-entry courses

Once all the components of the Program are running at maximum capacity, approximately the same amount of financial support through scholarships will be available to nurses as to medical practitioners in rural and remote areas of Australia.

There are a number of other initiatives that are funded by the Commonwealth to support a range of health practitioners, including nurses, including the Midwifery Upskilling Program, First-Line Emergency Care Courses for Remote Practitioners and the Bush Crisis Line.

Funding has also been provided to nursing professional organisations to undertake Secretariat functions, these include Council of Remote Area Nurses of Australia (CRANA) Inc and the Association for Australian Rural Nurses (AARN).

The other issue that is of great concern to the Government Senators and the profession is the variation in wages and conditions for aged care nurses compared to those in the acute setting. This variation creates its own difficulty in the areas of recruitment and retention. The Committee heard repeated evidence of these factors along with a real or perceived poor image of aged care nursing, that their professional standing was lower than those in the acute setting, that their work environment was less attractive, that there are fewer career structures or opportunities for professional development, and a need for greater skills development and training.

These issues have been comprehensively studied and reported upon by the Australian Nursing Federation's report '*Quality Wages, Quality Staff, Quality Care*'.

The Government Senators wish to note that the Commonwealth has already increased funding to the sector in an effort to ensure that aged care nurses are not worse off. There are, of course, different awards for registered nurses in hospitals and those working in aged care and they may vary between States. Providers may pay above the award and the Government encourages all areas of the workforce to use Australian Workplace Agreements (AWAs) so that employees as well as employers can agree to pay and conditions at the local level, subject to a 'no disadvantage' test of minimum conditions. The Commonwealth has ensured a strong basis for this to occur with increased funding to the sector.

Last year the government announced that $200 million would be provided over four years, commencing in 2002-03 for increases in residential care subsidies. This measure will provide additional funding to aged care providers for the provision of residential aged care and will incorporate a pricing review of the industry.

As part of the cooperative process to examine long term financing options for the aged care industry, the review will take into account the improved care outcomes that are now required under accreditation; underlying cost pressures, including movements in nurses' and other wages; and industry views.

Following the weight of evidence given by those working in or associated with aged care the Government Senators were pleased to note in the recent Budget that an additional $26.3 million will be provided over four years to fund up to 250 scholarships, valued at up to $10,000 a year, for students from regional areas to do undergraduate, postgraduate or re-entry nursing studies at rural and regional university campuses.

The Committee was also told about the need for appropriate training opportunities for personal care workers in aged care.

The Budget this year provided additional funding of $21.2 million over four years so personal care staff in smaller, less viable aged care homes can do a range of accredited courses related to geriatric care. Participating aged care homes will be helped with course fees and other associated costs, including travel, accommodation and replacement staff.

In total, the Government Senators note that $132.3 million will be provided under the Ageing Support and Strategies.

The issue of a Commonwealth Chief Nurse was proposed by many witnesses particularly as there is a Commonwealth Medical Officer. It needs to be noted that the CMO does not specifically look after the important issues surrounding doctors. Therefore the Government Senators recommend that the Government wait until the National Review of Nursing Education is completed before assessing the viability or suitability of such an initiative.

Many witnesses suggested that the Commonwealth should supply additional funding to the States for more nurses.

It needs to be acknowledged that through the Australian Health Care Agreements, the Commonwealth provides $31.7 billion over the five years of the 1998-2003 agreement for public hospitals. That amount represented a 28% real increase in the Commonwealth contribution.

It was disappointing to observe that following the increase a number of States either cut or slowed the rate of their real funding to health generally and hospitals specifically.

Commonwealth funding is not earmarked for particular hospitals or for particular components of hospital budgets, including nursing staff. It is the sole responsibility of the States and Territories to determine the operating budgets of their hospitals.

The Government Senators would however recommend that the Commonwealth Government examine the merit of determining the level of the States contribution for nursing staff prior to the signing of the next agreements.

The Committee was told in every venue that there was a shortage of university places for nursing and that many who applied missed out. The request was therefore made of the Committee that the Commonwealth provide more places for nursing.

It needs to be recognised that while the bulk of the funding for universities is the responsibility of the Minister for Education, Science and Training, higher education institutions are essentially autonomous organisations that are responsible for the distribution of funds between faculties and schools based on their own assessments of priorities and needs. Although universities are responsible for the allocation of places across various fields, they are discussed during the annual profiles consultations. They are expected to take into account the extent of student demand, and the needs of the labour market. In recent years the profiles discussions have specifically covered relative supply and demand in respect of a number of professions, including nursing.

While the National Review of Nursing Education may shed some light on this issue, the Government Senators would recommend that before taking any action the Government should wait to consider the recommendations of the Review.

In an effort to attract more students into nursing it was claimed that there should be an incentive of HECS exemption. The Government Senators found this somewhat contradictory to the above claim that the universities are over-subscribed for nursing.

Regardless of which is correct, the idea of HECS exemption for student nurses would have ramifications for the training of the wider health workforce and would need to be considered in that context. Such a decision could not be taken in isolation from other university courses.

Probably of more significance is the introduction earlier this year of the Postgraduate Education Loans Scheme (PELS). The Department of Education, Science, and Training introduced it. The Scheme provides an interest free loan facility similar to the HECS for eligible students enrolled in fee-paying postgraduate non-research courses.

PELS will be available to commencing students as well as students who commenced a course of study prior to 2002.

One issue of great significance to all in the profession is the widespread introduction of retractable needles and syringes. This is not only important for all health workers but also for the general public who may get needle stick injuries in public places.

It is for that reason the Government in the recent Budget announced that as part of its *Tough on Drugs* initiative it will provide $27.5 million over four years to develop and introduce retractable needles and syringe technology. This will particularly protect health workers and the general public but will also be available to people with diabetes who need to inject insulin.

The research and development of these new products will be carried out in Australia by Australian researchers and commercial interests. This measure represents a major preventative health measure.

There are many allied health professionals who feel that they can make a better contribution to health care with a view to progressively gaining more qualifications.

The Government Senators are therefore pleased to see the announcement, earlier this year, of the Health Training Package. It is the largest Training Package developed to date and covers an existing workforce of 150,000 ranging across ambulance service, dental support, general health services and complementary and alternative health care. Eventually it will also cover health technicians, public health and indigenous health work and it is anticipated that enrolled nursing qualifications will be integrated into the framework.

The Package is an industry-developed set of national qualifications and competency standards applying to non-university trained workers in that industry. Because it is developed by industry it will address the issues specific to that industry.

The Package will considerably enhance skill development in important service delivery areas. For the first time, health workers will be able to receive formal recognition of the accumulated skills and on-the-job experience. This will give them greater mobility, greater career choices and greater employment prospects. This will also make the industry more attractive to young people by identifying clear career paths.

While this initiative is recognised by Government Senators as a most valuable first step, they would recommend that following on from this, there be a thorough investigation as to how qualifications of all levels of nursing be recognised nationally.

The Government Senators also recommend that the Department of Immigration and Multicultural and Indigenous Affairs examine ways in which nurses who are working in Australia can, if they show that they will continue to work in areas of need, have their Working Holiday Maker visas extended. The duration should be determined on a case-by-case basis.

The Opposition parties call on the government to "facilitate and expedite the development of a national nursing workforce planning strategy". Such a strategy has already been established by the Commonwealth in conjunction with the States and Territories.

It was brought to the attention of the Committee that the amount of clinical practice students did meant that only half the year was being utilised. Given that many students wish to take on all types of part time work to earn money, the Government Senators would recommend that the Minister for Education, Science and Training discuss with the universities the possibility of them negotiating with the hospitals better utilisation of available time in which students could work for remuneration. This would give them a greater exposure to the workplace and provide an income at the same time.

All in all, the Government Senators believe that there is much to be done to make nursing a more attractive, long term proposition. The responsibility for this is not only the province of the Commonwealth Government. It needs the cooperation and goodwill of all stakeholders.

Senator Sue Knowles, Deputy Chairman
(LP, Western Australia)

Senator Tsebin Tchen
(LP, Victoria)

GLOSSARY

Note: This glossary is based on the glossary contained in the National Review of Nursing Education Discussion Paper, December 2001.

Accreditation

The regulatory mechanism by which a course or educational institution is deemed to comply with the standards for nursing education (adapted from National Nursing Organisations, 1999).

Allied Health Professionals

Those, other than medical practitioners and nurses, who provide clinical and other specialised services in the management of patients, including physiotherapists, occupational therapists, dieticians and pharmacists.

ANCI Nursing Competencies

The national standards developed by the Australian Nursing Council Incorporated (ANCI) that provide a framework for professional nursing practice by Registered and Enrolled Nurses. The competencies take account of the various roles and functions nurses fulfil and identify a combination of the attributes competent nurses must have.

Australian Health Ministers' Advisory Council (AHMAC)

The Australian Health Ministers' Advisory Council (AHMAC) is a committee of the heads of the Commonwealth, State and Territory Health authorities. AHMAC is the major decision-making body on national health issues, advising the Australian Health Ministers' Conference on policy, resource and financial issues. It also considers recommendations from the National Health and Medical Research Council.

Australian Medical Workforce Advisory Committee (AMWAC)

The Australian Medical Workforce Advisory Committee (AMWAC) was established in 1995 to assist with the development of a more strategic focus to national medical workforce planning in Australia. AMWAC is a national advisory body that reports to the Australian Health Ministers' Advisory Council (AHMAC). The prime focus of AMWACs work is Australian medical workforce research and data analysis, although it also aims to provide workable policy solutions where appropriate. AMWACs role as a workforce planning agency is centred around examining:

- the structure, balance and geographic distribution of the medical workforce;
- medical workforce supply and demand;
- present and future medical workforce training needs;
- models for projecting future medical workforce requirements and supply; and
- development of medical workforce data collections.

AMWAC comprises representatives from Commonwealth departments, State and Territory Health authorities, the Australian Institute of Health and Welfare, the Australian Medical Council, peak organisations representing various sections of the medical workforce including the Australian Medical Association, the medical colleges and university medical schools), and consumer organisations.

Australian Health Workforce Advisory Committee (AHWAC)

The Australian Health Workforce Advisory Committee (AHWAC) was formed in December 2000 to assist with the development of a more strategic focus to health workforce planning in Australia. AHWAC is a national advisory body that reports to the Australian Health Ministers' Advisory Council (AHMAC). The prime focus of AHWAC is on national health workforce planning and analysis of information and the identification of data needs. Advice is to be provided to AHMAC on a range of health workforce matters including:

- the composition and distribution of the health workforce in Australia;
- health workforce supply and demand; and
- the establishment and development of data collections concerned with the health workforce.

AHWAC's membership comprises representatives from Commonwealth departments, State and Territory Health authorities, the Australian Institute of Health and Welfare and peak organisations representing various sections of the health workforce.

Australian Health Workforce Officials Committee (AHWOC)

The Australian Health Workforce Officials Committee (AHWOC) was established in June 2002. Its purpose is to provide a forum for reaching agreement on key health workforce issues requiring collaborative action and to advise on health workforce requirements, as a basis for assisting AHMAC to fulfil its roles.

AHWOC's role is to:

- advise AHMAC on priority workforce issues requiring national collaboration;
- provide advice to AHMAC on policy, funding and health care delivery options and implications for health workforce development;
- provide a forum for ongoing communication and consultation between the Commonwealth, States and Territories in relation to workforce priorities, the development of appropriate and supported industrial frameworks and workforce developments within jurisdictions;
- advise AHMAC on implementation issues arising from Australian Medical Workforce Advisory Committee (AMWAC) and Australian Health Workforce Advisory Committee (AHWAC) recommendations;
- work with AMWAC and AHWAC, and convene specialist groups where necessary, to provide advice on:

  - structure, balance, geographic distribution and future demand and supply requirements for priority skilled health workforces in Australia,
  - development and refinement of models for describing and predicting future skilled health workforce requirements in line with emerging technologies, treatment patterns and models of clinical care,
  - current and future educational and training requirements of priority skilled health workforces, and
  - establishment and development of data collections, analyses and workforce performance indicators to assist workforce planning; and
- liaise with peak groups and organisations as required.

Clinical nurse specialist

An expert clinician and client advocate in a particular speciality or subspecialty of nursing practice. The clinical nurse specialist applies focused knowledge and skills acquired through speciality specific education to a population defined primarily by diagnosis, therapeutic intervention, gender or age. In addition to direct practice, the clinical nurse specialist is involved in consultation, research, and education with the aim of improving the quality of care and services in the role of change agent.

Clinical Placement/Practicum

A component of a nursing education program that provides students with opportunities to marry theoretical knowledge with practical application and develop the required clinical competencies through the care of patients/clients.

Continuing Professional Education

Lifelong process of active participation in learning activities to enhance professional practice and which are designed to enrich the nurse's contribution to health care.

Credentialling

Some specialty nursing groups have implemented credentialling processes as a means of self-regulation for a particular speciality area, so that nurses may demonstrate their competence and be publicly accountable for the services they provide. Nursing specialty and other organisations 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. The International Congress of Nurses has resolved that self-regulatory systems for nursing must provide for:

- high standards for the personal and professional growth and performance of nurses
- public sanction for nurses to perform to the extent of their capabilities
- participation of the profession to the public for the conduct of its affairs on their behalf

- proper recognition for the contributions of the profession and opportunity for the self-actualisation of its members.

Effective Full-Time Student Units (EFTSU)

A unit of measure used by the Department of Education, Training and Youth Affairs and Higher Education institutions generally to represent student load in relation to a unit of study. The total EFTSU are expressed as a proportion of the workload for a standard annual program for students taking a full year of study in a course. A student doing a standard annual full-time workload for a course generates one EFTSU while a full-time student doing a standard annual workload for one semester generates half an EFTSU.

Enrolled Nurse (Division 2 – Victoria)

A nurse who is on the roll maintained by the State or Territory nurses board or nursing council to practise nursing under some form of supervision in the State or Territory. These requirements, which may vary between States and Territories, normally include a specified level of education or its equivalent. Education is generally undertaken in the vocational education and training sector at a Certificate IV or Diploma level.

Healthcare System

The composite of all informal and formal components of health care delivery, including the nurse and the patient/client.

Healthcare Worker

A generic term that can refer to any provider of health care services, but most often refers to paraprofessionals or unlicensed assistant personnel.

Mentorship

A relationship between an experienced nurse and a less experienced nurse whereby the experienced nurse may provide advice and/or assistance which is likely to be career oriented rather than clinically oriented. Mentorship is usually longer in term than preceptorship.

Midwifery

A Midwife is a person who, having been regularly admitted to a midwifery educational program duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the

absence of medical help. She has an important task in the health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and childcare. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service.

