

**Human
Services**



Peoplefirst

Nurse Recruitment and Retention Committee

**Final Report
May 2001**

**Policy and Strategic
Projects Division**



Nurse Recruitment and Retention Committee

Final Report

May 2001

Further Information

For further information contact:

Geraiut Duggan
Nurse Policy Branch
Policy and Strategic Projects

Department of Human Services
Level 12, 555 Collins Street
Melbourne 3000

Telephone: (03) 9616 6984
Facsimile: (03) 9616 9877

The government response to these recommendations can be found at:
nursing.health.vic.gov.au

Acknowledgments

The members of the Nurse Recruitment and Retention Committee have many people to thank for their input into the deliberations of the Committee. This includes the members coopted to the subcommittees who gave freely of their time, effort and expertise over an intense period of time. It also includes the many people who prepared submissions for the Committee and responded to our surveys, and the peak and other groups that engaged in discussion with members of the Committee. Special thanks to the many nurses who attended the public forums and the focus groups and who were free, frank and open in their comments. We also appreciate the efforts of many in the Department of Human Services who provided us with technical advice and data to inform our deliberations.

The report was prepared for the Victorian Minister of Health.

Published by Policy and Strategic Projects
Division

Victorian Government Department of Human
Services, Melbourne Victoria

May 2001

Also Published on www.dhs.vic.gov.au

© Copyright State of Victoria 2001

(1310101)

2 May 2001

The Hon John Thwaites MP
Minister for Health
555 Collins Street
MELBOURNE 3000

Dear Minister

It is with pleasure that I present to you the completed report of the Nurse Recruitment and Retention Committee.

As you requested, we sought information through an exhaustive consultation process, ensuring that all levels of nurses in all areas of practice had the opportunity to bring issues to us. In addition, a literature search was undertaken that emphasized the national and international dimensions of the problems we are facing in Victoria. Although issues of recruitment and retention are complex, common themes have emerged from our consultations and information gathering. In essence these relate to conditions of work, especially heavy workloads and inflexible working conditions, the absence of a clinical career structure, lack of recognition for and support of nurses, difficulties with education and the image of nursing.

I am pleased to report that the members of the committee have unanimously endorsed all the recommendations.

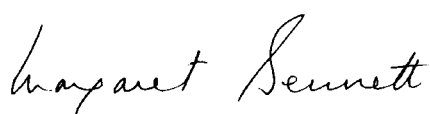
The report initiates the extent of the problems of recruitment and retention in Victoria. It recommends strategies aimed at attracting people into nursing, recruiting those who have left back into nursing and retaining nurses who are currently employed in the public health sector in Victoria. The recommendations are organized in an order of priority, so that not only immediate issues are addressed, but those of the medium and longer term.

A small number of the recommendations contained in this report have already been recommended as part of the arbitration decision handed down by Commissioner Blair on 31st August 2000. These focus largely on the improvement of working conditions for nurses and are considered as high priority areas in this report. However, the issues are many and complex and require long term as well as immediate solutions. The wide range of strategies recommended here requires co-ordinated action by Governments, State and Commonwealth health care facilities and education providers.

Currently, many parts of the world are addressing issues of nurse recruitment and retention. There is a paucity of information of the effectiveness or otherwise of strategies that are implemented. Victoria needs to evaluate its implemented strategies. They should result in the attraction of sufficient people of high calibre to nursing to ensure supply meets demand, the stemming of the exodus of experienced qualified nurses not only from the bedside but also from the profession, and the retention of nurses who not only provide best practice care, but are satisfied in their work

I commend the report of the committee to you for your consideration.

Yours sincerely



Professor Margaret Bennett
Chair,
Nurse Recruitment and Retention Committee

Foreword

The Government appointed the Nurse Recruitment and Retention Committee in February 2000 to provide advice on matters relating to the registered nurse workforce in Victoria.

Nurses are critical to the delivery of quality healthcare in the State, in both the hospital and community settings. The Government moved quickly to establish the Committee in response to widespread concern regarding staffing shortages and the lack of workforce planning to address the shortages. Of particular concern to the Government were reports that around 20% of the registered nursing workforce were choosing not to work in the profession. The Committee was charged with investigating why nurses were leaving the profession, to advise on strategies to encourage existing nurses to remain, and to recruit nurses back into the public health system.

The Committee was asked to consult widely, and to seek the views of the healthcare industry, the education sector, trade unions and peak bodies. In particular, the Government wished to hear the views of nurse clinicians who deliver nursing care, in the acute care, mental health, aged care, community and midwifery settings. In seeking these views the Committee was asked to consult with nurses working in regional and rural Victoria, as well as those in metropolitan areas. I would like to thank all nurses who contributed to the committee's consultation, either through submissions, focus groups, surveys or attendance at public forums.

The work of the committee was undertaken during the period when extensive discussion was taking place, under the direction of the Australian Industrial Relations Commission, on the public sector and mental health nursing workforce agreements. Since that time many of the recommendations in this report have been fully funded and implemented by the Government following the finalisation of the industrial agreement.

Of the report's 86 recommendations, 44 are targeted at Government. The Government has already enacted or commenced work on over half of these, and in many cases it has exceeded the Committee's recommendation, including:

- paid study leave for over 1200 nurses
- scholarships for Division 1 nurses undertaking post-graduate programs in four areas of critical shortage: perioperative, neonatal intensive care, intensive care and emergency nursing
- an extensive print and radio advertising campaign to inform the nursing workforce of changed pay and conditions
- \$7 million spent establishing refresher and re-entry programs to assist nurses returning to work
- a review of the provision of childcare for nurses
- funding to assist undergraduate nurses undertaking clinical placements

The Government remains committed to supporting and promoting the profession of nursing in Victoria. I have established the Nurse Policy Branch within the Department of Human Services to coordinate and oversee the implementation of this report's recommendations, in addition to policy work related to, amongst other things, the Nurse Practitioner Project, the extension of the scope of practice for Division 2 nurses and the ongoing work of the Nurse Back Injury Prevention Project.

I would like to take this opportunity to thank Professor Bennett and all the committee and sub committee members (listed in Appendix Two of this report) for their hard work and dedication in completing this report. In accepting the report's recommendations, I am confident that Victorian nurses will now feel that they can practice in an environment where they are valued and rewarded for their crucial contribution to the health of all Victorians.



John Thwaites MP
MINISTER FOR HEALTH

Contents

Acknowledgements	ii
Foreword	iv
Abbreviations and Conventions	vii
Executive Summary and Recommendations	1
Recommendations — High Priority	2
Recommendations — Medium Priority	11
Recommendations — Long Term Priority	13
The Nurse Recruitment and Retention Committee and the Enterprise Agreement for Nurses	14
1. Introduction	19
1.1 Committee Process	19
1.2 Committee Membership	19
1.3 Establishment of Sub-Committees	19
1.4 Information Collection and Consultation Process	20
1.5 Context	20
1.6 Report Structure	20
Part 1—The Scope of the Problem	23
2. Nursing Shortages	25
2.1 The International Experience	25
2.2 The Victorian Nursing Workforce	31
2.3 National Data Sets	34
2.4 Victorian Data	35
2.5 Indicators of Shortage in Victoria	37
3. Problems in Nursing	41
3.1 Workload	41
3.2 Unsafe Working Environment	44
3.3 Equipment Available	45
3.4 Career Structure	45
3.5 Support for Nurses	45

3.6 Education Cost and Access	46
3.7 Family Issues	46
3.8 Specific Issues for Rural Nurses	47
3.9 Specialty Issues	47
3.10 Management	48
Part Two – Strategies	49
4. Attracting Nurses into the Workforce	51
4.1 The Image of Nursing	51
4.2 Undergraduate Recruitment	51
4.3 Attracting Nurses Back into Nursing	52
4.4 Injured Nurses.....	56
5. Education of Nurses	57
5.1 Undergraduate Education	57
5.2 Postgraduate Education.....	65
5.3 Graduate Nurse Programs	67
5.4 Continuing Education	69
5.5 Study Leave.....	72
5.6 The Training and Development Grant.....	73
6 Retaining Nurses in the Workforce	77
6.1 The Workplace	77
6.2 Working Conditions	88
6.3 Special Issues	102
Bibliography	107
Appendices	
One—Terms Of Reference	113
Two—Committee Membership	114
Three—Quantitative Survey of Registered, Non-Working Nurses	115
Four—Qualitative Survey of Registered, Non-Working Nurses	143
Five—Report of the Open Consultation Forums	155
Six—Report of the Focus Group Consultation	165
Seven—Submissions Received	205
Eight—Survey Instruments	207
Nine—Training and Development Grant Details	208

Abbreviations and Conventions

ABS	Australian Bureau of Statistics
ACCCN	Australian College of Critical Care Nurses
ACNMI	Australian College of Nurse Management Inc
ADO	Accrued day off
AHMAC	Australian Health Ministers Advisory Council
AIRC	Australian Industrial Relations Commission
AIH&W	Australian Institute of Health and Welfare
AMHS	Area Mental Health Service
ANUM	Associate Nurse Unit Manager (formerly Associate Charge Nurse)
ANCI	Australian Nursing Council Inc.
ANF	Australian Nursing Federation, Victorian Branch (unless otherwise stated)
ANZCMHN	Australia and New Zealand College of Mental Health Nurses
Acute inpatient unit	Short stay psychiatric ward, usually co-located with a general hospital.
Assistants in nursing	Non-nursing trained workers whose duties involve direct patient contact. Often assisting nurses.
AQF	Australian Qualification Framework
Award	Nurses (Victorian Health Services) Award 1992
Casemix	Health service funding formula based on clinical activity
CAT	(Psychiatric) Crisis Assessment and Treatment
CEAV	Careers Education Association of Victoria.
Certificate IV in Health (Nursing)	Course leading to registration as a Division 2 Nurse with the Nurses Board of Victoria
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
DETYA	Department of Education, Training and Youth Affairs
Department of Human Services	Department of Human Services (Victoria)
Division (1–5)	This refers to the Division of the Nurses register maintained by the Nurses Board of Victoria. The number refers to the specific division.
Division 1	Formerly known as general nurses, now includes all (since 1994) three-year university educated nurses

Division 2	Formerly known as enrolled nurses. Now trained in the Vocational Education and Training sector.
Division 3	Formerly known as psychiatric nurses. register closed; new, overseas or interstate trained psychiatric nurses are now registered in Division 1.
Division 4	Formerly known as intellectual disability nurses, register closed.
Division 5	Mothercraft nurses, register closed.
DoN	Director of Nursing
EFT	Effective full-time
EN	Enrolled Nurse (Division 2 Nurse)
ENTER	Formerly TER: the tertiary entry score required for university application.
ENSIG	Enrolled Nurses Special Interest Group
FFP	Full Fee Paying (Fee charged on full cost recovery basis for University courses)
FTE	Full-time equivalent Graduate Nurse Program A hospital-based education program for nurses in their first year of postgraduate clinical practice
HACSU	Health and Community Services Union
HECS	Higher Education Contribution Scheme (A proportion of the cost of a university course charged to the student)
Horizontal Violence	Covert or overt harassment perpetrated by nurses against their colleagues
HSUA	Health Services Union of Australia
NBV	Nurses Board of Victoria
NENA	National Enrolled Nurses Association
NHS	National Health Service (United Kingdom)
NUM	Nurse Unit Manager (formerly Charge Nurse)
Nurse Policy Branch	The Branch of Department of Human Services established to coordinate Victorian Government nursing policy
PETE	(Office of) Post-Compulsory Education, Training and Employment
OTFE	Office of Training and Further Education
Postgraduate Qualification	A University course undertaken in advanced or specialist practice by a registered nurse
Preceptor	A trained nurse acting in a mentor-type role for a student or new graduate nurse
RCNA	Royal College of Nursing Australia
RFM	Relative Funding Model
RN	Registered Nurse

RPN	Registered Psychiatric Nurse
SCN	Senior Clinical Nurse. Proposed title to replace Clinical Nurse Specialist CNS
TAFE	Tertiary and Further Education
Telehealth	Videoconferencing network
Time in lieu	Time taken off to compensate for extra time worked. An alternative to paying overtime rates.
T&D	Grant Training and Development Grant
UHCW	Unlicensed Health Care Workers, for example, Personal Care Attendant
VET	Vocational Education and Training
VHA	Victorian Healthcare Association
VHIA	Victorian Hospitals Industrial Association
Victorian Deans of Nursing	Victorian and Tasmanian Deans of Nursing
VTAC	Victorian Tertiary Admissions Centre
VCOPNO	Victorian Council of Peak Nursing Organisations

Executive Summary and Recommendations

As a result of a Government initiative to address the current shortage of nurses in Victoria, in February 2000, the Minister for Health established the Nurse Recruitment and Retention Committee. The purpose of the Committee was to provide advice to the Minister on matters in relation to the registered nurse workforce in Victoria.

The Committee membership was chosen by the Minister for Health and was composed of a broad cross-section of the nursing workforce, drawn from metropolitan and rural clinical nurses, industrial and professional bodies, the tertiary sector and hospital management.

The Committee focuses on issues relating to the attraction and recruitment of nurses, the exodus of nurses from the workforce, and the retention of qualified, experienced nurses within the public hospital sector.

The Committee established three sub-committees to explore the issues around attraction and recruitment, education and retention. Each sub-committee coopted a wide range of specialist expertise from the health care and education sectors to add to deliberations. Emphasis was placed on ensuring that the rural and regional perspective was well represented.

The Committee sought information through a process involving an extensive literature review and submissions from public and private hospitals and peak organisations. The Committee undertook an exhaustive consultation process to access the views of clinical nurses and conducted a series of surveys, focus groups, nine open forums in both metropolitan and regional Victoria, as well as consultation with individuals and groups in relation to specific areas of nursing. All levels of nurse, in all areas of practice, had the opportunity to bring issues to the Committee.

The Committee handed down an interim report to the Minister for Health in April 2000. As a result the of its recommendations, the

Government announced \$1 million funding for public hospitals and health services to develop and run re-entry and supervised practice programs to enable nurses who had allowed their registration to lapse to regain registration and re-enter the nursing workforce.

Context

There is widespread support for the view that there are insufficient nurses staffing the Victorian public health care system. The Department of Human Services, in its *Nurse Labourforce Projections, Victoria 1998–2009* report of 1999, estimated that with current levels of demand for health services, Victoria would face a shortfall of 5,500 registered nurses by 2008. Department of Human Services data demonstrates that, of 69,000 nurses with current registration in Victoria, more than 13,000 are not currently employed in the nursing workforce.

While Victoria, unlike many other States and Territories, has been able to fill places on undergraduate nursing courses, there is concern that 30 per cent of new graduates of Division 1 and Division 2 courses choose not to practise nursing or leave the nursing workforce after their first year of employment.

The problems facing the nursing workforce are not unique to Victoria. New South Wales, Queensland, South Australia and Western Australia have all conducted and reported on nurse recruitment and retention issues within the last five years as have, amongst others, the governments of the United Kingdom and New Zealand. The findings of many of these reports are applicable to Victoria.

The Committee has been hampered by the lack of available nursing workforce data. A review of local and international literature has shown that many state and federal governments have identified lack of workforce data and lack of integrated nurse labourforce planning as major impediments to addressing nursing workforce shortfalls. The Committee makes several

recommendations aimed at improving the data available to Victorian labour force planners.

The issues surrounding recruitment and retention of nurses are complex and are influenced by a multitude of factors, not all of which are within the scope of governments to control. The ageing of the nursing workforce, the proliferation of career opportunities available to women, the increasing demands placed on the health care system by society, rapid changes in health care technology with associated requirements for educational preparation, and the trend towards community care for all but the sickest patient, have a direct effect on the demands made on the nursing workforce.

This report describes in detail many of the issues that have been brought to the Committee as pressing issues that need to be addressed to return stability to the nursing workforce. While some of the issues apply to clearly defined areas of nursing specialty, there are other general issues which the Committee considers to be of paramount importance, and which are raised in this summary.

During the lifetime of the Committee, the Australian Nursing Federation (ANF), the Health Services Union of Australia Number 1 Branch (HSUA) and the Health Services Union of Australia Number 2 Branch (Health & Community Services Union—HACSU) lodged enterprise bargaining claims on behalf of public sector nurses in the general and mental health sectors. There was considerable overlap in many of the issues considered by the Committee and those contained in the claims. The claim for general nurses went before the Industrial Relations Commission for arbitration in August 2000, and a decision was handed down on 31 August 2000. A comparison of the Commission's decision and the Committee's recommendations is made following the list of recommendations on page 32.

Workload

Representations to the Committee from those working in the public hospital system, and those who have left, make clear the view that nursing is increasingly becoming physically and mentally exhausting. For a variety of reasons, the workload has increased to the

point where many nurses are no longer prepared to work under the resultant stress. It is clear that unless workloads are reduced, and nurses feel they have more control over their working conditions and environment, there will not be the attraction for either recruitment or retention in the Victorian nursing workforce. The control of nursing workloads is discussed in section 6.1 of this report.

Education

The Committee makes recommendations about the educational preparation of nurses throughout the continuum from undergraduate preparation to postgraduate, specialist education. It is clear that preparation for clinical practice and access to continuing education are key factors influencing the retention of nurses. The Committee received numerous submissions relating to the undergraduate preparation of nurses, particularly in relation to the transition to clinical practice and ability of new graduates to care for those with mental illness. In addition, issues relating to the cost of, and access to, postgraduate specialist education have been consistently raised with the Committee as a cause of stress to the nursing workforce. Education issues are discussed in Chapter 5 of this report.

Career Structure

The consultation process has revealed to the Committee the extent to which the current career structure acts as a disincentive for clinical nurses with skill and expertise to remain in the patient care setting. The interpretation of the existing career structure, particularly in relation to Clinical Nurse Specialists (CNSs), and the lack of coherent career paths within clinical nursing and management, have led the Committee to make a series of recommendations in section 6.2.

Attrition

The Committee is concerned with the current rate of attrition from the nursing workforce. As graduates decline to enter the workforce, new practitioners leave the workforce early in their careers and experienced clinicians reduce their working hours or leave nursing altogether, there is concern that losses to the workforce

will continue to outstrip the number that enter. Of concern are the nurses currently in the workforce who have indicated their intention to leave the industry within the short term unless changes in workload and working conditions occur.

Rural Victoria

Representations before the Committee highlighted that the recruitment and retention issues common in the rural and regional areas are different from those in the metropolitan area. This report addresses these issues in a series of specific recommendations.

Specialty Areas

The problems surrounding specialty nursing practice were highlighted in the consultation process. Of particular concern was the inability to attract and retain specialist clinical nurses within the aged care sector, and the continuing poor reputation of the specialty amongst many nurses in the acute sector. Mental health nursing faces similar problems attracting new graduates into the specialty, and the consultation process revealed increasing difficulties retaining experienced staff, particularly in the acute inpatient setting. The Committee also identified structural, recruitment and retention issues in the specialty areas of critical care, emergency, neonatal, medical/surgical, neuroscience, cardiothoracic, perioperative, rural midwifery and renal nursing. However, the Committee concludes that there are few, if any, nursing specialties that have not experienced some degree of recruitment and retention problems in recent years.

Division 2 Nurses

Numerous representations were received from nurses registered in Division 2. The Committee believes that many of the issues for this sector of the workforce relate to the inherent tension between the desire for extended scope of practice held by many Division 2 nurses, and the requirements of the aged care industry. The Committee has identified major problems in the health care industry relating to the image of Division 2 nurses, amongst both patients and health care workers. The Committee takes the

position that the under-utilisation of Division 2 nurses has contributed to current problems in the industry.

Priority of Recommendations

In order to attract, recruit and retain nurses in the Victorian nursing workforce, those recommendations rated high priority, if approved by the Minister of Health, require immediate implementation. At the commencement of the Committee's deliberations, it was anticipated that the Nurse Policy Branch of the Department of Human Services Department of Human Services would be in operation some time in September 2000, soon after the report was presented to the Minister of Health. Unfortunately, at the time of writing, processes are still in progress for the appointment of the Assistant Director, Nurse Policy Branch. To expedite the approved recommendations, the Committee considers it essential that the Department sets up processes for the immediate implementation of the recommendations and ensures that there is effective input from nurses in all phases of this implementation. The report contains other recommendations that do not require specific implementation dates. These are listed as long term priority recommendations.

Recommendations—High Priority

Recommendation 1

That the Department of Human Services establishes mechanisms and strategies to ensure the immediate implementation of the recommendations approved by the Minister of Health and that there be effective nursing input into this process through consultation and establishment of appropriate work groups.

That the Department of Human Services monitors the strategies in relation to workload, working conditions, career structure, qualifications, allowance and study leave as determined by the Australian Industrial Relations Commission (AIRC) and evaluates their impact on recruitment and retention of nurses in the Victorian public health workforce.

Refresher and Re-Entry

Recommendation 10 (section 4.3.3)

That the Department of Human Services ensures that Group A, B and C public hospitals have access to refresher and re-entry programs for Division 1 and 2 nurses, and that regional mental health services have programs in place for nurses in Divisions 1 and 3.

Recommendation 11 (section 4.3.3)

That Government provides funding to participating hospitals of \$2100 for each nurse undertaking re-entry programs or accredited supervised practice programs.

The following criteria must be met:

- Tailored nursing programs must contain clear learning and performance parameters.
- Nurses participating in the re-entry program will not be charged fees or other costs.
- The course must be accredited by the Nurses Board of Victoria (NBV).

The educational component of the re-entry course may involve consortia arrangements as appropriate to local needs.

Recommendation 12 (section 4.3.3)

That Government provides funding of \$130 per week Full-Time Equivalent (FTE) to each unregistered nurse undertaking a re-entry program or accredited supervised practice program, in line with current Austudy arrangements. Rural nurses required to travel more than 100km each way to undertake a program will attract \$170 per week (FTE), to reflect the increased burden of travel costs on rural nurses.

Recommendation 13 (section 4.3.3)

That the NBV review its current policies, procedures and publications in relation to recency of practice requirements.

Recommendation 14 (section 4.3.4):

That regionally-based health services establish a uniform approach to refresher programs that consider both education and clinical requirements of the individual nurse, and may include consortia arrangements as a method of program delivery.

Recommendation 16 (section 4.3.5):

That the Department of Human Services conducts a statewide advertising program aimed at encouraging both registered non-practising and unregistered nurses to return to work.

Recommendation 15 (section 4.3.4)

That Government pays \$450 to each health service providing refresher or reskilling programs for every registered nurse not currently practising that they place on a refresher or reskilling program.

The following criteria must be met:

- Individual nursing programs must contain clear learning and performance parameters.
- Nurses participating in the refresher or reskilling program will not be charged fees or other costs.
- Nurses undertaking refresher or reskilling programs are entitled to be paid according to the provisions of the *Nurses (Victorian Health Services) Award 1992*.

Education

Recommendation 19 (section 5.1.1.1)

That the Minister for Health, in conjunction with the Victorian Minister for Post Compulsory Education, Employment and Training, approaches the Commonwealth to review the funding model for the clinical learning component of the degree programs leading to nursing registration to ascertain if the current level accurately reflects the true costs of clinical learning programs.

Recommendation 20 (section 5.1.1.1)

That nurses undertaking preceptorship roles have access to suitable education to equip them to perform this role. Funding for these programs should be accessed through the undergraduate teaching allowance of the Training and Development (T&D) Grant.

Recommendation 21 (section 5.1.1.1)

That the Department of Human Services establishes a working party with the Victorian Deans of Nursing, Directors of Nursing and other relevant bodies to review the clinical learning programs in the undergraduate programs for Division 1 nurses to develop a

statewide strategy to maximise clinical learning outcomes.

Recommendation 22 (section 5.1.1.2)

That the Victorian Deans of Nursing, through the Nurse Policy Branch, develop a group of relevant stakeholders (including the professional colleges) to review the place of the specialty components within the undergraduate course. This review should investigate the development of innovative curricula that takes into account the accommodation of specialist areas through streaming and also considers the appropriate length of funded degree programs leading to nursing registration in the context of this issue.

Recommendation 23 (section 5.1.1.3)

- a) That financial support of \$100 per week be provided to both metropolitan and rural undergraduate students in their second and subsequent year(s) of the undergraduate course undertaking rural placements, where significant travel and accommodation costs are incurred.
- b) That the Department of Human Services administer this initiative using the following criteria.

That the student be:

- An Australian permanent resident or citizen undertaking a rural placement in the second or subsequent year(s) of a Bachelor of Nursing program.
 - Not in receipt of any other scholarship or grant for this purpose.
 - Required to travel in excess of 100 km each way from their usual place of residence to attend the rural placement.
 - Required to provide supporting documentation from the university acknowledging placement.
 - Required to undertake a placement of not less than two or more than five weeks.
- c) That the Department of Human Services adopts a 'first come' basis once equity across regions had been achieved for its allocation should the number of applicants exceed the available funding.
 - d) That the Department of Human Services reviews the initiative as a retention strategy paying particular attention to the length of the time of the placement.

Recommendation 24 (section 5.1.2.1)

That the Department of Human Services, together with the Australian & New Zealand College of Mental Health Nurses (ANZCMHN), develops a marketing strategy to attract and recruit nurses into the mental health areas.

Recommendation 25 (section 5.1.2.2.)

That all area mental health services (AMHS) offer placements, appropriate to the clinical learning needs of students, at all stages of the undergraduate course. The requirement for agencies to provide these placements, within their service capacity, be incorporated into health service agreements between the Department of Human Services and the individual agencies.

Recommendation 26 (section 5.1.2.2)

That the Mental Health Branch of Department of Human Services coordinates a group of relevant stakeholders to review the mental health content—both theory and clinical learning—of the Bachelor of Nursing courses and make recommendations to the NBV as to the guidelines that should be adopted in relation to mental health content. This process to be completed by June 2001 so that the guidelines developed can be adopted for the 2002 academic year.

Recommendation 27 (section 5.1.3)

That Department of Human Services convenes an intersectoral steering committee comprising representatives of vocational education and training sector, the health care industry, the higher education sector, professional organisations, NBV, and the Industry Training Board. The role of this group will be to address the educational issues associated with the developing role and expanded scope of practice of the Division 2 nurse. In particular, but not limited to, the committee should pay attention to:

- The need to revise the Certificate IV in Health (Nursing) curriculum, including the clinical practice component, to reflect relevant changes flowing from changes in the scope of practice, new modes of service delivery and current areas of practice, that is, acute care and its specialties, aged care, mental health and community settings.

- The current credit transfer arrangements between Certificate IV in Health (Nursing) course and undergraduate degrees leading to registration in Division 1

Recommendation 29 (section 5.2.1.2)

That the Minister of Health:

- a) Approach the Commonwealth government to increase the number of Higher Education Contribution Scheme (HECS) places allocated to nursing.
- b) Make an approach to the university vice chancellors to increase the number of HECS places allocated to nursing within Victorian universities.

Recommendation 30 (section 5.2.1.2)

To increase uptake of postgraduate places:

- That the Department of Human Services funds scholarships to a maximum of 50 per cent of the fee (HECS or full fee) for postgraduate courses in areas of identified need over the next three years.
- That the Department of Human Services establishes an equitable, transparent process and provides feedback to the profession on the number of places funded.
- That health care facilities consider ways to provide financial support to nurses undertaking such courses in identified areas of need.
- That a minimum of 25 per cent of these scholarships be allocated to regional/rural areas.
- That the Nurse Policy Branch monitors this strategy and evaluates its effectiveness as a recruitment and retention strategy by December 2003.

Recommendation 31 (section 5.2.1.2)

That the Victorian Deans of Nursing develop options to facilitate easier access to postgraduate study, especially through the encouragement of multiple entry and exit points, a variety of modes of delivery and systems that enable maximum recognition of prior learning, especially learning achieved through continuing education modules.

Recommendation 32 (section 5.2.1.2)

That the Victorian Deans of Nursing develop collaborative arrangements that maximise postgraduate courses for smaller specialties and small cohort courses.

Recommendation 33 (section 5.2.2)

That the intersectoral group in Recommendation 27 also pay attention to the:

- Effectiveness of current post-basic modules and the need for additional modules to meet industry requirements.
- Recognition of prior learning arrangements between post-basic and continuing education undertaken and for post-basic modules and the Division 1 degree program.

Recommendation 36 (section 5.3.2)

That the intersectoral group (Recommendation 27) should look to developing programs to assist Division 2 nurses to make the transition from the educational to industry sector during the first six months of practice. These programs should reflect the principles adopted for the Division 1 graduate nurse program and include a preceptor component.

Recommendation 37 (section 5.4.1)

That the Department of Human Services collect data relating to current expenditure on continuing education for nurses in each facility. Through its health services agreements with health care facilities, the Department of Human Services ensures that funding is provided for continuing education to a level of 1.5 per cent for metropolitan and two per cent for rural facilities based on the budget for the total nursing EFT across the facility. These funds to be shown as a separate line item. The T&D Grant for continuing education should be continued in its present form.

Recommendation 38 (section 5.4.2)

That the Department of Human Services:

- a) Ensures information on existing multimodal education products and postgraduate modules and courses be disseminated to health care facilities and their nurses via the most appropriate method, such as the Clinicians Health Channel.
- b) Reviews existing multimodal education products with a view to identifying what is currently available, the product's ability to meet current industry needs, and to identify unmet needs. The review should also evaluate, as well as recommend, appropriate products for multimodal education such as tele/video conferencing, distance education

and CD-ROMs, to fill identified gaps in continuing education.

- c) Explores what is currently available in tele/video conferencing facilities in Victoria and that a strategy be developed to make effective use of these as a means of delivery of continuing education in rural and regional Victoria.

Recommendation 39 (section 5.5.5)

That the Department of Human Services allocates places for paid study leave for four hours per week per place for nurses undertaking postgraduate and post-basic courses by any mode of delivery. Such allocation is to be based on areas of identified need and EFT with a minimum of 25 per cent of the total places allocated to the regional/rural areas and 25 per cent of total places allocated to Division 2 nurses. The Department of Human Services should ensure a mechanism for reporting back to the profession on its process.

Recommendation (section 5.5.5)

That nurses apply for study leave to their health service or AMHS. Where applications exceed allocations, a ranking system be used incorporating the following principles as guides—length of service, results of performance appraisal where available and, if not available, their contribution to the service and service priority for its areas of need/shortage, including aged care and mental health nursing.

Recommendation 41 (section 5.6.5)

That the Department of Human Services reviews the T&D Grant in relation to the undergraduate teaching allowance, the graduate nurse program, and the postgraduate program (including midwifery). The review should ensure that:

- a) The manner in which the Grant is made available to the hospitals is transparent and acquittal processes ensure the funds are used for their intended purpose.
- b) The funding for undergraduate nursing be allocated according to student numbers undertaking placements in a hospital.
- c) The medical and nursing components are separated and the nursing component is shown as a line item in the budget.
- d) A nursing reference group is established to

review the graduate nurse program guidelines paying particular attention to:

- How the funds are used to support the new graduate through supervision and preceptorship
 - The capacity to provide for rotations in specialty areas such as critical care, renal, perioperative nursing
 - The provision for both rotations in, and separate programs for, aged care and mental health as a positive recruitment strategy
 - Provide for Division 2 nurses.
- e) A nursing reference group is established to develop guidelines for postgraduate courses along the lines of the graduate nurse program, ensuring that the distribution of the monies provides for equity between facilities.
 - f) That allocation to the aged care T&D Grant be increased as a positive recruitment strategy.
 - g) That the mental health funding be analogous in structure to the acute T&D grant.
 - h) That the continuing education grant continue as it is.

Retention

Recommendation 42 (section 6.1.1.2)

That in the absence of statewide workload data, each ward/unit establishes a template for an appropriate workload for that ward/unit consistent with a ratio ranging from 1:3 to 1:5 (excluding the nurse in charge of the am and pm shifts) for the acute general medical/surgical wards/units. The Nurse Policy Branch reviews the impact of ratios on workloads until more explicit data are collected and analysed.

Recommendation 43 (section 6.1.1.2)

That the Department of Human Services convenes a working party comprising relevant stakeholders including ANF, HSUA and Directors of Nursing to jointly:

- a) Determine the data needed to evaluate nurse/patient ratios and skill mix across the State.
- b) Review available dependency systems and, if needed, commission further studies on such systems to evaluate their effectiveness and report back to the Minister for Health.

Recommendation 44 (section 6.1.1.2)

That policies and procedures should be in place to enable the Nurse Unit Manager and Associate Nurse Unit Manager (ANUM) to control workloads by adjustment of staff numbers as appropriate and, where workloads are unreasonably high, additional staff are unavailable and patient flow cannot be controlled, that adequate support be given to enable beds to be closed as a last option in the control of workload.

Recommendation 45 (section 6.1.1.2)

School holidays are known periods of nurse shortages and that hospitals minimise the amount of elective surgery during such times.

Recommendation 47 (section 6.1.1.3)

That health facilities establish a policy that nursing be undertaken only by those nurses registered under the provisions of the *Nurses Act 1993*.

Recommendation 48 (section 6.1.2.2)

That attention be paid to rostering and that the following principles be implemented:

- a) Flexibility, fairness and equity of rostering—through such means as self-rostering and job sharing.
- b) No gaps in the roster caused by short shifts.
- c) Encouragement of voluntary permanent night duty, but with access to continuing education, periods of day duty and strategies to avoid a ‘night duty culture’.

Recommendation 49 (section 6.1.2.2)

That strategies be put in place by each hospital to reduce the need for excessive overtime, but where it is required, hospitals be reminded of their award obligations regarding overtime provisions.

Recommendation 50 (section 6.1.2.2)

That management encourage Nurse Unit Managers to claim legitimate overtime to ensure that a negative culture does not develop in relation to payment of overtime.

Recommendation 51 (section 6.1.2.3)

That all health care facilities restore an overlap period between shifts. The length to be determined by local need and the requirement

for sufficient hand-over time, meal relief, undertaking of double duties and provision of some in-service education and team building.

Recommendation 52 (section 6.1.2.4)

That full-time nursing staff have access to an accrued day off (ADO), to be taken in a flexible manner suitable to the nurse and the local facility circumstances, and that the Department of Human Services adjusts the casemix funding formula to allow for the full implementation of ADOs.

Recommendation 53 (section 6.1.3.1)

Health care facilities ensure that:

- a) Strategies are being implemented to employ nurses on a permanent basis to fill permanent vacancies.
- b) Recruitment procedures for replacement of permanent positions are developed to ensure that such vacancies are filled within eight weeks of notice of resignation.
- c) Use of agency nurses is restricted to unplanned absences only.

Recommendation 54 (section 6.1.3.1)

That the Department of Human Services monitors statewide trends in agency usage in the public health care industry on a quarterly basis.

Recommendation 55 (section 6.1.3.1)

That casemix funding be adjusted so that hospital funding is sufficient to ensure that ward/unit budgets and permanent staffing profiles include provision for leave relief such as annual leave and ADOs.

Recommendation 56 (section 6.1.3.2)

That health facilities are encouraged to (re-) establish Nurse Banks to meet the ad hoc staffing needs of the facility and that these nurses have access to the ongoing education program of the facility.

Recommendation 58 (section 6.1.4.2)

That the Department of Human Services review of the Graduate Nurse Program address the issue of the vulnerability of new graduates to physical and horizontal violence in the workplace.

Recommendation 59 (section 6.1.4.2)

That provision of formal independent counselling for victims of bullying and interpersonal conflict, be available for all nurses working in the public system. In addition, the Committee recommends that all nurses working in the public system have access to critical incident debriefing services.

Recommendation 60 (section 6.1.4.2)

That the Department of Human Services, in conjunction with key stakeholders (which should include relevant industrial and professional bodies, as well as human resources professionals and the Victorian Workcover Authority), establishes a review of workplace culture with the aim of ensuring that each health care facility has in place a formal mechanism for dealing with workplace bullying.

Recommendation 61 (section 6.1.4.2)

That the Department of Human Services encourages all publicly funded agencies to undertake an appropriately recognised and validated staff satisfaction survey on a regular basis, and that these agencies demonstrate to the Department of Human Services changes they have initiated as a result of survey findings.

Recommendation 62 (section 6.1.4.3)

That all hospitals review their budget allocations for medical consumables and equipment for nursing care and where the budget is inadequate, in order to avoid the inefficiencies of practice that results from such inadequacies, to request that the Department of Human Services considers additional finances to restore and maintain medical consumables and equipment levels.

Recommendation 63 (section 6.1.5.1)

That the Department of Human Services, as a matter of urgency, undertakes a review of nurses' childcare needs across all sections of the nursing workforce, with a view to formulating a strategy to best meet assessed needs.

Recommendation 66 (section 6.2.1.1)

That the CNS position at Grade 2 year 7 be maintained in the health care sector and be

used as a strategy for retaining experienced, qualified nurses at the bedside.

Recommendation 67 (section 6.2.1.2)

- a) That for candidates applying for CNS positions, hospitals adopt the following general principles:
- Recognition of the Registered Nurses (Victorian Health Services) Award 1992 definition.
 - Level of clinical practice reflects the level of remuneration, that is, higher level of skill than would be expected of other grade 2 nurses but less than grade 3 positions.
 - The primary focus of the position is clinical.
 - Criteria for CNS must be achievable in normal paid rostered hours.
 - Criteria for performance review processes be consistent with the review process of all nurses in the facility.
 - Publish criteria for the CNS position.
- b) Applicants must show a commitment to the development of an area of specialty, their own development and the hospital in which they are employed, and must demonstrate one criterion in each of the three sections.

Clinical Skill

- Higher levels of skill demonstrated in clinical decision making—in particular in problem identification and solution, and analysis and interpretation of clinical data.
- Maintenance and improvement of clinical standards.

Professional Behaviour

- Positive role modelling.
- Act as mentor or preceptor to less experienced nurses, including graduate nurses.
- Support of, and contribution to, quality improvement and research projects within the area of practice and ward/unit.
- Acting as a resource person to others in relation to clinical practice.

Professional Development

- Membership of relevant professional body.
- Contribution to the education of other professionals, for example, being willing to

provide at least one in-service education program each year.

- Undertaking own planned professional development and competence through various forms of continuing education, such as conferences, study days, formal study, reading.
- c) Department of Human Services to review all criteria and ensure statewide consistency of application of criteria.

Recommendation 68 (section 6.2.1.3)

That as a matter of urgency, the Department of Human Services requests that facilities indicate the number of CNS positions that are needed for the implementation of recommendation 67 above. That data be collected regarding the number of CNS positions in the public sector, following implementation of this recommendation and that this number is used as a baseline for the funding of CNS positions across the public sector.

Recommendation 69 (section 6.2.1.3)

That the Department of Human Services recommends a mechanism to ensure that adequate funding is provided for the CNS classifications according to the baseline figures as established in recommendation 68 above, for the 2001–2002 financial year and beyond.

Recommendation 71 (section 6.2.1.4):

That Victorian Hospitals Industrial Association (VHIA), ANF and the Department of Human Services develop a CNS stream within the Registered Nurse Award which ensures that there are CNS positions at grades 2, 3 and 4, and that the definition of the responsibilities of the Grade 3 and 4 be completed by the end 2001.

Recommendation 72 (section 6.2.2)

That in order to ensure an appropriate clinical career path for nurses in Victoria, the parties respondent to the Registered Nurses (Victorian Health Services) Award 1992 remove the current award provision which restricts Clinical Nurse Consultants (CNC) to chemotherapy, stomal therapy, diabetes education and infection control, to ensure that the CNC position can be appointed in any clinical area.

Recommendation 74 (section 6.2.4.1)

That the senior nurse manager (however titled) be a member of the hospital executive and have recognized input into resource allocation and utilisation appropriate to the nursing services of the facility.

Recommendation 75 (section 6.2.4.2)

That all health care facilities ensure that strategies are in place for succession planning for all levels of nursing management.

Recommendation 76 (section 6.2.4.2)

That nurse managers have input into the budget setting process and have responsibility for its ongoing implementation.

Recommendation 77 (section 6.2.4.2)

That all nurse managers be encouraged to:

- a) Participate on a regular basis in in-service education in general, financial and human resource management.
- b) Pursue postgraduate management and have access to paid study leave.

Recommendation 79 (section 6.3.1)

- a) That clinical supervision for registered nurses be introduced into the public health system as a strategy for retaining experienced, qualified nurses in clinical settings and that each nurse, regardless of full-time or part-time status, will receive two hours per month of clinical supervision time.
- b) That funding be provided for the introduction, implementation and evaluation of clinical supervision for registered nurses and that the Department of Human Services take responsibility for the allocation of funds and establish a process for the allocation to health services.
- c) That the Department of Human Services evaluates the implementation of clinical supervision.

Recommendation 85 (section 6.3.3.4)

That the Department of Human Services provides specific funding for the complete implementation of a no lift program in the public aged care sector.

Recommendations—Medium Priority

Data

Recommendation 4 (section 2.2.1)

That nurses in education courses be reported from the Victorian Department of Education, Employment and Training to the Department of Human Services annually (for Division 1) and six-monthly (for Division 2).

Recommendation 5 (section 2.3)

That the Department of Human Services, in conjunction with the NBV, publish the Victorian proportion of the AIH&W labour force statistics in 'real time' as a separate report.

Recommendation 7 (section 2.4)

That the Department of Human Services commissions regular payroll reports (at least three-monthly), reporting total numbers and total EFT of nurses by agency by grade, by service and by full-time or part-time status.

Recommendation 8 (section 2.4)

That the Department of Human Services recommends the following changes to the AIH&W annual survey tool:

Q16: To assist workforce planning, mental health be categorised by community mental health and inpatient mental health, and palliative care to be added as a clinical specialty in its own right.

Q17: Specify that the post-basic qualifications be graduate certificate (including hospital-based courses which predate the transfer of nurse education to the tertiary sector), graduate diploma, masters, PhD or post-basic TAFE/VET module. This is to exclude 'informal' courses and in-service education which confound interpretation of Victorian specialist nurses.

Recruitment

Recommendation 9 (section 4.2)

That the Department of Human Services:

- Liaises with the Careers Education Association of Victoria (CEAV) and Victorian Directors of Nursing (public and private) to increase the provision of the

number and quality of work experience places for Year 10 secondary school students.

- Explores the feasibility of using the school nurse network as a method of raising the profile of nursing amongst school students.
- Works closely with CEAV to ensure that teachers have a better understanding of nursing as a career.
- Undertakes research to prepare a core set of materials to be made available for high school students describing the role and education pathways for nursing. The materials should emphasise the variety of clinical settings, should avoid gender and racial stereotypes and should give equal prominence to Division 1 and 2 education pathways. The materials should also be available in both paper and electronic formats.
- Seeks advice on materials and strategies to attract people in age groups other than traditional school leavers to consider nursing as a career.

Recommendation 17 (section 4.4)

That the Department of Human Services explores the extent to which return to work programs for injured nurses have been implemented in public health care facilities in Victoria.

Education

Recommendation 18 (section 5.1.1.1)

That the Victorian Deans of Nursing carry out a mapping exercise to ascertain both the availability of clinical placements within the health system and the requirements of the students for such placements. The results of such a project should form the basis for the establishment of a coordinated system to facilitate bookings and placements of all undergraduate nursing students.

Recommendation 28 (section 5.1.3)

That the Minister of Health recommends to the Minister for Post Compulsory Education and Training that the level of funding for the Certificate IV in Health (Nursing) reflect the requirements for registration.

Retention

Recommendation 46 (section 6.1.1.3)

That each facility undertakes a review of activities, such as telephone answering, routine clerical activities and some housekeeping activities, such as unmade bed making, and recommend to the Department of Human Services strategies that will either introduce such positions in addition to nursing positions that assist the nurse at ward/unit level, or extend the hours of such assistance as necessary.

Recommendation 64 (section 6.1.6)

That the Department of Human Services, in conjunction with its regional offices, establish work groups of relevant stakeholders to:

- Develops strategies to provide support and peer review opportunities for nurses in rural hospitals.
- Explores the establishment of a locum nurse bank in rural areas where relieving nurses are not available and develop marketing strategies and an incentive scheme for the bank
- Examines the security risks for nurses working in both the hospital and community in rural regions and develop a statewide policy with strategies such as training programs, use of two staff where appropriate, suitable vehicles, telecommunication devices and safety equipment and personnel for security management and risk minimisation.

Policy and strategy implementation and their outcomes to be reported to the Department of Human Services Nurse Policy Branch.

Recommendation 65 (section 6.1.6.1)

That regional and rural health facilities ensure that classification structures in rural areas adequately reflect the levels of responsibility associated with the isolated environment in which nurses practise and is no less than comparative services/functions in the metropolitan areas.

Recommendation 70 (section 6.2.1.4)

That the parties respondent to the *Registered Nurses (Victorian Health Services) Award 1992* work towards a consent award variation,

whereby the title 'CNS' be changed to Senior Clinical Nurse (SCN) to more accurately reflect the expectations of the position.

Recommendation 73 (section 6.2.3.1)

That ANF, HCSUA, VHIA and Department of Human Services establish a suitable mechanism for recognising postgraduate qualifications for nurses within areas of nursing at specific levels within the context of the career structure. Until this mechanism is established and qualifications are recognised in this process, an interim qualifications allowance for nurses should be introduced, similar to that of other health professionals in Victoria for qualifications relevant to the area of current practice.

Recommendation 78 (section 6.2.4.2)

That rural and regional hospitals explore strategies to ensure that there is training and development for ANUMs to facilitate succession planning to Nurse Unit Manager (NUM) positions and that, where appropriate, consideration be given to jobsharing within the NUM position.

Recommendation 80 (section 6.3.2)

That health agencies be encouraged to consider whether there are opportunities to employ Division 2 nurses in the acute sector in positions currently not filled by Division 2 nurses.

Recommendation 81 (section 6.3.2)

That the Department of Human Services considers a campaign amongst Division 1 nurses, undergraduates and the wider health care industry, to promote a better understanding of the role of Division 2 nurses.

Recommendation 82 (section 6.3.3.1)

That ongoing in-service education be provided in the public aged care sector (nursing homes and hostels) and that resources be sufficient for this activity.

Recommendation 83 (section 6.3.3.2)

That the Department of Human Services collects data relating to the staffing mix in the public aged care sector and, in particular, identifies:

- The number of CNS positions required following the implementation of Recommendation 68 and ensures that this number be used as a basis for the funding of CNS positions.
- The number of CNC positions, especially, but not limited to continence management, and dementia care.
- Nurse practitioner roles as they are implemented and evaluated as part of the Government's funding of nurse practitioner projects.

Recommendation 84 (section 6.3.3.3)

That the State Government recommends to the Commonwealth Government that the documentation required for the Residential Classification Index Tool currently being used in the aged care sector be simplified, to reduce the documentation required to allow more time for nurses to be able to deliver direct patient care. The Committee recommends that the Victorian Minister for Health raises this issue at the Australian Health Ministers Advisory Council (AHMAC) to seek the support of other State Governments.

Recommendation 86 (section 6.3.4)

That the Department of Human Services, together with key stakeholders, collects data relating to the recruitment and retention of midwives in rural areas and the implemented strategies be evaluated by the Department of Human Services.

Recommendations—Long Term Priority

Recommendation 2 (section 2.1.11)

That the Commonwealth include all States and Territories, and all relevant nursing peak bodies, in its new Health Workforce Advisory Council when issues relating to nursing are considered.

Recommendation 3 (section 2.1.11)

That notwithstanding local initiatives, the Victorian Government continues to lobby the Commonwealth to coordinate issues relating to nursing workforce planning for which it has responsibility, including the tertiary education of nurses, migration policy and aged care nursing.

Recommendation 6 (section 2.3)

That the Department of Human Services makes available to the Victorian Department of Education, Employment and Training nursing labour force statistics, on a regular basis, to assist in the provision of postgraduate and post-basic specialty nurse course planning in the university and VET sector.

Recommendation 34 (section 5.2.2)

That the Department of Human Services evaluates the effectiveness of the provision of scholarships for Division 2 nurses to undertake post-basic modules as a recruitment and retention strategy by December 2003.

Recommendation 35 (section 5.3.1)

That the Department of Human Services commissions and funds a research project to evaluate differing models of preceptorship within Graduate Nurse Programs in order to identify best practice.

Recommendation 57 (section 6.1.4.1)

That the Department of Human Services, in conjunction with key stakeholders, evaluates work currently in progress in the health care industry to assess the prevalence and control of workplace violence (physical and verbal) both directed at nurses, and from within nursing, and to consider whether a coordinated statewide campaign is required.

The Nurse Recruitment and Retention Committee and the Enterprise Agreement for Nurses

Running in parallel to the work of the Committee was a round of negotiations for an enterprise agreement being conducted by the ANF and HSUA. Because of its focus on nurse recruitment and retention, the Committee addressed several of the matters that were included in the ANF claim.

The negotiations over the claim resulted in industrial action being taken and the matters were forwarded to the Australian Industrial Relations Commission (AIRC). Commissioner Blair handed down a ruling on the issues on 31 August 2000. As indicated below, of the matters in the claim that were being addressed by the Committee, some were in accord, others agreed in part, but in some areas the Committee chose a different approach from the unions. These are shown in Table 1.

In terms of recruitment and retention, there is no doubt that short term measures are necessary to ensure that the workload is reduced and that working conditions are made more attractive to recruit nurses back into the workforce and to retain those nurses who are there.

Workloads

The AIRC and the Committee considered nurse patient ratios. The AIRC established fixed ratios for different hospitals and some specialty areas. The Committee considered that more flexibility should be introduced and that the judgment of the NUM should be recognised as an important factor. Therefore, the recommendations of the Committee include a range of ratios and the use of local templates. While both groups considered bed closure, the approach by the Committee allows for more flexibility at the local level, without compulsory involvement of the ANF.

Given the lack of data on which measurement of workload is based, both groups recommended the establishment of a working party to examine workload issues. Until such data are derived, the Committee saw a need for

the Department of Human Services to monitor the impact of the ratios on workload prior to the reporting of such a working party.

A fixed skill mix was decided by the AIRC, but the Committee considered that there were insufficient data available to make such judgments across the range of clinical settings. It therefore recommended that data be collected prior to the establishment of fixed skill mix ratios. The Committee recommends that the imposition of a skill mix ratio be monitored prior to the establishment of a firm database for an appropriate skill mix in the different clinical areas.

Workload can be affected by not only the skill mix, but also the assistance available to the nurse. The Committee has also recommended that consideration be given to either the introduction or, where already available, an extension of the hours of the position termed 'ward assistant' or 'ward clerk'. In this way, some of the activities of the nurse can be delegated to enable the nurse to focus on nursing activities.

Working Conditions

Both groups urged the filling of permanent positions, the use of nurse bank where interim vacancies occurred, and the use of agency nurses for 'unexpected' or 'unplanned' vacancies only. Similarly, both groups saw a need to restore the ADO as a strategy to encourage nurses to fill full-time positions. The Committee, however, emphasised the need for flexibility in implementation of the ADO to meet both local needs and the needs of the individual. While the AIRC ruled in favour of restoring the 8:8:10 rosters, the Committee saw this as too rigid. Underlying the notion of the 8:8:10 rosters is an overlap period and the Committee considered that there should be a degree of flexibility in that period, not necessarily tied to the fixed rosters. AIRC decided on the inclusion of a secret ballot of ward/unit nurses if alternatives to the 8:8:10 were being considered.

The Committee heard many arguments for flexibility in rostering and notes that the AIRC recommended local discussion about part-time rosters. The Committee introduced principles to be considered, to ensure that there was maximum flexibility in relation to the length of shift and the number of days worked. Such flexibility was seen as one of the most important factors in recruiting nurses back into the workforce. Both groups recognised the problems associated with night duty although the Committee was in a position to consider a wider range of issues other than increased allowances.

Both groups recognised the need to collect workforce data on a regular basis.

Study Leave

Both groups recommended four hours study leave for 26 weeks for postgraduate studies. The AIRC also decided to introduce two days paid study/conference leave and three days paid professional development leave. The Committee addressed the matter of funding for both these activities in some of its recommendations.

Career Structure

Unlike the AIRC, the Committee considered that it did not have enough data to support the appointment of a full-time Grade 7 (DoN) and Grade 6 (Deputy DoN) on each campus, but rather saw the need for such data to be collected. In relation to Grade 5 (Assistant DoN) positions, while data before the Committee indicated that the shortfall could be in the vicinity of 200 positions. It welcomes the additional 50 positions as a starting point. Both groups saw the need for further data collection. The issue of full-time charge nurses (NUMs) is agreed by both groups, however, information before the Committee strongly indicated the need for joint appointments in rural and regional areas to overcome the shortage of attracting nurses on a full-time basis.

In relation to Nurse Educators, the Committee heard considerable anecdotal information on a perceived shortage of nurse teachers. However, information gathered by survey indicated a small deficit only.

Both groups supported removal of the limitation of areas of practice of the CNC and the Committee demonstrated the shortage in the area and welcomes the introduction of 50 EFT positions. However, the AIRC did not address the need to review the definition and classification of the CNC and its relationship to the CNS position. The CNC, by definition, requires the nurse to reduce or be removed from a direct hands-on clinical role. The AIRC failed to respond to what the Committee heard as a very strong position—the need for clinical nurses to have a career pathway that retained them at the bedside. The Committee sees a strong need for the introduction of a CNS position that recognises advanced and expert practice rewarded at Grades 3 and 4.

Both groups agreed that the current CNS positions should remain and that nurses who met the current definition and the criteria (as identified by the Committee), should be appointed to the position. The Committee, however, was made aware of the difficulties of the current definition, that is, its focus on experience or qualifications and its failure to recognise advanced and expert levels of clinical practice. The Committee is firmly of the view that clinical nurses are more likely to remain in the workforce if they have the opportunities of promotion beyond Grade 2 and their advanced and expert level skills, normally acquired through both qualification and experience, are recognised and rewarded through this pathway. The Committee was also of the view that if such a pathway were introduced it would remove the need for a qualification allowance. The Committee saw the qualification allowance as an interim measure only, with a longer term solution of a strong clinical career pathway.

In the areas considered by both the Committee and the AIRC, it would be appropriate to monitor their impact on recruitment and retention.

Recommendation 1:

That the Department of Human Services establishes mechanisms and strategies to ensure the immediate implementation of the recommendations approved by the Minister of Health and that there be effective nursing input into this process through consultation and establishment of appropriate work groups.

That the Department of Human Services monitors the strategies in relation to workload, working conditions, career structure, qualifications allowance and study leave as determined by the AIRC and evaluates their impact on recruitment and retention of nurses in the Victorian public health workforce.

Table 1: Comparison between Decisions of the AIRC and Recommendations of the Committee

<i>a. AIRC Decision</i>	<i>b. Committee Recommendation</i>	<i>c. Comment</i>
Workload Issues		
a. Fixed nurse/patient ratios for Group A–D hospitals and other areas.		
b. Workload templates, range of ratios 1:3 to 1:5.		
	Department of Human Services monitors impact of workload.	
c. Committee recognises Nurse Unit Manager expertise and introduces flexibility.		
	Need for evaluation of strategy.	
a. Working party to examine workload issues.		
b. Working party evaluate data and review dependency systems.		
c. Longer term strategy to determine basis for workload measurement.		
a. Bed closure automatic local implementation Committee.		
b. Bed closure as last resort with local Committee.		
c. Recognition of Nurse Unit Manager expertise.		
a. Fixed skill mix.		
b. Collect data.		
c. Not enough data to make recommendation.		
Working Conditions		
a. Return of Accrued Day Off (ADO) for full-time staff.		
b. Access to ADO by full-time staff taken in flexible manner.		
c. Flexibility important.		
a. 8:8:10 rosters with secret ballot if alternative required.		
b. Flexibility, fairness and equity in rosters.		
	Restore overlap period.	
c. 8:8:10 too rigid and flexibility needed in overlap period.		
a. Discussion locally re: part-time rosters.		
b. Rosters flexible, fair and equitable with no gaps.		
c. Need for flexibility re: short shifts and number of days worked.		
a. Department of Human Services collects workforce data especially full-time/part-time to provide to ANF.		
b. Department of Human Services commissions regular payroll reports—agency, grade, service, full-time/part-time to feed into workforce planning.		
c. Clear need for additional data.		

- a. Increase night duty/permanent night duty allowances.
 - b. Recognition of issues of rotating night duty and night duty culture.
 - c. Committee comments on range of issues around night duty.
- a. Encourage permanent staff, use bank staff in interim and agency for unexpected vacancies.
 - b. Employ permanent staff, encourage nurse banks, agencies for unplanned absences only.
 - c. Issues complex.

Career Structure

- a. Full-time Director of Nursing (DoN) each campus
 - b.
 - c. Encourage, but not enough data before Committee to make recommendation.
- a. DoN on Exec Committee, hospital decision.
 - b. DoN on Exec Committee.
 - c. Essential strategy of resources to be adequate for nursing.
Not enough data available.
- a. Deputy DoN, some >30 beds may appoint on each campus.
ADoN collect data current situation. Appoint 50 FTE.
 - b. Department of Human Services investigate if a need.
 - c. Data shows shortfall could be around 200 FTE.
- a. Full-time NUMs necessary.
 - b. Department of Human Services collects data for baseline figure and then appoints in areas of need.
 - c. Difficulty attracting full-time NUMs, joint appointments under principles needed.
- a. Nurse educators—collect data, appoint 50 EFT.
 - b. Rural/regional areas consider joint appointments for NUM positions.
 - c. Survey established only a small need for nurse educators.
Also recommended a revision of definition and classification.
- a. Remove restrictions on CNC role.
 - b. Remove restrictions on CNC role.
 - c. No recommendation made, but survey identifies need for small number of additional positions.
- a. Department of Human Services determines current situation, appoint 50 EFT.
 - b.
 - c. Being used as recruitment and retention strategy especially critical care.
- a. Appoint Clinical Nurse Specialist (CNS) if meet definition and criteria.
 - b.
 - c. Rewards years of experience only. Does not extend clinical career path.
- a. Increments grade 2 to year 7 and 8
 - b. Department of Human Services establishes base line for all who meet definition and criteria and ensures funding.
 - c. Recognises value of qualified experienced clinical nurse. Retain at bedside. AIRC failed to recognise CNC not direct clinical role and no progression available for nurse to stay at bedside. Long term retention strategy.
- b. Extend CNS to grades 3 and 4.
 - c. Recognition of qualification via a clinical career structure has higher potential of retaining clinical nurses in longer term.

- a. Return of qualifications allowance.
- b. Interim qualification allowance and qualifications built into extended clinical career structure.

Leave

- a. 4 hrs for 26 weeks for postgraduate study.
- b. 4 hrs for 26 weeks for postgraduate study.

- a. 2 days paid study/conference leave.

- a. 3 days paid professional study leave.
- b. 2 hours per month clinical supervision time.

1. Introduction

As a result of a Government initiative to address the current shortage of nurses in Victoria, the Minister for Health established the Nurse Recruitment and Retention Committee in February 2000. The purpose of the Committee was to provide advice to the Minister on workforce matters in relation to the registered nurse workforce in Victoria.

Recommendation 1: That the Department of Human Services establishes mechanisms and strategies to ensure the immediate implementation of the recommendations approved by the Minister of Health and that there be effective nursing input into this process through consultation and establishment of appropriate work groups.

That the Department of Human Services monitors the strategies in relation to workload, working conditions, career structure, qualifications allowance and study leave as determined by the AIRC and evaluates their impact on recruitment and retention of nurses in the Victorian public health workforce.

As part of its terms of reference, the Committee was to provide a report to the Minister for Health by 30 April 2000 and a final report by 31 August 2000. The terms of reference are attached as Appendix 1.

1.1 Committee Process

The purpose of the Committee was to provide advice to the Minister for Health on workforce matters and to address the shortage of nurses in the short, medium and long term.

1.2 Committee Membership

The Minister for Health appointed members to the Committee. The membership was selected from representatives of the unions: Australian Nurses Federation, Victorian Branch (ANF) and Health Services Union Australia Branches Number 1 (HSUA) and 2 (Health & Community Services Union). In addition, representatives from the Royal College of

Nursing Australia (RCNA), Australian College of Nurse Management Inc (ACNMI), Victorian and Tasmanian Deans of Nursing and the Victorian Hospitals Association (VHA) were appointed, as were a number of nurse clinicians from metropolitan and rural hospitals. An independent chair was appointed.

1.3 Establishment of Sub-Committees

In order to achieve the terms of reference in an efficient manner, three sub-committees were established, namely Attraction and Recruitment; Education; and Retention. Members of the Committee were asked to indicate on which sub-committee they would like to serve. The chair of the Committee appointed chairs to the sub-committees, and each sub-committee had the power to coopt other persons on either a permanent or temporary basis. (A list of members and coopted members are attached as Appendix 2.)

1.4 Information Collection and Consultation Process

The Committee's terms of reference included the requirement to engage in 'a process of consultation with relevant bodies and organisations in Victoria and with Commonwealth departments'. To this end, the following processes were established:

A call for submissions from DoNs of health care facilities in the public and private sectors, and from peak nursing (and medical) organisations. In the submission, information relating to issues of attraction and recruitment, education and retention was called for, as was an invitation to indicate strategies that were proving successful in the three areas. A list of those organisations which provided submissions is attached as Appendix 7.

A number of individual current and former nurses made written submissions to the Committee.

In addition to submissions, the Committee sought face-to-face meetings with several peak bodies—Australian College of Midwives Inc, Australian and New Zealand College of Mental Health Nurses, Victorian Perioperative Nurses Group, Enrolled Nurses Special Interest Group and Australian College of Critical Care Nurses (ACCCN)—as well as a specially convened group of representative NUMs, to expand on issues raised in submissions and to discuss a range of professional workplace issues.

The Committee was keen to seek the views of nurses who maintained registration with the NBV but who chose, for whatever reason, not to practise as a nurse. To this end, the Committee commissioned Campbell Research and Consulting to survey a sample of this group of nurses. The reports resulting from the survey are attached (appendices 3 and 4).

The Committee also sought the views of nurses who have allowed their registration to lapse. A call for expressions of interest was made via local and statewide newspaper advertisements.

The Committee sought information on a range of professional issues pertaining to currently registered nurses and ex-nurses. A series of focus groups were held in Melbourne and Shepparton with participants from throughout Victoria. The Committee commissioned Research International to undertake this project. The report of the focus groups is attached as Appendix 6.

Public consultation forums for all Victorian nurses employed as grades 1 to 4 in Divisions 1 to 4 were held at the following venues:

31 May 2000	Parkville	Royal Melbourne Hospital
5 June 2000	Traralgon	Latrobe Regional Hospital
7 June 2000	Hamilton	Western District Health Service
8 June 2000	Heidelberg	Austin and Repatriation Medical Centre
14 June 2000	Bendigo	Bendigo Health Service
15 June 2000	Clayton	Monash Medical Centre
19 June 2000	Prahran	Alfred Hospital

28 June 2000	Mildura	Mildura Base Hospital
6 July 2000	Benalla	Goulburn Ovens Institute of TAFE

The Committee commissioned an independent facilitator from the Union Research Centre on Organisation and Technology (URCOT) to run the forums. The report on the consultation process is attached as Appendix 5.

The Committee generated a number of surveys of hospitals, health care services and education facilities. The surveys sought a range of information on such issues as vacancy data, refresher and re-entry course provision, postgraduate nursing course places, post-basic modules for Division 2 nurses, Division 2 articulation courses, senior nurse (grades 5, 6 and 7) positions, paid study leave provision, clinical nurse specialist positions and agency nurse usage.

The Chair of the Committee and the Chair of the Retention sub-committee met with DoNs from rural and metropolitan Victoria. In addition, the Chair of the Committee addressed a recruitment and retention summit in Albury at the request of Greater Murray Area Health Services.

1.5 Context

During the lifetime of the Committee, several enterprise agreements in the nursing sector expired. As a consequence, the ANF (Victorian Branch) and HSUA No 1 Branch lodged an enterprise bargaining claim for general nurses in the public sector, and HSUA No 2 Branch (Health & Community Services Union) and ANF (Victorian Branch) lodged a claim on behalf of nurses in the public mental health sector. The Committee was mindful that some of the issues contained in these claims bore a direct relationship to its terms of reference. A comparison of the Committee's recommendations and the decision of the Industrial Relations Commission in relation to the ANF claim is in the executive summary.