Nurse Bank

A discrete supply of casual nurses managed 'in house' by the hospital. Nurses work across the hospital according to their availability.

Nurse Educator

A general term covering nurses who are responsible for providing nursing education in educational institutions such as universities and technical colleges, hospitals, and health care agencies.

Nurse Practitioner

A Nurse Practitioner is a registered nurse who is educated to function in an advanced clinical role. The scope of practice of the Nurse Practitioner will be determined by the context in which the Nurse Practitioner is authorised to practice by the respective State registration Board and may include legislative authority not currently within the scope of nursing practice.

Nursing

Nursing is an integral part of the health care system, encompassing the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual, family, and group 'responses to actual or potential health problems'. These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population.

Nursing Home

A facility that provides long term 24 hour per day skilled nursing care, personal care and physician supervision to chronically ill, frail or disabled persons.

Nursing Workforce

The Australian nursing workforce in our statistical collections consists of nurses educationally prepared at two levels, that being the Registered Nurse and Enrolled Nurse (ANCI), and assistants in nursing and personal care assistants who are not regulated. The workforce reflects a fluctuating number and skill mix of full time, part time or casual workers.

Patient/Client

The individuals, families, groups, or communities that are the recipients or beneficiaries of nursing care.

Personal Care/Assistants/Assistants In Nursing

Commonly referred to as PCAs or AINs, these are generally unregulated and unlicensed health workers. Being outside the regulation and registration system, they cannot properly be described as nurses, but are sometimes described for statistical purposes as part of the 'nursing workforce' or as working in 'nursing occupations'. They are required to act under the direct or indirect supervision of a Registered Nurse.

Preceptorship

A particular teaching/learning method in which an experienced nurse provides direct guidance to a beginning or less experienced nurse. Preceptors are expected to be competent clinicians and are required to be role models. The preceptor role is clinically oriented, shorter term rather than longer term, and linked to particular learning goals or a particular period of time.

Registered Nurse (Division 1 – Victoria)

A nurse who is on the register maintained by the State or Territory nurses board or nursing council to practise nursing in that State or Territory. RNs undertake a minimum of 3 years undergraduate preparation in the higher education sector at a Bachelor degree level.

Scope of Nursing

The scope of nursing practice is that which nurses are educated, authorised and competent to perform. The actual scope of practice of individual practitioners is influenced by the settings in which they practice, the health needs of the people, the level of competence of the nurses and the policy requirements of the service provider. It encompasses clinical, educational, administrative and scholarly dimensions of nursing practice on a continuum from beginning to advanced. It also incorporates generalist and specialist practice of the registered nurse. (Queensland Nursing Council, 2001). There is recognition that nursing practice often overlays the practices of other healthcare professionals and health workers.

Standards for Practice

Authoritative statement, promulgated by the profession, by which the quality of practice, service, or education can be judged. These include the ANCI *National Competency Standards for the Registered Nurse and the Enrolled Nurse* (2000), the *Code of Ethics for Nurses in Australia* (1993), and the *Code of Professional Conduct for Nurses in Australia* (1995).

Separations

A process by which an admitted patient completes an episode of care. In general, a separation is synonymous with discharge. The number of separations is a measure of hospital activity. Separations are counted instead of admissions because some information that classifies the episode of care can be determined only after the episode has concluded. For acute hospitals, the number of separations will be similar to the number of admissions for the same reporting period.

Training Package

An integrated set of nationally endorsed standards, guidelines and qualifications for training, assessing and recognising people's skills, developed by industry to meet the training needs of an industry or group of industries. Training packages consist of core endorsed components of competency standards, assessment guidelines and qualifications, and optional non-endorsed components of support materials such as learning strategies, assessment resources and professional development materials.

APPENDIX 1

LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS AND OTHER ADDITIONAL INFORMATION AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1 Mr Mark O'Brien (NT)
2 Dr Stephen Harrop (QLD)
3 Mr David Dixon (NSW)
4 Dr Christopher Churchouse (WA)
5 Professor Mark Bassett (ACT)
6 Ms Sue Bunt (NSW)
7 Ms Cheryl Byrne (QLD)
8 Anonymous
9 Mr Chris Sinclair (QLD)
10 Mrs P Bardini (QLD)
12 Ms Lee Stevens (NSW)
13 Ms Rosalie Reed (QLD)
14 Ms Rayner Quinn (NSW)
17 Ms Susan Hatcher (NSW)
19 Ms Vivienne Paramore (NSW)
22 Ms Emma Byth (QLD)
23 Ms Julia Poole (NSW)
26 Mrs Lorraine Brookes (VIC)
27 Ms Karen Watson (QLD)
30 Ms Kerry Peart (VIC)
31 Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) (QLD)
Supplementary information
Provided at hearing 26.3.02:
- Recommendations to Develop Strategies for the Recruitment and Retention of Indigenous Peoples in Nursing, August 1998
- Indigenous health in core nursing curricula and the development of recruitment and retention strategies for Indigenous Australians in Nursing Education – Consultation Draft, November 2001
- Draft report on the key themes arising from the Indigenous Nursing Education Workshop, Sydney, January 2002

32 Ms Lucy Daniels (QLD)
33 Ms Rachelle Cunnane (QLD)
36 Ms Kordinelija Stott (TAS)
44 Open Learning Agency of Australia Pty Ltd (VIC)
45 James Cook University, School of Nursing (QLD)

51 Nursing Board of the Northern Territory (NT)
53 Mrs Miriam Dayhew (NSW)
73 Ms Catherine McCutcheon and Ms Jennifer Rochow (ACT)
84 Ms Karen Cohen (NSW)
85 Mr Glenn Ross (NSW)
86 Nurses Board of South Australia (SA)
98 Mrs Audrey Harris (TAS)
108 Community Mental Health Nurses Committee, Mental Health Services, South (TAS)
121 Mrs Sharron Camenzuli (ACT)
123 Albany Regional Hospital, Director of Nursing (WA)
125 Ms Diana Davey (ACT)
145 Combined Pensioners and Superannuants Association of NSW, Bathurst Branch (NSW)
146 Australian Association of Maternal Child and Family Health Nurses (VIC)
147 Ms Michelle Hunter (QLD)
151 Ms Janice Buckman (QLD)
152 Ms Faye Tomlin (QLD)
153 Ms Thea van de Mortel (NSW)
154 Ms Barbara Waters (NSW)
164 Ms Leonie Valuntas-Achilles (NSW)
165 Ms Jan Becquet (NSW)
166 Ms Jane Nichols (NSW)
167 Ms Judy Keeley (NSW)
168 Ms Mary Griffin (NSW)
173 Swan Health Service (WA)
174 St Vincent's Hospital, Nursing Learning Support Service (NSW)
192 Australian Council of Deans of Nursing (WA)
194 Ms Penny Hill (QLD)
195 Our Lady of Consolation Aged Care Services Ltd (NSW)
196 Ms G Watson (NSW)
197 Institute of Nursing Executives NSW & ACT (NSW)
213 AARN Victorian Branch Steering Members (VIC)
249 National Association of Rural Health Education and Research Organisations' (QLD)
264 Australian & New Zealand College of Mental Health Nurses Inc (Tasmanian Branch) (TAS)
265 Ms Mary Hayton (QLD)
284 K Draddy and Other Nursing Staff (NSW)
296 Nurses Registration Board of NSW (NSW)
Supplementary information
- Responses to questions following public hearing22 March 2002, dated 3.4.02

321 Ms Sally Weber (QLD)
322 Ms Patricia Porter (QLD)
323 Dr Paul A Cunningham (NSW)
324 Ms Tania Arnott (NSW)
325 Ms Linda Betts (VIC)

326 Ms Therese Theile (QLD)
327 Tasmanian Operating Room Nurses (TAS)
328 Ms Joanna Peters (NT)
329 Ms Jo Hardy (QLD)
330 Dr Stephen Hayes (NSW)
331 Brisbane South Community Nurses, QNU Branch (QLD)
332 Ms Judy Edwards (NSW)
333 Ms Caroline Ross-Smith (ACT)
334 Dr Heather Gibb (NSW)
335 NurseLink (SA)
336 Ms Janette Dillon (QLD)
337 Mr Adrian Piccoli MP (NSW)
Supplementary Information
- Additional information dated 20.8.01

339 Barham Koondrook Soldiers' Memorial Hospital (NSW)
340 Nursing Staff from a Sydney Hospital (NSW)
354 Ms Shirley McLean (QLD)
355 Network 9 Health Council (NSW)
357 Ms Sue Hair and Other Registered Nurses (NSW)
358 Ms Michel Burgum; Ms Rae Peel and Ms Beth Anderson (WA)
359 Aegis Health Care Group (WA)
360 Ms Sue O'Sullivan and Ms Catherine Heal (NSW)
364 Ms Jennie West; Ms June Graham; Ms Ailsa Hawkins; Ms Nerida Ambler; Ms Kate Rawlings; Ms Carmel Peek and Ms Anne Saxton (NSW)
365 Ms Derene Anderson (NSW)
366 Ms Kirsten Didlick (ACT)
367 Victorian Council of Peak Nursing Organisations (VIC)
368 Ms Susan Howe (ACT)
369 Child Youth and Family Health (QLD)
370 King Edward Memorial Hospital for Women, Obstetric Clinical Care Unit (WA)
Supplementary information
- Responses to questions following public hearing 27 February 2002, dated 15.3.02

371 Mrs Peta Nottle (WA)
374 Mr C R Palmer (QLD)
375 Ms Dorothy Carsen (QLD)
376 Australian Society of Anaesthetists Ltd (NSW)
377 Mater Misericordiae Hospitals of Central Queensland (QLD)
378 Ms Allison Patchett (VIC)
379 Australian Nursing Federation (Victorian Branch) (VIC)
380 Catholic Care of the Aged (NSW)
408 Ms Julie Droguett (NSW)
409 La Trobe University School of Nursing (VIC)
410 Charles Sturt University, School of Nursing and Health Science, Bathurst (NSW)
411 Royal Adelaide Hospital Nursing Executive (SA)
412 Ms Melissa Harvey (NSW)

413 Adelaide University, Department of Clinical Nursing (SA)
Supplementary information
- Responses to questions following public hearing, dated 27.3.02

433 Aged Care Association of Victoria Ltd (VIC)

434 Redcliffe-Caboolture Health Service District (QLD)

435 Ms Barbie Sawyer (VIC)

436 Mr Colin Ellis (NSW)

437 Australian Midwives Act Lobby Group (SA)

438 Australian & New Zealand College of Mental Health Nurses Inc (WA)

439 Australian Neonatal Nurses Association (NSW)
Supplementary information
- Competency Standards of Neonatal Nurses and Information pamphlet, provided at hearing 22.3.02

440 Avondale College School of Nursing (NSW)

441 Ms Alison Evans (ACT)

442 Dr Richard Waller (VIC)

443 Ms Jeanette Dixon (QLD)

444 Nurses Board of the ACT (ACT)

445 Leeton Shire Council (NSW)

446 Dr Anita Peerson (QLD)

447 Ms Jane Foy (VIC)

448 Wollongong Hospital ICU Nursing Staff (NSW)

449 University of Tasmania, School of Nursing (TAS)
Supplementary information
- *Who cares for the mentally ill? Theory and practice hours with a 'mental illness' focus in nursing curricula in Australian universities,* ANZJMHN (1996) 5, 77-83, G A Farrell and J M Carr, provided at hearing 15.3.02
- Responses to questions following public hearing 15 March 2002, dated 22.3.02

450 Peak Nursing Council (WA)

451 Edith Cowan University, School of Nursing & Public Health (WA)

452 Lutheran Community Care (QLD)

453 Ms Sandra Mahlberg (ACT)

454 Australian Council of Community Nursing Services Inc (ACCNS) (SA)

455 Royal Flying Doctor Service (NSW)

456 Australian Physiotherapy Association (VIC)

457 Queensland Nurses' Union (QNU) (QLD)
Supplementary information
Provided at hearing 26.3.02
- Nurses Paycheck (ANF) Vol.1 No.2, March 2002
- Pamphlets - *EB5 It's time to value nurses!* and *Nurses. Worth looking after.*
- Additional information relating to the recent Queensland Industrial Relations Commission decision on minimum staffing ratio, dated 1.5.02

458 Monash University, School of Nursing (VIC)

466 Nurses working in the Northern surrounds of Sydney (NSW)

470 Flinders University of South Australia, School of Nursing and Midwifery; Flinders Medical Centre; Noarlunga Health Services and Queen Elizabeth Hospital (SA)

471 NSW Neonatal Clinical Nurse Consultant Network (NSW)
472 Concord Hospital, Burns Unit Staff (NSW)
473 Doutta Galla Aged Services Limited (VIC)
474 Queensland Nurses Union - Royal Women's Hospital Branch (QLD)
475 Mr Paul Preobrajensky and Mr Gavin Meredith (NSW)
476 Royal District Nursing Service (VIC)
477 National Nursing Organisations (NNOs) (VIC)
478 Ms Catherine Hall (SA)
479 Australian & New Zealand College of Mental Health Nurses Inc (WA Branch) (WA)
Supplementary information
- Additional information following hearing 27 February 2002 dated 6.3.02
- Additional information following hearing 27 February 2002 dated 11.3.02

480 The NSW College of Nursing (NSW)
Supplementary information
- Responses to questions following hearing 22 March 2002 dated 7.5.02

482 Staff at Wellington Park Private Care (QLD)
483 Ms Kate Wadelton (NT)
509 Nursing Unit Manager's Society of NSW Inc (NSW)
510 Deakin University, School of Nursing (VIC)
511 Staff of the School of Nursing & Health Studies at Central Queensland University and the Staff of the Mater Hospitals Group (QLD)
701 Mr Brendan Porter (QLD)
702 Ms Honora Graham (QLD)
703 Ms Barbara Gleeson (ACT)
704 Queensland Nurses Union, Mt Isa Branch (QLD)
705 Ms Karen Thompson (WA)
706 Royal Perth Hospital Nursing Executive Council (WA)
Supplementary information
- Responses to questions following public hearing 27 February 2002, dated 18.3.02
- Additional information dated 13.5.02

707 Ms Gillian Hazleton (ACT)
708 Greater Murray Area Health Service (NSW)
709 Ms Sandra Reddy (ACT)
710 Mr John Rihari-Thomas (NSW)
711 Ms Marilyn Wallace (ACT)
712 Association of Neonatal Nurses of NSW (NSW)
Supplementary information
Provided at hearing 25.3.02:
- NSW Nursing Workforce Research Project, Comments from NSW Pregnancy and Newborn Services Network and Association of Neonatal Nurses of NSW, January 2001
- Standards for Neonatal Nursing Practice