In addition, during the lifetime of the Committee, the Minister for Health released the *Victorian Nurse Practitioner Project: Final Report of the Taskforce December 1999* (Department of

Human Services 2000), and announced the development of an implementation strategy to progress the role of nurse practitioner in Victoria.

1.6 Report Structure

This report will be presented in two parts, as six chapters. Part 1 will outline the problems facing nursing in Victoria while Part 2 will propose a range of strategies to deal with the problems.

Part 1

Chapter 2 of this report presents an overview of available international and local literature on nursing supply and examines the supply of nurses in Victoria through the tertiary education sector, through migration, and through re-entry to the workforce. Indicators of nursing shortage are critically examined and recommendations are made on a range of issues relating to nursing workforce data.

Chapter 3 presents an overview of current problems in nursing, as relayed to the Committee through its consultation process, and through recent literature. Issues relating to workload, the working environment, rural isolation, specialty issues and management are presented.

Part 2

Chapter 4 presents a range of strategies designed to attract nurses into the workforce. Attraction of school students into Division 1 and 2 training and attraction of nurses no longer in the workforce back to nursing are discussed.

Chapter 5 examines issues relating to nurse education. The T&D Grant, the State Government's education framework for public health facilities, is described, and strategies relating to Division 2, Division 1, graduate year, postgraduate and continuing education are recommended.

Chapter 6 puts forward a range of strategies to address the problems raised in chapter 3. The clinical career structure, workload, management issues, workplace safety and leave entitlements are discussed, and recommendations relating to these issues are presented.

Part 1—The Scope of the Problem

2. Nursing Shortages

2.1 The International Experience

There is a wide body of international literature suggesting a shortage of nurses in many parts of the world, including Africa, the United Kingdom, Denmark, Israel, Italy, Norway and the Middle East, countered by a surplus in some Asian nations, such as the Philippines (Oulton 1998). Many national and state governments have instigated reviews of nursing and have raised issues which are relevant to the Australian context and are concordant with submissions made to the Committee. The key findings of relevant international studies are summarised below.

2.1.1 United Kingdom

Warnings about the impending shortage of nurse supply in the United Kingdom had been suggested since the mid 1980s (Reid 1986) and a steady decline in registered nurse numbers reached its nadir in 1998 (247,200). By the mid-1990s, the Government's Audit Commission had highlighted the economic cost to the state of preventable staff attrition and urged that policies be put in place in National Health Service (NHS) Trusts to minimise staff turnover 'based on an understanding of the views and aspirations of staff' (While & Blackman 1998).

Buchan & Edwards (2000) report that Britain has a serious shortage of nurses, both in overall terms and in areas of specialty, with a decline in nursing registrations of 6000 between 1990 and 1998 (approximately 0.9%). Factors cited for the decline included systemic issues such as greater than expected demand for nurses outside of the NHS, uncoordinated nurse training and workforce planning, increased demand for health care and an ageing workforce, as well as subjective factors such as poor work environments. The paper noted that the British Government had called for the creation of 15,000 new nursing positions and 6,000 new training places to address the current and anticipated shortfall, although the lack of integrated workforce planning in Britain meant that it was unclear what specialist skills the

nurses should have, and into which work settings they should be recruited.

The English Department of Health, in its *Making a Difference* Report (Department of Health 1999), identified the following issues as major problems in nursing:

- **Pay.** Identifying problems with local pay arrangements the Department's first strategy was to implement in full a pay review body recommendation for an unstaged cross sector pay rise.
- **Safe workplace issues.** The Department noted increasing assaults against nurses by clients, and an increase in workplace related injuries. It was noted that English magistrates have been directed by the Lord Chancellor to treat assaults on nurses performing NHS duties as an aggravating factor when sentencing offenders, and stated that the view that assault is 'part of the job' is no longer to be tolerated in health care. In addition, strategies to address back injuries amongst nurses were recommended.
- **Re-entry to the workforce.** The Department identified that 80% of non-working nurses wished to return to nursing and places for 2,800 nurses on return to practice courses were created as part of a national recruitment campaign.
- **Career structure.** The Department concluded that the existing career structure created barriers to promotion and job satisfaction, and was effectively under-funded. It recommended a simplified, articulated four-tier career structure comprising health care assistant, registered practitioner, senior registered practitioner and consultant practitioner.
- **Leadership.** The report recognised problems with nursing leadership, particularly at unit manager level, and a direct relationship between poor leadership and poor standards of patient care. It recommended succession planning, a framework for clinical supervision (statutory for midwives) and greater representation for ethnic minorities in leadership roles.

- **Student preparation.** The report identified problems with the provision and quality of clinical placements for student nurses. It called for longer clinical placements in a supported learning environment (the current curriculum requires 50% of the course be spent in clinical placements).
- **Recruitment and retention.** The Department has established a permanent recruitment and retention section within the NHS executive to oversee the nursing workforce.

The Department recognised, in its response to the Health Committee in the *Report on Future Staffing Requirements* (Department of Health 1999), that a long term strategy to avoid future staffing shortage would involve abandoning local pay arrangements in favour of centralised, industry-wide pay reviews (p. 15), and would hinge on effective forward planning of the workforce. The response also noted that, as a result of a return to nursing campaign, the Department had received calls from 5,000 nurses enquiring about returning to work in the NHS.

Although it is premature to fully evaluate the effectiveness of the British campaign, it is apparent that there are many parallels to be drawn between the problems encountered in the NHS and the Victorian health care system.

2.1.2 Ireland

The *Report of the Commission on Nursing* (1998) dealt predominantly with the evolving role of nurses in the overall management of health services, structural and work changes in nursing and barriers to promotion. It included an examination of the nurse manager role and an examination of the nurse education framework, including professional development. Although many of the recommendations are specific to the Irish context, it is noted that many submissions to the Commission complained of bullying in the workplace (§11.9–11.11), and the report recommended the introduction of formal and informal workplace procedures to deal with the issue.

2.1.3 The United States

In the United States there is an estimated 2.55 million registered nurses, of whom 83% are estimated to be working in nursing (Moses

1998). Several studies have indicated a looming national shortage of nurses due to the ageing workforce, particularly in specialty areas such as critical care where what is described as the 'baby boom nurse supply' is waning (Buerhaus, Staiger & Auerbach 2000¹). In addition, career choices for women are expanding, there continue to be changes in technology and disease patterns, and increasing demand for nurses is outstripping university supply (Buerhaus 1998, Buerhaus, Staiger & Auerbach 2000²). Others have indicated a potential oversupply of nurses due to hospital downsizing and the inability of the community sector to absorb redundant nurses (Pew Health Professions Commission 1995). Despite the lack of consensus on the national supply of nurses, most commentators agree on the need for interdisciplinary workforce planning at both national and local level (American Nurses Association *www* 1999).

Because of differences in health care delivery and population patterns between states, nursing supply issues in the United States have been dealt with predominantly at a local level. In California, in an attempt to identify whether the state was facing an emerging shortage, Coffman & Spetz (1999) conducted a longitudinal analysis of the 230,000 registered nurses in that state. It was found that most of the nurses were working in nursing (77% full-time) and that, of the remainder, most were likely to re-enter the labour market. With an estimated 23% growth in the state's population the study concluded that 43,000 nurses were needed by 2010 and a further 74,000 by 2020. The study concluded that the labour market was unable to resolve the demand issue without government intervention and funding for basic RN programs (to educate beginning practitioners). The study recommended that efforts should be made to increase the ethnic diversity of the Californian nursing workforce to reflect the state's ethnic and racial diversity.

In the American context, recruitment and retention strategies have for many years been linked to the concept of magnet hospitals. The concept arose from the observation that, during the 1980s, a group of hospitals demonstrated no difficulty in attracting and retaining staff, thereby being designated as 'magnets' (Scott, Sochalski & Aiken 1999). The designation is

now formalised as magnet hospitals are subject to a credentialing process by the American Nurses Credentialing Center, with the aim 'to attract and retain professional nurses and thereby provide quality patient care through nursing excellence' (American Nurses Association *www* 2000).

Research has identified common attributes shared by magnet hospitals, and the link between the attributes and patient outcomes. The essential shared characteristics of magnet hospitals are:

- **Autonomy of nursing practice.** The nurses in a magnet hospital have the ability to maintain control over work, both in relation to decision making affecting patient care and organisationally in terms of practice environment, such as staffing levels (Scott, Sochalski & Aiken 1999). This is deemed the most important single factor in the magnet hospital model (Havens & Aiken 1999).
- **Leadership.** The role of nursing leadership is emphasised in the magnet hospital model. Nurse leaders act as advocates for staff, maintain high educational and clinical standards and are accessible to staff, as well as acting as role models. Nurse leaders have a formal role in organisational decision making, within flat management structures (Havens & Aiken 1999).
- **Interdisciplinary relationships.** Good working relationships and communication between nursing and medical staff are cited as a key element in nursing job satisfaction (Aiken, Smith & Lake 1994).
- **Staff retention.** Demonstrably lower vacancy rates and staff turnover rates have consistently been noted in magnet hospitals (Kramer 1990).

While research into magnet hospitals continues, and interest in adoption of the model spreads outside of the United States (Havens & Aiken 1999), there is already sufficient evidence to demonstrate a direct relationship between the ability of a nurse to organise his or her work and a variety of organisational and patient centred outcomes. However, as Torrance & Wilson (2000) caution, any application of the magnet hospital model to Australia should be cognisant of the fact that it is more than just a framework for industrial reform.

2.1.4 Canada

Canada has a similar health care structure to Australia and has traditionally recruited from, and lost nurses, doctors and allied health practitioners to, Australia.

One study, which described the Canadian nursing workforce, showed that nearly 25% of all nurses were aged over 50 years (Canadian Institute for Health Information 1999), and fewer than 10% were aged below 29. Using these data, the Canadian Nurses Association (CNA) has predicted a shortfall in nurses in English speaking provinces of between 59,000 and 113,000 by 2011, with Quebec predicting a shortfall of 11,000 between 2001 and 2015 (British Medical Journal 2000). The CNA also points to the lack of available full-time work for nurses, coupled with downsizing of the hospital sector, as disincentives for new graduates to remain in nursing as a career.

The CNA has responded with a call for the Canadian Federal Government to become involved in coordination of national nursing issues relating to population health and health protection (nursing is currently seen as primarily a state responsibility), and is campaigning for funding to support nursing research and development so that the public can be informed about what nurses contribute to the health care sector.

2.1.5 New Zealand

In 1998, the New Zealand Government established a ministerial taskforce on nursing to recommend strategies to deal with barriers to nursing. Although the taskforce dealt primarily with a range of professional issues, the final report (Ministry of Health 1998) identified a series of structural workforce barriers that placed stress on nurses. These included:

- The inability of health care managers to measure workload and skill mix.
- Increasing patient acuity. The report advocated the development of a nationally consistent system to recognise patient acuity and the corresponding nursing skill mix required to care for patients.
- Lack of recognition of nursing leadership.
- Increased use of casual staff.
- Increased difficulties in retaining nursing staff.

- The inability to provide services such as preceptorship, mentoring and reflective practice in a crisis environment.

The New Zealand health system is reportedly facing chronic difficulties recruiting specialist nurses from within the country and overseas, while shortages of experienced mental health and Maori nurses are noted to be particularly problematic. There are proposals within New Zealand to restore enrolled nurse training, which was ceased in the mid-1990s, in a bid to address current nurse shortages (Nurses.Co *www* 2000).

In 2000, the New Zealand Ministry of Health estimated that there was a pool of 10,000 trained nurses not currently practicing in New Zealand (Nursing Review 2000), compared with 11,000 in 1998, and a sample was surveyed to determine what would bring them back to clinical practice. The survey revealed that 76% would consider returning to the workforce and that flexible hours (19.5%), return to work programs (16.2%), salary increases (12.7%) and child care provision (11.5%) were factors that would influence return (New Zealand Health Information Service *www* 2000).

In addition, the Ministry reported that 1,200 nurses left New Zealand to work overseas in 1999 (compared with 500 in 1995), 200 of which were new graduates.

2.1.6 Australia

Several State governments in Australia have instigated recruitment and retention enquires in the last five years, either in response to perceived shortages or as part of routine workforce planning functions. While difficulties in recruiting specialist nursing staff underpin many of the enquiries, there is a lack of definitive data on the extent of shortages. This is discussed further in section 2.5.

2.1.6.1 New South Wales

The NSW Government released its *Nursing Recruitment and Retention Taskforce Final Report* in 1996 (NSW Health 1996). The report identified 32 issues affecting nursing recruitment and retention including problems with nursing management, lack of recognition of experience and skill, access to educational opportunities, organisational changes,

increasing patient acuity, flexible working hours, child care and differing interpretation of the role of enrolled (Division 2 equivalent) nurses across the State.

The report recommended a range of human resource management initiatives and structural changes including adoption of flexible work practices, funded study leave and travel for education, professional recognition and development of professional networks. The report specifically did not identify or quantify attrition from the NSW workforce or indicate what, if any, level of shortage the State was experiencing. However, recent press reports have quantified the NSW shortage at 1300 nurses, although the source of the data is unknown (The Australian, 20 July 2000).

As a result of the 1996 taskforce report, the NSW government is currently addressing the following issues (NSW Health 2000):

- A marketing and promotional campaign to attract people to nursing as a career.
- Reviews of workplace issues including child care, study leave, flexible working arrangements and access to education.
- The establishment of a standing ministerial Committee on the Nursing workforce.
- Lobbying the Commonwealth on issues relating to the coordination of the national nursing workforce, postgraduate and undergraduate education.
- A career structure review, including the role of the clinical nurse specialist, clinical nurse consultant, enrolled nurse and nurse practitioner.
- State funded refresher and re-entry programs.
- Hospital trained enrolled nurse conversion courses (to Certificate IV in Health [Nursing] level).
- Clinical specialty orientation programs.

2.1.6.2 South Australia

The *South Australian Nursing Recruitment and Retention Taskgroup Report* (Department of Human Services 1998) identified problems recruiting and retaining specialist nursing staff in rural and remote South Australia. It identified problems in retention of nurses following their graduate year (citing a 35% attrition rate), loss of nurses to the private

sector, falling undergraduate intakes and chronic problems filling positions in the mental health, midwifery, critical care, neonatal and renal specialties. The report quantified shortages by citing vacancy rates in specific geographical areas or health services (83 in rural South Australia, 40–60 FTE in specific metropolitan health services) but did not offer any data on the extent of shortages across the State. The report identified hierarchical management structures, inflexible rostering, lack of child support and lack of role models as issues adversely affecting nurse recruitment and retention.

Amongst its recommendations, the report advocated provision of funded refresher programs, child care provision, exchange programs to facilitate backfill and allow rural nurses to take study leave, rural financial incentives, professional development funding and a campaign to market nursing.

A recent University of South Australia study examined recruitment, retention and role development of enrolled nurses in rural South Australia (Bradley 2000). Amongst its recommendations are a view to expanding the skills, roles and professional development of the enrolled nurse, consideration of an improved career continuum from nursing auxiliary to nurse practitioner, and provision of flexible access to education for the enrolled nurse.

2.1.6.3 Queensland

The Queensland Government *Report into Nursing Recruitment and Retention* (Queensland Health 1999) reported growth trends in the employment of nurses in the State and in the average length of service. Problems were identified in recruiting into specialist positions (critical care, perioperative, oncology, paediatric, mental health and midwifery) and specific geographical locations, but overall the report found that Queensland is not suffering statewide shortages experienced in other Australian States.

The report's recommendations include a campaign to promote nursing as a career, improving the training infrastructure, facilitating work experience for school students and recognising the role and value of enrolled nurses

(Division 2 equivalent) and assistants in nursing.

2.1.6.4 Western Australia

The Western Australian Government commissioned the *Attracting Nurses Back Into the Workforce* report to identify factors that would encourage non-practicing registered nurses to return to the clinical setting (BIZRAC 1997), and to identify some of the principal reasons nurses leave the workforce. The report found that flexible hours, increased pay, affordable on site child care, refresher courses, part-time work and the availability of dayshift only rosters, are factors that would encourage nurses back.

In another supply-side initiative, and in response to falling nursing undergraduate intakes, the Health Department of WA commissioned research (Donovan Research 1998) to identify effective strategies to be used in a campaign to promote nursing as a career. This resulted in a multimedia campaign to promote nursing as a career, entitled 'Are you good enough to be a nurse?', targeted predominantly at school students in Years 10 to 12. The Committee understands that the WA Government is undertaking a preliminary analysis of the campaign.

2.1.6.5 The Commonwealth

In 1999, the Commonwealth Department of Health and Aged Care sponsored a national forum in Canberra entitled 'Rethinking Nursing'. The forum was held in response to a request from the then Victorian Minister for Health that the AHMAC address issues relating to Commonwealth higher education policies, as they related to nursing, and a national, coordinated approach to nurse workforce planning. The forum, which included representatives from all national nursing peak bodies, considered a range of issues relating to the nursing workforce including recruitment and retention, education and the status of nursing. A series of four recommendations were made in the forum proceedings *Rethinking Nursing* (Department of Health and Aged Care 2000):

- That a national nursing workforce advisory committee be established.
- That a national nursing workforce strategy be developed.

- That each State, Territory and the Commonwealth develop a chief nurse/ chief nursing officer position.
- That coordination between educators and the workforce is improved.

The recommendations were designed to address the lack of national coordination in nurse workforce planning and the dislocation in supply of, and demand for, specialist postgraduate nursing courses in the tertiary sector. The recommendations were twice submitted to AHMAC but were twice rejected in favour of a workforce planning approach that covered all health disciplines. As a result, the Health Workforce Advisory Council will be established and its first task will be to examine nursing sub-specialties such as critical care and midwifery. At this stage the Council will comprise membership from selected States only. Given the extent of work carried out on recruitment and retention by the States and Territories to date, the Committee believes it is imperative that all States and Territories are represented on the Council when nursing issues are considered, to ensure that adequate sharing of information takes place.

Recommendation 2: That the Commonwealth include all States and Territories, and all relevant nursing peak bodies, in its new Health Workforce Advisory Council, when issues relating to nursing are considered.

In the Rethinking Nursing report, the Commonwealth acknowledges that while it has a broad policy leadership role in health, it has to date had little direct responsibility for the nursing workforce (Department of Health and Aged Care 2000). Nationally the Commonwealth has sponsored research by the ANZCMHN into the Australian mental health nursing workforce (Clinton 1999). The report, Scoping Study of the Mental Health Nursing Workforce, recommended that Commonwealth, State and Territory responsibility for planning and development of the mental health nursing workforce be delineated, and that the Commonwealth require the States and Territories to improve nurse workforce planning as part of the next Medicare agreement. In addition to mental health, the Committee notes that the Commonwealth

Department of Health and Aged Care has recently engaged a consultant to report on strategies to recruit and retain aged care nurses.

The Committee believes the Commonwealth can play a key role in coordinating national nursing policy and workforce planning, through its broad policy leadership role in health. The Commonwealth has direct responsibility for higher education, immigration, and much of the aged care sector. In the higher education sector, access to postgraduate education places, the proportion of HECS funded university places, quarantining of nursing from postgraduate fees, undergraduate selection, the traineeship model for enrolled/Division 2 nurse education and the attrition from nursing courses (or subsequent refusal to practice), are all matters which need to be addressed by the Commonwealth, States and Territories jointly. The Committee has identified these educational issues as key impediments to maintaining a stable nursing workforce.

Recommendation 3: That notwithstanding local initiatives, the Victorian Government continues to lobby the Commonwealth to coordinate issues relating to nursing workforce planning for which it has responsibility, including the tertiary education of nurses, migration policy and aged care nursing.

2.1.12 Summary

It is apparent that concerns over nursing shortages are a worldwide phenomenon, and that many jurisdictions assume that such concerns will remain for the foreseeable future. Whilst there have been many enquiries into the state of the nursing workforce, none appear to have arrested the general decline in nursing numbers or compensated for the ageing workforce. The nursing workforce is a dynamic entity which is sensitive to changes in health care delivery patterns and which swings from oversupply to undersupply in a relatively short period of time (Department of Human Services 1999², Buerhaus, Staiger & Auerbach 2000¹).

In reviewing the literature on the nursing workforce, many common themes are apparent. The first, and probably most important, is the lack of a coherent workforce planning model

which enables prospective adjustment of nursing supply to fit demand. Many of the reports reviewed by the Committee for this report were written against the background of an immediate or impending nursing workforce crisis, and many coincided with significant changes to health care structures, such as the trend towards shorter patient stay episodes and the shift to community care. While much of the literature recommends an increase in labourforce planning capacity at government level, it is by no means clear that a workforce planning model exists which is universally applicable. Supply-side planning is evident through strategies based on adjustment of base practitioner supply, re-entry and migration, however, the issue of quantification of demand for nurses (as well as para-nursing support), particularly in the face of changing technologies, patient acuity and health care structures, has been markedly less evident in the literature to date.

Coupled with the lack of workforce planning is the underlying problem of paucity of workforce data. In many jurisdictions the nursing workforce has been held to equate with the number of nurses registered by the regulatory authority. While the trend towards recency of practice requirements and mandatory professional development in many countries may force a closer relationship between registered and working nurse numbers, it is clear that many jurisdictions, including Victoria, still have large numbers of nurses who are registered but are not prepared to practice. The Committee suggests that any improvement in Victorian workforce data capacity will have to address the retrospective nature of current data, and that effort should be made to devise prospective data sets that can take into account current and future workforce participation intentions of nurses. In support of this the Committee notes the findings of the focus group research undertaken by Research International which found that, 'when asked their future intentions, most (nurses) intend to either scale back their participation, or plan to leave within the next 5–10 years' (Research International 2000, Appendix 6).

The literature suggests that health planners have paid insufficient attention towards emerging career choices for nurses. In

particular, the trend towards casual work and self-employment (via nursing agencies) has destabilised the workforce in many countries with an effect on permanent staff and patient outcomes (Snell 1997). Societal changes have led to a greater diversity in career choices for women, as well as working pattern choices, leading to greater expectations in balancing a career with life outside of work. The literature suggests that the nursing workforce is often structured to accommodate the full-time 'career' nurse rather than the increasing number of women and men who, for family, education, age, health or other reasons, choose to work outside this structure.

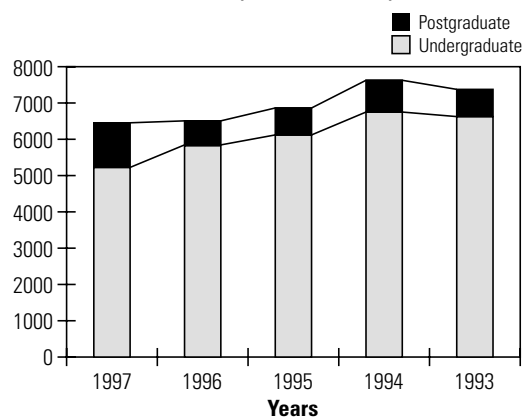
2.2 The Victorian Nursing Workforce

2.2.1 Nursing Supply

Division 1

Nationally, the overall number of graduates from the Bachelor of Nursing programs has been steadily declining (AIH&W 1999). Figure 1 shows this decline in the graduates from undergraduate programs over a five-year period. This decline is associated with a rise in postgraduate numbers in 1997, in part as a result of the recommendation of the Commonwealth *Review of Specialist Nurse Education* to increase specialist postgraduate places, based on projected workforce requirements for more specialist nurses (Russell, Gething & Convery 1997). The total numbers and commencements have shown increases above the 1997 figures for both 1999 and 2000.

Figure 1. Australian Graduates from Undergraduate and Postgraduate Courses during the Years 1993–1997 (AIH&W 1999)

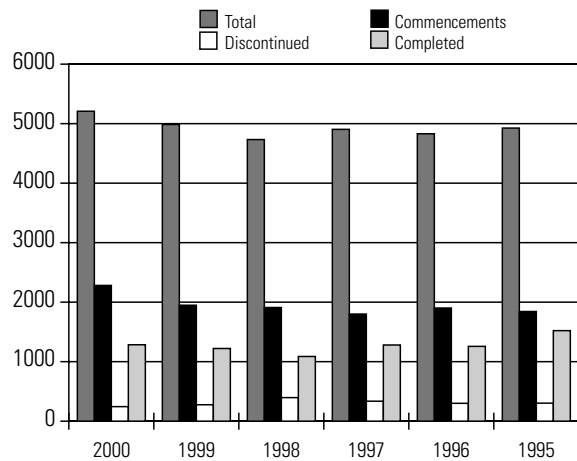


In contrast to many other States, and for reasons that are unclear, Victoria has not faced difficulties in filling undergraduate nursing places (Figure 2). Further, the attrition rate for the undergraduate courses remains comparable with the average undergraduate attrition rate. Figures from the Victorian Department of Education Higher Education Branch indicate that, since 1996, the apparent completion rate for nursing undergraduates has fallen by 3.8% to 63.3%, while in the same period the apparent completion rate as an average of all undergraduate courses has fallen by 2% to 59.5%. In contrast to nursing, occupational therapy, physiotherapy and radiography apparent completion rates have all risen in the same period by 15%, 8% and 18% respectively.

During the same period, the average ENTER score for undergraduate nursing courses in Victoria has risen from 59 in 1996–97 to 70 in 1999–2000 (the average ENTER score for all fields of study 1999–2000 is 76). It should be noted that ENTER scores are not the sole determinant of entry to all nursing courses.

A concern put to the Committee in public forums relates to the issue of undergraduate preferences. There appears to be a widespread perception that many students enter nursing courses because they are unable to obtain places on preferred courses, or else enter nursing to transfer during the course to a different discipline with a higher ENTER score, such as psychology. The Committee has no data to support this perception. Data supplied to the Victorian Department of Education by the Victorian Tertiary Admissions Centre (VTAC) shows that, for the last three years, the proportion of undergraduates with a place on a first preference nursing course, that is those who obtained a place on their first choice course at their first choice campus, was consistently 20%. Overall, the first preference and total preference applications through VTAC show a fairly stable pattern of demand for places on nursing courses, with a slight increase in demand evident in 1999–2000.

Figure 2: Victorian Undergraduate (Division 1) Students 1995–2000*



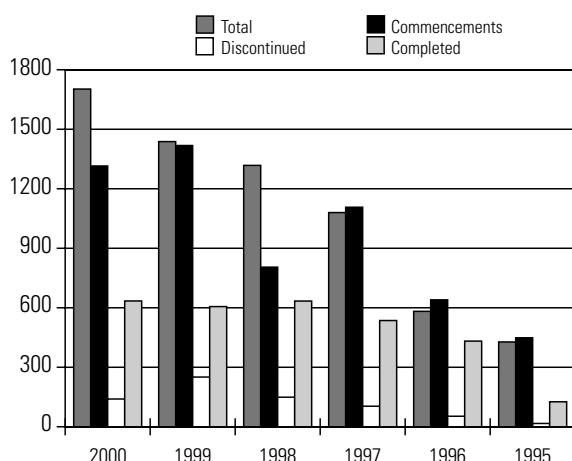
*Nurses Board of Victoria *Annual Report 1999*. NBV Melbourne and additional NBV data.

Division 2

The total number of Division 2 students in Victoria has been increasing steadily (Figure 3). The data reflects the transfer of education from the hospital-based system to the VET sector. The earlier years in this time period (1995–96) reflect the closure of the Melbourne School for Enrolled Nurses, which was responsible for the education of the majority of Enrolled Nurses (now Division 2) in Victoria. There has been a steady increase in graduates from the Certificate IV in Health (Nursing) course (full-time, part-time or traineeship) since Division 2 education was transferred to the VET sector in 1997, although the number of commencements has reduced in 2000 since the peak year of 1999.

The number of discontinuing students showed an increase in 1999. This may in part be attributable to the selection criteria adopted for the traineeship model of training, criteria which no longer apply, hence the lower number in 2000.

Figure 3. Victorian Undergraduate (Division 2) Students 1995–2000*



* Nurses Board of Victoria Annual Report 1999. NBV Melbourne and additional NBV data.

The Committee has had difficulty obtaining accurate data relating to nurses in training, and has noted discrepancies in several of the data sets supplied by various State and Commonwealth bodies. The Committee considers it of crucial importance that numbers of students in training, and associated completion and attrition, be accurately monitored to ensure a predictable workforce supply.

Recommendation 4: That nurses in education courses be reported from the Victorian Department of Education, Employment and Training to the Department of Human Services annually (for Division 1) and six-monthly (for Division 2).

2.2.2 Migration and Immigration

In Victoria in the 1999–2000 financial year, 112 specialist nurses were granted temporary resident visas for employment in the public and private sector (source: Department of Human Services Workforce Branch). Of those, 16 were employed in mental health, one in aged care and 95 in the acute sector. Sixty-nine were from the UK, 13 were Irish and one was from New Zealand. To place the figure in context, 450 temporary resident visas were issued in the 1998–99 financial year for nurses nationally (AIH&W 2000) (1999–2000 figures are unavailable).

Nurses granted temporary residence play a peripheral role in the staffing of the Victorian health system. The use of such nurses has been restricted to areas of geographical and specialty shortage where local candidates have not been found. It is argued by some that the cost of business sponsorship and migration agents has led many health care facilities to view this as an option of last resort. In global terms, the use of foreign nursing labour to address shortages has led to an international ‘robbing Peter to pay Paul’ syndrome that has been described as not being in the long term interest of the nursing profession, and unsustainable (Glaessel-Brown 1998).

In the same period (1999–2000) 168 nurses settled in Victoria as permanent migrants (Department of Immigration and Multicultural Affairs).

2.2.3 Attrition from the Workforce

Since 1996 there has been a 3.14% decline in the number of nurses registered in Victoria. This is due in part to the application of recency of practice provisions introduced into the *Nurses Act 1993*, where nurses without sufficient recent clinical experience are removed from the register. There has been a small increase in the number of Division 1 nurses but this should be balanced with the closure of Divisions 3, 4 and 5 of the register to new entrants.

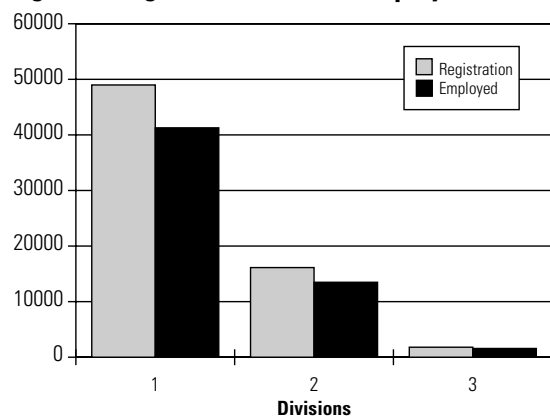
Table 2 . Registration (Victoria) in 1996–2000*

Division	Years					Diff 2000–1996 %
	2000	1999	1998	1997	1996	
1	49,835	49,628	48,990	48,757	48,743	2.25
2	15,686	15,960	16,133	16,175	16,792	-6.59
3	1,710	1,763	1,802	1,836	1,924	-11.12
4	743	512	554	597	703	5.68
5	822	1,060	1,366	1,721	2,383	-65.5
Multiple	763	871	966	1,055	1,268	-39.83
Total	69,559	69,794	69,811	70,141	71,813	-3.14

* Nurses Board of Victoria Annual Report 1999. NBV Melbourne plus registration figures as at 31/3/00

Comparison between registration and workforce data is of interest. According to the latest Victorian figures, in 1998 there were 69,811 nurses registered, and 56,350 of these were in the workforce (Department of Human Services 1999²). Thus, 13,461 nurses were registered, but not employed in nursing. This represents a significant number who might be able to be attracted back into the nursing workforce. A sample of this cohort was surveyed by the Committee to ascertain whether they represent a source of future nursing labour, or whether they are removed from nursing altogether. The survey is attached as appendices 3 and 4.