714 Ms Shirley Willis (NSW)
715 Ms Jill Kaye (NSW)
716 Palliative care nurses special interest group ANF (Vic Branch) (VIC)
717 Mr Phillip Hickox (ACT)

718 St George Hospital, Midwives in the Division of Women's and Children's Health and the Midwifery Practice & Research Centre, Kogarah (NSW)

719 The Prince Charles Hospital Health Service District (QLD)

720 Bega Nurse Education Project Committee (NSW)

721 Murwillumbah District Hospital Nursing staff (NSW)

722 The Canberra Hospital, Nursing Directorate (ACT)

723 Nursing Staff, Mater Misericordiae Hospitals, Brisbane (QLD)
Supplementary information
- Articles - *Does International Nurse Recruitment Influence Practice Vales in US Hospitals*, First Quarter 2001 and *Recrutiment Campaign Targets Nursing Shortage*, March 2002

724 University of Canberra, School of Nursing (ACT)

725 Australian Catholic University, School of Nursing (Victoria) (VIC)

726 University of Wollongong (NSW)

727 Mr Andrew Crowden (SA)

728 National Enrolled Nurse Association (NENA) (VIC)
Supplementary information
- NENA News vol.13 2002, provided at hearing 28.2.02
- Additional information dated 10.5.02

729 Ms Mary Beaumont (VIC)

730 Sir Charles Gairdner Hospital, Nursing Executive (WA)
Supplementary Information
- Responses to questions following public hearing 27 February 2002, dated 12.3.02

733 Royal Prince Alfred Hospital Clinical Nurse Consultants Group (NSW)

734 The Royal Society for the Welfare of Mothers and Babies (Tresillian Family Care Centres) (NSW)

735 Dr Bob Wright (NSW)

736 Queensland University of Technology, School of Nursing (QLD)

737 Eyre Regional Health Service Inc (SA)

738 Ms Judi Weaver (NSW)

739 Mr Ian Davis (QLD)

740 Flinders University of South Australia, School of Nursing and Midwifery (SA)
Supplementary information
- Responses to questions following public hearing 27 March 2002, dated 17.4.02

741 Australian and New Zealand College of Mental Health Nurses (Victorian Branch) (VIC)

742 Ms Peggy O'Connor (NSW)

743 Mr Stuart Greenway (NSW)

744 Best Practice Australia Pty Ltd (QLD)
Supplementary information
- *Attributes that Reduce the Risk of Nurses Leaving*, March 2002

745 Ms Andrea Jordan (NSW)

746 Pioneers Home (QLD)

747 Australian College of Operating Room Nurses (ACORN) (SA)

748 Australian College of Nurse Management Inc (VIC)

749 Griffith University, School of Nursing, Faculty of Nursing & Health (QLD)

750 Rockingham/Kwinana District Hospital and Murray District Hospital Senior Nursing Staff (WA)
751 Latrobe Regional Hospital (VIC)
752 Mr John Richards (VIC)
753 Association of Paediatric & Child Health Nurses (WA Inc) (WA)
754 Health and Community Services Union (TAS)
Supplementary information
- Responses to questions following public hearing 15 March 2002, dated 25.3.02

755 University of South Australia, School of Nursing & Midwifery (SA)
Supplementary information
- Additional information dated 10.5.02

756 Ms Jo Nugteren (TAS)
757 The Women's Health Program, Southern Health (VIC)
758 Ms Lynette Nancarrow (NSW)
759 Griffith Base Hospital Nursing Unit Managers/Nurses (NSW)
760 Ms Jan Saarinen (TAS)
761 Ms Sharon Austen (QLD)
762 Nurses Board of Western Australia (WA)
763 Australian Confederation of Paediatric and Child Health Nurses (ACPCHN) (NSW)
764 Dr Tracy Reibel (WA)
765 Nurses Board of Victoria (NBV) (VIC)
766 Centre for Psychiatric Nursing Research and Practice (CPNRP) (VIC)
767 Mr William Jansens (NSW)
768 Complementary Therapies Special Interest Group of the ANF (Vic Branch) (VIC)
731 Ms Corinne Trevitt (ACT)
769 Ms Christine Giles (VIC)
770 Mr James Mitchell (QLD)
771 Ms Joyce McClean, Mr Luke Beckman, Ms Jennifer Quilty, Ms Diane Priddle (NSW)
772 TAFE NSW Nursing Unit (NSW)
773 Australian Nursing Federation (Tasmania Branch) (TAS)
774 Ms Liz Crock (VIC)
775 Aged and Community Services Tasmania (TAS)
776 Ms Susan Skinner (QLD)
777 ACT Mental Health Service (ACT)
Supplementary information
Provided following the public hearing 21.3.02:
- The Canberra Hospital Nursing Staff Agreement 2002-2004
- Position Statement - Management of Nursing and Health Care Services
- Discussion Paper No.1: Occupational Violence: Reporting Patterns, and Variations between Health Sectors, University of NSW, August 2001
- Discussion Paper No.2: Prevention of Occupational Violence in the Health Workplace, University of NSW, October 2001
- Discussion Paper No.3: 'Internal' violence (or Bullying) and the Health Workforce, University of NSW, December 2001

- Article: Beyond the myth of the male nurse, Nursing Review, March 2002
- From apprentices to academics: Are nurses catching up?, Collegian Vol.9 No 1, pp.24-30, 2002
- Nursing and the 21st Century: What's happened to leadership?, Collegian Vol.9 No.1, pp.31-35, 2002
- Violence: It's not part of the job, Australian Nursing Journal, April 2002
- Strategies for a Sustainable Nursing Workforce, Health Manager, Summer 2001/2002

778 Ms Leone Lovell/Leyshon (NSW)
779 Ms Diana Innes (QLD)
780 Women's and Children's Health (WCH), Victoria (VIC)
781 Mr Darren Clarke (NSW)
782 Associate Professor Ged Williams (NT)
783 Focus group of specialist nurses (ACT)
784 University of Western Sydney, College of Social and Health Sciences (NSW)
785 Ms De-arne Hodges (TAS)
786 Australian Federation of University Women (VIC)
787 Australian Faith Community Nurses Association Inc. (SA)
788 National Prescribing Service Limited (NSW)
790 Dr Alexander Donald (QLD)
791 Ms Thelma Williams (NSW)
792 Ms Barbara Cook (QLD)
793 Ms Jennifer Smart & Ms Verna Marin (SA)
794 Community Nurses Special Interest Group (ANF WA Branch) (WA)
Supplementary information

- Responses to questions following public hearing 27 February 2002, dated 21.3.02

795 Ms Gail Buiatti (NSW)
796 Mr Noel Loughman (NSW)
797 Ms Faith Guesmer (QLD)
798 Victorian Maternal & Child Health Coordinators Group (VIC)
799 Ms Kelly Tarabbia (NT)
800 National Rural Health Alliance Inc (ACT)
801 Mercy Hospital for Women (VIC)
802 Ms Kate Rawlings, Ms Rhonda Winskill, Ms Margo Nancarrow (NSW)
803 Mr Alan Snow (VIC)
804 University of Southern Queensland, Department of Nursing (QLD)
805 Group of nurses at The Prince Charles Hospital Health Service District (QLD)
806 Royal Australasian College of Surgeons (VIC)
807 Mr Hayden McDonald (NSW)
808 South Eastern Sydney Area Health Service, Nursing Council (NSW)
809 Mrs Mary Morgan (QLD)
810 ACT Community Care (ACT)
811 Ms Katrina Brunning (QLD)

812 Australian Catholic University, Faculty of Health Sciences (NSW)
Supplementary information
- Additional information dated 25.3.02

813 Australian College of Emergency Nursing Ltd (NSW)

814 Australian College of Critical Care Nurses Ltd (VIC)

815 Wesley Gardens (NSW)

816 University of Ballarat (VIC)

817 Tasmanian Department of Health and Human Services, Family, Child & Youth Health Service (TAS)

818 University of New England, Nursing Program Directorate (NSW)

819 Blacktown Hospital, Women's & Children's Health (NSW)

820 NSW Rural Health Network (NSW)

822 Australian Health Workforce Advisory Committee (AHWAC) (NSW)

823 Ms Lyn Fish (TAS)

824 University of Technology, Faculty of Nursing, Midwifery & Health, Sydney (NSW)
Supplementary information
- Learning Outcomes and Curriculum Development in Major Disciplines: Nursing - Final Report, January 2002
- Additional information following hearing 22 March 2002 dated 7.5.02

825 New South Wales Neonatal Nurse Educators Group (NSW)

826 Frontier Services (NSW)

834 Australian Nurse Teachers' Society (NSW)

835 Australian Private Hospitals Association Limited (ACT)
Supplementary information
- Copy of opening statement, provided at hearing 21.3.02
- Submission to ACCC on anti-competitive practices dated 30.1.02 and 8.3.02 received following hearing 21 March 2002

836 Charles Sturt University, School of Clinical Sciences, Wagga Wagga (NSW)

837 Directors of Nursing Association Qld (Inc) (QLD)

838 Nursing Board of Tasmania (TAS)
Supplementary information
- National Review of Nursing Education, submission dated 7.9.01 and Response to Discussion Paper dated 2.02, provided at hearing 15.3.02
- Additional information dated 24.5.02,

839 Ms Therese Anderson (VIC)

840 Ms Nerilee Baker (NSW)

866 Enterprise & Career Education Foundation (NSW)
Supplementary information
- Creating Tomorrow's Workforce Today - Aged Care Targeted Industry Project 2000 – 2001, provided at hearing 22.3.02

867 NSW Health Department (NSW)
Supplementary information
- NSW Health Strategy for the Electronic Health Record, dated February 2002

868 Ms Marilyn Hickman (WA)

871 UnitingCare Australia (ACT)
Supplementary information
- Alternative Futures for Aged Care in Australia; Establishing benchmarks of aged care clinical care and quality of life indicators; With my Heart on my Sleeve – The Weroona life stories project, provided at hearing 21.3.02

885 Private Hospitals Association of Victoria (VIC)

886 Australian College of Midwives Incorporated (VIC)

887 Queensland Nursing Council (QLD)
Supplementary information
- Responses to questions following public hearing 26 March 2002, dated 8.4.02

888 Australian College of Health Service Executives (NSW)

889 Child and Family Health Nurses Association (NSW) Inc. (NSW)

890 Australian Healthcare Association (ACT)

891 New South Wales Midwives Association (NSW)
Supplementary information
Provided at public hearing 22.3.02
- *National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban and Regional Australia*, February 2002
- *Safety in Birth - A National Crisis,* UTS/AMAP, July 2001
- *Contemporary issues in Australian midwifery regulation,* Australian Health Review, vol 24 no 4 2001, pp.103-118, Pat Brodie and Lesley Barclay

893 Australian Nursing Homes and Extended Care Association (New South Wales) (NSW)

894 Bendigo Health Care Group, Senior Nurse Council (VIC)

895 Southern Health Nurses (VIC)

896 Ms Helen Porritt (ACT)

897 Catholic Health Australia (ACT)
Supplementary information
- Copy of opening statement, provided at hearing 21.3.02

898 Ms Anne Ferguson (VIC)

899 New South Wales Nurses' Association (NSW)
Supplementary information
Provided at hearing 22.3.02
- What do nurses think about aged care? - A report on nurse perceptions about the aged care sector, September 2001
- Public and Private Hospital, Nursing Homes and Training Nurses' Awards

900 Adelaide Community Healthcare Alliance (SA)

910 Mr Alan Grentell (NSW)

912 Australian Midwifery Action Project (NSW)
Supplementary information
- Additional information dated 14.6.02

913 Aged & Community Services Australia (VIC)

914 RMIT University, Department of Nursing and Midwifery (VIC)
Supplementary information
- Response to National Review of Nursing Education Discussion Paper, 28 February 2002, provided at hearing 28.2.02

- Responses to questions following public hearing 28 February 2002, dated 5.4.02

915 Mr Chris Stuart (VIC)

917 Concerned nurses of East Gippsland (VIC)

918 Ms Jeanne McLauchlan (ACT)

919 Australian Nursing Federation NT Branch (NT)

920 Austin & Repatriation Medical Centre (VIC)

921 NSW Farmers' Association (NSW)

923 Tasmanian Department of Health and Human Services (TAS)

924 Ms Judy Lynch (QLD)

925 Oncology Nurses Group of the Queensland Cancer Fund (QLD)

926 Australian Nursing Council Inc (ACT)

Supplementary information

Provided at hearing 26.3.02:

- An Overview of the ANCI
- ANCI Position Statements - Establishment of a Nursing Directorate headed by a Chief Nurse in the Commonwealth Government; Cross Border Nursing Practice: Waiver of Fees; and Continuing Competence in Nursing
- ANCI National Competency Standards for the Registered Nurse, May 2000
- Ninth Annual Report of the ANCI, 2000-2001
- Additional information 15.5.02, 7.6.02 and 10.6.02

927 Royal College of Nursing, Australia (ACT)

Supplementary information

- Correspondence with Department Human Services Victoria relating to evidence given at the hearing on 28.2.02
- Additional information dated 10.5.02

928 Department of Education, Training and Youth Affairs (ACT)

Supplementary information

Provided at hearing 28 August 2001:

- Statistics – Commencing Nursing Students: Broad Level of Course by Gender 1991-2000 and by Tertiary Entrance Scores, 1999-2000
- The Research projects for the Review

The Research Projects for the Review (amended list) received following the hearing dated 21.09.01

Responses to questions following public hearing on 28 August 2001, dated 22.2.02

929 Ms Michelle McSaveney (QLD)

930 Mrs Freda Shannon (WA)

934 Australian Catholic University, School of Nursing (NSW) (NSW)

936 Women's Hospitals Australasia & Children's Hospitals Australasia (ACT)

937 ACT Government (ACT)

940 Department of Human Services, South Australia (SA)

941 Nurses in Aged Care, North East Victoria (VIC)

942 Queensland Health (QLD)

Supplementary information

Provided at hearing 26.3.02

- Ministerial Taskforce - Nursing Recruitment and Retention, Final report, September 1999

- Policy and Guidelines for the placement of pre-registration nursing students Undertaking Clinical Education in Queensland Health Facilities
- Preceptor Program for Nursing Transition Support - Framework and Training Modules, March 2001
- Industrial Relations Policy Manual (extracts) - Accommodation Assistance - Rural and Remote Incentive, July 1999 and Remote Area Incentive Package - Registered Nurses, March 2000
- Agency Fees as at 12 March 2002
- Proposed Queensland Public Health Sector Certified Agreement (No.4) 2000 – wage rates
- Drug Therapy Protocols - Immunisation Program; Isolated Practical Area Indigenous Health Workers; Isolated Practice Area; Sexual Health Program
- People Plan: Building the Future for Queensland Health, February 2002
- Business Planning Framework: Nursing Resources Handbook and Manual
- Handbook for the Collection, Storage and Transport of Pathology Specimens in Rural and Remote Queensland 2001
- Think Nursing
- The Primary Clinical Care Manual 2001
- Additional information 14.5.02

944 Commonwealth Department of Health and Aged Care (ACT)
Supplementary information
- Response to questions on notice dated 24.9.01

946 Mr Malcolm Tulett (SA)

947 Ms Elizabeth McAlpine (VIC)

949 Ms Dianne Phillips (QLD)

950 The Royal Australasian College of Physicians, Paediatrics & Child Health Division (NSW)

951 Mr Martin Morrissey (NSW)

952 Department of Immigration and Multicultural Affairs (ACT)

953 National Centre for Vocational Education Research Ltd (SA)

954 Ms Katrina Anthoney (NSW)

956 Ms Carolina Weller (VIC)

957 Ms Mary Bridgid Naylor (NSW)

958 Aboriginal Medical Services Alliance Northern Territory (NT)

959 Network 3 Health Council, GMAHS NSW (NSW)

960 Victorian Government (VIC)
Supplementary information
- Correspondence relating to evidence given at the hearing on 28.2.02, dated 7.5.02
- Responses to questions following public hearing28 February 2002, dated 8.5.02
- Additional information dated 13.5.02

961 National Tertiary Education Union (VIC)

962 Australian Nursing Federation (ACT)
Supplementary information
- Report on the state of the nursing workforce in Australia and 2002-03 pre-budget submission, dated February 2002, provided at hearing 27.3.02
- Addition information dated 24.4.02, 23.5.02, 27.5.02 and 6.6.02.

965 Ms Jeanette Bolton (NSW)
966 BD (Becton, Dickinson and Company) (NSW)
967 Health & Community Services Union (HACSU) Victoria No. 2 Branch (Vic)
968 Australian Infection Control Association (AICA) (QLD)
969 Lt Mark A Mudge (SA)
970 SANE Australia (VIC)
971 Network 2 Health Council, GMAHS NSW (NSW)
972 Ms Marsha Williams (NSW)
973 Christian Science Committee on Publication Federal Representative for Australia (NSW)
974 Ms Lynne Phillips (VIC)
975 The University of New South Wales, Centre for Clinical Governance Research, Faculty of Medicine (NSW)

Submissions provided as individual responses to the questionnaire circulated by the ANF. A summary of these submissions is provided as Appendix 3.

11 Ms Lesley Douglass (QLD)
15 Ms Chris Cocks (QLD)
16 Ms Roseanne Bradley (QLD)
18 Ms Brenda Goldie (QLD)
20 Ms Jean Hall (QLD)
21 Ms Maree Henricks (QLD)
24 Ms Linda Brownbill (QLD)
25 Mr Danny Hember (QLD)
28 Ms J Green (QLD)
29 Ms Gayle McGetrick (QLD)
34 Anonymous
35 Ms Lynda Roberts (QLD)
37 Ms M Burke (QLD)
38 Ms Kym Rogerson (QLD)
39 Ms Kerry Richardson (QLD)
40 Ms Tanya Dole (QLD)
41 Mr Alan Jessop (QLD)
42 Ms Robyn Timms (QLD)
43 Ms Veronica Istvandity (QLD)
46 Ms Denise Sharp (QLD)
47 Mr Dean John Stevens (QLD)
48 Ms Joanne Williams (QLD)
49 Ms Ruth Flynn (QLD)
50 Delia O'Brien (QLD)
52 Ms Maggie Lasdauska (TAS)
54 Ms Carey A Mather (TAS)
55 Mr Andrew J Johnson (QLD)
56 Mr James Edmondson (ACT)
57 Mr Anthony Schoenwald (QLD)
58 Ms B Southwood-Jones (ACT)
59 Ms Sue Franklin (ACT)
60 Ms Shirynne Cowan (ACT)
61 Ms Jillian De Vry (ACT)
62 Ms Katina Urlich (ACT)
63 Ms Joan Welch (ACT)
64 Ms Marianela Aguilera (ACT)
65 Ms Juliee Langridge (ACT)
66 Ms Desley Rudd (QLD)
67 Ms Dianne Koch (QLD)
68 Ms S Beaton (QLD)
69 Ms Amanda Gear (QLD)
70 Ms K Finnimore (QLD)
71 Ms Annette Potter (QLD)
72 Mr Paul Van Houts (QLD)
74 Ms Jo Broadbent (QLD)
75 Ms Margaret Noy (ACT)
76 Ms Leonie Golby (ACT)
77 Ms J Stewart (QLD)
78 Ms Sue Skyring (QLD)
79 Ms Nola Wong (ACT)
80 Ms T Kay (ACT)
81 Ms M Hodge (ACT)
82 Ms Jillian Martin (ACT)
83 Ms Janelle Mayers (QLD)
87 Ms Melanie Todd (QLD)
88 Mr Anthony Butcher (ACT)

89 Ms A Martyn (ACT)
90 Ms K Huey (NSW)
91 Ms J Enright (ACT)
92 Ms M Falconer (ACT)
93 Ms Suzanne Leonard (ACT)
94 Ms V Cowsill (ACT)
95 Ms Pip Murdoch (ACT)
96 Ms Linda Benz (QLD)
97 Ms Elizabeth Cavanagh (QLD)
99 Ms Erica Wright (ACT)
100 Mr Greg Unicomb (ACT)
101 Ms Margaret Flaherty (ACT)
102 Ms Virginia Dixon (ACT)
103 Ms Helen Blue (ACT)
104 Ms Anke Lebang (ACT)
105 Ms Elizabeth Regan (ACT)
106 Ms Fran Dumbrell (ACT)
107 Ms J Moore (ACT)
109 Ms K Bilanenko (ACT)
110 Ms Robyn Carder (QLD)
111 Ms Christel Jennekens (QLD)
112 Mr Eddie Blackwock (QLD)
113 Ms A Ford (QLD)
114 Ms P E Lorenz (QLD)
115 Ms Patricia Anne O'Halloran (QLD)
116 Mr Stephen Bentley (QLD)
117 Ms Bobbi Megaw (QLD)
118 Ms Skye Evers (ACT)
119 Ms Heather Hart (ACT)
120 Ms Helen Burnette (VIC)
122 Ms Merren Armstrong (TAS)
124 Ms Jocelyn Larkins (VIC)
126 Ms D J Proud (ACT)
127 Ms Elizabeth Barnes (ACT)
128 Ms Annette Pincott (ACT)
129 Ms Joan Dun (ACT)
130 Ms Sarah Raiser (ACT)
131 Ms Julie Skelton (QLD)
132 Ms Genevieve Hetherington (ACT)
133 Ms Beverley Belgrove (QLD)
134 Ms Bernadette McGrath (VIC)
135 Ms Diana Churchill (ACT)
136 Ms Judi Walsh (ACT)
137 Ms Ann Jackson (ACT)
138 Ms Rowena Kilpatrick-Lewis (ACT)
139 Ms Paula Elliott (ACT)
140 Ms Jacqueline Basser (ACT)
141 Ms Marie Nielsen (QLD)
142 Ms Margaret Fishlock (VIC)
143 Ms Maureen Halpin (VIC)
144 Ms Kim Treasure (VIC)
148 Ms Paula Street (VIC)
149 Ms Elizabeth Lewis (VIC)
150 Ms Bridget O'Ryan (VIC)
155 Ms Elizabeth Lapridge (VIC)
156 Ms C Claver (VIC)
157 Ms Susan Lee Blake (ACT)
158 Mr Ben Kennedy (ACT)
159 Ms Frances Robison (NSW)
160 Mrs Jill Zupp (QLD)
161 Ms Therese Kathleen Simms (QLD)
162 Ms Diane Melchers (QLD)
163 Mr Robert Kaye (QLD)
169 Ms Amanda Loader (QLD)
170 Ms Carole Wallace (ACT)
171 Ms Alix Palmer (ACT)
172 Mr Scott Patterson (QLD)
175 Ms Olive Doig (ACT)
176 Ms Daniel Wood (NSW)
177 Ms Brenda Roberston (ACT)
178 Ms S Pittella (VIC)
179 Ms Josephine Kerring (VIC)
180 Ms Nicole Rhodes (VIC)
181 Mr Timothy Nyborg (VIC)
182 Ms Linda Wall (QLD)
183 Ms Kerri Viney (QLD)
184 Ms Margaret Coxon (QLD)
185 Ms Andrea Goltz (QLD)
186 Ms Susan Murtagh (QLD)
187 Ms P M Mitchell (QLD)
188 Ms Loretta Forbes (QLD)
189 Ms Thressa Wynn (QLD)
190 Ms Esther Chamberlain (QLD)
191 Mr Ian Buttsworth (QLD)
193 Ms Helen Klimkowicz (QLD)
198 Ms Jeanette Yeaman (ACT)
199 Ms Anne Louise Beard (ACT)
200 Ms Therese Verdon (ACT)

201 Mr Jason Chong (VIC)
202 Ms Maria Murphy (VIC)
203 Ms Christine Derby (VIC)
204 Ms L M McMillan (VIC)
205 Ms P De Leeuw (VIC)
206 Ms Melissa Carter (QLD)
207 Ms Dinah Morrison (ACT)
208 Ms Joyce McNiven (ACT)
209 Ms Debby Edward (ACT)
210 Ms Helen Perkins (ACT)
211 Ms Pam Rodda (ACT)
212 Ms Gill Brown (VIC)
214 Ms Lorraine Kruse (QLD)
215 Mr Paul Rosenquist (VIC)
216 Ms Lisa Miteff (VIC)
217 Ms Jan Mullins (VIC)
218 Ms Cheryl Axell (VIC)
219 Ms Margaret Radmore (VIC)
220 Ms Amanda Tonks (VIC)
221 Ms Rosemary Law (VIC)
222 Ms Sue Whitehead (VIC)
223 Ms Margo Fitzgerald (VIC)
224 Ms Marcelle Porra (VIC)
225 Mr Paul Clark (VIC)
226 Ms Barbara Bell (VIC)
227 Ms Terry Swanson (VIC)
228 Ms Pip Carew (VIC)
229 Ms Helen Price (VIC)
230 Ms Amanda Maberry (VIC)
231 Ms N O'Donnell (VIC)
232 Ms Sally Nolan (ACT)
233 Ms Deborah Hudson (NSW)
234 Ms Christine Soma (ACT)
235 Ms Lyn Watson (ACT)
236 Ms Caroline Thompson (ACT)
237 Ms Natalie Smith (ACT)
238 Ms Phil Whitfield (QLD)
239 Mr Stephen Bone (QLD)
240 Ms Lyn McLeod (VIC)
241 Mr David Robson (QLD)
242 Ms Helen Bryan (QLD)
243 Ms Carolanne Boland (QLD)
244 Ms B Ham (QLD)
245 Ms Judy Matthews (QLD)
246 Ms Michelle McSaveney (QLD)
247 Ms Arna Chauncey (QLD)
248 Ms Anne Evans-Murray (QLD)
250 Ms Charito Yugst (VIC)
251 Ms Vicki Brown (ACT)
252 Ms Maureen Ferris (ACT)
253 Mrs Sally Cooper (ACT)
254 Ms Judy Biggs (ACT)
255 Ms Wendy Marshall (ACT)
256 Mr Steve Keily (ACT)
257 Ms Louise White (NSW)
258 Ms Michelle Murray (ACT)
259 Ms Jenny Bellingham (ACT)
260 Ms Gillian Stanbrook (QLD)
261 Ms Cathy Fallon (VIC)
262 Mrs Kerry Stokes (VIC)
263 Ms Carol McCrae (VIC)
266 Ms Andrea Woodward (VIC)
267 Ms Jenny Schroor (QLD)
268 Mr Kenley Arndt (QLD)
269 Ms Anna Clarke (ACT)
270 Ms Robyn Slade (ACT)
271 Ms Linda Denman (ACT)
272 Ms Kerrie Carroll (ACT)
273 Mr Greg Hill (QLD)
274 Ms Robyn Jorgensen (QLD)
275 Ms Gwen Thompson (QLD)
276 Mr David Monk (QLD)
277 Ms Barbara Hoey (QLD)
278 Ms Jane Evans (QLD)
279 Ms Amanda Bell (QLD)
280 Ms Michelle Wells (QLD)
281 Ms Rewi Schmidt (QLD)
282 Ms Cheryl Brillanti (VIC)
283 Mr Furnen (VIC)
285 Ms Margot Anne Maule (VIC)
286 Ms Meran Taylor (VIC)
287 Ms Margaret Ray (VIC)
288 Ms Carol Ricketts (VIC)
289 Ms Robyn Jones (VIC)
290 Ms Sue White (VIC)
291 Ms Harland (VIC)
292 Ms Margaret Cumming (VIC)
293 Ms S Walsh (VIC)