Figure 4: Registered Nurses in Employment 1998



(NBV Annual Report 1999 and Department of Human Services 1999)

2.3 National Data Sets

The AIH&W, established as a statutory body in 1987, publishes nursing workforce data every two years. The data are based on information collected by the Nurses Boards in each State and Territory, and is processed by the State and Territory health departments.

The AIH&W reports are calculated from a variety of data sources including Australian Bureau of Statistics (ABS), Department of Employment, Workplace Relations and Small Business (DEWRSB) and Department of Education, Training and Youth Affairs (DETYA). The principle source of data is the survey distributed by the State and Territory nurse registration boards during the annual registration renewal. The response rate to the AIH&W survey in Victoria is usually around 80%, which compares favourably with allied health (physiotherapy 92%, pharmacy 61%) and

medicine (74%). However, interpretation of the information is hampered by the fact that it is self-reported data which requires assumptions to be made for the non-responding cohort. Despite these caveats, the data set remains the most consistent and widely used source of nursing labourforce data for Victorian workforce planning purposes.

The AIH&W data publication is subject to significant time delays, predominantly due to time taken in obtaining State and Territory data, and because of the relative status of nursing in the Institute's work plan priorities. This has the effect of rendering these data outdated for workforce planning purposes. As a result of the recent AHMAC meeting, the Commonwealth is undertaking a national review of national nursing data and the availability of these data for use by key stakeholders.

The Committee noted that the then Victorian Department of Health and Community Services published Victorian labourforce data bulletins on an annual basis as a service to assist key stakeholders in workforce planning. This practice could be reinstated by Department of Human Services in conjunction with the NBV.

Recommendation 5: That the Department of Human Services, in conjunction with the NBV, publish the Victorian proportion of the AIH&W labourforce statistics in 'real time' as a separate report.

The Committee is concerned at the apparent dislocation between workforce data pertaining to specialist nursing workforce need, and provision of postgraduate specialist nursing courses through the higher education sector. The Committee advocates for regular workforce data to the higher education sector so that provision can be made for specialist nursing courses in areas of need. This is discussed further in section 5.2.1.

Recommendation 6: That the Department of Human Services makes available to the Victorian Department of Education, Employment and Training Victorian nursing labourforce statistics on a regular basis, to assist in the provision of postgraduate and post-basic specialty nurse course planning in the university and Vocational Education and Training Sector.

The most recent comprehensive AIH&W nursing report (AIH&W 1999), using data from 1996 to 1998, reported that the number of registered nurses in Australia remained unchanged from a decade earlier. It did recognise, however, that there was a steady decline in the number of available hours worked by nurses, with a corresponding rise in patient numbers per FTE nurse. This was coupled with an increased demand for nurses within the health care system.

Other features of the report were:

- A low national unemployment rate for nurses (2.4%).
- An ageing of the nursing workforce. The average age of nurses in Australia is currently 40.1. In 1986, 23.3% of nurses were aged less than 25, in 1996 the percentage was 9.9%. In 1986, 17.5% of nurses were aged over 45, in 1996 this had increased to 28.6%.
- An increase in temporary resident nurses working in Australia.
- An increase in the age of students entering undergraduate nursing programs (the average age of undergraduates is reported as 24.5, compared to 21.8 five years earlier). See Figure 5, section 4.1.
- Australia continues to have a greater number of nurses per head of population than other English speaking OECD countries with 962.3 per 100,000.

Other Commonwealth agencies also provide nursing data. DEWRSB reports on nursing specialty shortages, based on periodic phone surveys of hospitals where information on difficult to fill vacancies is obtained. These data are not always consistent with those maintained by the Department of Human Services (table 3 below) and are used by the Commonwealth to inform policy issues such as skilled migration and the granting of temporary resident visas. Table 3 below shows nursing specialty shortage as interpreted by DHS and DEWRSB respectively.

In addition to the above, the Commonwealth releases census data through the ABS after each quinquennial census. The most recent census was conducted in 1996 and the data pertaining to nursing has been tabulated as a special commission for the Committee by the ABS. The data was sought primarily to establish the

sample size for the survey on currently unregistered nurses and correlates to the number of nurses on the NBV register (69,000). While the data is of historical interest, it is proposed that 1996 workforce figures bear little relevance to the 2000 workforce and, given the lead time the ABS requires to process Census data, it is unlikely that future Census data will be of use in 'real time' workforce planning.

Table 3: Comparative Qualitative Nurse Shortage Estimates, Department of Human Services and Commonwealth

	Department of Human Services	DEWRSB Shortage
Perioperative	Y	Y
Emergency	Y	Y
Cardiothoracic	Y	Y
Neurosciences	N	Y
NICCU	Y	N
Paediatric	N	N*
ICU/CCU	Y	Y
Renal	Y	N
Aged Care	Y	N
Oncology	N	N*
Midwifery	Y (Rural)	Y
Mental Health	Y	Y
Rural Generalist	Y	N

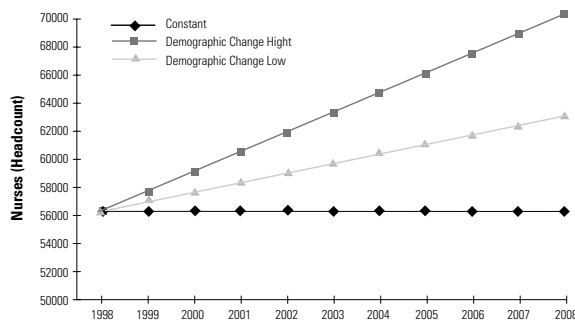
(DESBWR 2000, Department of Human Services 1999)

* No Victorian shortage but shortages identified in other States.

2.4 Victorian Data

In 1998, the Department of Human Services commissioned a nursing workforce study (Department of Human Services 1999²), to establish labourforce projections for the period 1999 to 2008. This followed previous studies in 1991 and 1993, the latter of which predicted an impending oversupply of nurses. The 1993 study resulted in a small reduction in the number of undergraduate nursing places and a reduction in Division 2 training positions. The method used for the studies was a stocks and flow model using proprietary software. The 1999 study found that, on current high demand projections, Victoria would be facing a shortage of up to 5,500 nurses by 2008. This shortage is undifferentiated and does not quantify shortage by nursing specialty, grade, experience, division or geography.

Figure 5: Nurse Supply Requirements, Victoria 1998–2008 (Department of Human Services 1999²)



In addition, the Department of Human Services commissioned an evaluation of the methodology used in the studies of 1991 and 1993. The study found that the assumptions which underpinned the Department of Human Services labourforce studies were essentially sound but that changes in the health care delivery system, particularly the application of the casemix funding model, the increase in demand for health services (as calculated by the Acute Health Branch of Department of Human Services), restructuring of aged care services, the establishment of health care networks and the integration of mental health services could not be anticipated at the time of the studies (Department of Human Services 19991).

One essential difference between the study of 1998 and the studies of 1991 and 1993, was a dramatic increase in attrition rates, particularly following completion of Division 2 training. Losses to the labourforce in 1998 totalled 4,376 nurses (7.41% of the workforce), which were not balanced by the 1,682 nurses (2.85%) entering or re-entering the workforce.

In addition to the labourforce reports, the Government has commissioned periodic qualitative and quantitative studies that explore issues in nursing specialties such as critical care and midwifery (Health and Community Services 1993, Department of Human Services 1996).

While labourforce projections have defined overall supply and demand issues, there is a paucity of data on workforce variation between studies. Currently the Department of Human Services has no consistent data on the number of nurses working in the public hospital system. It cannot establish the number of part-

time workers, the split between divisions, the number of casual nursing staff or the number of agency staff employed by public hospitals with any confidence. Equally, the Department of Human Services cannot, with confidence, predict the number of nurses actually required in the public health system. This has major implications for monitoring the ongoing effectiveness of any recommendations produced by the Committee relating to nurse recruitment and retention, as well as for the ability to conduct routine labourforce planning. It also has major industrial implications for the Government, as individual grades of nurses cannot be identified centrally. Labourforce estimates used in this report are based on reports commissioned by the Department of Human Services, Human Resources Branch, from Allegiance Systems, which has the contract to manage the public hospital payroll in most Victorian public healthcare facilities. The report used data from March 2000.

Recommendation 7: That the Department of Human Services commissions regular payroll reports (at least three-monthly), reporting total numbers and total EFT of nurses by agency, by grade, by service and by full-time or part-time status.

In addition to difficulty relating to overall nursing numbers, the Department of Human Services lacks any information about the post-basic qualifications held by nurses. While the NBV maintains a data set on nurses with a specific qualification in post-basic midwifery and maternal and child health, there is no record of the number of nurses with qualifications in specialties such as critical care or oncology. Data exists on the number of nurses with formal post-basic nursing courses (AIH&W survey Q17) but interpretation of this data is limited by several factors. The first is that the data is self-reported, without any corroborating information. The second factor is that 'post-basic' is interpreted in survey responses to mean anything from informal continuing education to adult education and non-nursing courses (such as massage and aromatherapy). While the respondent may use skills gained from these courses in everyday nursing care, the courses are not generally considered 'nursing'. The third factor is that the level of course is not recorded, so that a post-

basic VET module, a graduate certificate and a PhD are recorded in the same context. The fourth factor to consider is that the data does not identify nurses undertaking training.

The Committee was asked to examine changes that may be necessary to the Victorian component of the AIH&W annual survey (term of reference 2.7). It was noted that nurses working in mental health were classified as one homogenous group in the current survey. Given the current problems attracting mental health nurses into the inpatient setting, and the migration of experienced nurses from inpatient to community settings, the Committee believes that the question relating to area of clinical nursing should differentiate 'community mental health' and 'inpatient mental health' to assist workforce planning.

The Committee also notes the increasingly high profile of palliative care nurses in Victoria. As these nurses work across setting boundaries (inpatient and community) they are not identifiable in the current survey as a discrete clinical specialty. Again, the Committee advocates identification of this group within the survey.

Recommendation 8: That the Department of Human Services recommends the following changes to the AIH&W annual survey tool:

Q16: To assist workforce planning, mental health be categorised by community mental health and inpatient mental health, and palliative care to be added as a clinical specialty in its own right.

Q17: Specify that the post-basic qualifications be graduate certificate (including hospital based courses which predate the transfer of nurse education to the tertiary sector), graduate diploma, masters, PhD or post-basic TAFE/VET module. This is to exclude 'informal' courses and in-service education which confound interpretation of Victorian specialist nurses.

2.5 Indicators of Shortage in Victoria

As previously discussed, there is a body of international literature suggesting a worldwide shortage of nurses. Despite this, much of the evidence is anecdotal, descriptive and localised. Buchan & O'May (1998) review the evidence for nursing shortages and critically analyse the five commonly used indicators for shortage. These indicators will be applied to the Victorian context.

2.5.1. Vacancies

The inability of an organisation to fill vacancies is often cited as an indicator of nursing shortage. Buchan & O'May contend that vacancy rates, while a useful indicator, may in fact underestimate shortage where, for example, vacancies are not advertised, or where vacancy data are collected at an atypical time point. Submissions before the Committee suggest that many facilities no longer advertise hard to fill vacancies, using the rationale that repetitive advertising acts as a disincentive to prospective applicants, who may perceive low morale within the organisation. This has implications for any vacancy data collection method that relies on published vacancies.

The Committee has been informed that at least one large Melbourne hospital, when completing a vacancy survey, had no vacancies at that point in time, yet were anticipating severe shortages during the winter. In addition, the Committee has learnt that some hospitals maintain unfilled vacancies as part of their staffing profile, with no intention of filling them. It is concluded that vacancy data, to be useful for workforce planning purposes, should be collected on a regular basis and with a consistent response rate, and should have the capacity to reflect seasonal variations.

In Victoria, a statewide vacancy survey was undertaken in 1999, in both the public and private sectors (ACNMI *et al.* 1999). Although the response rate was relatively low (35% in the aged care sector, 41% in the acute sector) it revealed that 58% of acute facilities and 57% of aged care facilities had unfilled vacancies at the time of the survey (February 1999).

The Committee, in its consultation process, sought data from public and private hospitals on current vacancy rates. Public sector responses on vacancies were obtained from 27 health care facilities (20 rural) but this was countered with a negligible response from the private sector. The number of vacancies organisation-wide ranged from 0.6 to 58 EFT. The data suggested that the majority of metropolitan hospitals were having difficulty filling vacancies, particularly in specialist areas such as critical care and inpatient mental health services, and suggested a shortage of experienced, qualified nurses. In rural facilities, the responses offered a greater variation. Some facilities had no problems filling vacancies (with a waiting list for permanent positions apparent in some hospitals) while others faced chronic problems filling rural generalist, aged care, mental health and midwifery positions. It should be noted that the Committee viewed this as indicative information only, and no attempt was made to aggregate the data.

2.5.2 Turnover

Turnover rates, and the ability of facilities to retain staff, have been suggested as a method of monitoring recruitment and retention difficulties (Kramer 1990). A distinction should be drawn, however, between controlled and uncontrolled turnover as, during the restructuring of the Victorian health care system, anecdotal evidence suggests many nurses were offered retrenchment packages to leave the industry.

The Committee attempted to seek qualitative and quantitative data on turnover rates but was hampered by the lack of industry benchmarks in what is traditionally a highly mobile industry. As one submission to the Committee stated, '(our) nursing service attrition rate fluctuates between 12–15% which could be considered low. There is no industry benchmark...but I suspect that anything over 25% would be an indication of organisational difficulties'.

Other submissions complained about a lack of nursing turnover with one stating that, 'some rural hospitals have little or no staff turnover for months, even years. This leaves little room to permanently employ suitably qualified staff who may be actively seeking work'.

2.5.3 Overtime

Overtime rates have been suggested as another indicator of nursing shortage. Interpretation of data in the Victorian context is hampered by the fact that, according to both research (Considine & Buchanan 1999) and evidence from the Committee's consultation process, the true extent of overtime in the public health care sector is significantly under-reported. The indicators used to define overtime can range from ad hoc additions to shift length, double shifts, work on days off, the use of on call arrangements to cover routine services and formal overtime arrangements (either paid or with time in lieu arrangements). In addition, evidence from the consultation process suggests a widespread expectation that non-clinical work tied to a specific role, such as CNS and ANUM, be conducted outside of normal rostered working hours. The degree to which such overtime represents shortages is unclear for, as Buchan & O'May (1998) state, 'unpaid clinical hours are cheaper than recruiting more paid nursing staff, even if resources are available to meet the bill'.

Given the issues outlined above, a conservative estimate of overtime in the Victorian public system (Considine & Buchanan 1999) is that between 300 and 450 full-time nursing positions a week are being filled using unpaid labour through overtime. Considine & Buchanan also report that 18.8% of overtime worked was always paid, 19% was unpaid, and that 30.5% of overtime worked was repaid as time in lieu (p. 4).

2.5.4 Unemployment Rates

The unemployment rate for nurses in Victoria is estimated to be 2% (ABS information line, July 2000) compared with a statewide rate of 7.2% (DESBWR 2000). The former rate is identical to that of United Kingdom nurses. According to the British Government's Ray Review Body, an unemployment rate of 2% is usually regarded as indicative of full employment (Buchan & O'May 1998).

The 2% unemployment rate in Victoria suggests that most of the pool of non-working nurses in Victoria described in section 2.2.3 is likely to be either working in another industry, or out of the workforce altogether, rather than unemployed and seeking nursing work.

2.5.5 Surrogate Markers

Clinical indicators have been suggested as a method of supporting data on staff shortages. In America, hospital infection rates (Fridkin *et al* 1996) and mortality rates (Aiken, Smith & Lake 1994) have both been correlated to staffing levels. Such data need to be interpreted with caution in the Victorian context. Increasing patient acuity, changes in the pattern of microbial infection and the trend towards reduced length of hospital stay render the use of historical data relating to infection rates difficult to apply to the current context. The Committee notes that the Victorian Government has legislated that hospitals are to submit data on infection rates after specific surgical procedures to the Department of Human Services Quality Council. Mortality data is subject to similar interpretation problems relating to historical controls as the trend continues for sicker patients to be admitted to hospital while the less unwell are treated in the community or on a day basis.

Other markers have been suggested as indicators of shortage, such as the number of days emergency departments spend on ambulance bypass, patient satisfaction indices or medication errors. However, as their relationship to understaffing, as opposed to generalised systemic stress, is difficult to define, these markers are not considered in this report.

The Committee sought information on sick leave rates in its call for submissions. As expected there was wide variation in the method of sick leave reporting which did not assist in the aggregation of data. Of the facilities that provided serial data for 1998 to 2000, none demonstrated trends towards significant increases in sick leave, with most reporting annual sick leave rates in the range of 2 to 6% (sick leave hours taken as a percentage of all nursing hours worked).

2.5.6 Summary

While the data on shortages in Victoria is patchy, there is strong evidence of uncertainty of the supply of nurses in the workforce. At this stage, the projection of statewide shortage in the most recent Department of Human Services labourforce study (Department of Human Services 1999²) appears still to be relevant. Of more concern, the consultation process has revealed that many nurses currently working are considering leaving the profession in the near future (Research International 2000, Appendix 6). This may exacerbate projected shortages with as many as 12% of nurses who have already left the system indicating that they are not prepared to return (Campbell Research & Consulting 2000, appendices 3 and 4).

While the data available to the Government relating to nursing is acknowledged as sub-optimal, it should be noted that this is a situation experienced by Governments both internationally and within Australia. This should be regarded as an opportunity to improve and systematise the State's data collection policies to ensure accurate labourforce planning capacity in the future.

3. Problems in Nursing

As previously described in section 1.4, the Committee undertook a consultation round which comprised written and verbal submissions, focus groups and forums. In seeking information, the Committee focused on two key issues: why people are leaving nursing and what would bring them back.

One of the features of the consultation process was that the issues raised were usually consistent across peak bodies, DoN and clinicians. The key issues are summarised below, and are discussed in detail later in the report.

3.1 Workload

The perception that workloads have increased was articulated by clinical nurses regardless of clinical setting, geographic location or level of practice. This increase in workloads was given as the most common reason for nurses leaving the profession (appendices 3 and 4). A number of factors appear to be contributing to this clear perception of increased workload.

3.1.1 Factors Contributing to Increased Workloads

The first of these contributing factors was acuity of patients/residents. The level of acuity of patients has changed in acute areas, nursing homes and in the community. Bed days have reduced over the past decade (Productivity Commission 1998) and, with associated specialisation of services, there is generally no longer the mix of short and longer stay patients within the acute wards. In addition, the complexity of care has increased, coupled with a trend towards community aftercare. The level of care is, therefore, constant with high levels of acuity for short stay patients. As was indicated in the focus groups, there seems to be no 'downtime' any more. In addition, patients are discharged to aged care facilities and the community in more acute phases of their illnesses, often, it is claimed, without adequate discharge planning.

The second contributing factor was availability of nurses. There appear to be fewer nurses currently employed. According to Commonwealth figures (AIH&W 1999), patient separations per FTE have increased by 8.1% and patient days per FTE by 9.3% in public hospitals. At the same time, there has been an overall decline in staffing availability of 5.1%. This staff availability has been exacerbated by the fact that only 68% of graduate nurses entered the Victorian workforce in 1998. Demographic trends appear to require 57,585 to 57,645 nurses working in 2000. However, in 1998, there appeared to be a net loss with 2,947 entering and 4,394 leaving the workforce.

In addition, figures show that around 13,461 nurses were registered but not working in Victoria in 1998. (NBV Annual Report 1999, Department of Human Services 1999²). The survey of a sample of this population has indicated that 51% would be prepared to return to work if, among other aspects, the workload could be reduced; while a further 32% were unsure if they would return (appendices 3 and 4). Coupled with this reduction of availability is the reduction of experienced qualified nurses at the bedside. From information before the Committee, shortages have been identified in general areas as well as the specialties of critical care, accident and emergency, mental health, aged care, neonatal intensive care and rural midwifery (Department of Human Services 1999, ACNMI *et al.* 1999). The major shortage appears to be in experienced qualified nurses. In particular, the survey, forums and focus groups identified the following as contributing to this loss:

- Budget cuts and 'an emphasis on cost reduction by hospital management' (Appendix 6, p 20).
- Rounds of redundancy packages.
- General dissatisfaction with working conditions.

That third perceived cause of an increase in workload is the casualisation of the workforce. Increasing numbers of nurses now work part-

time (Department of Human Services 1999², AIH&W 1999). In some rural and metropolitan areas the ratio of part-time to full-time reported to the Committee is as high as 80:20. Choice of part-time employment may reflect lifestyle choices in some instances, it may indicate budget considerations in others, and in some circumstances may represent an attempt by nurses to have some control over their workload. There is no doubt that greater continuity of care can be achieved with a higher full-time workforce. The lack of continuity of care places an added strain on those experienced nurses who must ensure continuous quality nursing care.

Where the number of staff is not sufficient for the patient load, agency nurses tend to be used. In some instances, hospitals have contracts with only one agency and the nurses become familiar with the units in that hospital. However, this is not always the case. Hospitals may find themselves with nurses who do not know the unit and in some instances do not have the qualifications or experience necessary to provide quality care for the patients in the unit. This increases the load on the full-time experienced nurses. Many nurses saw the orientation and supervision of agency staff as an additional burden in an already overstretched work environment, and there was a widespread perception that many agency nurses were often being used in circumstances other than of last resort by management. The over award pay rates offered by agencies to certificated specialist nurses was considered a destabilising factor by many nurses, compounding the difficulties facing health care facilities in attracting permanent staff.

With the loss of experienced nurses from wards/units, the concomitant increase in new graduates and relatively inexperienced nurses results in inordinately heavy workloads being carried by both the experienced and less experienced nurses. The former tend to suffer 'burn out' and the latter may find themselves unable to cope with the heavy demands. Therefore, both groups may choose to either leave the workforce, reduce to part-time or join an agency. This situation has been described in the focus group report as a 'vicious cycle' (Appendix 6, p 22).

3.1.2 Control over Workloads

Nurses expressed a feeling of powerlessness in controlling their workloads. Different methods have been used to determine workload, one of which is the nurse/patient ratio. Such ratios appear to have increased in many areas. The data reported by Considine & Buchannan (1999) shows that, for acute wards, 66% of the research sample reported a current ratio of 1:5–1:6. Of particular concern was the reporting by 22% of the sample of ratios in excess of 1:8. The issue of what is a desired nurse/patient ratio for the acute wards is a matter of debate. When Considine & Buchannan posed this question, 68 % of their sample who were currently working with ratios of 1:4–1:5 indicated this as desirable.

Data before the Committee also show that current ratios vary considerably. For the acute medical/surgical area, reports have ranged from 1:3 to 1:10. Those hospitals that have attempted to address the ratio issue report ranges of 1:4–1:5. The focus groups referred to ratios of 1:6–1:8 as the norm (Appendix 6, p 20), a view supported by nurses at the forums.

Where the workload was considered too high, and additional staff could not be provided, an obvious strategy to ensure reasonable workloads was to close beds. Even where a ward/unit was successfully using a workload measurement tool such as Trendcare, and therefore had evidence that the ratio was too high, beds were rarely closed. This situation was imputed to the use of the casemix funding formula and budget allocation. Nurses frequently recounted instances where, on request for bed closure, there were implied threats that such closure would result in more drastic consequences for the hospital as a whole. Several NUMs expressed a feeling of lack of support from management in this area.

Other areas in which nurses expressed feeling a lack of control over their workloads was in the hours worked. Discussion in the forums and focus groups centred around:

- Short shifts, resulting in shortages of staff for periods of time during the day (for example, a six-hour shift might leave two hours with insufficient staff).

- Rotation of shifts including compulsory periods of night duty.
- Time off during school holidays and time to pick children up from school or childminding services.

Several instances of successful self-rostering were cited and the resultant satisfaction with this system. However, there were others who indicated that this had either not worked, or would not work in their clinical areas, because of the competing demands of school holidays for example.

There were several advocates for self-selected permanent night duty, especially where issues such as access to continuing education and night duty culture were addressed. In all instances, there was a suggestion that where it was difficult recruiting permanent night duty staff, added incentives were required, such as a higher night duty loading.

3.1.3 Effects of High Workloads

In addition to the reported effect of experienced nurses leaving the workforce, there are a number of other effects of high workloads. The first, most worrying factor, has been a reduction in the quality of patient care. One nurse at a forum summarised this as a situation where the nurse was so busy, that they only had time to concentrate on the tasks to be done, and was constantly working out how the remainder of the tasks were to be done. Thus there was little capacity to 'be with' the patients, listen to them and try to individualise their care. Time was only meeting immediate needs. For many nurses, this is a source of frustration and stress. Nurses consider that it is their role to be able to provide quality, holistic care, not care that is based only on tasks.

The demands of direct patient care were such that other areas of practice also suffered. Documentation and other administrative activities were given low priority. Conversely, the nurse managers (ANUM and NUM) found that they too were heavily involved in direct patient care, and that management activities were done with difficulty, often in their own time. In addition it was reported that there was little time for research, quality management projects and teaching. The expectation to undertake these activities was considerable and

clinical nurses in particular felt that there was an obligation for them to be involved in these activities. There was no time allocated and, as indicated above, research activities were commonly undertaken in the nurses' own time. The point was made repeatedly that other health professions, because of their inherent ability to control their own workload, did not face the same problems as nurses in being released from the bedside for other professional activities. There was a position put before the Committee at the forums that the increase in these activities for clinical nurses was the result of budget cuts, where Grade 5 positions that had responsibility for quality management, for example, were no longer employed, and that responsibility for these activities had 'flowed down the line'. One person at a forum suggested that nurses with the appropriate expertise should be employed in these positions to free the clinical nurse from such activities. However, a counter view is put for more time to allow clinical nurses to undertake these activities, as they added value and variety to their role.

For the experienced nurses who remain at the bedside, there has been an increase in the time spent on supervision of inexperienced nurses (new graduates and agency nurses). In general, experienced nurses accept that supervision and monitoring are part of the role associated with clinical experience. However, with high numbers of new graduates, and with agency nurses often unfamiliar with unit requirements and sometimes lacking the experience necessary for the type of patient in the unit, the amount of time spent on this activity is perceived as excessive and detracts from the ability to apply continuous quality care to patients. In addition, as new graduates do not receive the support and mentoring required to help build their confidence, this contributes to their attrition from the workplace.

For all nurses, irrespective of position, there were reports of increased levels of overtime and unpaid work. This was reported by Considine & Buchanan (1999) and was reinforced at the forums. This was due not only to heavy workloads, but also to a loss of 'handover' time, as shift times frequently do not overlap at all. Particular references were made at the forums to the amount of time nurses at CNS

grade and above were expected to spend in 'project' work in their own time. Further, there was an expectation that meetings would be attended in the nurses' own time. Overtime was a constant factor for which nurses were reluctant to claim, although entitled so to do under the Award. It appears that claiming overtime is actively and/or passively discouraged in some areas, and while there were examples of staff being granted time off in lieu, these were the exception rather than the rule.

Opportunities for undertaking postgraduate study reduced with a heavy workload, as did time for continuing education. Nurses report finding it difficult to keep their knowledge and skills up-to-date. Further, there were few opportunities for professional development, considered an essential part of the role of a professional. Not only were workloads such that these activities were curtailed, but there was little availability of backfill for their absence.

Low staff morale and stress were constant themes conveyed to the Committee. In addition to the factors indicated above, other aspects contributing to low morale and stress were:

- Lack of camaraderie—a situation exacerbated by heavy workloads, no shift overlap time in which bonding and team building could occur and lack of strong nursing leadership. One person at a forum pointed out that the outsourcing of services such as cleaning, catering and security had exacerbated this problem, as the feelings of loyalty and belonging were no longer evident among hospital staff as a whole.
- The feeling that nurses were not respected and valued as professionals. Frequent examples were given during the forums of a perceived lack of respect for nurses by colleagues, other health professionals (particularly the medical profession), and non-nursing management. This was demonstrated most clearly in the lack of a nursing voice in clinical decision making and in policy development. Several suggestions were made that could enhance the feeling of value to the nurse. These were not necessarily monetary, but rather the occasional word of praise, the seeking of the opinions of the nurse and the involvement

of the nurse in policy making and clinical decisions.

- Few support services for nurses. The complaints ranged from the lack of decent hot food in after hours shifts (not pre-dispensed machine food) through to counselling services, child minding facilities, car parking facilities, access to the DoN, access to health services for all nurses and sabbatical leave for clinical nurses.

In summary, the effects of the increased workload are perceived as wide-ranging reductions in the quality of care, inadequate time for effective supervision and monitoring of inexperienced staff, insufficient time for pursuing studies, continuing education, professional development, research and other projects necessary for the improvement of quality care, the inability to balance between activities and administrative functions, and increasing levels of stress.

3.2 Unsafe Working Environment

There was widespread concern that nurses were increasingly bearing the brunt of community frustration and aggression in both the hospital and community setting. The Committee received numerous complaints of widespread physical and verbal aggression in almost all clinical settings, as diverse as emergency departments, aged care and community paediatrics. Concern was raised that both hospitals and the community are becoming more dangerous places to work and that security precautions are inadequate. There was also concern at the perceived lack of support from management for nurses subjected to workplace violence. In addition, the Committee received reports of open drug dealing in some public hospitals, accompanied by harassment and intimidation of staff.

In the rural mental health sector the issue of sole practitioners working in isolation without staff and equipment back up was highlighted as a major workplace safety issue. This is discussed further in section 6.1.6.1.

In addition to violence from the community, there were widespread reports that nurses are subject to 'horizontal violence', characterised by bullying, verbal harassment and ostracism, both by nursing colleagues and other health

professionals. It was observed that this is often directed at junior nurses and is cited as a contributing factor to attrition. This is discussed further in section 6.1.4.2.

Workplace injury was identified as another major cause for concern, notwithstanding initiatives to reduce the incidence of such injuries through appropriate patient handling such as the Nurses Back Injury Prevention Project (Department of Human Services 2000). The Committee received numerous submissions from nurses injured at work, both physically and mentally, who stated they were unable to find suitable work or support to facilitate their return to nursing.

3.3 Equipment Available

A common complaint emerging from the forums was the lack of equipment in the nursing care of patients. It was suggested that where adequate equipment is not available, the quality of care diminishes and the efficiency of the nurse is compromised. Shortages were indicated not only in acute care hospitals, but also the aged care sector and the community. Particular reference was made to the 'no-lift' policy. Although this initiative has been funded by the Government and preliminary reports suggest it appears to be working well in areas where the funding has been utilised effectively, unsolicited examples were given of a lack of equipment preventing the policy from being implemented. These examples were largely from the public acute care and private aged care sector. However, in addition, there were anecdotes provided of lack of basic equipment such as dressings, syringes, bed linen and ventilators recounted by some of the hospital nurses at the forums.

Both the community and aged care sector nurses related another common example of limited equipment and resources. Patients were reported to be discharged with inadequate amounts of emergency medication and dressings, particularly at the weekend when it was difficult to obtain either repeat prescriptions or equipment.

3.4 Career Structure

The inability of the current career structure to retain nurses in clinical positions was a

recurring theme. Many cited the difficulty in meeting the criteria for existing clinical positions, such as CNS, due to additional requirements being added at a local level, and applied inconsistently. There was no clinical career path beyond grade 2; many saw entry into management and education as the only way of progressing a nursing career and complained of a glass ceiling syndrome in the clinical career pathway. This theme emerged as one of the strongest in terms of retaining experienced, qualified nurses at the bedside and within the nursing workforce.

3.5 Support for Nurses

Two themes emerged in this area. The first related to the need for assistance to the nurse in areas that were not direct nursing activities. Areas suggested were routine administrative activities not requiring the clinical judgment of the nurse, answering telephones on a 24-hour basis and some housekeeping activities, including making of unoccupied beds. There was a suggestion in a small number of submissions that delegated nursing activities should also be undertaken by others, such as unregistered health care workers (UHCW). These suggestions were from the critical care and acute care areas.

The second area relating to support was an expressed perception of lack of support by management. This appeared linear in nature. Grade 2 and 3 nurses indicated a lack of support from Grade 4 nurses, and Grade 4 nurses a lack of support from levels above. NUMs in particular indicated that their role had changed, and that many duties had been delegated downward, without requisite checks to ensure that the nurses had the skills or training to undertake these activities, particularly in relation to the management of unit-based budgets.

The DoN (however titled) was singled out, in some instances, as having lost control of nursing, particularly the nursing budget. As indicated above this lack of support may have related to bed closure where workloads were unacceptably high. A strong plea was made from the forums for strong nursing leadership in areas such as control over workloads. Several comments were made at the forums of the lack of understanding of non-nurse management in

relation to issues around quality versus quantity of nursing care.

As discussed, there are a number of factors that appear to be contributing to the frequently reported increase in workload: fewer nurses (particularly experienced nurses) in the public system, casualisation of the workforce, increased patient acuity, equipment shortages, nurse to patient ratios, control over workload and support for the nurse. There have been a number of effects resulting from the higher workloads expressed to the Committee.

3.6 Education Cost and Access

3.6.1 Undergraduate Preparation

The Committee received criticism of undergraduate preparation of nurses. As previously discussed, there is a strong perception that the entry score requirement for nursing is too low, allowing unsuitable candidates to enter nursing courses. In addition to concerns from specialist areas such as mental health (sections 3.9.1 and 5.3.4) there were numerous complaints concerning the clinical aptitude of new graduates, particularly in their ability to handle patient caseloads and to work according to shift patterns. Much of the blame for this is focused on the reduction of clinical experience hours during the undergraduate course, particularly the lack of appropriate clinical experience during the first undergraduate year.

This should be balanced by concern from clinicians in areas such as aged care who resent having first year students undertaking clinical experience in the specialty in the belief that it is an undemanding area to work, and by concern from clinicians in specialist areas that undergraduates are often not offered specialist experience, making it more difficult to recruit new graduates to the areas.

3.6.2 Postgraduate Education

There was widespread concern from all sectors of nursing about the costs of postgraduate education, particularly under the full fee structure. Nurses were concerned that there was unrelenting pressure to undertake postgraduate qualifications in nursing (and to progressively higher levels) without any

resultant increase in pay, opportunity for promotion or assistance from management to undertake courses. Many nurses reported having to drop from full-time to part-time employment to undertake study, with resultant loss of income. Some were employed at a lower grade not only while studying, but on completion of study.

3.6.3 Professional Development

In addition to formal postgraduate education, some nurses were concerned with inequities in the provision of professional development and continuing education. Many indicated that in-service education courses (including mandatory competency assessments such as resuscitation training) were conducted with no regard to shift patterns, requiring attendance on days off. Concern was also raised over the lack of support from nursing management for attending conferences. Parallels were drawn with other health professionals who were supported and were able to attend such activities without concern over backfill. Rural nurses stated that much of the education was provided in Melbourne, without provision for distance education, requiring considerable travel. Existing structures to facilitate education, such as the TeleHealth network, appear to be markedly underutilised.

3.7 Family Issues

The inability of nurses to balance work with family life was raised in many contexts as a reason nurses leave the industry. The lack of flexible, affordable child care facilities (particularly for unplanned or emergency care), the lack of flexible working arrangements, and problems surrounding school holidays, were cited as important factors. One large facility conducted a survey of child care needs and found that 47% of respondents reported child care problems as affecting their productivity, and 60% reported problems obtaining short notice child care when their child was sick.

Specialty areas with high demand for round the clock staffing, such a critical care, reported greater problems with attracting staff with family commitments because of the high prevalence of night duty.

3.8 Specific Issues for Rural Nurses

Submissions from rural facilities and clinicians emphasised the difficulty in maintaining clinical skills in areas not serviced by educational facilities. Difficulties in obtaining leave to attend metropolitan education meant that many, particularly those with family commitments, were unable to access external professional development courses. The high rate of part-time work offered in rural hospitals was cited as a disincentive for experienced nurses needing full-time work to move to rural areas. Hospitals in tourist areas such as the Surf Coast reported particular difficulty attracting and retaining staff because of housing costs.

Isolation was frequently cited as an issue effecting the rural workforce, in particular, lack of supporting networks and peer review mechanisms, especially for the sole practitioner. Sole practitioners were frequently on call, in addition to their normal working week and difficulties were identified in finding relief for them in areas where there were no agencies or nurse banks.

Safety issues were indicated for all rural nurses, especially mental health nurses. Such issues arose in relation to distances travelled, especially on unmade roads and through 'black spots' in communication. Nurses working alone where there was inadequate security equipment and personnel were also deemed at risk.

3.9 Specialty Issues

The Committee recognised that particular areas of nursing specialty are prone to recruitment and retention problems that are not generally applicable to the nursing workforce as a whole, particularly the aged care, critical care, mental health and midwifery workforce.

3.9.1 Mental Health

There was considerable concern from all sectors of mental health nursing that the undergraduate nursing curriculum offers insufficient mental health training, both in terms of theory and clinical experience. This lack of preparation was contrasted with the increasing profile of patients with mental health

problems in the general hospital environment, and the expectation that nurses educated under the comprehensive curriculum are competent to nurse them.

The ANZCMHN informed the Committee that the most significant problem facing mental health nursing is recruiting beginning level practitioners into mental health services. This is having a particularly detrimental effect on the psychiatric service sector, as few new graduates are entering the profession (Pante 1999, Department of Human Services 1998). The College proposes a four-year degree as a mechanism of achieving an adequate level of mental health content in the undergraduate curricula. The need to improve the input of clinical services into curricula design is identified and the college proposes that 'curriculum advisory boards', with significant clinical agency representation, be established.

Retention issues are identified as a major issue, with an ageing nursing mental health workforce (the average age is 43) seen as an unresolved problem. The lack of qualified staff has contributed to morale problems, sick leave and resignations of the few remaining mental health nurses.

The Committee was informed that there has been a steady migration of staff from inpatient acute units into the community. As patient acuity in the inpatient setting rises (aggravated by an increase in the number of behaviourally disturbed patients with drug and alcohol problems) and the number of experienced staff in the units decreases, there is concern that the undergraduate students undertaking clinical placements in the units are discouraged from mental health nursing as a career choice.

3.9.2 Aged Care

The aged care sector submissions cited particular problems with the unregulated workforce, the perceived poor image of the specialty in the profession, the physically arduous nature of the work, the undervalued role of Division 2 nurses in aged care, and difficulties balancing care of clients with the documentation required for Commonwealth accreditation. Other issues raised include funding, postgraduate education, clinical career path, including a paucity of CNCs in areas such

as dementia and continence management. Particular concern was also expressed about the failure of the complete introduction of a no lift program.

3.9.3 Midwifery

The Committee received numerous representations about issues relating to rural midwifery. A key issue was that nurses with postgraduate midwifery qualifications were often unable to practice in their chosen speciality in rural areas. The principal reason is that, in many hospitals, the number of confinements is insufficient to warrant full-time midwifery practice, so that midwives are expected to work in other clinical settings as well. For those who do choose to practice there was widespread concern that they were effectively being 'deskilled' through lack of exposure to complex cases and low confinement rates. Conversely, new graduates were reported to be reluctant to practise in rural areas as they were often expected to be the sole practitioner on a shift, without the collegiate and technological support available in metropolitan facilities. Initiatives such as telephone support and clinical refresher experience in metropolitan hospitals were cited as possible solutions to this problem.

In rural midwifery practice, conflict with medical staff and the decline in the number of general practitioners (GPs) with obstetric practices were raised as issues of concern.

The introduction of the casemix funding model was blamed by some midwives for the perceived fragmentation of midwifery care and, in particular, the inability of hospital-based midwives to offer quality postnatal care because of the trend towards short hospital stay. Concern was also raised about the difficulty facing midwives in private practice in obtaining admitting rights to hospitals.

The Committee received representations from the Australian College of Midwives Inc (ACMI), which highlighted its position on midwifery training. In particular, the College is seeking introduction of direct entry midwifery courses, in part to ensure that midwives are able to solely practice their chosen specialty without having to practice as generalists. There was insufficient information before the

Committee for it to recommend this as a recruitment strategy.

3.9.4 Critical Care

Critical care nurses described major problems in retaining staff and pointed to the comparative rarity of experienced nurses in the specialty. The high proportion of night duty and the prevalence of burn out amongst staff were cited as major contributing factors. Many nurses were critical of the Department of Human Services, pointing out that it had published research (Department of Human Services 1993, Department of Human Services 1996) demonstrating problems in the specialty, but that no apparent remedial action had been taken. The issues raised by this group have been considered in other areas of this report.

3.10 Management

Criticism of nursing management was commonly expressed. The criticism ranged from generalised problems with organisational management, and the way nurses were treated and consulted in times of change, to issues relating to ward management. One of the most commonly cited opinions, both from junior nurses and nurse managers themselves, was that many nurse managers, due to workload, are unable to adopt leadership, mentorship and advocacy roles in nursing, and that many nurse managers lack basic human resource management skills or education.

A number of problems have been identified that have contributed to the current problems relating to recruitment and retention of experienced qualified nurses in the Victorian workforce. The major ones of these appear to be increased workloads, and control over workloads, fewer nurses (particularly experienced nurses) in the public system, casualisation of the workforce, unsafe workplaces, equipment shortages, lack of clinical career structure, support for nurses, education access, family issues, specific issues for rural nurses and those in specialty practice and issues with management. Each of these areas will be considered in detail in Part 2 of the report.

Part 2—Strategies

4. Attracting Nurses into the Workforce

The Committee identified two areas of recruitment in which strategies need to be implemented:

- Attracting new people into nursing.
- Recruiting back those nurses who have left the nursing workforce.

In relation to attracting new people, the focus is on the image of nursing and undergraduate attraction.

4.1 The Image of Nursing

The Committee coopted a representative from the Careers Education Association of Victoria (CEAV) to advise on strategies to improve the image of nursing in schools. The rationale for this was that other States are having difficulty filling undergraduate places and data before the Committee indicated that many undergraduate places were filled with students in second or third preference courses (see section 2.2.1). The Committee, therefore, worked on the assumption that filled undergraduate courses could not be taken for granted in Victoria in the long term.

The Committee was advised that information aimed at influencing the career choice of school leavers should be targeted at students in Years 9 and 10, and that current materials available are sub-optimal. One issue of concern was that careers teachers are currently experiencing difficulties in placing students for work experience across all sectors of industry, and it was noted that few hospitals are making provision for students to visit. Work experience is cited as one of the most effective methods of influencing the career choice of students.

The Committee was informed that nursing is not effectively promoted in many schools as it is not considered prestigious because of its relatively low ENTER score. It was proposed that one method of addressing this is to instigate closer links between the Department of Human Services and the CEAV so that teachers may gain a better appreciation of nursing as a career option, and a greater

understanding of the wide range of employment settings available to nurses.

The Committee notes the recent expansion of the Victorian school nursing program, with 120 nurses planned to be employed in Victorian secondary schools. While the focus of the program is adolescent health, the fact that nurses will be based in schools may be a useful source of information dissemination on nursing as a career.

Strategies will have to be developed to ensure the nursing workforce better represents the community it serves. Currently less than 8% of Australian registered nurses are male (AIH&W 1999), and nurses from Croatian and Vietnamese backgrounds are still markedly under-represented in the nursing workforce (Tang *et al.* 1999, Pitman & Rogers 1990). The Committee believes it is important to encourage culturally and linguistically diverse groups to enter nursing so that the composition of the profession in Victoria can reflect the community it serves.

4.2 Undergraduate Recruitment

In addressing term of reference 2.8 (see Appendix One) the Committee reviewed publicity material available in other States to attract students into undergraduate programs.

The State Governments of Western Australia and New South Wales were identified as having a coordinated package of publicity material available for the wider community, and the South Australian and Queensland recruitment and retention reviews have recommended similar approaches.

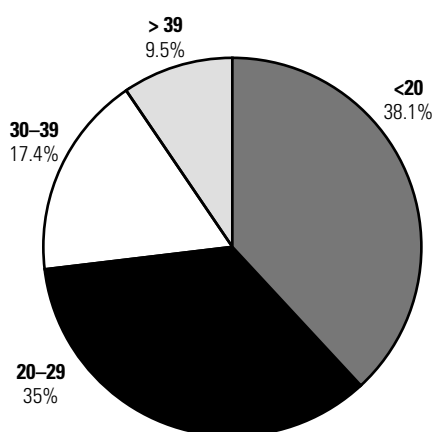
Western Australia has undertaken a recruitment campaign arising from research that recommended targeting school students (Donovan Research 1998). The theme of the campaign is 'Are you good enough to be a nurse?' and the campaign is based on a web site (www.nursing.health.wa.gov.au), brochures, posters, cinema and radio

advertisements and the print media (Dolly and Express magazines). Material has also been developed for teachers. HealthWest (the Health Department of WA) is currently evaluating the effectiveness of the program and a request has been made to supply Victoria with data when available in order to inform the Department of Human Services' deliberations concerning the need for advertising campaigns.

The Committee reviewed representative material from other States to identify what type of material should be developed for Victoria. The CEAV representative felt that none of the existing material could be adapted for use in the Victorian context without further research.

Any effort to attract nurses into undergraduate courses will need to account for the changing demographic of nursing undergraduates, as the average age of entrants is now 24.5 (AIH&W 1999). While a proportion of this group are likely to be Division 2 nurses undertaking Division 1 programs there appears to be a source of nurses within an age group not previously targeted through recruitment material. The Committee believes further work should be undertaken to identify the composition and information needs of groups other than school leavers who may wish to consider a career in nursing.

Figure 6: Undergraduate Profile by Age, Australia (AIH&W 1999)



Recommendation 9: That the Department of Human Services:

- a. Liaises with the CEAV and Victorian DoNs (public and private) to increase the provision of the number and quality of work experience places for Year 10 secondary school students.
- b. Explores the feasibility of using the school nurse network as a method of raising the profile of nursing amongst school students.
- c. Works closely with CEAV to ensure that teachers have a better understanding of nursing as a career.
- d. Undertakes research to prepare a core set of materials to be made available for high school students describing the role and education pathways for nursing. The materials should emphasise the variety of clinical settings, should avoid gender and racial stereotypes and should give equal prominence to Division 1 and 2 education pathways. The materials should also be available in both paper and electronic formats.
- e. Seeks advice on materials and strategies to attract people in age groups other than traditional school leavers to consider nursing as a career.

4.3 Attracting Nurses Back into Nursing

The Department of Human Services labourforce projections indicated that, in 1998, there were 13,461 nurses (or 19% of registered nurses) not working in nursing. To attract these nurses back into the workforce, the Committee needed to know why they left and what their requirements were for returning

4.3.1 Registered Non-Working Nurse and Unregistered Nurse Reports

The Minister for Health charged the Committee with making recommendations on nursing refresher and re-entry courses. The Committee made interim recommendations for the expenditure of funds committed by the Government for 2000 based on available data. The Committee commissioned Campbell Research & Consulting to undertake a survey of

nurses who had indicated, through registration with the NBV, that they were not currently working in nursing. The survey was conducted according to NBV privacy guidelines and the responses received were anonymous. The survey yielded quantitative and qualitative data, both reported separately (appendices 3 and 4). The quantitative survey showed that 51% of registered nurses not currently working as a nurse planned to actively seek work as a nurse, with a further 32% unsure. The Committee believes that this group, with carefully managed and supported re-entry strategies, represents an important source of nursing labour.

During the promotion of public forums for nurses, the Committee advertised for nurses who are no longer registered to complete a survey on re-entry requirements and working intentions. The response rate to the survey was low (n<100), therefore, the Committee treated the data as indicative only. It was noted that much of the material gleaned from the survey was consistent with the findings of the Campbell Research & Consulting reports.

4.3.2 Framework for Re-Entry

The Committee drew a distinction between refresher and re-entry courses. Refresher courses are designed for nurses who are still registered, while re-entry programs (including supervised practice) are a NBV requirement for nurses who have allowed their registration to lapse and do not meet the recency of practice

provisions under section 14 of the *Nurses Act 1993*.

Re-entry courses, including supervised practice, for unregistered nurses must be accredited by the NBV, both for theoretical context and clinical experience.

The Committee sought information on the current supply of refresher courses, both with (category 2) and without (category 1) a formal educational component. In addition, information was sought on the supply of NBV accredited supervised practice (category 3) and formal re-entry courses (category 4).

The results show that, of the public hospitals accredited by the NBV to conduct courses in categories 3 and 4, few actually run them. In fact, of the projected throughput for 2000 in category 4, 50% will be through one hospital.

The Committee surveyed public hospitals on the provision of refresher courses, with 58 responses received. It found that only 21 hospitals were running such courses, with or without a formal education component, and 109 nurses undertook such courses in 1999. The principal reason given by most hospitals for not running courses was lack of demand. Of concern to the Committee was that, of the hospitals offering refresher courses, none paid participants despite the requirement to do so under section 6 (a)(6)(1) of the *Nurses (Victorian Health Services) Award 1992*.

Table 4: Supply and Demand—Public Sector Refresher and Re-Entry Programs, 1999–2000

Course Type	Hospitals conducting courses	Nurses through in 1999	Projected throughput 2000	Waiting list	Fees charged to nurse —range	Any facilities offering free courses ?
Informal refresher courses (1)	8	38	43	5	\$450–1500	Y
Informal refresher courses with educational component (2)	13	71	45	3	nominal–\$900	Y
Accredited supervised practice (3)	15	40	79	35	\$650–1500	Y
Accredited re-entry courses (4)	5	45	83	19	\$70–2500	N

Table 5: Distribution by Location and Division of Public Sector NBV Accredited Courses

	Div 1	Div 1	Div 2	Div 2	Both	Both	Div 3	Div 3	Total
	(Metro)	(Rural)	(Metro)	(Rural)	Div 1 & 2	Div 1 & 2	(Metro)	(Rural)	
Supervised Practice	4	2	1	2	1	16	2	1	29
Re-entry	3	0	0	1	0	0	0	0	4

4.3.3 Distribution and Cost Issues

There is a marked maldistribution of re-entry courses across the State. Mental health nurses wishing to undertake a course of supervised practice can only do so currently in Bendigo, Dandenong and Parkville, while Division 2 nurses wishing to undertake re-entry courses can only do so in regional Victoria. In addition, while a large number of facilities are accredited to run supervised practice and re-entry courses, many have little or no throughput activity.

The survey of unregistered nurses informed the Committee that there is unmet demand for re-entry courses where the clinical experience is provided at a local level. Demand for courses is also cost sensitive, both in terms of the course cost and lost income and incidental expenses, such as travel. Nurses are ineligible for payment by hospitals while undertaking courses, as they are not registered.

The Committee argues strongly for the establishment of a network of re-entry courses and accredited supervised practice arrangements to service all areas of the State. This will ensure that nurses required to undertake clinical experience are able to do so locally, minimising transport costs and disruption to family life.

The Committee recommends that all Group A, B and C hospitals (That is, the larger teaching and base hospitals, and smaller regional hospitals) have access to supervised practice and re-entry courses. This may involve consortia arrangements with other hospitals, services or education providers, however, to access funding, such arrangements must not involve cost to participants. All courses will have to be accredited with the NBV. It should be noted that the NBV does not stipulate minimum clinical hours to be worked during re-entry courses or supervised practice

programs, as the length of the program is determined by individual assessment of the knowledge and skills required.

The Committee reviewed the data on supervised practice and re-entry course provision in relation to cost to participant. It noted that, while some facilities offered low cost access, availability was often hampered by factors such as other calls on clinical educator time. In facilities with high throughput, the cost of providing such courses ranged from \$1,500 to \$2,500, while university based courses cost up to \$3,500. The Committee recommends the sum of \$2,100 be offered to facilities for every nurse put through these courses on the basis that this appears to represent the middle range of current fees charged. It is anticipated that the payment will reduce the prevalence of high cost courses and will act as an incentive to facilities with little current activity to provide more course places.

Recommendation 10: That the Department of Human Services ensures that Group A, B and C public hospitals have access to refresher and re-entry programs for Division 1 and 2 nurses, and that regional mental health services have programs in place for nurses in Divisions 1 and 3.

Recommendation 11: That Government provides funding to participating hospitals of \$2100 for each nurse undertaking re-entry programs or accredited supervised practice programs.

The following criteria must be met:

- Tailored nursing program must contain clear learning and performance parameters.
- Nurses participating in the re-entry program will not be charged fees or other costs.

- The course must be accredited by the NBV.
- The educational component of the re-entry course may involve consortia arrangements as appropriate to local needs.

(NB this recommendation specifically excludes overseas trained nurses undertaking DETYA/Department of Human Services funded conversion courses, as they are already funded jointly by Department of Human Services and the Commonwealth under a different model).

The Committee considers that nurses undertaking re-entry courses and supervised practice experience, who are ineligible for payment, face severe financial hardship, particularly if they have been previously employed. A notional payment, based on the minimum Austudy allowance, would assist participants to pay for costs incurred during the course, such as travel.

Recommendation 12: That Government provides funding of \$130 per week (FTE) to each unregistered nurse undertaking a re-entry program or accredited supervised practice program, in line with current Austudy arrangements. Rural nurses required to travel more than 100km each way to undertake a program will attract \$170 per week (FTE), to reflect the increased burden of travel costs on rural nurses.

Information gathered through the focus group consultations highlighted a degree of ambiguity and dissatisfaction with the information provided by the NBV in relation to the maintenance of registration and re-entry to the register. In addition, the focus groups raised problems with the NBV's definition of 'sufficient nursing practice' for registration, in that the Board's criteria were not felt to be widely understood.

Recommendation 13: That the NBV review its current policies, procedures and publications in relation to recency of practice requirements.

4.3.4 Refresher Courses

Skills update or refresher courses are not the only means for nurses who *hold current registration* to re-enter the workforce after a

break of practice. Some negotiate orientation and supervision arrangements with employers as part of an employment arrangement, while others require minimal or no assistance at all. The degree of supervision and confidence building required by nurses re-entering the workforce, or changing clinical practice setting, should be a matter of individual negotiation and should result in mutually agreed learning outcomes. The Committee views with concern submissions outlining complex, standardised refresher courses for nurses, of considerable duration and cost to the participant, that have been submitted to the Department of Human Services.

It is the Committee's view that refresher or reskilling arrangements should be considered as a legitimate recruitment tool for health services rather than as a source of revenue, and that hospitals should adopt a uniform approach to currently registered nurses wishing to re-enter the workforce or change practice setting.

Recommendation 14: That regionally-based health services establish a uniform approach to refresher programs that consider both education and clinical requirements of the individual nurse, and may include consortia arrangements as a method of program delivery.

The Committee is of the view that providing funding to hospitals for short 'return to practice' courses of three weeks duration, as applied in the United Kingdom (Department of Health 1999), may assist in returning nurses to work. Providing such courses in each mental health service, major teaching and base hospital will assist in retaining nurses, unlike the current arrangements where a few facilities offer courses and then lose participants to hospitals closer to the participant's home. The Committee acknowledges that some nurses will need more than three weeks to reach required competency and confidence, while others may need less. However, as submissions before the Committee indicate that many nurses are prepared to return to work if reskilling arrangements are expedited, the Committee is of the opinion that funding based on a three-week model may go some way to facilitate their return to work.

The Nurses (Victorian Health Services) Award 1992 section 6 (a) (6)(1) makes provision for registered nurses undertaking refresher programs to be paid, however, the common practice is that this program is undertaken in an unpaid capacity. The Committee believes that registered nurses undertaking refresher courses are contributing to the nursing workforce and should be paid their legal entitlements under the Award.

Recommendation 15: That the Government pays \$450 to each health service providing refresher or reskilling programs for every registered nurse not currently practicing that they place on a refresher or reskilling program.

The following criteria must be met:

- Individual nursing programs must contain clear learning and performance parameters.
- Nurses participating in the refresher or reskilling program will not be charged fees or other costs.
- Nurses undertaking refresher or reskilling programs are entitled to be paid according to the provisions of the Nurses (Victorian Health Services) Award 1992.

4.3.5 Cost of Recommendations

The preceding recommendations are predicated on funding of \$740,000 per annum being available for refresher and re-entry courses, as per the Government's policy commitment. The Committee advocates \$500,000 being made available for re-entry courses and \$240,000 for refresher courses. It is anticipated that funding would enable 533 nurses to undertake refresher courses and 120–136 nurses to undertake re-entry courses under the recommended arrangements.

The Committee cautions that the gains will be initially modest due to the preference for many nurses to return to work on a part-time or casual basis only. The Committee believes that some of the current arrangements for nurses to re-enter the workforce are cumbersome, expensive and act as a disincentive to those who are perhaps ambivalent about resuming their career. To this end it is proposed that a

formal campaign to encourage nurses back to work be considered.

Recommendation 16: That the Department of Human Services conducts a statewide advertising program aimed at encouraging both registered non-practicing and unregistered nurses to return to work.

4.4 Injured Nurses

Of concern to the Committee was the proportion of nurses responding to the various surveys that had left nursing because of illness and injury. Of the unregistered cohort, 18% gave this as the principal reason, while the survey of registered nurses highlighted the issue of many nurses leaving the profession because of physical illness, such as back injury, or as a result of psychological stress.

The qualitative survey of registered non-working nurses shows that many injured nurses wish to return to work, but feel unable to do so because of lack of support from management and colleagues, and because of the physically and mentally demanding nature of the work.

While the Committee believes that Government initiatives such as the appropriate manual handling initiatives will reduce the number of nurses who leave the profession because of injury, there are still nurses who should be supported back into the workplace, both through the occupational health and safety framework and through the support of fellow nurses.

Recommendation 17: That the Department of Human Services explores the extent to which return to work programs for injured nurses have been implemented in public health care facilities in Victoria.

5. Education of Nurses

The Committee has received a range of submissions in relation to the education of all divisions of nurses in all education areas, namely undergraduate, postgraduate, graduate nurse year and continuing education. In addition, a number of submission were received regarding the education for mental health nursing practice. Concern was also expressed about the State Government's T&D Grant. Education was, therefore, considered by the Committee to be a major issue in relation to both recruitment and retention of nurses in the Victorian workforce.

5.1 Undergraduate Education

5.1.1 Division 1

Three major themes emerged in relation to the undergraduate preparation of Division 1 nurses:

- Clinical placements
- Preparation for speciality practice
- Rural issues.

5.1.1.1 Clinical Placements

Access

Clinical experience is an essential part of the undergraduate curriculum as it enables the application and consolidation of theory and the development of the competencies required of a beginning nurse. A consistent theme raised before the Committee was the readiness of graduates to practice as beginning level practitioners on completion of their undergraduate course. In many instances it was perceived that the quality and/or quantity of clinical experience in the undergraduate course was insufficient, with the result that new graduates were ill-equipped to cope with the realities of clinical practice in the clinical setting. The major factors contributing to this perception were difficulties with access to clinical facilities, preparation of clinical supervisors and preceptors, and the learning environment in the clinical area.

To prepare the nurse for beginning practice, clinical placements are required in a wide variety of settings, in all years of the course. Both hospitals and universities have reported to the Committee that obtaining clinical placements for students is an increasingly difficult task. Changes in the health system in recent years have reduced overall bed numbers and clinical placement opportunities, while allied health and medical students seek placements in the same diminished clinical settings. Some hospitals have indicated they will take third year students only, while others only offer placements in a limited range of clinical areas.

One way to guarantee clinical placements is for a university to affiliate with one or more hospitals. Under such arrangements students from a particular university are given first choice of the available clinical placements. As well as assuring clinical placements, this approach has the advantage of increasing the familiarity of the student with the hospital (potentially engendering a sense of identification), and consequently enhancing their learning opportunities. Hospital staff are better able to familiarise themselves with the learning objectives of the university and can identify to a greater degree with the students. These arrangements are generally not exclusive and both universities and hospitals have a capacity to utilise other institutions if circumstances require. It may mean, however, that students from other universities become limited in the choice of clinical placements available to them.

Currently, there is no data indicating what clinical facilities are available statewide and how they are being accessed by students of nursing. In order to rationalise the scarce resources available to medical students, both Victorian medical schools coordinate their use of clinical places. It would be advantageous to nursing if a similar approach were adopted.

Recommendation 18: That the Victorian Deans of Nursing carry out a mapping exercise to ascertain both the availability of clinical placements within the health system and the requirements of the students for such placements. The results of such a project should form the basis for the establishment of a coordinated system to facilitate bookings and placements of all undergraduate nursing students.

Funding

The Victorian Deans of Nursing have identified several issues associated with funding and support for the clinical component of the undergraduate nursing programs. The relative funding model (RFM) for nursing does not adequately reflect the increasing costs associated with clinical supervision of students at a ratio of one clinical teacher to eight students (a registration requirement). Additional problems exist within universities regarding the wide variation in the way funding is allocated to undergraduate programs in nursing. The Australian Council of Deans has raised with the DETYA the urgent need for a review of the RFM discipline weighting for nursing across Australia.

These funding issues are seen as one of the significant contributing factors to the problems presented to the Committee in relation to the undergraduate nursing program, particularly in relation to the commonly held view that new graduates lack the practical skills required for clinical practice.

Recommendation 19: That the Minister for Health, in conjunction with the Victorian Minister for Post Compulsory Education, Training and Employment, approach the Commonwealth to review the funding model for the clinical learning component of the degree programs leading to nursing registration to ascertain if the current level accurately reflects the true costs of clinical learning programs.

Preceptors

Those who act as clinical supervisors or preceptors may be provided by either the university or seconded from the health care facility. The stated advantage of this latter

approach is that hospital staff know both the hospital environment and the nurses working there, and the nurses know them. This not only promotes the student's acceptance into the hospital environment, but also contributes to a sense of common purpose, leading to a more fulfilling educational experience.

Supervision/preceptorship of students is a skill and needs to be supported by education, yet in the hospital environment the education opportunities for nurses to take on preceptorship roles may be limited. Nurses taking on these roles without adequate education may unwittingly contribute to a negative experience for students.

Funds are made available to hospitals, via the undergraduate teaching allowance component of the T&D Grant, to support undergraduate students (section 5.6.1). Such funds should be accessed for the education of supervisors/preceptors.

Recommendation 20: That nurses undertaking preceptorship roles have access to suitable education to equip them to perform this role. Funding for these programs should be accessed through the undergraduate teaching allowance of the Training and Development Grant.

Learning Environment

The quality of clinical experience is influenced by the capacity of hospitals to provide a positive learning environment for students while on placements. Many factors impact on this capacity. As indicated elsewhere in this report, workplace issues have hampered the capacity of nurses to provide education and support to undergraduate students. In particular, the core group of experienced, permanent staff have increasingly had to take on a disproportionately prominent role in supporting students, in addition to the other functions required to maintain a hospital ward or clinical unit. As nursing workloads have increased, the capacity to support students has reduced. In such an environment the support of students is at risk of being perceived as an added burden rather than a core professional responsibility. In order to address these problems, hospitals and universities have adopted a number of strategies. The issue of a

learning environment and acceptance of students goes to the core of many of the problems surrounding the undergraduate course. The extent to which students feel welcome and valued is an important factor in achieving the goals of the clinical placement and their image of nursing.

Submissions before the Committee have raised a number of issues relating to the clinical learning component of the undergraduate curriculum, not only in terms of access but also in relation to the supervision provided to the students and the learning environment of the hospitals. A review of clinical learning requires input from not only the Department of Human Services and Victorian Dean of Nursing, but also the Directors of Nursing.

Recommendation 21: That the Department of Human Services establishes a working party with the Victorian Deans of Nursing, Directors of Nursing and other relevant bodies to review the clinical learning programs in the undergraduate programs for Division 1 nurses to develop a statewide strategy to maximise clinical learning outcomes.

5.1.1.2 Preparation for Specialty Practice

The issue of preparation for specialty practice was a constant theme raised in relation to mental health nursing and these issues will be considered separately in section 5.1.2. However, the issue was also raised by a number of other groups, in particular aged care, critical care, operating room, neurosciences and renal nursing. The perceived lack of theoretical and clinical learning in these areas was seen as contributing to ongoing recruitment difficulties.