294 Ms Susan Hayes (VIC)
295 Ms Jo Smith (VIC)
297 Ms Michelle Coombe (ACT)
298 Ms Judy Lamond (ACT)
299 Ms Gillian Pini (ACT)
300 Ms Mary Brammall (ACT)
301 Miss Elaine Collins (NSW)
302 Ms Julie Hewitt (ACT)
303 Ms Lyndall Carey (ACT)
304 Mr Anthony Noakes (ACT)
305 Mr Michael Farncourt (QLD)
306 Ms Priscilla Heath (QLD)
307 Mrs Dylis Turnbull (QLD)
308 Ms Kerri Salter (QLD)
309 FCA Monk (QLD)
310 Ms Gillian Rees (QLD)
311 Ms Glenys Munro (QLD)
312 Ms Sandra Muggeridge (QLD)
313 Ms Shirley Houlehan (NSW)
314 Ms M Crossland (VIC)
315 Ms Anne MacFarlane (VIC)
316 Ms Marree Adams (VIC)
317 Ms Louise Padgett (VIC)
318 Ms Sandra Buckley (VIC)
319 Ms Gaille Abud (VIC)
320 Ms Amanda Fraser (VIC)
338 Ms Jillian Harburg (ACT)
341 Ms Mary Peters (ACT)
342 Ms Erika Goracki (ACT)
343 Mr Paul Deuer (ACT)
344 Ms Lyn Boreham (ACT)
345 Ms Annemarie Kidd (ACT)
346 Ms Helen Sandland (ACT)
347 Ms M Pateman (NSW)
348 Ms Jan Platten (ACT)
349 Ms Bev Lord (QLD)
350 Ms Angela Bishop (QLD)
351 Ms Biene Kittelly (QLD)
352 Ms Sandra Naman (QLD)
353 Ms Judith Lindgren (ACT)
356 No Submissions
361 Ms Judith Grant (QLD)
362 Ms Marilyn Weeks (QLD)
363 Ms Annette Dahler (ACT)
372 Ms Caroline Trezise (QLD)
373 Ms Joan Low (QLD)
381 Mr Greg Camoll (ACT)
382 Ms Ruth Walpole (ACT)
383 Ms Pat Tozer (ACT)
384 S E Corney (ACT)
385 Ms Louise Criddle (ACT)
386 Ms Rosemary Stokoe (ACT)
387 Ms Catherine Spencer (ACT)
388 Ms C MacKinnon (VIC)
389 Ms Claire Wallace (VIC)
390 Ms Jennifer Schroeder (VIC)
391 Ms Ruth Nickless (VIC)
392 Ms Rhonda Warr (VIC)
393 Ms Petrize Randall (QLD)
394 Ms I Foulds (VIC)
395 V Breman and S Turner (VIC)
396 Mrs C Jacob (VIC)
397 Ms Alex Cowdery (QLD)
398 Ms Lois Maharaj (QLD)
399 Ms Nadine Fearnley (QLD)
400 Ms Fiona Scott (QLD)
401 Ms Elizabeth Allan (QLD)
402 Ms Karen Joyce (QLD)
403 Ms Judith Ellen Renehan (QLD)
404 Ms Bronwyn Hinwood (QLD)
405 Ms Danielle Jackson (QLD)
406 Ms Slew-Tuan Smith (QLD)
407 Mr R Thorn (QLD)
414 Ms Sue MacLean (QLD)
415 Ms Margaret Staggs (QLD)
416 Ms Lesley McLean (QLD)
417 Ms Rosalind Woodward (QLD)
418 Ms DA Randell (QLD)
419 Ms Margaret Wilson (QLD)
420 Ms Gail Morosini (QLD)
421 Ms Michelle Windsor (QLD)
422 Ms J Sealey (QLD)
423 Ms Madeleine Leftley (ACT)
424 Ms Sandy Vojko Persi (ACT)
425 Ms Susan Kowalski (ACT)
426 Ms Genna Pereira (ACT)
427 Ms Angela Squires (ACT)
428 Ms Jo Jesse (NSW)

429 C M Johnston (ACT)
430 Ms Lisa Carruthers (ACT)
431 Ms Margaret Wylks (ACT)
432 Ms Helle Hirsch (ACT)
459 Ms Dorothy Thomas (QLD)
460 Ms Julie Nicole Boxsell (QLD)
461 Mr Joseph Kelly (QLD)
462 Ms Peta Jauch (QLD)
463 Ms Linda Byrnes (QLD)
464 Ms Wendy Pope (QLD)
465 Ms Joan-Mary McRae (QLD)
467 Ms Karyn Beers-Daniel (QLD)
468 Ms Mary Hartley (QLD)
469 Ms Sue Millar (SA)
481 Ms Leianne McArthur (QLD)
484 Ms Elizabeth Nugent (ACT)
485 Ms Rhonda Branz (NSW)
486 Ms Judith Fountain (ACT)
487 Ms Susan Collins (ACT)
488 Ms Lorna MacLellan (ACT)
489 Ms Christine Rees (ACT)
490 Ms Mary Cumming (ACT)
491 Ms Jackie Ballard (QLD)
492 Ms Sonya Gibbons (QLD)
493 Ms Julia Ritson (QLD)
494 Ms Magella Van Tienen (QLD)
495 Ms Barbara Nabbs (QLD)
496 Miss K Sawyer (QLD)
497 Ms Donna Buckle (QLD)
498 Ms Anne Murphy (QLD)
499 Ms Lola Mudie (QLD)
500 Ms Maree Doherty (QLD)
501 Ms Michelle Ashworth (VIC)
502 Ms Marg Moss (VIC)
503 Ms Val Dowell (VIC)
504 Ms Sandra Decker (VIC)
505 Mr Brad Russell (VIC)
506 Ms Margaret Bakonyi (VIC)
507 Ms Sue Peters (VIC)
508 Ms Sally Fegan (VIC)
512 Ms Cynthia McBride (QLD)
513 Ms Diane Wallis-Petersen (QLD)
514 Ms Caroline Muller (QLD)
515 Ms Nola Burley (QLD)
516 Ms Jacqui Smith (QLD)
517 Ms Nancy Coll (QLD)
518 Ms Anita Eisenreich (QLD)
519 Ms Debra Goodchild (QLD)
520 Mr Trevor Ellis (QLD)
521 Ms Dawn Paul (VIC)
522 Ms Kay Stocker (VIC)
523 Mc Eileen McDonnell (VIC)
524 Ms Simone Chettie (VIC)
525 Ms Angela Collins (VIC)
526 Ms Jan Griffin (VIC)
527 Ms Jeanette Dyson (VIC)
528 Ms Suzanne Schena (VIC)
529 Ms Saz Newbery (TAS)
530 Ms Julie Driver (TAS)
531 Ms Ruby Chan (TAS)
532 P Cameron (TAS)
533 Ms Elizabeth Clark (TAS)
534 Ms Jane Nichols (TAS)
535 Ms Sue Burke (TAS)
536 Ms Sheryl Alexander (TAS)
537 Ms Jane Jupe (TAS)
538 Ms Lyn Hooper (TAS)
539 Ms Helen Watts (TAS)
540 Ms Jeannie Green (TAS)
541 Ms Christine Muske (TAS)
542 Ms Carol Campbell (TAS)
543 Ms Trinette Rodwell (TAS)
544 Ms Lynne Smith (QLD)
545 Ms Colleen Woodhall (TAS)
546 P A Wainwright (TAS)
547 Ms Meredith Horwood (TAS)
548 Ms Sarah Johnson (TAS)
549 Ms Andrea Hitchens (TAS)
550 Ms Merlene O'Malley (TAS)
551 Ms Janie Wilson (TAS)
552 Ms Barbara Murphy (TAS)
553 Ms Jennifer Ransley (TAS)
554 Ms Ms Theng Cheng Hioh (TAS)
555 Ms Jane Banham (TAS)
556 Ms Jennifer Ladds (TAS)
557 Ms Rhonda Harris (TAS)
558 Ms Susan Gee (TAS)
559 Ms Kathy Clarke (TAS)

560 Ms Suzanne Graves (TAS)
561 Mr Justin Knight (TAS)
562 Ms K McCarthy-Bushby (TAS)
563 Ms Roslyn Woolford (TAS)
564 Ms Rosemary Whatley (TAS)
565 T Arnol (TAS)
566 Ms Philippa Perinski (TAS)
567 Mrs Sue Rushton (TAS)
568 Ms Derry Hoffman (TAS)
569 Ms Denise Walshe (TAS)
570 Mr Ross Mace (TAS)
571 Ms Bee Bradshaw (TAS)
572 Mr Andrew Saint (TAS)
573 Ms Antoinete Symons (TAS)
574 Ms Cheryl Smith (TAS)
575 Ms Elizabeth Hore (TAS)
576 Ms Anita Fahey (TAS)
577 Ms Marsha Rechberger (TAS)
578 Ms Joan Pickford (TAS)
579 Ms Nadine Price (TAS)
580 Ms Catmarie Foster (TAS)
581 W Noye (TAS)
582 E Hay (TAS)
583 Ms Tracy Gunston (TAS)
584 Ms Lisa Shelverton (TAS)
585 Ms Penni Ives (TAS)
586 Ms Ann Dodd (TAS)
587 Ms Leanne Moore (TAS)
588 Ms Erene Lunstedt (TAS)
589 Ms Duncan (TAS)
590 Ms Ruth King (TAS)
591 Ms Rhonda McCoy (TAS)
592 Ms Janet Cook (TAS)
593 Ms Alanna Dalwood (TAS)
594 Ms Fiona Down (TAS)
595 Ms Emmaline Shewan (TAS)
596 Ms Elizabeth Dawson (TAS)
597 Ms Anne Priest (TAS)
598 Ms Gaye Nichols (TAS)
599 Ms Pam Sykes (TAS)
600 Ms Jo Sims (TAS)
601 Ms R Brown (TAS)
602 Ms Helen McCowan (TAS)
603 Ms Janet Pendrigh (TAS)
604 Ms Diane Lyons (TAS)
605 Ms N Stratton (TAS)
606 J Richards (TAS)
607 Ms Anita Johnstone (TAS)
608 Ms Barbara Hoyt (TAS)
609 Ms Julia Taylor (TAS)
610 Ms Petrina Osborne (TAS)
611 Ms Marilyn Keizer (TAS)
612 Ms Debbie Seymour (TAS)
613 Ms Denise Kerslake (TAS)
614 Mrs Jennie Norman (TAS)
615 Ms Amelia Denton (TAS)
616 Ms Ronnie Kimber (TAS)
617 Ms Jude Maslin (TAS)
618 Ms Helen Starosta (TAS)
619 Ms Wendy Ashley (TAS)
620 Ms Kim Hedley (TAS)
621 P McGuire (TAS)
622 Mr M El-Said (TAS)
623 Ms Lucia Malengarb (TAS)
624 Ms Margaret Byrne (TAS)
625 Ms Judy Scott (TAS)
626 Mr John Loudon (TAS)
627 Ms Jedda Gibson (TAS)
628 Ms Susanne Lee (TAS)
629 Ms Sonia Mackenzie (TAS)
630 Ms Jennifer Tennant (TAS)
631 Ms Lea Young (TAS)
632 Ms Jannette Rare (TAS)
633 Ms Nola Polmear (TAS)
634 Ms Raie Semmens (TAS)
635 Ms Jenny Killworth (TAS)
636 Ms Georgina Connelley (TAS)
637 W Clark (TAS)
638 Ms Margaret Cole (TAS)
639 Ms Pam Harper (TAS)
640 Ms Alison Salisbury (TAS)
641 Ms Heather Allen (TAS)
642 Ms Janet Whitlock (TAS)
643 Ms Lisa Burnell (TAS)
644 Ms Ali Huntir (TAS)
645 Ms Yvonne Thomas (TAS)
646 Ms Pamela Cornish (TAS)
647 Ms Carol Barber (TAS)

648 Ms Anne Faulde (TAS)
649 Ms Fiona Trzeciak (TAS)
650 Ms Catherine Rosewell (TAS)
651 Ms Margaret Hunt (TAS)
652 Ms Eluned Vosper (TAS)
653 Ms Judy Hayes (TAS)
654 Mr Tony Furmage (TAS)
655 Ms N Webb (TAS)
656 Ms Penny Hampton (TAS)
657 Ms Kiren Couser (TAS)
658 Ms Carolyn Dawson (TAS)
659 Ms Leah Cashion (TAS)
660 Ms Carol Edwards (TAS)
661 Ms Elizabeth Hamilton-Godfrey (TAS)
662 Ms Jennifer Jones (TAS)
663 Ms Elizabeth Hinn (TAS)
664 Ms Lorraine McGee (TAS)
665 Ms Jacqui McElwee (TAS)
666 Ms Anne How (TAS)
667 Ms Patricia Reasen (TAS)
668 Ms Bridget Feavon (TAS)
669 Ms Emily McCrossen (TAS)
670 Mrs Jenny Hill (TAS)
671 Ms Dina Knowles (TAS)
672 Ms Glenna Thompson (TAS)
673 Ms Eileen Brown (TAS)
674 Ms Lesley West (TAS)
675 Ms Miranda King-Smith (TAS)
676 Ms Jenny Wise (TAS)
677 Ms Gillian Hunter (TAS)
678 Ms Patricia Nichol (TAS)
679 Ms Lorraine Semmter (TAS)
680 Ms Gabrielle Salvatore (TAS)
681 Ms Kathryn Sawford (TAS)
682 Ms Christine Turale (TAS)
683 Ms Barbara Roach (TAS)
684 Mr Philip Luccdou-Wells (TAS)
685 Ms Anna Folkerts (TAS)
686 Ms Jenny Morrison (TAS)
687 Ms Louise Smith (TAS)
688 Ms Susan Wogg (TAS)
689 Ms Barbara Ruschanow (TAS)
690 Ms Pamela Tait (TAS)
691 Name Withheld (TAS)
692 Ms E Saltmarsh (TAS)
693 Ms Ruth Avenim (TAS)
694 Mr Jason Bramish (TAS)
695 Ms Susan Whitmore (TAS)
696 Ms Martina White (TAS)
697 Ms Jillian Higgins (TAS)
698 Ms Lorraine Woods (TAS)
699 Ms Maureen O'Brien (VIC)
700 Ms Marguerile Smyth (ACT)
713 Ms Melanie Squires (ACT)
732 Ms Dawn Underwood (QLD)
789 Ms Kathryn Weaver (QLD)
821 Ms Belinda Davis (QLD)
827 Ms Deborah Wenham (QLD)
828 Mr Lindsay Winter (QLD)
829 Mr Paul Merton (QLD)
830 Ms Judith Macey (QLD)
831 Ms Susan Adams (QLD)
832 Ms Heather Nolan (QLD)
833 Ms Kathleen Geisler (SA)
841 Ms Sue Dean (NSW)
842 Ms Maureen Read (ACT)
843 Ms Denise O'Toole (ACT)
844 Ms Roxanne Ottaway (ACT)
845 Ms Noelle Leonard (ACT)
846 Ms Nadine Fairall (NSW)
847 Mrs Candelaria Angeles (ACT)
848 Ms Vicki Matthews (ACT)
849 Ms Moya Homan (ACT)
850 Ms Elizabeth Gunn (ACT)
851 Ms Sylvia Budynek (ACT)
852 Ms Edwina Smith (NSW)
853 Ms Mary Beveridge (NSW)
854 Ms Nancy David (ACT)
855 Ms Joy Tilsed (QLD)
856 Ms Sheila Penman (WA)
857 Ms Margaret O'Brien (QLD)
858 Ms Vicki Jones (QLD)
859 Ms Judith Buddy (QLD)
860 Ms Patricia Janke (QLD)
861 Ms Jennifer Holmes (QLD)
862 Ms Kay Genninges (QLD)
863 Ms Karen Berry (QLD)
864 Ms Barbara Duke (QLD)

865 Ms Debbi Nagel (QLD)
869 Ms Elaine Rogers (QLD)
870 Ms Deborah Ravida (VIC)
872 Ms Toni Ormston (VIC)
873 Ms Juliana Keyte (VIC)
874 Ms Gabrielle Peatt (VIC)
875 Ms Alice Wu (VIC)
876 Ms Jennifer Gillett (VIC)
877 Ms Sue Breese (VIC)
878 Ms Catherine McCarthy (VIC)
879 Ms Meg Jarvis (VIC)
880 Ms Leanne Stammers (VIC)
881 Ms J Allan (QLD)
882 Ms Dallas Meyers (QLD)
883 Ms Janet Yong (ACT)
884 Ms K Milbourne (ACT)
892 Ms Karen Champion (QLD)
901 Mr Warren Hann (QLD)
902 Ms Sarah Morton (QLD)
903 Ms Virginia Howie (QLD)
904 Ms Shirley Ann Fynney (VIC)
905 Ms Lesley Buttery (VIC)
906 Ms Debra While (VIC)
907 Ms Catherine Teague (VIC)
908 Ms Billie Searson (ACT)
909 Ms Joanne Hogan (NSW)
911 Ms Christine Hill (VIC)
916 Ms Moya Kennelly (ACT)
922 Ms Mary Bolger (VIC)
931 Ms Judy Clancy (QLD)
932 Ms Christine A Volk (QLD)
933 Mr Bill Klaric (VIC)
935 Ms Roma Toovey (QLD)
938 Ms Katherine Crowe (ACT)
939 P Stewart (QLD)
943 Ms Kylie Draper (VIC)
945 Ms Jennifer Maree Miragaya (ACT)
948 Ms Cheryl Hill (VIC)
955 Ms Jenny Wiley (QLD)
963 Ms Heather Utber (ACT)
964 Ms Michele Vieira (NSW)

An additional 34 individual responses to the questionnaire circulated by the ANF were received by the Committee either without identification or an address.