The foundation for fostering interest in clinical specialties begins at undergraduate level. The Committee recognises that additional specialty placements have the potential to place demands on an already crowded undergraduate curricula. The capacity to accommodate increased specialty content is limited, particularly in the context of competing calls for more areas of clinical practice. Thus, the current length of the undergraduate degree course is an issue that needs further examination. A view put to the Committee argued that a four-year undergraduate course

would allow these issues of specialty content to be adequately addressed, especially through a streaming model. This approach is not uncommon in other health and human service disciplines; social work, physiotherapy, radiography, podiatry and pharmacy courses are all of four-year duration in Victoria. Innovative curricula in nursing already exist and evaluation of these programs and the implementation of other programs should be encouraged.

Recommendation 22: That the Victorian Deans of Nursing through the Nurse Policy Branch develop a group of relevant stakeholders (including the professional colleges) to review the place of the specialty components within the undergraduate course. This review should investigate the development of innovative curricula which takes into account the accommodation of specialist areas through streaming and also consider the appropriate length of funded degree programs leading to nursing registration in the context of this issue.

5.1.1.3 Rural Undergraduate Placements

In its health policy, the Government made a commitment to provide resources to support clinical placements for 400 undergraduate nursing students a year in rural hospitals (Australian Labour Party, Victorian Branch 1999).

Given the shortages of nurses who understand the needs of rural communities, incentives are required to increase the number who access rural placements during their undergraduate course.

The additional costs incurred by rural students on placements have been well documented over the years as a disincentive to undertake such placements. These costs can include travel costs, often over significant distances; accommodation costs, which may relate to two abodes as mortgage and rental expenses must be maintained; and child care costs.

This initiative should target those students who are more likely to enter the workforce on completion of their undergraduate programs. Therefore, it should apply only from year two of the course as it is in year one that the highest attrition occurs.

The Commonwealth funded a one-off scheme that has now ceased: the approach used for that program is recommended to be used in Victoria.

Process

The criteria for the Victorian incentive will exclude those who receive any other financial support. To this end, the scheme needs to be administered centrally and the Department of Human Services is well placed to do this. In order to ensure equity and transparency, if there are more applications than available funding, then a 'first come' basis would be used, once equity across regions had been achieved.

The issue of a time limit was considered by the Committee. In agreement with the former Commonwealth scheme, the minimum was set at two weeks. The Committee believed that some students might be disadvantaged by the former Commonwealth scheme's upper limit of five weeks. Information before the Committee suggested that some of the rural placements exceeded five weeks. Consideration was given to extending the upper limit to 10 weeks. However, more information needs to be collected and the Committee therefore recommends that for the first year of the scheme the upper limit be five weeks. After the initial uptake in 2001, the process will be reviewed with consideration given to the viability of introducing a 10-week upper limit for some students.

Recommendation 23:

- a) **That financial support of \$100 per week be provided to both metropolitan and rural undergraduate students in their second and subsequent year(s) of the undergraduate course undertaking rural placements, where significant travel and accommodation costs are incurred.**
- b) **That Department of Human Services administers this initiative using the following criteria.**
That the student be:
 - **An Australian permanent resident or citizen undertaking a rural placement in the second or subsequent year(s) of a Bachelor of Nursing program.**
 - **Not in receipt of any other scholarship or grant for this purpose.**

- **Required to travel in excess of 100 km each way from their usual place of residence to attend the rural placement.**
 - **Required to provide supporting documentation from the university acknowledging placement.**
 - **Required to undertake a placement of not less than two or more than five weeks,**
- c) **That the Department of Human Services adopts a 'first come' basis once equity across regions had been achieved, for its allocation, should the number of applicants exceed the available funding.**
 - d) **Department of Human Services reviews the initiative as a retention strategy paying particular attention to the length of the time of the placement.**

5.1.2 Undergraduate Preparation for Nursing in Mental Health

Issues relating to preparation of nurses for mental health nursing have been highlighted to the Committee. In essence, the concerns relate to attraction of nurses to the mental health field, and curriculum content, both theoretical and clinical, relating to psychiatric nursing to ensure that beginning nurses, whether in a general or specific mental health setting, are able to provide quality care for the mentally ill.

5.1.2.1 Attraction to Mental Health Area

During the 1980s, Australia developed and implemented the national mental health reform process. This process has had far reaching consequences for the practice of psychiatric nursing. The key platforms of reform were deinstitutionalisation and the mainstreaming of mental health services into general health settings. The result of these changes has been the closure of the stand-alone psychiatric hospitals and the transition to a community-focused mental health service system, with only a small number of inpatient beds remaining for the acutely ill. The reform process has also led to mental health consumers making greater use of health and other human services.

In the mid-1990s, university-based undergraduate direct entry psychiatric nursing courses were phased out. The *Nurses Act 1993*

no longer required the separate registration of psychiatric nurses and the Division 3 register was closed to new entrants. Nurses successfully completing the undergraduate degree in nursing were registered in Division 1 and this became the entry-level qualification for nurses seeking to work in mental health settings. The view was that the undergraduate degree would provide an adequate mental health content to prepare nurses to practise as beginning level practitioners in mental health facilities, and all nurses would have some mental health nursing skills. Those nurses seeking to practice beyond beginning level in mental health would undertake postgraduate studies.

Since this change, mental health services consistently report significant difficulties recruiting nurses into their services, with sub-specialties such as psychogeriatrics reporting even greater difficulties. This view was also supported by submissions to the Committee from professional and industrial bodies.

The Department of Human Services Mental Health Branch, in its submission to the Committee, described the current situation as a 'crisis in mental health nursing'. It characterised the crisis as a situation where demand exceeds supply, and where pre-service preparation is inadequate, leading to a shortage of new graduates entering mental health settings. The Victorian group of the ANZCMHN suggested it would support any initiative developed by the Department of Human Services to change the image of mental health nursing and therefore attract nurses to the area. Such an approach would need to commence with programs aimed at schools.

Recommendation 24: That the Department of Human Services, together with ANZCMHN, develop a marketing strategy to attract and recruit nurses into the mental health areas.

5.1.2.2 Undergraduate Curriculum Concerns

From the submissions put to the Committee it could be concluded that the preparation at undergraduate level has not been adequate. In addition to a failure to attract nurses to the mental health area, nurses in general health settings do not have adequate mental health skills. Nurses in mental health settings struggle

as beginning level practitioners and the uptake of postgraduate studies has been poor. Attention needs to focus on the undergraduate program.

This concern is not peculiar to Victoria. A recent Commonwealth Department of Health report into the *National Mental Health Nursing Workforce* identified undergraduate nurse education as a key issue, stating that current courses provided an 'inadequate theoretical and clinical preparation for the beginning level practitioner of mental health nursing' (Clinton 1999).

Within the Victorian context, in 1995, the then Minister for Health wrote to the heads of schools of the Victorian universities and the NBV expressing concern about the psychiatric nursing content in the undergraduate degree. As a result, a survey of Victorian undergraduate curricula was undertaken, which reported considerable variation in the identifiable psychiatric content, ranging from, at worst, no discrete content to, at best, 17.4% of the curricula (Department of Human Services 1998). Mirroring this finding, a survey of new graduates of the comprehensive curricula who had chosen to work in the mental health sector found that they did not feel adequately prepared (Pante 1999). The current Government, in its mental health policy, states that it would 'examine ways of expanding the undergraduate training of nurses to more adequately prepare them to work in mental health settings' (Australian Labor Party, Victorian Branch 1999).

Information from the forums confirmed the position that undergraduate programs were not adequately preparing new graduates for nursing in mental health settings. A senior nurse highlighted this when she reported that she now employed allied health graduates in preference to nursing graduates because of their better mental health knowledge.

The undergraduate program is also not adequately preparing graduates who work in general health settings with people who have mental health problems. A key goal of the national mental health reform process has been to increase the use of health and human services by people with mental health

problems. Thus, there is a need for nurses to have enhanced mental health skills in order to meet the needs of these patients. The *Second National Mental Health Plan*, which identified the role of health services in the provision of services to mental health consumers, sought to promote amongst health services an increased knowledge and understanding of mental health and mental disorder as well as an awareness of their additional needs (Department of Health and Aged Care 1998).

The undergraduate curriculum not only has problems with the amount of theoretical content included, but also with the clinical learning component for mental health nursing. Two issues have been raised with the Committee, firstly access to a range of psychiatric and mental health settings and, secondly, the clinical learning environment.

A broader range of placements not only allows greater numbers of students to experience the sector but leads to a more positive experience for the student. Some mental health services offer students placements in all components of their organisation, including CAT teams. However, the Committee heard of some mental health services that would not take students at all, others taking only third year students, and some placements restricted to specific components of the service. In some circumstances only the traditional 'places students go', such as inpatient units or community care units, were offered. Other components of the service capable of taking students, such as CAT teams or Mobile Intensive Support Teams, are under either not offered, or used only occasionally.

It has been reported to the Committee that where a mental health service has a clear strategy in place to provide clinical placements and encourage educationally rewarding experiences for undergraduate students, it can attract graduates into their services without difficulty. This approach needs to be extended across the whole of the mental health sector.

Recommendation 25: That all area mental health services offer placements, appropriate to the clinical learning needs of students, at all stages of the undergraduate course. The requirement for agencies to

provide these placements, within their service capacity, be incorporated into health service agreements between the Department of Human Services and the individual agencies.

As with all other clinical placements, how the students are welcomed and valued influences their commitment to the area. The learning environment must be a positive one for the student.

A view put to the Committee was that there appears to be residual resistance in the mental health sector towards the undergraduate 'comprehensive' nursing course. This has contributed to a less than enthusiastic welcoming of students (and graduates) of the current undergraduate course. The prevailing attitude in some parts of the mental health sector appears to be that the nursing education system has failed psychiatric nursing and that it should therefore be ignored. This view is self-defeating and only serves to compound current problems.

As indicated above, the role of the clinical supervisor/preceptor is crucial in setting a positive learning environment for the student. This is equally true in the mental health sector. Clinical supervisors/preceptors require education to prepare them for their role. Identifiable funds need to be available to support undergraduate placements: in the acute sector the 'undergraduate teaching allowance' component of the T&D Grant is designed to support this activity. In the mental health sector an appropriate proportion of training monies need to be identified for this purpose. See Recommendation 20, section 5.1.1.1.

It has been suggested to the Committee that mental health services need to take a more proactive stance in making placements available and supporting students on placements. To overcome the problem of attracting nurses into the mental health sector, the sector must market itself more effectively to its potential future nursing workforce.

To address the curricula issues, guidelines relating to the mental health content of the undergraduate courses need to be developed. These guidelines should be adopted by the

NBV as a requirement for the mental health content in courses the NBV accredits as leading to registration as a nurse. A group coordinated by the Department of Human Services Mental Health Branch comprising the Nurse Policy Branch, the Centre for Psychiatric Nursing Research and Practice, the ANZCMHN, Victorian Deans of Nursing, relevant peak nursing bodies and service providers, together with the NBV, should examine this issue. This review will need to be completed mid-2001 in order for the guidelines to be adopted by the NBV and the curricula modified in time for the following academic year (2002). As some work has already been completed in this area, the report *Undergraduate Nursing Education in Victoria: Psychiatric Knowledge, Attitudes and Skill Requirements for Beginning Level Division 1 nurses* (Department of Human Services 1998) could inform this process.

Recommendation 26: that the mental health branch of the Department of Human Services coordinates a group of relevant stakeholders to review the mental health content—both theory and clinical learning—of the Bachelor of Nursing courses and make recommendations to the Nurses Board of Victoria as to the guidelines that should be adopted in relation to mental health content. This process to be completed by June 2001 in order that the guidelines developed can be adopted for the 2002 academic year.

5.1.3 Division 2 Nurse Education

The report of the *National Review of Nurse Education in the Higher Education Sector* (1994) identified Division 2 nurses as an integral component of the health care system, '...there is a move away from the role of the RN as a general broad based practitioner, with the EN taking part of that role'. In order to fulfil greater expectations, Division 2 nursing education needs to reflect current industry needs. The contributions of the Division 2 nurse to the health care industry has been limited by a lack of awareness of their potential (Dunn 1998).

The Commonwealth (AIH&W 1998) identified a 37% decrease in enrolled nurse numbers in the workforce between 1991 and 1996. As

discussed in 2.2.1, a shortage of Division 2 nurses developed through the 1990s following the closure of the Melbourne School for Enrolled Nurses (Bassett 1993). The combination of decreasing student numbers in the years preceding 1992 and the closure of the largest enrolled nursing school contributed to a significant shortage of Division 2 nurses in the metropolitan area. This shortage was tempered in regional Victoria as a small number of education programs continued in this setting.

The Nursing Workforce Survey (ACNMI et al. 1999) identified that, despite education recommencing in the tertiary sector in 1995, a shortage of Division 2 nurses still exists, particularly in the aged care sector. The Victorian data reinforces this finding showing in 1998 a net loss of 5% of the Division 2 workforce (Department of Human Services 1999²). In addition, registration figures have reduced by 6.59% since 1996 (Table 2).

The current pre-registration course for Division 2 nurses, the Certificate IV in Health (Nursing), was developed with an emphasis on aged care. In contrast, the previous hospital certificate prepared the graduates for a wider range of settings, including the acute care sector and mental health.

The Department of Human Services labourforce study (Department of Human Services 1999²) showed that of the current Division 2 workforce, 53% worked in aged care, 26% in acute care and associated specialties and 7% in mental health. A position frequently put before the Committee was the need to revise the current scope of practice of the Division 2 nurse and, in particular, prepare the graduate for a wider range of practice areas. The question of whether the preparation for extensions of practice for the Division 2 nurse should be at pre-registration or post-basic level is not one that the Committee can answer.

An area identified as important in extending the scope of practice for the Division 2 nurse is the administration of medications. In 1998 the then OTFE funded a research project into the issues surrounding assistance with medication administration required by clients of community services and health organisations, and consequent training implications (CSHITB

1999). In 1999 the then Minister for Health requested that the NBV undertake a study into the expansion of the role of the Division 2 nurse in relation to medication administration. The NBV report is currently before the Minister for Health. If the role is expanded in this direction, then the education underpinning such a change will need to be considered at either pre-registration or post-basic level.

In addition, given the emphasis on competency-based curricula in the VET sector, it is important to note that the ANCI is currently reviewing the enrolled nurse competency statements in the light of changes in current curricula and industry requirements.

The Committee has heard concerns expressed about the quality and quantity of clinical experience within the Certificate IV in Health (Nursing) course. As with the Division 1 program there have been concerns expressed about both access to appropriate venues and the learning climate. In particular, the Committee's attention has been drawn to the limitations of clinical experience in areas such as acute care and mental health. Problems have been identified in relation to the aged care sector, a situation exacerbated by the shortage of Division 1 nurses in the aged care sector and workload issues. Further, as indicated in section 6.3.2, Division 1 nurses do not always understand the role of the Division 2 nurse. This may also impact negatively on the quality of the clinical learning environment.

The Committee recognises that Division 2 is a career path in its own right. However, one path open to the Division 2 nurse is articulation into the Division 1 undergraduate program. Currently, in Victoria, between 15–25% of entrants to the Division 1 undergraduate course are Division 2 nurses. VET coordinators report that 23% of their graduates enter such a program immediately and a further 13% enter within three years. The amount of credit for Certificate IV in Health (Nursing) programs into degree courses leading to registration as a Division 1 nurse was also an issue brought before the Committee. The amount of credit offered varied between universities. The range was between two months to a full year. It would appear that universities that also provide VET sector courses are more likely to

give a full year credit to a Certificate IV graduate. There is no doubt that more consideration needs to be given to credit and recognition of prior learning in the university sector.

It is essential that the Division 2 curriculum reflects the demands of the health care industry. Revision of the pre-registration curriculum should include the revised ANCI competencies as well as increased scope of practice issues. It should examine the clinical experience and the articulation arrangements in a Bachelor of Nursing (BN) program. A steering committee comprising representation of all key stakeholders is essential to avoid duplication of effort, confusion and potential exploitation of the Division 2 nurse.

Recommendation 27: That the Department of Human Services convenes an intersectoral steering committee comprising representatives from vocational education and training sector, the health care industry, the higher education sector, professional organizations, NBV, and the Industry Training Board. The role of this group will be to address the educational issues associated with the developing role and expanded scope of practice of the Division 2 nurse. In particular, but not limited to, the Committee should pay attention to:

- **The need to revise the Certificate IV in Health (Nursing) curriculum, including the clinical practice component, to reflect relevant changes flowing from changes in the scope of practice, new modes of service delivery and current areas of practice, that is, acute care and its specialties, aged care, mental health and community settings.**
- **The current credit transfer arrangements between Certificate IV in Health (Nursing) course and undergraduate degrees leading to registration in Division 1**

Funding of the clinical component of the Certificate IV in Health (Nursing) course has been an issue since the program was first implemented. As with the Division 1 undergraduate course, the funding model appears inadequate. Prior to the course being accredited by the NBV, a request was made and

granted by the then OTFE that additional hours of clinical experience be added to the curriculum. VET coordinators consider that the level of funding was not adjusted to accommodate this change.

Recommendation 28: That the Minister of Health recommends to the Minister for Post Compulsory Education and Training that the level of funding for the Certificate IV in Health (Nursing) reflect the requirements for registration.

5.2 Postgraduate Education

5.2.1 Divisions 1 and 3

Throughout the submission and consultation activities of the Committee, issues relating to postgraduate education featured prominently. Clearly the most significant issue related to the cost of postgraduate education and the negative effect this is having on the nurses undertaking such studies. Access and the modes of delivery of existing courses were also significant issues. For further discussion of issues associated with postgraduate education and recommendations see sections 5.5 (study leave), and 6.2.3 (qualification allowance).

5.2.1.2 Cost of Postgraduate Courses

The HECS course fee is \$3,200 while the range for full fee paying places is \$8,000–10,000. It is the Committee's view that the allocation of additional HECS places to postgraduate nursing would be a key strategy in addressing shortages in specialty areas.

The Committee undertook a survey on the supply of, and demand for, postgraduate nursing places in Victorian universities. The survey identified a disparity between available postgraduate places and those filled. In 2000, there was a total of 75 postgraduate nursing courses offered. Of the 1,008 postgraduate places available across the range of specialist nursing courses, only 725 (72%) places were filled. However, all of the 176 HECS places were filled, with the vacancies occurring in the full fee paying places. Thus, the comparatively high cost of undertaking postgraduate courses was cited as a significant disincentive to further study and has contributed to the under-subscription to courses in 2000. If the number of HECS places were to be increased, then the

uptake into such courses would be enhanced. As places in universities are a Commonwealth matter, the issue needs to be addressed with the Commonwealth Minister for Education, Training and Youth Affairs to make more HECS places available for nursing nationally. Within universities the available HECS places are allocated according to university profiles. The Minister of Health should discuss with the Vice Chancellors the matter of increased allocation of HECS places within the universities as a recruitment and retention strategy for nurses in Victoria.

Recommendation 29: That the Minister of Health:

- **Approach the Commonwealth government to increase the number of HECS places allocated to nursing.**
- **Approach the university Vice Chancellors to increase the number of HECS places allocated to nursing within Victorian universities.**

A Government initiative had been to provide scholarships for additional places for postgraduate education for nurses. However, in view of the low uptake of places, attention needs to be focused in the first instance on attracting nurses to undertake qualifications in the identified areas of nurse shortages, namely acute medical/surgical (metropolitan), aged care, critical care, emergency mental health, perioperative and renal nursing (metropolitan and rural) and midwifery (rural). For future years the areas of need would be identified by both the Department of Human Services on its workforce data and the hospitals with specific needs. Given the disproportion of full fee paying to HECS places, it is recommended that these scholarships be 50% of the fee, but that a cap be set at \$4,500 in the first year. The health facilities may offer other financial incentives, such as a matched scholarship, or an up front loan for the remaining 50%. In the allocation of scholarships the ratio of rural to metropolitan would need to be taken into consideration.

Recommendation 30: To increase uptake of postgraduate places:

- **That the Department of Human Services a) funds scholarships to a maximum of 50% of the fee (HECS or Full Fee) for postgraduate courses in areas of**

identified need over the next three years, and b) establishes an equitable, transparent process and provides feedback to the profession on the number of places funded.

- That health care facilities consider ways to provide financial support to nurses undertaking such courses in identified areas of need.
- That a minimum of 25% of these scholarships be allocated to regional/rural areas.
- That the Nurse Policy Branch monitors this strategy and evaluates its effectiveness as a recruitment and retention strategy by December 2003.

Access to Postgraduate Courses

Four issues were raised in relation to access to current postgraduate courses. The first of these related to the mode of delivery of the courses. Concern was expressed about those courses that were offered at Master level only and did not provide for exit points at graduate certificate (six months FTE) and graduate diploma (one year FTE) level. The argument put to the Committee was that the courses of shorter length prepared the nurse to function within the specialty area and would be an attractive option for some nurses, giving them the choice of being able to continue their education at a later time. It also was viewed as a useful way of building confidence in those nurses who considered that they might not be successful at postgraduate level and therefore would not enrol in the more daunting higher level courses. Other universities offer single subjects as a way of easing students into the more extensive course. In this way, new knowledge and skills are learned in specific areas and the nurse may then gain the confidence necessary to continue with a postgraduate course.

The second concern expressed was that some courses were offered in full-time and on-campus mode only. The loss of earnings was cited as a disincentive to full-time study and the need for more flexibility in mode of study was urged. Some universities are already offering considerable flexibility and information about such courses should be disseminated widely.

The third issue raised was the availability of recognition of prior learning provisions by the universities to allow maximum credit into postgraduate courses. Learning should be seen as a lifelong venture, with the ability to articulate into programs at different entry points. Currently a diverse range of clinically focused nursing education is offered either as a one-off session or an extended module to develop an in depth understanding of the topic area. These modules are an efficient way to offer skill development in areas of need identified by the health service. The continuing education unit might offer them in a health facility, a university or in a collaborative undertaking. A collaborative review of the content of such continuing education modules could result in a system whereby the continuing education modules are granted as credit to appropriate postgraduate courses. In this way, modules are developed that not only meet the need for knowledge and skill enhancement in clinical areas, but enable a system to be established that gives maximum recognition of prior learning, to make learning seamless.

Some universities have established their own professional development units. Students in these units are not required to have enrolled in a postgraduate course but can undertake study in particular disciplines. This has made postgraduate education more manageable for a number of staff in terms of both financial and time commitments.

Ease of access to postgraduate courses and maximum recognition of prior learning are considered by the Committee to be strategies to facilitate uptake of postgraduate places and thus enhance the further development of qualified nurses in the nursing workforce.

Recommendation 31: That the Victorian Deans of Nursing develop options to facilitate easier access to postgraduate study, especially through the encouragement of multiple entry and exit points, a variety of modes of delivery and systems that enable maximum recognition of prior learning, especially learning achieved through continuing education modules.

The final area of concern about access to postgraduate courses related to the difficulties of individual universities meeting the needs of small numbers of nurses wanting to study in specialist areas. For example, courses in renal, neonatal and neuroscience nursing were offered in 2000 by more than one university, but in total attracted comparatively small numbers of applicants. A renal nursing course was offered by two universities but one discontinued the course as it could not attract sufficient applicants to make the course viable. Within the range of postgraduate courses available there will always be a proportion of courses that will attract small numbers. This however does not obviate the need of the health industry to receive graduates from such courses. In fact, renal nursing is a current area of shortage. Offering courses for small numbers of students is not a financially viable option and universities will choose not to offer these courses. This effectively reduces access for students to their university of choice. While alternative modes of delivery can be beneficial in such circumstances this approach does not overcome the problem. This decreased access in turn can decrease demand for the course and further exacerbate the problem. The option for offering such courses rests with the Victorian Deans of Nursing to develop collaborative arrangements across the State to ensure that the needs of the health industry are met through postgraduate education.

Recommendation 32: That the Victorian Deans of Nursing develop collaborative arrangements that maximise postgraduate courses for smaller specialties and small cohort courses.

5.2.2. Division 2

As indicated above, submissions and formal discussions with stakeholder groups expressed the need to consider some expansion of the role of the Division 2 nurse. The health care industry suggests that it needs second level nurses with increased knowledge and skills and Division 2 nurses require a clear professional pathway in which to apply their expertise. The potential advent of an expanded scope of practice will place greater emphasis on both the revision of current post-basic modules and the development of new units of study. In this

context the current AQF classification may require re-examination.

Currently, the range of post-basic modules includes those in dementia, continence, mental health rehabilitation, perioperative and acute care nursing. However, to meet industry requirements, additional post-basic modules should be examined closely and recommendations made by the intersectoral working group indicated in Recommendation 27. In addition, the career path for Division 2 nurses needs to be examined to ensure that there is maximum recognition of prior learning given by the VET sector for continuing education and for articulation into the Division 1 degree program for post-basic studies.

Recommendation 33: That the intersectoral group in Recommendation 27 also pay attention to the:

Effectiveness of current post-basic modules and the need for additional modules to meet industry requirements.

Recognition of prior learning arrangements between post-basic and continuing education undertaken and for post-basic modules and the Division 1 degree program.

The interim report of this committee recommended that scholarships be provided for Division 2 nurses undertaking post-basic modules in areas of shortage over a three-year period. The use of these scholarships as a recruitment and retention strategy should be evaluated after three years.

Recommendation 34: That the Department of Human Services evaluates the effectiveness of the provision of scholarships for Division 2 nurses to undertake post-basic modules as a recruitment and retention strategy by December 2003.

5.3 Graduate Nurse Programs

5.3.1. Division 1

The issue of the educational preparation of the new graduate was frequently raised through the submission and consultation processes. The transition from undergraduate student to registered nurse is key phase in the professional

development of a nurse as knowledge and skills are consolidated in the process of becoming members of the clinical team. The graduate year program is intended to facilitate this transition during this important phase of their professional development. Research demonstrates that new graduates feel overwhelmed and unprepared for the rigours of practice (Beeman 1999), while graduates state that they have difficulty fitting in and doubt their own ability to acquire the necessary skills.

In 2000, a total of 109 hospitals (public and private) offered approximately 1,223 graduate nurse program places (Victorian Medical Postgraduate Foundation Nursing Computer Match booklet 1999). Reports to the Committee indicated that hospitals, both rural and metropolitan, were not able to fill all of these places. The places in public hospitals (excluding mental health services) are supported by the Department of Human Services T&D Grant, and must comply with the Department of Human Services Graduate Nurse Program Guidelines (Department of Human Services 1997). A number of issues have been brought before the Committee in relation to the way in which graduate nurse programs are conducted, the support for the graduate, and the models of rotation used during the program.

Support is provided to the new graduate through either a designated clinical teacher or an experienced nurse who undertakes a preceptor role. The capacity of clinical teachers to provide the support to graduate nurses is significantly influenced by the ratio of teachers to graduates. Feedback to the Committee indicated that the numbers of clinical teachers in the health system is insufficient to fulfil this role.

In the absence of sufficient clinical teachers, the preceptor role is delegated to the experienced nurse. A number of issues were raised in relation to clinicians acting as preceptors. Firstly there was little recognition of this role within patient/workload allocations. It was indicated that in some circumstances, a preceptor and a graduate nurse were not rostered on the same shifts. The Department of Human Services Graduate Nurse Program

Guidelines indicates that a preceptor should be available for the first six to eight weeks of a clinical rotation. The impact on the clinical load of both the preceptor and the graduate should be recognised in workload allocation (Department of Human Services 1997).

Secondly, the capacity to successfully carry out a preceptor role requires considerable skill: this education was not always available. The graduate nurse focus group (Research International 2000, Appendix 6) reported the need to 'provide in service training to other nurses imparting basic teaching skills (such as how to 'show' rather than 'do' when working with graduates) and tolerance for graduates within particular nursing segments'.

It is essential that the new graduate is given the support and guidance necessary for them to develop confidence in their skill and abilities. If this support is not provided, the new graduates tend to leave the profession and a vicious cycle is set up within the profession where the new leave, the experienced become more stressed and they too leave in turn. There is a variety of models of preceptorship being used in Victoria. There is little data to indicate what is best practice.

Recommendation 35: That the Department of Human Services commissions and funds a research project to evaluate differing models of preceptorship within Graduate Nurse Programs in order to identify best practice.

Issues relating to workload, staffing levels and skill mix all need to be addressed to ensure that the graduate nurse year can be effectively implemented. These are considered elsewhere in this report. The graduate nurse year is funded from the T&D Grant (section 5.6) and there are guidelines associated with its implementation. These guidelines need to be reviewed (Recommendation 41) .

The other areas of concern raised with the Committee, both by its members and through submissions, is the place of specialty components such as aged care, critical care, renal and mental health, within graduate nurse programs. The lack of a rotation in specialty areas was seen as contributing to the recruitment difficulties in the specialties,

especially in mental health and aged care. By making a rotation more widely available to graduates who have an interest in one of these areas, beginning level nurses will have an opportunity to gain some experience and confidence in these specialties.

Currently some aged care services, and to a lesser degree mental health services, offer a full graduate year program based in these respective service sectors. While the numbers of people accessing these programs is small, a demand exists. In many professions a small percentage of people will decide during their initial education as to which particular area they wish to work in.

A variation on this phenomenon is particularly evident in mental health, with some nurses' primary interest being in the mental health service sector. Nursing is seen as a way of qualifying to work in that sector (Research International 2000, Appendix 6).

Given the significant difficulties aged care and mental health face in attracting new graduates to their service systems, graduates should be encouraged into these areas, either through a rotation or a full graduate year. See Recommendation 41, section 5.6.5.

5.3.2 Division 2

The consultation and submission process undertaken by the Committee identified low levels of confidence amongst new graduates from Certificate IV in Health (Nursing). It was suggested that a lack of consolidated clinical experience during the education course limited the ability of nurses to achieve realistic and effective work expectations.

The same arguments that support a graduate year program for the Division 1 nurses apply to new Division 2 graduates. Both nursing Divisions require assistance, support, acknowledgment and education during the transitional practice phase to promote a commitment to nursing. The provision of a supportive graduate practice setting will provide a secure environment for the beginning second level practitioner that will ultimately foster best practice.

It is the Committee's view that these issues of transition have not been readily acknowledged

by the health industry in relation to Division 2 nurses.

Recommendation 36: That the intersectoral group (Recommendation 27) should look to developing programs to assist Division 2 nurses make the transition from the educational to industry sector during the first six months of practice. These programs should reflect the principles adopted for the Division 1 graduate nurse program and include a preceptor component.

5.4 Continuing Education

5.4.1 Funding

Continuing education has been defined as 'planned educational activities developed to build upon and enhance the professional practice of nurses' (Alspach 1995). For the purpose of this section, continuing education will refer to both updating programs for new knowledge and skills in in-service and other programs, and other professional education acquired through attendance at conferences, seminars and workshops, commonly referred to as study days. Formal postgraduate education is not included in this definition.

It is a requirement of the ANCI Code of Practice that all nurses keep up-to-date with new knowledge, skills and technologies: participation in continuing education contributes to achieving this requirement. Responsibility to undertake continuing education is shared—it is the nurses' responsibility to undertake the learning and the responsibility of employing health care facilities to support this endeavour. However, in an environment of declining revenue, downsizing, rapid patient throughput and other constraints, the ability of health care facilities to provide support for continuing education is restricted.

There are costs associated with continuing education. These include the conduct of in-service programs, attendance and back fill. There are also costs associated with the attendance at courses or conferences not conducted on site. In some instances, there are additional costs for travel and accommodation.

Issues of distance and diseconomies of scale further exacerbate these problems in rural settings. There continues to be a strong

consensus among health care professionals that access to continuing education and training for rural health workers is inadequate. This, in turn, leads to long term workforce retention difficulties (Blue & Howe-Adams 1992, Malko 1992, Harris 1992, Hope 1993, Buckley & Gray 1993, Cramer 1994, Duffy 2000). The barriers to meeting the educational needs of rural health care professionals have been well documented, as have the preferences for mode of delivery and content. The barriers most frequently mentioned are related to costs, time, replacement staff, resources and support when education cannot be provided on site (Handley 1996, Spencer et al 1998).