Additional Information

Department of Health Western Australia
(Provided at public hearing in Perth on 27 February 2002)

- Opening Statement
- Report of the West Australian Study of Nursing and Midwifery - New Vision, New Direction, 2001
- Interim Report on Enhaced Role Midwife Project, November 2001
- Pamphlet - Nurse Practitioner Project, Phase Two

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Tuesday 28 August 2002

Parliament House, Canberra

Department of Health and Aged Care
Mr Robert Wells, First Assistant Secretary, Health Industry & Investment Division
Mr Charles Maskell-Knight, First Assistant Secretary, Health Access & Financing Division
Ms Christianna Cobbold, Assistant Secretary, Health Capacity Development Branch
Dr Joanne Ramadge, Clinical Adviser in Aged Care
Mr Terry Barnes, Assistant Secretary, Financing & Analysis Branch
Mr Craig Lindsay, Director, Workforce Support Section, Office of Rural Health

Department of Immigration and Multicultural Affairs
Mr Abul Rizvi, First Assistant Secretary, Migration and Temporary Entry Division

Department of Education, Training and Youth Affairs
Mr Michael Gallagher, First Assistant Secretary, Higher Education Division
Dr Tom Karmel, Assistant Secretary, Information and Analysis Group
Dr Elizabeth McDonald, Information and Analysis Group

Wednesday, 27 February 2002

King Edward Memorial Hospital for Women, Subiaco, Perth

Australian & New Zealand College of Mental Health Nurses (WA Branch)
Dr Eamon Shanley, Vice President
Mr Gary Phillips, Branch Secretary

Association of Paediatric & Child Health Nurses (WA)
Ms Pamela O'Nions, Secretary

Community Nurses Special Interest Group (ANF - WA Branch)
Mr Murray Masters, President
Ms Leanda Verrier, Vice President

Obstetric Clinical Care Unit, King Edward Memorial Hospital for Women
Mrs Sharon Faulkner, Clinical Manager
Ms Janice Butt, Coordinator Midwifery Education

Peak Nursing Council (WA)
Mrs Toni Bishop, Secretary
Mr Michael Finn, Member

Senior Nursing Staff at Rockingham/Kwinana District Hospital & Murray District Hospital
Ms Heather Gluyas, Director of Nursing & Acute Care Services

Swan Health Service
Ms Moyra Cattermoul, Acting Director of Nursing
Ms Jillian Betts, Community Nurse Consultant
Ms Yvonne Burns, Coordinator Nursing (Hospital)

Health Department of Western Australia
Ms Beryl Cosgrove, Senior Nursing Officer
Ms Carol Pinch, Project Officer

Royal Perth Hospital Nursing Executive Council
Ms Susan Abbotts, Chair
Professor Gavin Leslie, Critical Care Nursing

Nursing Executive, Sir Charles Gairdner Hospital
Ms Diane Twigg, Executive Director, Nursing Services
Ms Sue Davis, Coordinator, Nursing Services
Mr Meih Singh, Nurse Co-Director, Cancer Clinical Service Unit

Aegis Health Care Group
Ms SimoneTedman, Manager Staff Services

Thursday, 28 February 2002

Function Room Level 3, Dallas Brooks Centre, East Melbourne

Australian Council of Deans of Nursing
Professor Pauline Nugent, Chair

RMIT University, Department of Nursing and Midwifery
Professor Olga Kanitsaki, Head
Professor Megan-Jane Johnstone
Dr Maureen Farrell, Senior Lecturer

Monash University, School of Nursing
Ms Jenny Oates, Acting Head

Australian Catholic University, School of Nursing (Victoria)
Ms Maria Miller, Head, School of Nursing

Latrobe Regional Hospital
Ms Debra Cerasa, Director of Nursing
Ms Diane Kennedy, Manager OH&S/Recruitment (Nursing)

Mercy Hospital for Women
Ms Julie Collette, Director of Nursing
Ms Teresa Valentine, Professional Development Co-ordinator

Austin and Repatriation Medical Centre
Mr Mark Petty, Executive Director of Nursing
Mr Shane Crowe, Nurse Unit Manager, Neurosurgery unit
Mrs Andrea Driscoll, course Coordinator of Graduate Certificate of Intensive Cardiac Nursing
Ms Jennifer Hancock, Nurse Unit Manager, Intensive Care Unit

Department of Human Services
Mr Shane Solomon, Executive Director, Policy & Strategic Projects Division
Ms Belinda Moyes, Principal Nursing Advisor

Australian Nursing Federation (Victorian Branch)
Ms Anne-Marie Scully, Professional Officer

National Enrolled Nurse Association
Ms Maryanne Craker, Secretary
Ms Maggie Ormerod, Committee Member

Victorian Council of Peak Nursing Organisations
Ms Jenny Goold, Chairperson

National Nursing Organisations
Ms Rosemary Bryant, Chairperson
Ms Marilyn Schroeder, Member
Ms Elizabeth Stickland, Member
Ms Robin Tchernomoroff, Member

Health and Community Services Union (Victorian Branch)
Mr David Stephens, A/g State Secretary
Ms Denise Guppy, Senior Vice President

Friday, 15 March 2002
Town Hall, Hobart

Australian Nursing Federation (Tas Branch)
Ms Neroli Ellis, Branch Secretary

Health & Community Services Union (Tas Branch)
Mr Tom Kleyn, Industrial Officer
Ms Sue Burke, Member

Nursing Board of Tasmania
Ms Moira Laverty, Chief Executive Officer

University of Tasmania, School of Nursing
Mr Gerry Farrell, Head of School
Dr Andrew Robinson, Senior Lecturer

Aged and Community Services Tasmania
Ms Caroline Wallace, DON, Southern Cross Care

Australian & New Zealand College of Mental Health Nurses (Tas Branch)
Ms Cecily Pollard, State President
Mr Jim Pearson, State Councillor

Community Mental Health Nurses Committee
Ms Linda Graham

Tasmanian Operating Room Nurses Inc
Ms Helen Taylor, President
Ms Sharon Bingham

Department of Health and Human Services
Mrs Rae de Silva, Co-Director of Surgery, Royal Hobart Hospital
Mrs Kerry Crowder, DLO, Minister's Office

Thursday, 21 March 2002

Parliament House, Canberra

ACT Community Care
Ms Heather McDonald, Principal Nurse & Director, Clinical Effectiveness and Quality Management
Ms Debbie Booth, Deputy Director, Integrated Health Care Program
Ms Sue Byrnes, Clinical Nurse Consultant, Child, Youth & Women's Program

ACT Mental Health Service
Mr Kevin Kidd, Acting Professional Head, Mental Health Nursing

Focus Group of Specialist Nurses
Ms Mary Kirk, Director of Nursing, QEII Family Centre
Ms Carmel McQuellin, Representative

ACT Government
Ms Susan Killion, Executive Director, Department of Health and Community Care
Mrs Rhonda Maher, Associate Director of Nursing, Calvary Health Care ACT & ACT Department of Health and Community Care
Ms Joan Scott, Manager, Workforce Unit, Health Policy & Reform Group, Health Strategy & Acute Services, Department of Health and Community Care
Ms Donna Mowbray, Senior Nurse Adviser, Canberra Hospital

Nurses Board of the ACT
Ms Ellen O'Keeffe, Elected Member
Ms Jill Parke, Board Member

Australian Private Hospitals Association
Mr Michael Roff, Executive Director
Ms Catherine Miller, Chair, Nursing Task Force & Chief Executive Officer, Wakefield Hospital, SA

Australian Healthcare Association
Mr Mark Cormack, National Director

Catholic Health Australia
Mr Francis Sullivan, Chief Executive Officer
Ms Barbara Paris, Director of Nursing, The Mater Hospital, North Sydney

UnitingCare Australia
Ms Lin Hatfield Dodds, National Director
Mr Bruce Shaw, Senior Policy Officer
Ms Lee Chin, Manager, Strategy Development, UnitingCare NSW/ACT Ageing & Disability Service
Ms Joanne Toohey, Operations Manager, UnitingCare Lucan Care, Sydney
Ms Cara Thomas, Deputy Operations Manager, UnitingCare Lucan Care

National Rural Health Alliance
Mr Gordon Gregory, Executive Director

Friday, 22 March 2000

Furama Hotel Central, Surry Hills, Sydney

Australian Nursing Homes and Extended Care Association (NSW)
Ms Julienne Onley

Australian Neonatal Nurses Association (ANNA)
Ms Jo Kent-Briggs, Secretary, ANNA

Association of Neonatal Nurses of NSW (ANN)
Ms Jennifer Dawson, President, ANN

Australian College of Emergency Nursing Ltd
Ms Linda Sims, Executive Member

NSW Midwives Association
Ms Pat Brodie, President

Enterprise and Career Education Foundation
Mr Peter Watts, Business Development Manager

Shellharbour College of TAFE
Ms Sandra Bolack, Head Teacher, Nursing, Illawarra Institute
Ms Katherine Child, Student, Illawarra Institute
Mr Martin Roosenburg, Student, Illawarra Institute

University of Western Sydney
Professor John McCallum, Dean, College of Social and Health Sciences
Professor John Daly, Head, School of Nursing, Family & Community Health

University of Technology, Faculty of Nursing, Midwifery & Health
Professor Jill White, Dean

Australian Catholic University – Faculty of Health Sciences
Professor Elizabeth Cameron-Traub, Dean, Faculty of Health Sciences

Avondale College, School of Nursing
Dr Paul Race, Dean, Faculty of Nursing Health

TAFE NSW Nursing Unit
Dr Christine Manwarring, Manager, Health and Aged Services
Mr Alan Brown, Senior Education Officer, Nursing

NSW Health Department
Ms Judith Meppem, Chief Nursing Officer

Nurses Registration Board of NSW
Ms Kate Dyer, Deputy President
Ms Jan Dent, Executive Director

NSW Nurses' Association
Ms Tracey McDonald, Manager, Professional Services
Mr Brett Holmes, Assistant General Secretary

Royal College of Nursing, Australia
Ms Elizabeth Foley, Director, Nursing Policy & Strategic Directions
Ms Stephanie Dakin, Policy Officer
Ms Lexie Brans, Manager, Education & Ethics

NSW College of Nursing
Professor Judy Lumby, Executive Director
Adjunct Professor Lorraine Ferguson, Director of Education Services
Ms Tracey Osmond, Assoc Director, Education Services

Becton Dickinson & Co
Mr Michael Lyon, Managing Director

Tuesday, 26 March 2002

Administration Building, Mater Miscericordiae Hospital, South Brisbane

Queensland Nurse's Union
Ms Gay Hawksworth, Secretary
Mrs Kym Barry, Professional Officer
Ms Beth Mohle, Project Officer
Ms Amanda Richards, Occupational Health & Safety Officer

Best Practice Australia
Mr Glenn Parle, Executive Director

Queensland Health Department
Ms Sue Norrie, Principal Nursing Adviser
Ms Gloria Wallace, State Manager, Organisational Development

Queensland University of Technology, School of Nursing
Professor Patsy Yates, Director of Postgraduate Studies
Ms Robyn Nash, Director of Undergraduate Programs

Griffith University, School of Nursing
Professor Debra Creedy, Professor of Nursing and Health

University of Southern Queensland
Ms Roslyn Reilly, Head, Department of Nursing

Australian Nursing Council
Ms Leanne Raven, Chairperson
Ms Marilyn Gendek, Chief Executive Officer

Queensland Nursing Council
Ms Stephanie Fox-Young, Acting Executive Officer
Ms Cathie Nesvadba, Coordinator, Nurse Education

Congress of Aboriginal & Torres Strait Islander Nurses (CATSIN)
Ms Sally Goold, Chairperson

Women's Hospitals Australasia & Children's Hospitals Australasia
Professor Jeremy Oats, Vice President
Ms Jan Kingston, Convenor, Executives of Nursing of Children's Hospitals Australasia
Ms Anne Cahill, National Director

Directors of Nursing Association Qld
Ms Glynda Summers, Vice President
Ms Colleen Glenn, Executive Committee Member

Australian Confederation of Paediatric & Child Health Nurses
Ms Karen Mason, Executive Member

Oncology Nurses Group of the Qld Cancer Fund
Ms Jane Roach, President
Ms Anne-Marie Dewar, Secretary

Nursing Staff, Mater Misericordiae Hospital
Ms Judy Nelmes, Director of Nursing
Dr Grace Croft, Assistant Director of Nursing (Research)

Child Youth and Family Health
Ms Vicki Attenborough, Clinical Nurse Consultant

Brisbane South Community Nurses, QNU Branch
Ms Lyn Duncan, Clinical Nurse
Ms Narelle Janke, Nurse Practice Coordinator

Wednesday, 27 March 2002
Prince Alfred Room, Town Hall, Adelaide

Adelaide University, Department of Clinical Nursing
Dr Helen McCutcheon, A/g Head
Ms Judy Magarey, Lecturer
Ms Tina Jones, Lecturer

University of South Australia, School of Nursing & Midwifery
Ms Marie Heartfield, Program Co-ordinator, International Programs
Ms Terri Gibson, Program Director, Undergraduate Program

Flinders University of South Australia, School of Nursing & Midwifery
Professor Sally Borbasi
Dr Jane Neill, Senior Lecturer

Australian Nursing Federation
Ms Jill Iliffe, Federal Secretary
Ms Robyn Parkes, RN, Public Sector
Ms Toni Zuch, RN, Aged Care Sector
Ms Sue Blott, RN, Rural Sector

Australian Nursing Federation (South Australian Branch)
Ms Lee Thomas, SA Branch Secretary
Mr Rob Bonner, SA Branch Industrial Officer

Australian College of Operating Room Nurses
Ms Kim Hepper, Representative

Australian Council of Community Nursing Services
Ms Julie Black, Director of the Royal District Nursing Service Education Centre

Australian Faith Community Nurses Association
Dr Antonia van Loon, Director of Development

NurseLink
Ms Joy Nugent, Director

Department of Human Services
Ms Debra Pratt, Principal Nursing Adviser
Ms Kae Martin, Director, Strategy & Operations, Statewide Division

Nurses Board of South Australia
Ms Lynette Cusack, Chair
Ms Judi Brown, Chief Executive Officer/Registrar

Adelaide Community Healthcare Alliance
Ms Chris McKoy, A/g Director of Nursing, Ashford Hospital
Ms Deb Lewis, Director of Nursing, Western Hospital
Ms Sandy Rennie, Director of Nursing, Memorial Hospital
Ms Sue Imgraben, Director of Nursing, Flinders Private Hospital

Royal Adelaide Hospital Nursing Executive
Dr Leslye Long, Director of Nursing & Patient Care Services
Ms Heidi Silverston, Nursing Director, Administration

APPENDIX 3

ISSUES RAISED IN SUBMISSIONS RESPONDING TO ANF QUESTIONNAIRE

The ANF and some State branches circulated a questionnaire based on the Committee's terms of reference to its members for completion and submission to the Committee. The Committee received 658 submissions from individual nurses in response to this questionnaire.

The questions contained in this questionnaire are listed below, although there was some variation across the States in which questions were used.

Q1. Briefly describe your current work situation, and factors impacting on the working lives of nurses. (Qld, Vic, ACT, Tas)

Q2. What strategies do you think would assist in the recruitment and retention of nurses? (Qld, Vic, ACT, Tas)

Q3. What changes do you think would assist the interface between universities and the health system and better prepare nurses to meet future labour force needs? (Tas)

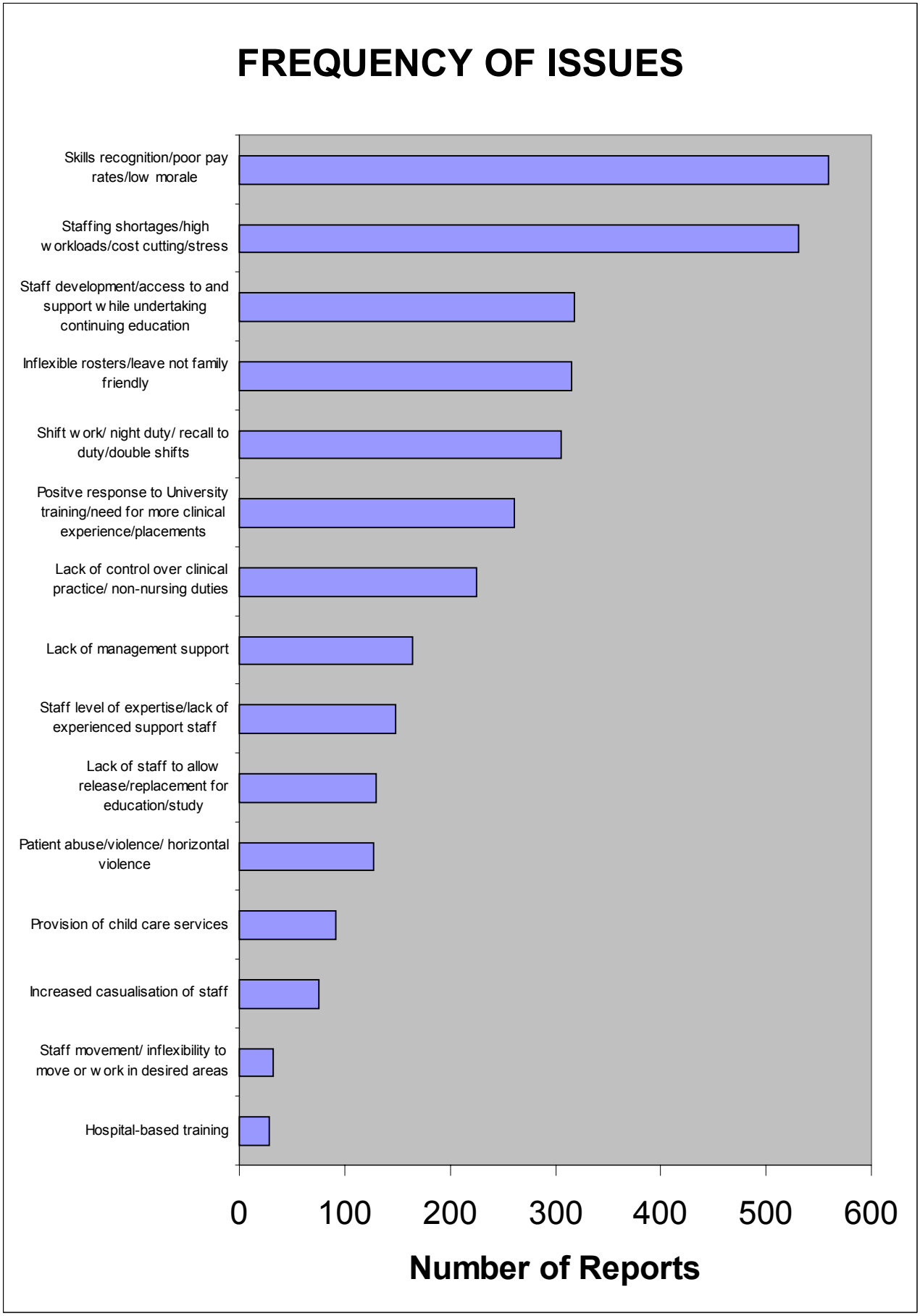
Q4. What has been successfully introduced recently to improve the recruitment and retention of nurses? (Vic)

Q5. What is still wrong with the system? (Vic)

Q6. What else can be done to address these shortfalls (eg education, scholarships)? (Vic).

The following information provides a listing of the general issues and concerns most commonly expressed by the nurses in response to the questionnaire, together with a profile of the respondents by area of practice, nursing specialty, length of nursing service and years they expect to remain in nursing.

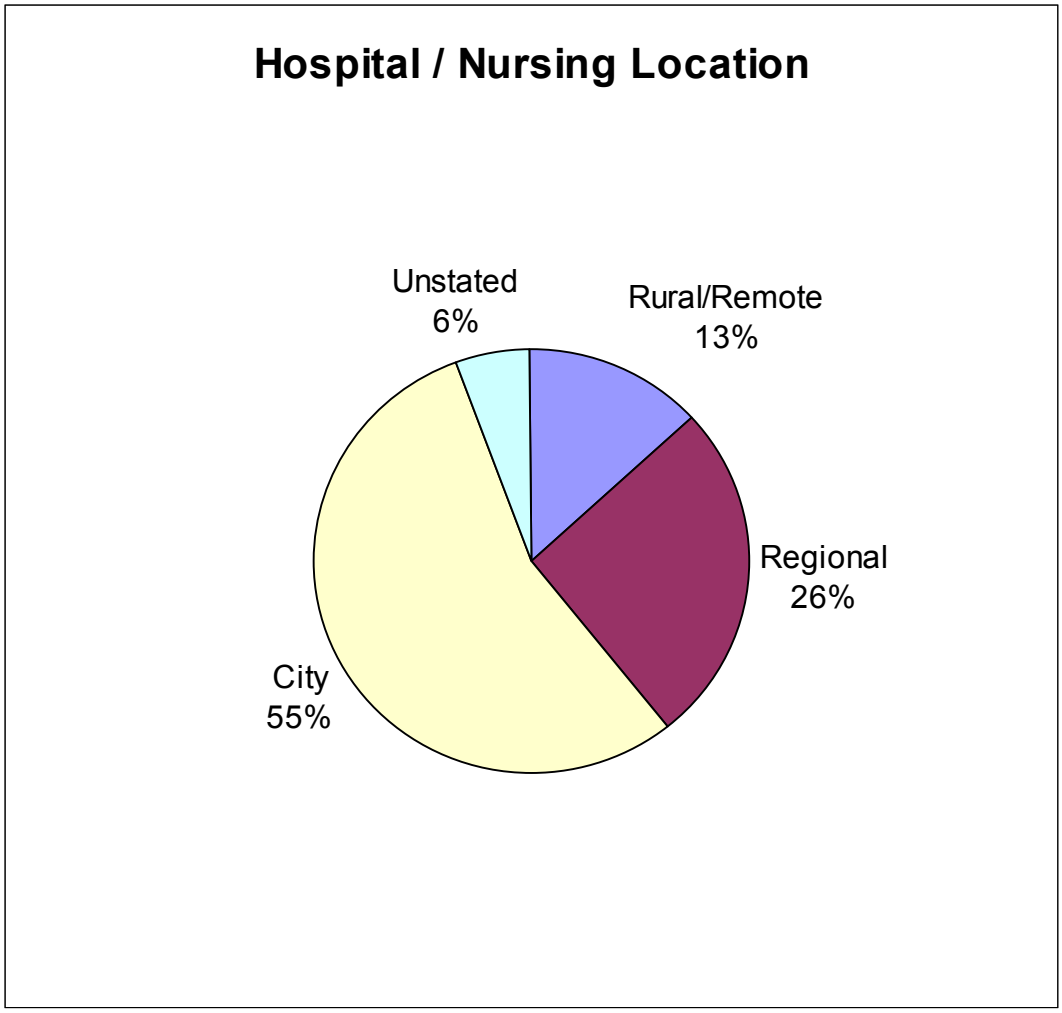
General issues/concerns most commonly expressed in nurse responses	No.	%
Skills recognition/poor pay rates/low morale	559	85.0%
Staffing shortages/high workloads/cost-cutting/stress	531	80.7%
Staff development/access to and support while undertaking continuing education	318	48.3%
Inflexible rosters/leave not family friendly	316	48.0%
Shift work/night duty/recall to duty/double shifts	305	46.4%
Positive response to University training/need for more clinical experience/placements	261	39.7%
Lack of control over clinical practice/non-nursing duties	225	34.2%
Lack of management support	164	24.9%
Staff level of expertise/lack of experienced staff support	149	22.6%
Lack of staff to allow release/replacement for education/study	130	19.8%
Patient abuse/violence/horizontal violence	127	19.3%
Provision of child care services	92	14.0%
Increased casualisation of staff	76	11.6%
Staff movement/inflexibility to move or work in desired areas	32	4.9%
Hospital-based training	28	4.3%
Total number of respondents		**658**


FREQUENCY OF ISSUES
Skills recognition/poor pay rates/low morale
Staffing shortages/high workloads/cost cutting/stress
Staff development/access to and support while undertaking continuing education
Inflexible rosters/leave not family friendly
Shift work/ night duty/ recall to duty/double shifts
Positve response to University training/need for more clinical experience/placements
Lack of control over clinical practice/ non-nursing duties
Lack of management support
Staff level of expertise/lack of experienced support staff
Lack of staff to allow release/replacement for education/study
Patient abuse/violence/ horizontal violence
Provision of child care services
Increased casualisation of staff
Staff movement/ inflexibility to move or work in desired areas
Hospital-based training
0
100
200
300
400
500
600
Number of Reports

Profile of nurses who responded to the questionnaire

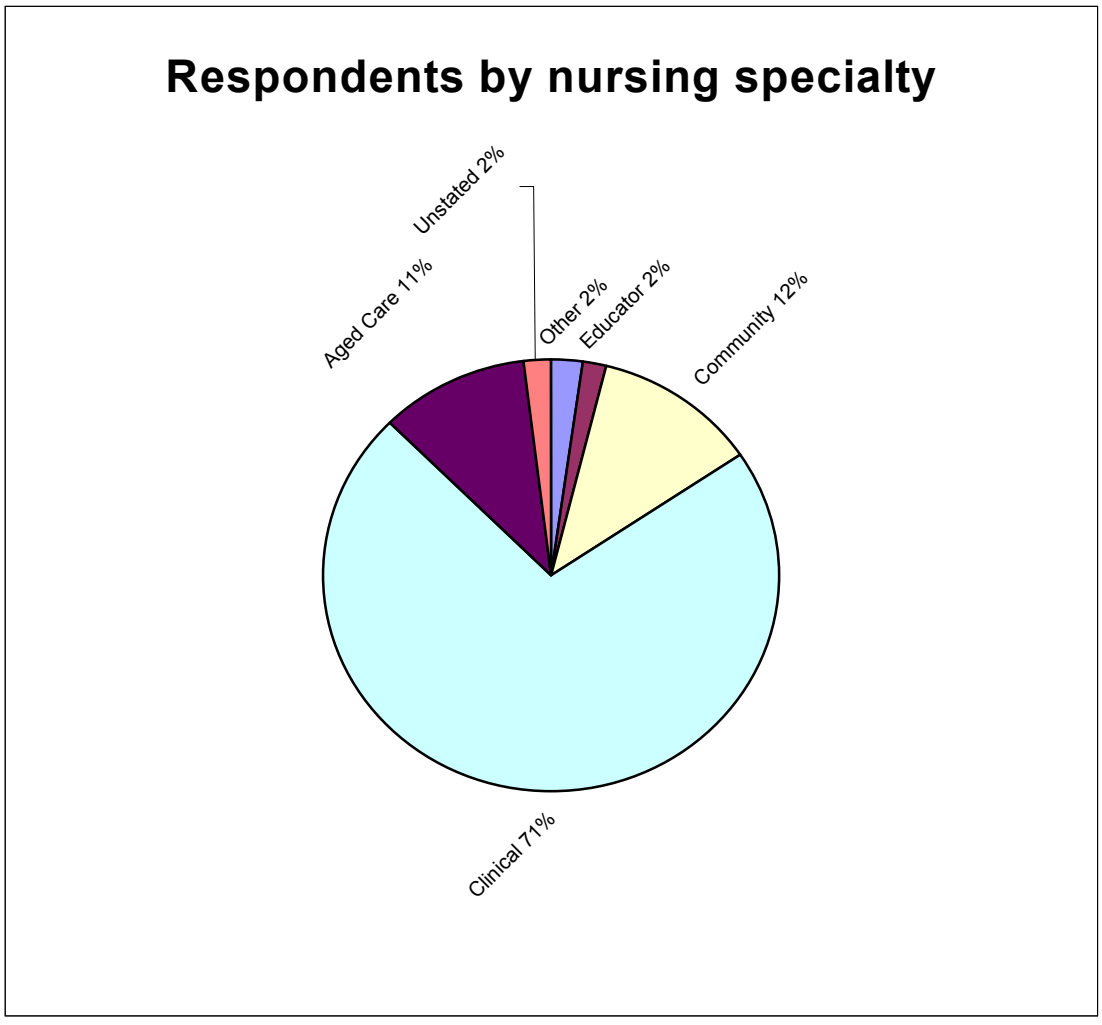
Location of Practice

Hospital/ nursing location	City	Regional	Rural/ Remote	Unstated	Total
Total for each area	362	171	87	38	658
Percentage	55.1%	26.0%	13.2%	5.6%	100%