The submission process, public forums and focus groups have supported the published studies above. Seminars, short skill-based courses and conferences are generally held in Melbourne or to a lesser degree in major regional centres. In order to access such courses, nurses from rural and regional services must travel, often considerable distances. This additional travel has multiple additional costs. The back fill or loss of a staff member is longer, travel costs are higher and accommodation costs are commonly incurred. While regional universities and other education providers are increasing the flexibility of their delivery systems the reality of rural practice is that, currently, a significant proportion of continuing education can only be undertaken by accessing Melbourne-based programs.

Information before the Committee would suggest inadequate expenditure on continuing education is a significant causative factor in the current nursing shortage and the provision of continuing education would act as a significant incentive to attract and retain nurses. The Considine & Buchannan (1999) survey indicated that the inability to take up educational opportunities was a significant problem in the workplace. Although paid study leave was available to almost 70% of their sample, less than half of the 47% who applied for it were granted it. Budget constraint was the reason given to 60% of these nurses. Professional development and training opportunities were included among the five most important factors influencing a return to work by those nurses who were registered but not working (Campbell, 2000). From the forums, a theme

related to the 'imbalance between a clear expectation and pressure for nurses to be pursuing on-going education and the minimal support provided in relation to leave or money' (URCOT 2000, p i, Appendix 5).

Access to continuing education is hampered by workload and shift arrangements. This theme was frequently identified in the various consultation processes undertaken by the Committee. While these issues are dealt with more fully in Chapter 6, it is evident that these issues have a significant impact on access to continuing education. High workloads and shift arrangements that eliminate ADOs and reduce shift overlaps, have a negative impact on the capacity of nurses to pursue continuing education.

Information before the Committee indicates that expenditure on continuing education varies between facilities. In some instances, the amount of budget expended on this activity for nursing is clearly transparent. However, this tends to be more the exception than the rule. There needs to be a more level playing field in relation to continuing education expenditure. A position was put firmly to the Committee that an additional 1.5% of nursing budget for metropolitan and 2% of rural budgets should be clearly allocated to continuing education for nurses. However, at this time, it is not known what is being expended and the Department of Human Services needs to gather the data on the current situation and then ensure that all facilities have a level of funding allocated as a line item in their budgets to 1.5% or 2% as indicated above, according to their FTE nursing numbers. The Committee recognises that the T&D Grant also provides \$4 million for continuing education, money that is allocated to submitted proposals on an annual basis. This Grant should continue in addition to the budget allocation.

Recommendation 37: That the Department of Human Services collects data relating to current expenditure on continuing education for nurses in each facility. Through its health services agreements with health care facilities, Department of Human Services ensures that funding is provided for continuing education to a level of 1.5% for metropolitan and 2% for

rural facilities based on the budget for the total nursing EFT across the facility. These funds to be shown as a separate line item. The Training and Development Grant for continuing education should be continued in its present form.

5.4.2 Mode of Delivery

There is a wide range of interactive and self-directed educational programs and resources that could be of benefit to the continuing education needs of nurses across the State. In many instances awareness of these resources is low. Should the availability of such programs be more widespread, resource allocation could be focused on areas of need, rather than duplicating existing programs.

The lack of knowledge regarding the content and availability of further education is not restricted to continuing education. The various universities that teach nursing offer a wide range of postgraduate courses from graduate certificate to doctorate level. They also offer modules that are often specifically geared to particular needs and attract credit points for postgraduate qualifications. An efficient system of information dissemination is required in terms of the content and availability of these courses

The Minister for Health, the Hon John Thwaites, has endorsed the implementation of the Clinicians Health Channel, a medium that provides Web-based access to an electronic health library for all Victorian acute public hospitals. The project is currently in trial stages, after which it is anticipated that a statewide license will be negotiated.

The Clinicians Health Channel is divided into several main categories comprising:

- Clinical news and views
- Electronic health library
- Guidelines and protocols
- Training and support
- Contributions to the channel
- Links.

The Clinicians Health Channel (or similar Web-based services) would provide an excellent resource for access to the wide range of multimodal continuing education programs and postgraduate education that are currently offered in Victoria.

As indicated above, access to continuing education for rural nurses is inadequate and costly. Both access and cost can be reduced if the education is delivered on site. Blue & Kirkbright (1998), in citing the *Project for Rural Health Communications and Information Technologies Report* (1996), note that 82% of the health professionals surveyed believed that information and telecommunications would help reduce their feelings of isolation. Utilisation of a variety of teaching modalities, including multipoint video, CD Rom and self-directed learning packages, offers a means to reduce professional isolation and provide relevant educational programs for rural nurses.

It is recognised that several avenues currently exist for rural health care facilities to increase their access to funding resources for educational purposes: these include the rural health support, education and training programs (RHSET or SETR). It would appear that, despite these programs, problems with continuing education for nurses remain. Indeed, only 23% of the Duffy (1999) sample indicated that they had access to computer technology and network.

While there is a range of education providers, the benefits to the overall health system are limited because health care facilities and nurses are either unaware of what is available or unable to access it.

The costs of continuing education in rural areas could be reduced if tele/video facilities were used at least for some continuing education. Currently, there are 32 teleconferencing facilities around Victoria, used for the delivery of Telehealth services. These facilities are mainly used by physicians for diagnosis and treatment of rural and regional patients. Potentially, this technology could be used to deliver continuing education to rural/regional nurses to enable increased access to ongoing education.

The delivery of such services has a cost and this would need to be balanced against the time, travel, accommodation, and back fill costs for both the facility and the nurse. Information before the Committee indicates that ongoing costs have been a issue, but as this is now being both subsidised and promoted by Department of Human Services and VHA, this will

potentially increase its viability as a means of delivering distance education.

Recommendation 38: That the Department of Human Services:

- a. Ensures information on existing multimodal education products and postgraduate modules and courses be disseminated to health care facilities and their nurses via the most appropriate method, such as the Clinicians Health Channel.
- b. Reviews existing multimodal education products with a view to identifying what is currently available, the product's ability to meet current industry needs, and to identify unmet needs. The review should also evaluate, as well as recommend, appropriate products for multimodal education, such as tele/video conferencing, distance education and CD-ROMs, to fill identified gaps in continuing education.
- c. Explores what is currently available in tele/video conferencing facilities in Victoria and that a strategy be developed to make effective use of these as a means of delivery of continuing education in rural and regional Victoria.

5.5 Study Leave

The Committee was asked to make recommendations regarding the Government initiative to 'provide paid study leave to 1000 nurses undertaking postgraduate courses in areas of specialist expertise'.

The aim of the initiative was to help overcome the shortage of nurses in the public sector, especially in specialist areas, by providing support to those undertaking postgraduate courses. As indicated earlier, shortages of nurses have been identified in a number of areas for which postgraduate courses are available for Division 1 and 3 nurses. In addition, submissions before the Committee indicate shortages of Division 2 nurses, not only in the aged care area, but in areas for which post-basic modules are available, such as continence, dementia, mental health, perioperative, acute and rehabilitation nursing.

The committee was guided by a number of

principles in the operationalisation of this initiative.

5.5.1 Principles

- Paid study leave be applied to nurses in all Divisions of the register in the metropolitan, regional and rural areas of Victoria.
- Paid study leave be applied to all nurses, employed full-time or part-time throughout Victoria in the areas of need currently identified not only in the acute care, but also aged care, mental health, community nursing and midwifery.
- Paid study leave be granted to all postgraduate courses, graduate certificates, graduate diplomas, masters or PhD for Division 1 and 3 nurses, and post-basic certificates/modules for Division 2 nurses, irrespective of mode of delivery.
- Department of Human Services processes be transparent and communicated to the nursing profession.
- Processes used to implement study leave be matched to the tertiary sector timelines to allow for planning of rosters and replacements.

5.5.2 Definition

To ensure equity across Divisions of the register, the term 'place' will be used. A place equates to 104 hours of study leave, that is, four hours per week for two semesters (26 weeks). As Division 2 modules tend to be of one semester equivalent duration, two Division 2 nurses may share one place.

5.5.3 Allocation of Funding

The Committee undertook a survey of health services to ascertain the extent of study leave provision. The survey returned 51 responses (43%). Of the respondents, only 19 hospitals (two metropolitan and 17 regional/rural) provided paid study leave. From the 51 respondents it was revealed that there were 750 nurses reported to be undertaking studies and only 179 (24%) received study leave. The metropolitan hospitals paid only 19% of their 594 nurses while regional/rural hospitals paid 44% of their 69 nurses. Six of these respondents considered the payment of study leave as an essential element to recruit qualified staff. Of the remaining 32 respondents, budget

constraints were given as the reason why study leave was not paid.

Data from a survey of universities indicated that currently there are 1,322 students undertaking postgraduate clinical courses in 2000 (including continuing students). It must be noted that this number includes those nurses in the private sector.

Data before the Committee from the VET sector (coordinators of Certificate IV in Health [Nursing] course) suggested that there was a poor uptake rate of post-basic modules by Division 2 nurses.

The recommendation to provide scholarships for extra places in both universities and the VET sector, makes the need for assistance to nurses who are upgrading their qualifications at a postgraduate and post-basic level a matter of urgency.

5.5.4 Quotas

To overcome current shortages, paid study leave should be directed at areas of need. Those identified in this report are acute medical/surgical (metropolitan), aged care (metropolitan and rural), critical care (metropolitan and rural), emergency (metropolitan and rural), mental health (metropolitan and rural), midwifery (rural), perioperative (metropolitan and rural), renal (metropolitan and rural). Attention should also be paid to the metropolitan-rural distribution of 75:25. In addition, registration data indicates that 75% of nurses are registered in Divisions 1 and 3 and 25% in Division 2. The allocation of funding in this initiative should reflect the proportion of nurses in each Division.

At this stage, it is unclear what the take up rate for places will be, especially in relation to the metropolitan, rural and Division 2 quotas. Where quotas are not met in one area, Department of Human Services will distribute places to areas where applications are in excess of quota to ensure that the full amount of funding is allocated in this first year of implementation.

5.5.5 Process

The Government initiative was funded at \$2.08 million per annum for a full year effect. At an

average of \$2,080 per place this would enable 1000 places to be taken up in any year. To ensure equity of distribution, the funds need to be managed centrally and therefore the Department of Human Services is the appropriate body to implement the recommendation. Criteria must be established to reflect this principle of equity. Such criteria might include identified areas of need and statewide and hospital EFT as a guide to overall distribution of places. To ensure transparency of process, a reporting mechanism needs to be developed to inform the profession about the allocation of places and their monitoring and evaluation.

Recommendation 39: That Department of Human Services allocates places for paid study leave for four hours per week per place for nurses undertaking postgraduate and post-basic courses by any mode of delivery. Such allocation to be based on areas of identified need and EFT with a minimum of 25% of the total places allocated to the regional/rural areas and 25% of total places allocated to Division 2 nurses. Department of Human Services to ensure a mechanism for reporting back to the profession on its process.

In addition, health facilities will need to establish processes internally. Such processes need to apply a number of principles to ensure equity and transparency where the applications exceed the allocation.

Recommendation 40: That nurses apply for study leave to their health service or area mental health service. Where applications exceed allocations, a ranking system be used incorporating the following principles as guides: length of service, results of performance appraisal where available and, if not available, their contribution to the service, and service priority for its areas of need/shortage, including aged care and mental health nursing.

5.6 The Training and Development Grant

The T&D Grant for nursing was established as a part of the acute casemix funding formula. It is a specified grant similar to those made for

medical and allied health. The nursing component of the Grant was established for two reasons: firstly to recognise and provide funding for specialist hospital post-registration programs already in existence and, secondly, to compensate hospitals for employing new graduates whose contribution to patient care was less than that of an experienced registered nurse. It is the single largest training specific funding mechanism available to the Victorian health system. There is also a continuing education grant and an undergraduate teaching allowance.

Each hospital receives funding for specialist and graduate nurse programs based on its number of students. This *per capita* grant has been adjusted over time to reflect more accurately the costing information available. In contrast, the continuing education grant is allocated on the basis of a business plan submitted by the hospital outlining continuing education or professional development programs. The undergraduate teaching allowance is allocated proportionally to hospitals that have nursing and medical undergraduate students.

The Grant is for the acute care setting only. The aged care and sub-acute sectors have a separate, similar grant. The mental health sector has a different method of funding its training and, because of the global nature of these funding arrangements, the nursing component is not identified.

Information before the Committee strongly suggests there are problems with the overall T&D Grant. These are outlined below for each of the components of the Grant.

5.6.1 Undergraduate Teaching Allowance

This allowance is combined for both nursing and medicine undergraduates. The Committee has received reports that accessing this grant has been difficult. It is not transparent in the budget and, more often than not, is not allocated to nursing. Further, it has been indicated to the Committee that the current system does not reflect the actual numbers of student placements offered, rather the primary determinant of funding is the amount of casemix the hospital receives. Given the issues

of transparency and acquittal of funds, the Committee is of the view that combining funding in this manner does not facilitate their distribution to nursing undergraduate clinical experience—the problems of which are outlined above (section 5.1.1.1).

5.6.2 Graduate Nurse Programs

As indicated above, the success of the graduate nurse program depends on the quality of the clinical supervision/preceptorship available to the new graduate. Problems were identified above in relation to the numbers of clinical teachers available and the clinical nurses providing the preceptorship. Attention was also drawn to the current apparent limitation of the graduate nurse year to allow for experience in specialty areas, particularly the special needs of aged care and mental health services. The need for a Division 2 graduate nurse program was also indicated.

Each of these areas needs to be considered in relation to the guidelines for graduate nurse programs. The current guidelines need to be reviewed to more closely reflect the needs of industry and ensure that new graduates are not lost from the workforce.

5.6.3 Postgraduate Programs

Currently there are no guidelines for the postgraduate grant other than the general criteria published in *Victoria—Public Hospitals Policy and Funding Guidelines 2000–2001* (Department of Human Services 2000).

Information before the Committee indicates that the grant is used differently by different facilities. In some instances it is used to provide the student with clinical teaching support, in other cases the money is provided to the university to reduce the cost of the fees charged to the student. In other cases it may be used to provide for back fill. The Committee recommends that guidelines should be developed to include similar principles to those in the graduate nurse program guidelines. Guidelines need to be developed as a matter of urgency, in order to ensure that there is equity in the system. The guidelines may also need to take into account the recommendations made in this report relating to assistance with fee cost through scholarships.

5.6.4 Continuing Education

Currently continuing education grants are allocated on the basis of submissions made by hospitals, based on standard guidelines. There is a requirement that hospitals must demonstrate that they have consulted with nursing staff and have a comprehensive needs analysis underpinning their submission. There is also a requirement that hospitals must evaluate the program, according to criteria they themselves develop. While every effort is made to assist hospitals to apply for funds, the limited pool available (currently \$4 million) and the increasing number of hospitals accessing funds, means that hospitals usually receive less than they request. This is complicated by many hospitals including a self-confessed 'ambit' component in order to achieve a greater level of funding. Currently all acute Victorian hospitals applying for the continuing education grant receive funds although the administration of the program is burdensome in terms of staff and time, both from the Department's perspective and from the hospital's.

The Committee considers that this grant should continue in its present form, as it provides additional monies for an important area of education, however its administration needs to be simplified.

5.6.5 Training and Development Grant Recommendations

The T&D Grant provides needed support for four areas of nurse education and it is essential that this support continues. However, in view of the problems outlined above, there would seem to be a need for specific review of the nursing component of the T&D Grant. The Committee notes that the Government policy states that 'Labor will also require public hospitals to make transparent their expenditure on clinical nursing training and to account for that expenditure against agreed benchmarks' (Australian Labour Party, Victorian Branch 1999) and applauds this approach. Further, it notes that recent concern was expressed about the detailed acquittal and recall of funding for postgraduate courses in the *Ministerial Review of Healthcare Networks* (Department of Human Services 2000, p.141), suggesting that this be devolved to the universities. The Committee

interprets this to mean that data on clinical placements, such as student numbers and duration of placement, should be provided by universities (as is currently the case with the allied health undergraduate component of the T&D Grant) and not that the universities provide financial acquittals. The rationale for this interpretation is that universities are not privy to information about how the grant is used by hospitals. The Committee also notes that the T&D Grant is currently under review by the Department of Human Services. The Committee supports this action, but points the review to the specific matters outlined in the recommendation below.

- Recommendation 41: That the Department of Human Services reviews the T&D Grant in relation to the undergraduate teaching allowance, the graduate nurse program, and the postgraduate program (including midwifery) The review should ensure that:**
- a) The manner in which the Grant is made available to the hospitals is transparent and acquittal processes ensure the funds are used for their intended purpose.
 - b) The funding for undergraduate nursing be allocated according to student numbers undertaking placements in a hospital.
 - c) The medical and nursing components are separated and the nursing component is shown as a line item in the budget.
 - d) A nursing reference group is established to review the graduate nurse program guidelines paying particular attention to:
 - How the funds are used to support the new graduate through supervision and preceptorship
 - The capacity to provide for rotations in specialty areas such as critical care, renal, perioperative nursing
 - The provision for both rotations in and separate programs for aged care and mental health as a positive recruitment strategy
 - Provide for Division 2 nurses.
 - e) Establish a nursing reference group to develop guidelines for postgraduate courses along the lines of the graduate nurse program, ensuring that the distribution of the monies provides for equity between facilities.

- f) That allocation to the aged care T&D Grant be increased as a positive recruitment strategy.**
- g) That the mental health funding be analogous in structure to the acute T&D Grant.**
- h) That the continuing education grant continue as it is.**

6. Retaining Nurses in the Workforce

As indicated in Chapter 3, several themes were raised with the Committee that were considered important to retain nurses in the workforce, particularly the experienced, qualified nurses. The first of these themes related to the workplace itself—workload, work conditions and the work environment. The second, equally strong theme, related to the lack of recognition and valuing of the clinical nurse—lack of a strong clinical career structure, management and other support for the clinical nurse, and recognition for qualifications and experience in clinical practice. In addition specific issues were raised in relation to the retention of nurses in rural and regional Victoria, Division 2 nurses and those nurses working in speciality areas including the public aged care sector.

6.1 The Workplace

6.1.1 Workload

As discussed in section 3.1.2, from the views strongly put to the Committee it is apparent that nurses will not be recruited back into the workforce, or sufficient numbers of experienced nurses retained, unless the issue of workload is addressed as a matter of urgency. The Committee takes the position that research has clearly shown that restoring workload management and clinical decision making to the nurse has demonstrable benefits in terms of recruitment and retention (Kramer 1990, Scott, Sochalski & Aiken 1999, Havens & Aiken 1999). Research has also shown that current flat rate formulas for funding nursing staff, such as those based on diagnostic related groups, does not allow for individual variability in the amount and quality of necessary nursing care it is possible to offer patients (Shamian, Hagan, Fu & Foggarty 1994).

What is a reasonable workload? The number of patients allocated to each nurse depends on a variety of factors including patient acuity, the skill mix of the nursing staff, time of day and other support services for the nurse. These factors may vary both within and between units.

Fundamental to the discussion relating to workloads is determining how many nurses are necessary to provide quality care to patients, and how these numbers are controlled.

6.1.1.1 Measurement of Workload

Nurse/Patient Ratios

The NUM assumes primary responsibility for control of workload in the ward or clinical unit. The NUM needs to have some measure of how many nurses are required on a shift, with the capacity to recruit more staff on some days and less on other days. In most instances this is a professional judgment by the NUM based on clinical experience, as there is a paucity of reliable data on what constitutes a reasonable workload.

In the absence of a validated and reliable measure, the decision of what is a comfortable workload is often left to the NUM, to whom three objective measures are generally available:

Nurse hours per patient bed day

A rule of thumb used for nurse allocation in some units is the number of nurse hours required per patient bed per day. Where the acuity level and skill mix is fairly stable this appears to be an adequate measure.

Nurse/patient ratios

The use of nurse/patient ratios is also a guide to level of workload. There are, however, no clear indicators as to what is a standard ratio, given the variability in acuity and skill mix. The ANF is advocating a ratio for the acute general medical and surgical wards of 1:4 for morning, and evenings, and 1:8 for night (in addition to the nurse in charge of the ward). A number of assumptions underpin these ratios. Firstly, that the level of acuity for acute wards is similar. Secondly, that wards contain patients with comparable acuity levels. Thirdly, that the level for acute care can be determined relative to other areas of care. Fourthly, that the skill mix can be maintained at a similar level, and that

the skill mix is adequate. Finally, it assumes that clinical activities are the same in the morning and evening, and that there is a significant change for the night shift. Support for the position of fixed nurse/patient ratios is claimed to have emerged from the Considine & Buchanan data (1999) where a 1:4 to 1:5 ratio was regarded by the majority of the research sample to be the desired ratio for acute wards. However, these were subjective data, and there is a need for more objective data to support an argument for fixed nurse/patient ratios.

It is claimed that a fixed ratio will provide some guide for what could be considered to be a reasonable workload for the acute care areas and then allow for adjustment up or down, accordingly in other areas of care. The critical care areas tend to run 1:1 ratio and the sub-acute and nursing home areas run on ratios higher than 1:5.

Many Directors of Nursing have indicated to the Committee that they do not support a fixed ratio. They claim that in some acute care areas a 1:3 is more appropriate, but not at all times and rural Directors of Nursing, in particular, claim that the mix in their units varies in level of acuity, and hence a given ratio would be difficult to achieve. They also indicate that if ratios are fixed, this does not allow for the flexibility of adjustment in workload that is inherent in the professional judgment of the NUM.

There is a paucity of information about an ideal skill mix. There is no doubt a need for sufficient numbers of experienced qualified full-time staff to ensure a continuity of quality care. More information needs to be collected on skill mix as part of the case for fixed nurse/patient ratios.

Dependency tools

An alternative to fixed ratios is a measurement tool for patient dependency. A tool commonly used in many hospitals, predominantly in the private sector, is Trendcare. Some hospitals have indicated that Trendcare does give accurate prospective workload figures that allow reasonable workloads to be determined for each shift. Others are sceptical, indicating that if it is not introduced or applied with an adequate education program, it can be

manipulated in undesirable ways. There would appear to be a need to evaluate Trendcare, and other available tools, in terms of validity, reliability and applicability to the Victorian public sector. If such a tool were found to be an effective measure of workloads for the variety of areas in which it is applied, then the need for fixed ratios would no longer be necessary.

In the absence of consensus on the effectiveness of measuring tools or other accurate workload measures, there would appear to be some value in suggesting that fixed ratios be applied in the acute medical/surgical wards only as a measure to avoid excessive workloads. However, there are many difficulties with a fixed ratio, while a range of ratios would allow for some degree of flexibility. Further, wards/units that have sound reasons for working outside set ratios should have the opportunity to provide the rationale for their chosen ratios. It is, therefore, necessary that the Department of Human Services has the capacity to review the impact of ratios on the workload until satisfactory measures are introduced.

6.1.1.2 Adjustment of Workload

As indicated above, it is up to the NUM or, in their absence, the ANUM to facilitate reasonable workloads. A suggestion put before the Committee was that each ward/unit develop a template for an appropriate workload in their area. Such a template would be developed in consultation with the ward/unit staff and reviewed weekly. The hospital would also convene a group reviewing such templates and the NUM would expect support from management when workloads were in excess of the template and bed closures had to be considered.

The issue of bed closure is an important one. An experienced NUM, with or without a template, will know the optimum working conditions for the skill mix on the unit. Whether working to fixed ratios or Trendcare if, in the professional judgment of the NUM, the workload is too high, more staff are not available, and they are unable to control the flow of patients, then an automatic closure of beds should occur, with the explicit support of management. Thus, there should be clear policies and procedures, based on best available

information about the ward/unit, to facilitate such closures. Casemix funding may need to be adjusted to ensure that such contingencies are accounted for without diminution of care.

Recommendation 42: That in the absence of statewide workload data, each ward/unit establish a template for an appropriate workload for that ward/unit consistent with a ratio ranging from 1:3 to 1:5, excluding the nurse in charge of the am and pm shifts, for the acute general medical/surgical wards/units and the Nurse Policy Branch reviews the impact of ratios on workloads until more explicit data are collected and analysed.

Recommendation 43: That the Department of Human Services convenes a working party comprising relevant stakeholders including ANF, HSUA and Directors of Nursing to jointly:

- **Determine the data that are needed to evaluate nurse/patient ratios and skill mix across the State.**
- **Review available dependency systems and, if needed, commission further studies on such systems to evaluate their effectiveness and report back to the Minister for Health.**

Recommendation 44: That policies and procedures should be in place to enable the NUM and ANUM to control workloads by adjustment of staff numbers as appropriate and where workloads are unreasonably high, additional staff are unavailable and patient flow cannot be controlled, that adequate support be given to enable beds to be closed as a last option in the control of workload.

There are times of the year when it is known that there will be a shortage of nurses, such as during school holidays. There is no reason why planning could not ensure that the amount of elective surgery is reduced during this time. This would ease the burden on nurses at a time when resources are limited. With careful adjustment of such surgery lists, there should not be a corresponding increase in waiting lists.

Recommendation 45: School holidays are known periods of nurse shortages and that hospitals minimise the amount of elective surgery during such times.

6.1.1.3 Assistance to the Nurse

In order to reduce the workload of the nurse there are many activities that the nurse currently undertakes that could be taken by a 'ward assistant' or 'ward clerk,' however named. These activities include answering the telephone, preferably on a 24-hour basis, but at least from 8am to 8pm (at the completion of official visiting hours), many clerical activities that are routine and repetitive, as well as some housekeeping tasks such as making unmade beds. Such a role should be seen as an assistant to the nurse and not as a replacement. The Committee is of the view that such assistance should not include the provision of nursing activities including those that tend to be classified as 'personal care', but are in fact the very basis of the activities of daily living which form an integral part of nursing (Henderson 1996). In the view of the Committee, nurses, as defined in the Nurses Act 1993, should be the ones to undertake nursing. This is particularly so not only in the acute care area, but also in the sub-acute and nursing home environment where the complexity and acuity of care is increasing. Experience from the USA would support the view that the use of personal care attendants is problematic in these sectors (Shindul-Rothschild, Berry & Long-Middleton 1996).

Recommendation 46: That each facility undertakes a review of activities such as telephone answering, routine clerical activities and some housekeeping activities, such as unmade bed making, and recommends to the Department of Human Services strategies that will either introduce such positions in addition to nursing positions that assist the nurse at ward/unit level, or extend the hours of such assistance as necessary.

Recommendation 47: That health facilities establish a policy that nursing activities be undertaken only by those nurses registered under the provisions the Nurses Act 1993.

6.1.2 Working Conditions

6.1.2.1 Rosters

There are a number of areas where the conditions of work can be considered to meet both the needs of staff as well as the requirements of the workplace. Nurses indicated to the Committee that they needed to have some control over their conditions of work.

Full-Time and Part-Time Work and Rostering

A constant theme in forums and focus groups was that of flexibility, particularly in relation to shift length and rostering. It is generally accepted that continuity of care can be achieved more easily where there are permanent staff, either full-time or part-time. It has been made clear to the Committee, particularly in the forums, that there is little attraction for some nurses to work on a full-time basis. With the current shortages of experienced qualified nurses, those who remain in a full-time capacity carry a heavy burden. Therefore, many opt for agency work where they can not only choose the shifts that they work, but also do not have to become involved in the daily management of the unit. There are a number of strategies that can be used to attract nurses back to permanent full-time or part-time positions.

The areas identified by the nurses included:

Shift rosters

Nursing, like many other professions, must provide a 24-hour service. The ability to ensure that all nurses receive the shifts that suit their lifestyle is not easily achieved, particularly in relation to school holidays and the collection of children from school and child care. What nurses need to feel is that they have some control over the situation and that there is flexibility, fairness and equity in rostering arrangements. Flexibility can be achieved through means such as self-rostering and job sharing. The Committee heard of both successful and unsuccessful self-rostering arrangements. Such a system requires the support of all staff and a willingness to share the hours to be worked with colleagues.

Job sharing

This is recognised by the Committee as an important way to achieve more flexibility in the workplace. The Committee considered job sharing using these guiding principles:

- nurses sharing the position are at the same grade of employment;
- each employee is clear about the job requirements;
- each employee is clear about replacement arrangements for sick leave and holidays, and entitlements are accrued at a part-time rate;
- processes are in place for termination of the job sharing arrangement.

Shift length

This was a matter of some discussion and varied according to the area concerned. The issue of short shifts and the ability to work a few days per week was an issue that was seen as attractive to those with young families. The argument was put that working for short periods not only maintained skills and knowledge, but encouraged nurses to return to permanent positions once family circumstances allowed this to happen. Many nurses perceived such flexibility as a measure of the value in which their experience was held. Opposition was expressed to short shift arrangements from some nurses on the basis of continuity issues, and gaps in the roster. The length of shift would appear to depend on local needs and should be considered at that level, however a governing principle would appear to be the proviso that no gaps should be left in the roster as a result of short shifts.

Night duty

The issue of rotating versus permanent night duty was raised in the forums. Strong views were expressed about rotations of night duty, and it was seen as a reason why some nurses were leaving the profession, particularly from the critical care areas. There were many who advocated voluntary permanent night duty. However, the dangers of not keeping up with current changes in knowledge, skills and technologies and the possibility of the development of a negative night duty culture were put forward as concerns. Measures to counter these problems included access to

education during the night or at times during the day convenient for the night nurse, in some cases a period of time on day duty and sufficient overlap period. In some instances, incentives were offered for permanent night duty, including (but not limited to) a hot meal.

Recommendation 48: That attention be paid to rostering and that the following principles be implemented:

- **Flexibility, fairness and equity of rostering, through such means as self-rostering and job sharing.**
- **No gaps in the roster caused by short shifts.**
- **Encouragement of voluntary permanent night duty, but with access to continuing education, periods of day duty and strategies to avoid a 'night duty culture'.**

Overtime

During the forums the issue of overtime was frequently raised. As indicated in section 3.1.3, the amount of unpaid overtime worked has been estimated at 300–450 EFT per week (Considine & Buchanan 1999). The Committee is of the view that each health facility should have in place strategies that reduce the amount of overtime worked. Every nurse is entitled, under the Award, to claim legitimate overtime worked and it would appear that some health facilities need to be reminded of their obligations in this area. The reward for overtime can be either remuneration or time off in lieu, whichever suits the hospital, the ward/unit and the individual nurse.

Recommendation 49: That strategies be put in place by each hospital to reduce the need for excessive overtime, but where it is required, hospitals be reminded of their award obligations regarding overtime provisions.

One problem that was frequently alluded to in the forums and focus groups was a prevailing culture in which nurses were discouraged both overtly and covertly from claiming overtime. Budgetary constraints were commonly used as a reason why overtime was not to be claimed. Some NUMs appear to have contributed to the development of this culture by not claiming overtime themselves, and by either actively or passively encouraging others not to claim. It is

proposed that one way to reverse this negative culture would be for the NUM to ensure that they claim overtime when this is worked.

Recommendation 50: That management encourage NUMs to claim legitimate overtime to ensure that a negative culture does not develop in relation to payment of overtime.

As the nurse workload becomes more reasonable as a consequence of the measures recommended in this report, the amount of overtime both claimed and rewarded could be used as a measure of the success, or otherwise, of a facility's ability to recruit and retain nurses.

6.1.2.2 Overlap Period

The Committee has been informed that one of the major causes of overtime relates to absence of an overlap between shifts. The ANF has indicated that the 8:8:10 roster is necessary to provide a two-hour overlap period, however this was not supported by a number of submissions, both written and verbal. It was felt that different needs of different units would not be met with such a prescriptive roster. However, the principle underlying this, namely that an overlap period is necessary between shifts, is one that is supported. The overlap period is not only necessary for reduction of overtime, but also enables the handover to be achieved effectively, allows for double duties during this period, meal breaks and provides time for education and team building.

Recommendation 51: That all health care facilities restore an overlap period between shifts. The length is to be determined by local need and the requirement for sufficient hand-over time, meal relief, undertaking of double duties and provision of some in-service education and team building.

6.1.2.3 Accrued Day Off

As discussed in Chapter 3, associated with the issue of an overlap period is that of length of shift and its relationship to the ADO. Some health care facilities have retained the ADO for nurses and others have removed it. The ADO has tended to be retained by allied health care professionals as the issue of back fill is not a major concern.