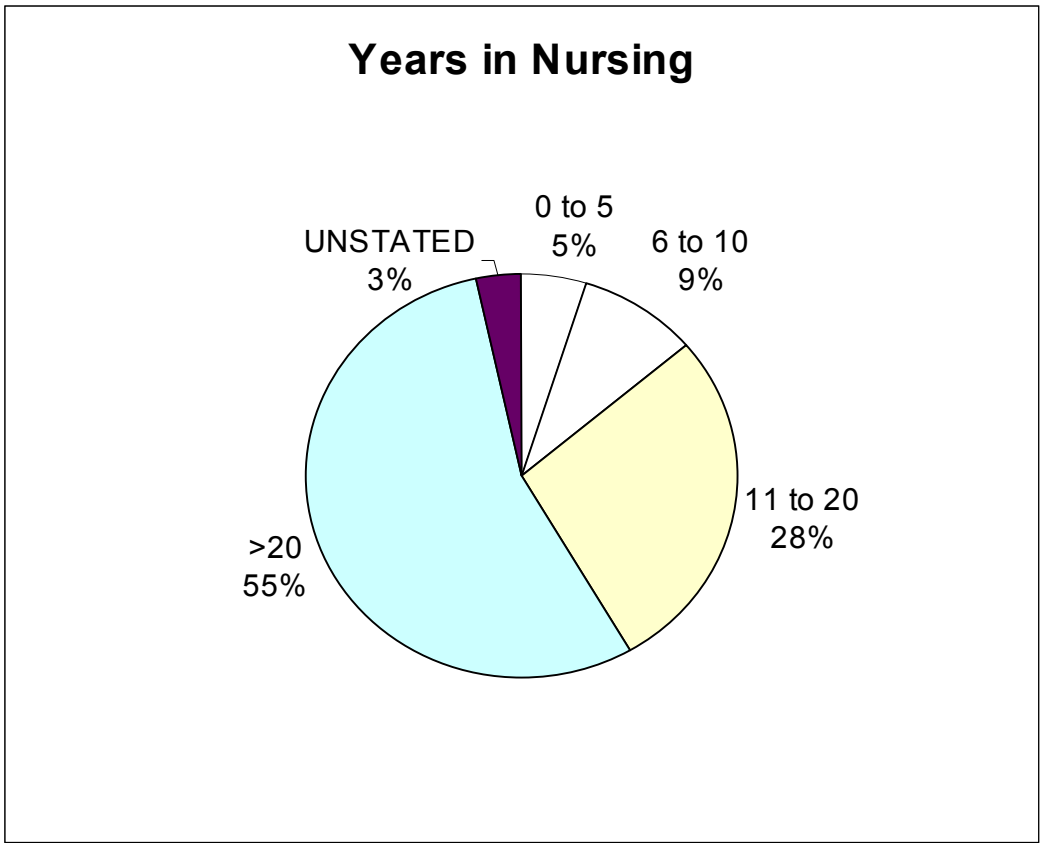
Nursing position

Nursing speciality	Clinical	Community	Aged Care	Educator	Other	Unstated	Total
	472	77	70	10	15	13	658
Percentage	**71.8%**	**11.7%**	**10.7%**	**1.5%**	**2.3%**	**2.0%**	**100.0%**



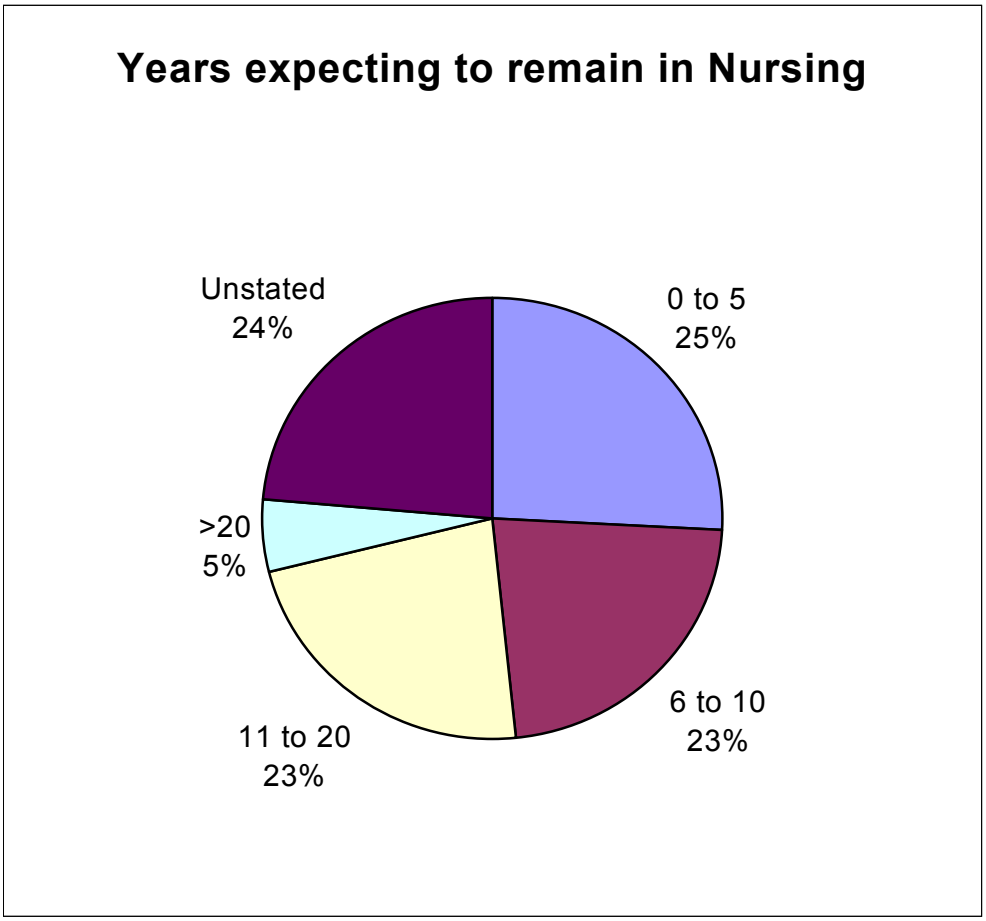
Length of nursing service

Years in nursing	0 to 5	6 to 10	11 to 20	>20	Unstated	Total
Respondents	33	59	182	361	22	658
Percentage	**5.0%**	**9.0%**	**27.7%**	**54.9%**	**3.3%**	**100%**



Years expected to remain in nursing

Years expecting to remain in nursing	0 to 5	6 to 10	11 to 20	>20	Unstated	Total
Totals	170	148	149	34	157	658



APPENDIX 4

BIBLIOGRAPHY

This Appendix contains a list of reports of recent reviews, inquiries or commissioned studies into all aspects of nursing in Australia; a list of submissions with helpful bibliographies on nursing; and a list of websites from a range of organisations involved in nursing both in Australia and overseas.

Reports of recent reviews, inquiries or commissioned studies

A Review of the Current Role of Enrolled Nurses in the Aged Care Sector: Future Directions, Working Group on Aged Care Worker Qualifications of the National Aged Care Forum, Department of Health and Aged Care, August 2001.

Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, Standing Committee on Aboriginal and Torres Strait Islander Health, AHMAC, May 2002.

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

An Overview of Issues in Nursing Education, Johnson, D. and Preston, B, Report to the Evaluations and Investigations Program, Higher Education Division, Department of Education, Training and Youth Affairs, Canberra, October 2000.

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Education Strategies for the Midwifery Workforce, NSW Department of Health, 2000.

Education, Training and Professional Support for Rural Nurses: a National Survey of Rural Health Training Units, Association for Australian Rural Nurses, 1998.

Enhanced Role Midwife Project, WA Department of Health, November 2001.

Enhancing Rural and Remote Health Care by making better use of the skills and capacity of nurses: Recommendations from a Workshop on remote and rural nursing practice, A Discussion Paper, National Association of Rural Health Education and Research Organisations, June 2001.

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International Mid-Term Review of the Second National Mental Health Plan for Australia, Betts, V and Thornicroft, G, November 2001.

Job Growth and Replacement Needs in Nursing Occupations, Shah, C & Burke, G. Report 01/18 to the Evaluations and Investigations Programme, Higher Education Division, Department of Education, Science and Training, 2001.

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Midwifery Workforce Planning for Queensland, Queensland Health, 1998.

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New Vision, New Direction: Report of the West Australian Study of Nursing and Midwifery, WA Department of Health, 2001 and 2002 Status Plan.

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NSW Midwifery Taskforce Report and Analysis of Responses, NSW Department of Health, 1996.

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Nurse Practitioner Project: Final Report of the Steering Committee, NSW Health Department, 1995.

Nurse Recruitment and Retention Committee, Final Report, Department of Human Services Victoria, May 2001 and Government Response, June 2001.

Nursing Education in Australian Universities: Report of the National Review into Nurse Education in the Higher Education Sector – 1994 and beyond, Canberra, 1994, Chair: Professor Janice Reid.

Nursing Recruitment and Retention Ministerial Taskforce, Final Report, Queensland Health, September 1999.

Nursing Recruitment and Retention Taskforce, Final Report, New South Wales Health Department 1996.

Quality of Working Life for Nurses: Report on Qualitative Research, commissioned study, Department of Health and Ageing, 2002.

Quality Wages, Quality Staff, Quality Care – An Analysis of the Nursing Wages Crisis Confronting Australia's Residential Aged Care Sector, Australian Nursing Federation, 2001.

Recommendations to Develop Strategies for the Recruitment and Retention of Indigenous Peoples in Nursing, CATSIN, August 1998.

Recruitment and Retention of Nurses in Residential Aged Care: Final Report, commissioned study, Department of Health and Ageing, 2002.

Recruitment and Retention of Nurses: Progress Report, June 2001, NSW Health.

Recruitment and Retention of Nurses 2000: Taskgroup Report, SA Department of Human Services, 2000

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Rural Health Stocktake Advisory Paper to the Commonwealth Department of Health and Aged Care, Best, J, March 2000.

Scoping study of the Australian mental health nursing workforce 1999: Final report, M. Clinton, Department of Health and Aged Care, 2001.

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Stop Telling Us to Cope!, A report for the NSW Nurses' Association by the Australian Centre for Industrial Relations Research and Training, May 2002.

Tasmanian Nurse Workforce Planning Project: Final report, Department of Health and Human Services Tasmania, November 2001.

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

The Role of Practice Nurses and Nurse Practitioners: Discussion Paper, General Practice Partnership Advisory Council, 2001.

Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010, Queensland Health Discussion Paper, September 2000.

Victorian Rural Nurse Project: Workforce Database – Final Report, Monash Centre for Rural Health, 1999.

Submissions with useful bibliographies attached

444 – Nurses Board of the ACT

449 – Tasmanian School of Nursing

783 – ACT Focus Group of Specialist Nurses

800 – National Rural Health Alliance

887 – Queensland Nursing Council

891 – NSW Midwives Association

912 – Australian Midwifery Action Project

927 – Royal College of Nursing, Australia

962 – Australian Nursing Federation

Useful websites

This list is not intended to be comprehensive. Many of the sites listed contain links to a wide range of organisations involved with nursing.

Australian Nursing Organisations

Australian College of Critical Care Nurses
www.acccn.com.au

Australian College of Midwives Incorporated
www.acmi.org.au

Australian Council of Community Nursing Services
www.accns.asn.au

Congress of Aboriginal and Torres Strait Islander Nurses
www.indiginet.com.au/catsin

National Enrolled Nurse Association
www.anf.org.au/nena

National Nursing Organisations
www.anf.org.au/nno

National Rural Health Alliance
www.ruralhealth.org.au

New South Wales College of Nursing
www.nursing.aust.edu.au

Nursing Careers Allied Health
www.ncah.com

Royal College of Nursing, Australia
www.rcna.org.au

Australian and New Zealand College of Mental Health Nurses
www.healthsci.utas.edu.au/nursing/college/index.html

Commonwealth and State Departments

Commonwealth Department of Health and Ageing
www.health.gov.au

Commonwealth Department of Education, Science and Training
www.dest.gov.au

Commonwealth Department of Immigration and Multicultural and Indigenous Affairs
www.immi.gov.au

ACT Health
www.health.act.gov.au

NSW Health
www.health.nsw.gov.au

Queensland Health
www.health.qld.gov.au

Department of Health - Western Australia
www.health.wa.gov.au

Department of Health and Human Services - Tasmania
www.dhhs.tas.gov.au

Department of Health and Community Services - Northern Territory
www.health.nt.gov.au

Department of Human Services - South Australia
www.sa.gov.au/health

Department of Human Services - Victoria
www.dhs.vic.gov.au

Australian Nurse Registration Authorities

Australian Nursing Council Incorporated
www.anci.org.au

Nurses Board of NSW
www.nursesreg.nsw.gov.au

Nurses Board of the ACT
www.healthregboards.act.gov.au

Nurses Board of South Australia
www.nursesboard.sa.gov.au

Nurses Board of Western Australia

www.nbwa.org.au

Nursing Board of Tasmania
www.nursingjobs.com.au/Tasmania/NursingBoard/default.htm

Queensland Nursing Council
www.qnc.qld.gov.au

Nurses Board of Victoria
www.nbv.org.au

Australian Nursing Federation (ANF) Branches

ANF National Office
www.anf.org.au

New South Wales (NSW Nurses' Association)
www.nswnurses.asn.au

Queensland (Queensland Nurses' Union)
www.qnu.org.au

ANF South Australia
www.sa.anf.org.au

ANF Tasmania
www.ice.net.au/anf

ANF Victoria
www.anfvic.asn.au

ANF Western Australia
www.anfwa.asn.au

International Nursing Organisations

International Council of Nurses
http://icn.ch

American Nurses Association
www.ana.org

Canadian Nurses Association
www.cna-nurses.ca

Royal College of Nursing UK
www.rcn.org.uk

The Nursing and Midwifery Council (formerly UKCC)
www.nmc-uk.org

The Nursing Council of New Zealand
www.nursingcouncil.org.nz