Australian data (AIH&W 1999) have demonstrated that while there has been little overall decline in the number of nurses nationally during the last ten years, there has been a decline in full-time equivalent (FTE) nurse employment, as more nurses choose to work part-time. The Committee considers that the linking of the ADO with full-time employment is one strategy that may facilitate the return to full-time employment. The Committee notes that the strategy is dependant on the willingness of employers to offer full-time work. Submissions from the consultation process suggest that some rural hospitals have significantly reduced opportunities for full-time employment, in part as a cost saving measure. Forums held in regional hospitals suggested that the inability to obtain full-time work is a major disincentive to specialist nurses relocating to rural areas.

The return of the ADO for nurses needs to be considered in conjunction with the issues of length of shift and the overlap period. Consistent with the rostering principles in section 6.1.2.1, there should be sufficient flexibility to meet the needs of individuals as well as the ward/unit. Therefore, the length of shift for full-time staff seeking access to an ADO should be based on local needs, with nursing staff working a roster pattern that allows them to work full-time. This should result in an increase in the shift overlap in the middle of the day (under most roster configurations) thus reducing the amount of unpaid overtime currently being worked.

The cost of the ADO lies largely in the requirement for back fill. Information before the Committee suggests that the ADO was removed by changing the hospital roster configuration, so that nurses continued to work a 38 hour week but reverted to reduced shift lengths. As a result nurses were present for the whole 20 day, four-week cycle, and as such the replacement cost of these staff was eliminated. While it is difficult to accurately cost the replacement of nurses taking an ADO, the VHA has estimated that the cost would be in the range of \$15–20 million per annum. This may be an overestimate, however, as a number of factors influence costing, including the number of facilities already providing an ADO, the number of full-time staff requiring back fill,

length of shifts, requirements for part-time staff, reduction of overtime and the migration of part-time staff to full-time employment.

Restoration of the ADO is seen as a strategy to encourage nurses to return to full-time employment to enhance continuity of quality nursing care. Further, increasing the length of the shift will help alleviate the issue of unpaid overtime, allow nurses to take breaks from the workplace once a month, and provide for greater satisfaction and retention of nurses. Submissions before the Committee from consultation forums suggested that many nurses regarded their work as mentally and physically exhausting, while the survey of non-working registered nurses (appendices 3 and 4) indicated that workload was the primary barrier to re-entry to nursing. Thus, return of the ADO could be considered as a powerful recruitment strategy to full-time employment and a retention strategy for those already employed full-time.

Recommendation 52: That full-time nursing staff have access to an ADO, to be taken in a flexible manner suitable to the nurse and the local facility circumstances, and that the Department of Human Services adjusts the casemix funding formula to allow for the full implementation of ADOs.

6.1.3 The Casual Workforce

6.1.3.1 Agency Nurses

Agency nurses have traditionally been employed in hospitals to cover ad hoc or unplanned periods of absence of permanent staff, for example due to sick leave, family leave or unpaid leave.

Over recent years the use of agency nurses appears to have increased significantly, although this was unable to be quantified due to lack of historical workforce data. Through the forums and focus groups the Committee was informed that the reasons for nurses leaving permanent employment and joining agencies included increased workloads, reduced flexibility with rosters, and freedom to work in a clinical setting without added administrative burdens. The Committee has also been informed that two important factors relating to agency nursing as a primary career

choice are certainty of work, with agencies able to offer regular preferred shifts to many of their staff, at times suitable to the nurse's lifestyle, and differential pay rates offered to nurses with postgraduate qualifications. For example, it is common for nurses with critical care qualifications to be paid at grade 4 or 5 level, and some agencies augment pay with enticements such as loyalty reward programs and professional development courses. Although attempts have been made to contain differential pay rates through preferred provider contract arrangements, and despite widespread concern over the sustainability of these remuneration levels, it appears that the current structure continues to flourish in what has become a sellers' market.

It was also reported through both the hospital submissions and the nurse forums that the increase in use of agency nurses has been largely due to an inability of hospitals to recruit nurses to permanent positions.

Department of Human Services figures indicated that agency nurses (nurses working for an agency as their principal form of employment) comprised 3.5 % of the Division 1 nursing workforce, while a further 14% worked for agencies as a second or third means of employment. In total 7,133 working Division 1 nurses were estimated to engage in some form of agency work (Department of Human Services 1999²). The workforce percentages are similar for nurses in Divisions 2 and 3.

As indicated in Chapter 3, there are a number of problems associated with the employment of agency nurses. An individual agency nurse's level of competence is not necessarily known when attending a shift and the nurse in charge is likely to allocate the less acute or complex patients to the agency nurse. As Snell (1997) notes, 'such staff are, in most cases, competent but their skills may not always match those of permanent staff, particularly if they are working in an area they are not totally familiar with'. As a result, permanent staff will be required to nurse patients on an ongoing basis, again causing increased pressure and stress on those staff. This is further supported by research that identifies the problem that, on most occasions, agencies are unable to supply a nurse who is adequately experienced and

appropriately qualified to fill the vacancy (ACNMI et al. 1999), which has resulted in further stress for permanent staff. In addition, agency nurses are often only present for one shift and the permanent staff report that they shoulder more responsibility for ensuring that there is continuity of care from one shift to another, as well as responsibility for orientation and supervision of agency nurses.

The use of permanent staff adds to the level of continuity of care and reduces the stresses on other nurses in the ward/unit for the reasons outlined above. However, what is unknown is whether nurses will return to permanent positions if workload is ameliorated and working conditions made more attractive. Agency nurses have had a role in the health care industry for the cover of unplanned leave of permanent staff but it is now suggested that they are being used to fill EFT vacancies, as hospitals are pressured to keep beds open due to casemix funding imperatives. By recruiting permanent nurses, the health care industry will reduce its reliance on agency nurses, so that they will be used to cover ad hoc or unplanned absences only. It is hypothesised that, as a result, permanent staff satisfaction will be increased and a reduction in the attrition rate of permanent staff may be achieved. Further, as permanent positions are filled, the need for agency nurses reduces and the attractiveness of agency work as the principle source of employment diminishes.

It can be anticipated that minimising agency use will offer significant financial benefits for hospitals. It is difficult to calculate the cost to hospitals of employing agency nurses in place of permanent workers. A complicating factor is that charges to hospitals by agencies do not only reflect staff replacement, but also on costs and the cost of differential payment rates for certificated staff. For example, one major metropolitan hospital reported that it has to budget 60% on costs for agency staff. Nonetheless, significant savings could be anticipated as more permanent staff are employed. This strategy for recruitment and retention of permanent staff will be effective only if adequate funding is provided for permanent staff, full-time employment is encouraged as appropriate (particularly in some rural areas), and the procedures for filling

vacancies are streamlined within health care facilities.

Recommendation 53: That health care facilities ensure that:

- Strategies are being implemented to employ nurses on a permanent basis to fill permanent vacancies.
- Recruitment procedures for replacement of permanent positions are developed to ensure that such vacancies are filled within eight weeks of notice of resignation.
- Use of agency nurses is restricted to unplanned absences only.

Recommendation 54: That the Department of Human Services monitors statewide trends in agency usage in the public health care industry on a quarterly basis.

Recommendation 55: That casemix funding be adjusted so that hospital funding is sufficient to ensure that ward/unit budgets and permanent staffing profiles include provision for leave relief such as annual leave and ADOs.

6.1.3.2 Nurse Bank Models

Most hospitals have at one time operated nurse banks. Bank nurses are employees of a hospital, employed on a casual basis only, unlike 'pool' nurses who are offered regular work. The nurses notify the hospital when they are available and as vacancies in rosters exist, they are 'booked' for those shifts. It was reported that many have allowed their banks to lapse in favour of contract arrangements with nursing agencies.

There are advantages to operating a nurse bank. As bank staff are employees of the health care facility, they have usually undertaken an orientation program and are conversant with hospital policies and procedures. Over time they also become familiar with the different wards or units and require less orientation when commencing a shift. They are known by the permanent staff and are more likely to develop a sense of organisational loyalty.

A further advantage of the bank system to the casual nurse is that they are able to access services offered to permanent staff, such as professional development and continuing

education activities. Submissions before the Committee highlighted the importance of continuing education to casual nurses as a recruitment and retention strategy.

One disadvantage of the nurse bank is that the shifts available might not suit the nurse, while the agency nurse has access to a greater number of health care facilities and can experience clinical work in hours that suit. However, it could be argued that the advantages of the nurse bank outweigh these disadvantages.

In summary, the Committee sees nurse banks as a way of meeting ad hoc staffing needs with nurses whose experience and qualifications are known and who are familiar with the ward/unit and type of nursing required.

Recommendation 56: That health facilities are encouraged to (re)establish Nurse Banks to meet the ad hoc staffing needs of the facility and that these nurses have access to the ongoing education program of the facility.

6.1.4 The Working Environment

6.1.4.1 Physical and Verbal Abuse

Nursing is recognised internationally as a discipline that exposes workers to occupational violence. A UK study showed that nearly 33% of all nurses surveyed had been violently attacked or abused by patients or by friends or relatives of patients (Trade Union Congress 1999). In Sweden occupational violence against nurses is described as commonplace (Arnetz, Arnetz & Soderman 1998). In Australia, the Australian Institute of Criminology has reported that the health industry is the most violent in Australia (Perrone 1999). It should be noted that while the incidence of violence against nurses appears to be rising, it is estimated that such violence remains seriously under-reported (International Council of Nurses 1999).

Physical, psychological and verbal violence perpetrated against nurses by clients and their relatives is subject to sanctions under common law, as well as occupational health and safety and equal opportunity legislation. It is also the subject of active campaigns by many State industrial bodies and statutory authorities.

The Committee notes that work is currently being undertaken by Victorian Workcover Authority and the ANF to address the issue of violence directed at nurses from clients and their families. The Committee also notes that Victorian occupational health and safety legislation places a clear responsibility on employers to protect staff from workplace violence. However, given the current level of estimated under-reporting of workplace violence and the clear relationship between violence and attrition (Hastie 2000), the Committee proposes that current strategies be reviewed in order to assess whether a formal statewide strategy needs to be adopted.

Recommendation 57: That the Department of Human Services, in conjunction with key stakeholders, evaluates work currently in progress in the health care industry to assess the prevalence and control of workplace violence (physical and verbal) both directed at nurses, and from within nursing, and to consider whether a coordinated statewide campaign is required.

6.1.4.2 Horizontal Violence

Evidence before the Committee suggests that violence in the nursing workplace is not only perpetrated by clients and their families. The specific concept of horizontal violence, and the more diffuse concept of 'workplace culture', has been described as a major cause of nursing attrition and a major barrier to re-entering the workforce. In the quantitative survey of registered non-working nurses, 12% stated that a negative work environment was a reason for not returning to nursing, and in the younger cohort (20–29 years old) 22% of nurses cited this reason (Campbell Research & Consulting 2000, Appendix 3).

It is the Committee's view that it should be acknowledged that horizontal violence is a factor in the attrition of nurses from the Victorian public health care system and that the nursing profession should review and implement strategies to address the endemic workplace culture issues that contribute to horizontal violence.

Horizontal violence has been widely described in recent literature (Hedin 1986) and appears to

have captured the imagination of many nurses working in the public sector. Intra-disciplinary violence cannot be described as a new phenomenon, and there has been a degree of acceptance of nursing 'eating its young' (Spring & Stern 2000). However, there has been a recent recognition of both its impact on individuals and on the health care industry as a whole.

Horizontal violence can be described as a sub-category of harassment and is more insidious in its effect, particularly as its perpetrators may not recognise it as such as it is usually low key, long term and difficult to quantify. It ranges from professional discourtesy (failure to return phone calls and rumour spreading) to professional degradation (ridicule of other's work, negative performance appraisals and condescension) to overt harassment (physical and verbal intimidation). Anecdotal evidence suggests new graduates are particularly prone to such abuse.

Recommendation 58: That the Department of Human Services review of the Graduate Nurse Program addresses the issue of the vulnerability of new graduates to physical and horizontal violence in the workplace.

To healthcare organisations the effects can be increased absenteeism, displacement, reduced productivity and efficiency, poor industrial relations, hasty decision making and increased staff turnover (Irish Health & Safety Authority 1998). British research (Quine 1999) has shown that nurses subject to horizontal violence have statistically significant lower levels of job satisfaction and higher levels of job induced stress, depression, anxiety and intention to leave the job. The research concludes that bullying is a serious problem and that systems for supporting staff and dealing with interpersonal conflict may have benefits for employers and staff alike.

The Committee notes that several hospitals have in place formal counselling services for nurses, predominantly for critical incident debriefing. The Committee's attention was drawn to the counselling service offered to Peninsula Healthcare staff and the critical incident protocols adopted by the Early Psychosis Intervention Centre as good examples of such services.

Recommendation 59: That provision of formal *independent* counselling for victims of bullying and interpersonal conflict, be available for all nurses working in the public system. In addition the Committee recommends that all nurses working in the public system have access to critical incident debriefing services.

Recommendation 60: That the Department of Human Services, in conjunction with key stakeholders (which should include relevant industrial and professional bodies, as well as human resources professionals and the Victorian Workcover Authority), establish a review of workplace culture with the aim of ensuring that each health care facility has in place a formal mechanism for dealing with workplace bullying.

The Committee believes that measurement of staff satisfaction is an important indicator of organisational difficulties or success, and will assist in the evaluation of the effectiveness of many of the strategies put forward in this report. Staff satisfaction surveys are commonly used in private enterprise and the public service to monitor organisational climate and workplace attitudes on an ongoing basis, and the Committee proposes that such an approach be undertaken with the nursing workforce.

Recommendation 61: That the Department of Human Services encourages all publicly funded agencies to undertake an appropriately recognised and validated staff satisfaction survey on a regular basis, and that these agencies demonstrate to the Department of Human Services changes they have initiated as a result of survey findings.

6.1.4.3 Equipment

Working conditions are made more difficult and inefficient when adequate equipment is not provided. Several hospitals reported a lack of equipment ranging from major items such as ventilators, to pillows and sphygmomanometers, to consumables such as syringes. Such a situation is unacceptable. It is incumbent upon management to ensure that the nurses have all the equipment necessary to provide not only safe, but also quality nursing

care and to do so in an efficient manner. It is also a Department of Human Services responsibility to ensure that available funds are expended wisely in relation to the total hospital equipment budget.

Recommendation 62: That all hospitals review their budget allocations for medical consumables and equipment for nursing care and where the budget is inadequate, in order to avoid the inefficiencies of practice that results from such inadequacies, to request that the Department of Human Services consider additional finances to restore and maintain medical consumables and equipment level.

6.1.5 The Nurse Friendly Workplace

6.1.5.1 Child Care

Evidence before the Committee from unregistered nurses and registered non-working nurses has highlighted the issue of child care as a major factor influencing whether to remain in the workforce. The Committee was granted access to internal research from a major metropolitan teaching hospital where staff were canvassed on their child care use and needs. The majority of staff were reported as happy with their current child care arrangements, and those unhappy with current child care arrangements had predominantly preschool children. The report indicated:

- 64% of nurses using child care reported sickness of a child as the principal reason for work absence.
- Around half the nurses surveyed felt their work had been affected by child care problems of other staff.
- 70% would return to work earlier from maternity/paternity leave if employer provided child care were available.

Evidence from forums suggests that while mainstream child care services are routinely used by nurses, there are major problems encountered when a child is sick, during school holidays and outside of office hours. In addition, the inflexible pre-booking approach of some child care facilities negates the ability of some nurses to offer short notice workplace flexibility.

The Committee, in common with the findings of other States, views the issue of appropriate

and flexible child care as a key factor in attracting and retaining nurses.

Recommendation 63: That the Department of Human Services, as a matter of urgency, undertakes a review of nurses' child care needs across all sections of the nursing workforce, with a view to formulating a strategy to best meet assessed needs.

6.1.5.2 Other Incentives

Other issues that have been raised through the focus groups and forums as incentives for nurses to return to nursing and or to work at particular hospitals are:

- Car parking—increased availability and at lower cost.
- Incentive schemes—such as private health cover, access to fitness training and on site health care.
- Counselling services.

The Committee has made no recommendations for these areas as it will depend on local circumstances and individual assessments by hospitals as to whether these would be useful incentives

6.1.6. Support for Rural Nursing Practice

As outlined in section 3.8, submissions from the rural sector highlighted major concerns about isolation, deskilling and support.

Submissions to the Committee offered specific suggestions to address some of the problems attracting nurses to rural areas. They included:

- Exploring State-funded scholarships for rural students to undertake the Bachelor of Nursing course, with an expectation of their returning to the local area for a graduate nurse year.
- Offering work experience (as personal care attendants) to undergraduate students in the local area during university vacations.
- Exploring payment options, such as assistance with living expenses and relocation expenses.
- Considering bonus payments (such as \$1000 at the end of each year of service) to all nurses working in a regional and rural setting.
- Using low cost hospital-owned accommodation where available.

The Committee noted that many of these initiatives paralleled existing schemes already in place for medical practitioners and funded by the Commonwealth Government.

Isolation was also frequently cited as an issue affecting the rural nurse workforce. Some submissions drew attention to the lack of supporting networks and access to peer review for their nurses. Given that all rural and regional health facilities are associated with a Regional Department of Human Services Office, it is essential that the needs of the isolated nurse and the sole practitioner are considered carefully and strategies put in place to provide support and peer review.

Sole rural practitioners are frequently on call in addition to their normal weekly working hours. This has the capacity to cause stress and the inability to plan for and enjoy leisure time, with the consequent risk of burnout. In addition, there were several submissions indicating the difficulties in providing relief or leave for the sole practitioner, particularly in areas where there are no nurse banks or agencies. One suggestion to the Committee was to introduce locum nurse banks in a similar manner to the GP locum relief service. To achieve this, it would be necessary to develop a successful marketing strategy to promote the concept of a locum nurse bank and to provide incentives, such as travelling time, accommodation and education opportunities, to assist recruitment. Such an initiative would need to be formally evaluated and the outcomes of the evaluation reported to the Department of Human Services, so that best practice can be encouraged and implemented more widely as appropriate.

In both mental health and general community nursing, there are safety issues associated with the sole practice in rural areas. Having to travel distances on unmade roads and pass through 'black spots' in telecommunication services create unnecessary risks for the nurse. The risk is heightened where suitable transportation (four-wheel drives) and telecommunications devices (two-way radios) are not available. It is important that appropriate equipment is supplied and that, where possible, two nurses attend calls in places of risk. Similar risks apply to nurses who are alone in places such as emergency departments in rural and regional

areas. The Committee believes it is essential that adequate security equipment and personnel support are provided in places where nurses may be at risk.

Recommendation 64: That Department of Human Services, in conjunction with its regional offices, establishes work groups of relevant stakeholders to:

- **Develop strategies to provide support and peer review opportunities for nurses in rural hospitals.**
- **Explore the establishment of a locum nurse bank in rural areas where relieving nurses are not available and develop marketing strategies and an incentive scheme for the bank.**
- **Examine the security risks for nurses working in both the hospital and community in rural regions and develop a statewide policy with strategies such as training programs, use of two staff where appropriate, suitable vehicles, telecommunication devices and safety equipment and personnel for security management and risk minimisation**

Policy and strategy implementation and their outcomes to be reported to Department of Human Services Nurse Policy Branch.

6.1.6.1 Rural Mental Health and Community Safety Issues

It has been reported to the Committee that, under some circumstances, mental health nurses in rural areas are at times required to practice in an unsafe manner in order to compensate for low staff numbers. For example, in addition to the safety issues outlined above, it was reported that mental state examinations to assess, amongst other things, danger to self or others, are being performed by solo practitioners. Such practices put the client, the nurse and the community at risk and the industry standard deems that such practices should be explicitly prohibited (Department of Human Services 1994). Standard operating procedure for CAT teams direct that all new assessments, and any assessment where there is a possibility of danger, are to be carried out by two practitioners. Assessments where a danger is identified are usually performed in a secure environment or with police presence. While the Committee has no evidence to indicate such practices are

widespread, it is of considerable concern that reports of such practices occur at all.

Another example of inappropriate cost control measures impacting on retention of nurses reported to the Committee relates to the classification of some community positions in rural services. It has been argued that the profiles of some community teams in rural areas are at a lower level than their metropolitan counterparts. In community-based mental health services the entry level positions are graded at RPN3, more senior clinical positions at RPN4. Teams that have a greater crisis assessment function have a higher loading of RPN 4s. While the ratio between the RPN3s and 4s vary, it is not uncommon on some CAT teams for the majority of nurses to be RPN 4s. While rural services do not normally have CAT teams, they nevertheless carry out the same crisis assessment functions, usually through an integrated team structure.

The issue brought before the Committee is that these situations create disincentives to work in rural settings. As with the issue of solo visits in dangerous circumstances, it is difficult to quantify such practices. Again it is thought this problem is not necessarily widespread, however it has been brought before Committee in the context of retention issues.

It could be argued, in the context of many rural practitioners working in isolated environments in a manner not dissimilar to that of a sole practitioner, that such classifications be higher than their metropolitan counterparts.

Recommendation 65: That regional and rural health facilities ensure that classification structures in rural areas adequately reflect the levels of responsibility associated with the isolated environment in which nurses practice and is on no less than comparative services/functions in the metropolitan areas.

6.2 Working Conditions

6.2.1 Clinical Career Structure

The following section examines the issues surrounding the current CNS position, the limitations of the CNC position and the need for a progressive career path for the CNS who is at advanced and expert level.

6.2.1.1 Clinical Nurse Specialist (CNS)

History of the CNS Position in Victoria

The position of CNS was established in Victoria with the advent of the nurses' career structure, defined in clause 3 (aa) of the *Nurses (Victorian Health Services) Award, 1992*. The award definition of the CNS is:

A registered nurse appointed to the grade with either specific postbasic qualifications and 12 months experience working in the clinical area of his/her specific post basic qualification and is responsible for clinical nursing duties; or minimum of four years post registration experience, including three years' experience in the relevant specialist field.

The aim in creating the position was to retain experienced clinical nurses at the bedside, within their area of clinical expertise. The position was introduced as a 1989 amendment to the *Registered Nurses Professional Pay Rates Award 1988* which saw the abolition of the qualification allowance. Criteria for the position were trialled in four Victorian hospitals and, until the implementation of the CNS position in March 1990, qualification allowance rates continued to be paid to grade 2 registered nurses (*Health Department of Victoria Circular, March 1990*). The rates of pay were set at a level between the highest grade 2 classification (grade 2 year 6) and grade 3A year 1. Funding was allocated in line with the professional pay rates agreement, but the difference in pay between the grade 2 positions and that of CNS was funded directly by the then Department of Health and Community Services (DH&CS) as, unlike other positions in the career structure, there were no designated numbers. The position was designated one of personal appointment, not incremental progression and applicants were assessed according to guidelines agreed to by the DH&CS and Victorian ANF.

The guidelines indicated the details of the definition and outlined a process for application, interview, notification, appeal mechanisms and ongoing applications. It did not specify criteria other than those implied by the definition. An applications package was developed as a result of the trial of the criteria

and was intended to have widespread application across the State. With separate funding, the appointment of a CNS position was not a budget consideration and, therefore, it was relatively easy for nurses to access this position.

Following the introduction of the casemix funding formula, the CNS position was absorbed into the budget allocation and was no longer funded as a separate entity. Since then, many health care facilities have introduced their own tailor-made criteria that are applied in addition to the award definition. Information before the Committee indicates that, in many instances, appointment to CNS positions has been difficult, even when the award criteria are met. Conversely, some health care facilities have used the CNS position as a tool to retain experienced nurses in specialist areas, such as critical care. Thus across the State, the ability to gain access to the CNS position is not equitable and the eligibility criteria vary markedly between health care facilities.

The current CNS position rewards those nurses with experience and qualifications who want to stay at the bedside. It has been used as a successful strategy by some hospitals for retaining such nurses at the bedside, especially in critical care nursing. The Committee views the CNS position as an important strategy to retain qualified experienced nurses in the workplace. As a matter of urgency, health care facilities need to accept the principle that this position does offer value and status to qualified and experienced nurses, and therefore should be used widely as a retention strategy.

Recommendation 66: That the CNS position at Grade 2 year 7 be maintained in the health care sector and be used as a strategy for retaining experienced, qualified nurses at the bedside.

6.2.1.2 Criteria for CNS Position

At present, the criteria used to appoint nurses to the CNS position vary across the Victoria. As previously described, there were a set of criteria piloted in four hospitals, but not subsequently adopted across the State. The criteria for application reflect the expectations of the position. During the open consultation forums, a theme that emerged frequently was the

demands that management placed on the CNS. For many, there was an expectation that the CNS would provide not only clinical leadership and teaching, but also undertake research and project activities, often in their own time. Further, they had to demonstrate a level of personal continuing education not required of other nurses. One CNS indicated that he had given up the CNS position and reverted to his former grade 2 position because of the unrealistic demands of management. The Committee considers that this may be a not uncommon situation. Others expressed the view that they did not even consider applying for the position, as both the selection criteria and the application process were too demanding.

A selection of the criteria currently being used in NSW and Victorian metropolitan (major and non-major) and regional hospitals was collected by the Committee and analysed. The criteria vary widely in terms of function, and all include the requirement for the CNS to act as role model for clinical practice. All but one includes a preceptor and/or mentorship role, particularly for graduate year nurses. Half the Victorian sample set the level higher than that expected of other grade 2 nurses, while the remainder set the level at that of expert, and an expert recognised as such by colleagues (a criterion used by Benner [1984] in her definition of the highest level of clinical practice). One hospital used the 'higher' and 'expert' labels, another 'higher' and 'complex' and another both 'advanced' and 'expert'. One used 'advanced' only. Clearly there is variation in the criteria applied to the level at which the CNS should operate: over half the sample consider it to be at the level of expert, but of those hospitals, only one had a criterion relating to a resource function, and none emphasised the leadership role.

In terms of the demonstration of commitment to the specialty, the hospital and the profession, all included a criterion for involvement in quality improvement projects, while half also specified involvement in research projects. All but one of the sample had a criterion relating to involvement in teaching, even specifying the number of sessions that the CNS should be involved in (the range was one to four where specified).

Two of the sample required the CNS to contribute to conferences or forums, with one requiring a paper to be delivered. Four hospitals expected the CNS to demonstrate how their own professional development was progressing and six expected the CNS to belong to a professional organisation.

Four of the hospitals included other criteria: membership of the occupational health and safety committee (1), demonstrating hospital values (2), assisting the NUM (1), involvement in critical incident documentation (1), meeting budget targets (1), orientation of staff (3), and assuming management in the absence of the NUM (1). One hospital specified that a CNS should mainly be appointed in an area where a medical specialist was involved.

The application and selection process in the sample varied; in some instances it was relatively simple while in others extremely complex. In some instances, the requirements for the CNS were in excess of those of other nurses, particularly in relation to demonstration of continuing competency and performance assessment.

The Committee recommends that a range of criteria are adopted and that hospitals publish their own set of criteria that meet their specific needs, but which are consistent with the general principles outlined below.

Recommendation 67:

a. That for candidates applying for CNS positions, hospitals adopt the following general principles:

- **Recognition of the Registered Nurses (Victorian Health Services) Award 1992 definition.**
- **Level of clinical practice reflects the level of remuneration i.e. higher level of skill than would be expected of other grade 2 nurses but less than grade 3 positions.**
- **The primary focus of the position is clinical.**
- **Criteria for CNS must be achievable in normal paid rostered hours.**
- **Criteria for performance review processes be consistent with the review process of all nurses in the facility.**
- **Publish criteria for the CNS position.**

b. Applicants must show a commitment to development of area of specialty, their own development and the hospital in which they are employed and must demonstrate one of criterion in each of the three sections.

Clinical Skill

- Higher levels of skill demonstrated in clinical decision making, in particular in problem identification and solution, and analysis and interpretation of clinical data.
- Maintenance and improvement of clinical standards.

Professional Behaviour

- Positive role modelling.
- Act as mentor or preceptor to less experienced nurses, including graduate nurses.
- Support of, and contribution to, quality improvement and research projects within the area of practice and ward/unit.
- Acting as a resource person to others in relation to clinical practice.

Professional Development

- Membership of relevant professional body.
- Contribution to the education of other professionals e.g. being willing to provide at least one in-service education program each year.
- Undertaking own planned professional development and competence through various forms of continuing education, such as conferences, study days, formal study, reading.

c. Department of Human Services to review all criteria and ensure statewide consistency of application of criteria.

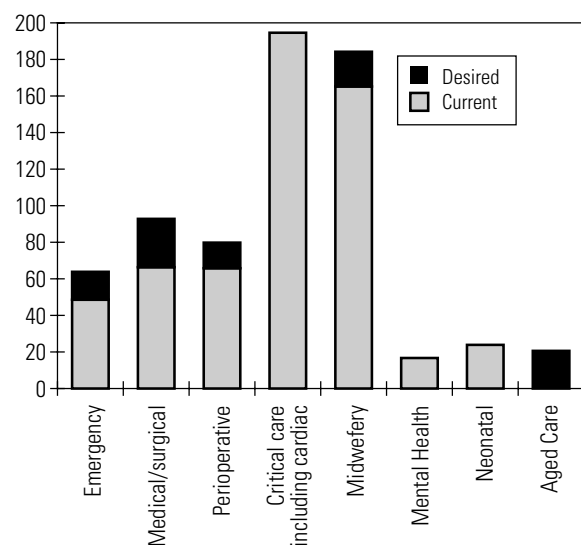
6.2.1.3 Funding

Currently there are 1,185 full-time equivalent CNS positions in the public health sector in Victoria, which account for 15.6% of all grade 2 positions. A number of submissions before the Committee indicated the difficulties in funding the number of grade 2 positions eligible according to the Award definition. A survey requesting information on the additional number of CNS positions that health care services would require if funding were

available yielded a figure of 170.16 EFT (64% response rate).

The current distribution of these places is of interest (Figure 7). The majority of the current places are in critical care (including cardiac care) and midwifery. In critical care, some hospitals have been using this classification as a retention strategy and none of the facilities sampled argue the need for additional places in this area. However, in other areas of identified need, such as emergency, medical/surgical and perioperative nursing and midwifery, more places were required. Of particular interest was the aged care sector. In the sample surveyed there were no CNS classifications, but a need was established for 20.6 EFT classifications. Likewise, there appeared to be few mental health classifications and these were considered sufficient. However, given that mental health nurses enjoy a better clinical career structure than general nurses, this is not a surprising finding.

Figure 7: Distribution of CNS Classifications Currently and Desired if Funding Were Available



It appears that the number of CNS positions currently available would be increased if more funding were available. The issue of funding needs to be addressed, as the casemix funding formula does not currently meet the demands for CNS positions. Therefore, in the short term, the Committee argues that additional funding needs to be provided to meet the immediate shortfall of CNS positions. More data needs to be collected to establish what is a realistic and desirable level of CNS positions in the public

health sector, preferably prior to the end of 2000. In the meantime, a review of casemix funding is required to ensure that it does allow for adequate funding for the CNS contribution to patient care, and in adequate numbers.

Data also need to be collected to establish what is a realistic number of places required. This data should be collected by April 2001 to ensure that the baseline is taken into consideration for the 2001–2002 budget.

Recommendation 68: That as a matter of urgency Department of Human Services requests that facilities indicate the number of CNS positions that are needed for the implementation of Recommendation 67 above. That the Department collects data regarding the number of CNS positions in the public sector, following implementation of this recommendation, and uses this number as a baseline for the funding of CNS positions across the public sector.

Recommendation 69: That Department of Human Services recommends a mechanism to ensure that adequate funding is provided for the CNS classifications according to the baseline figures as established in recommendation 68 above, for the 2001–2002 financial year and beyond.

If the CNS position is to be used as a strategy for retaining experienced, qualified nurses in the workforce, then implementation of the above recommendations is required as a matter of urgency.

Costing

As indicated above, when the concept was first introduced, in the pre-casemix era, the CNS classifications were funded separately. The classification is now a matter of budget allocation.

As the casemix funding formula does not currently meet the demands for CNS positions, additional short term funding needs to be provided to meet the immediate shortfall of CNS classifications. On the figures extrapolated from the survey, it is calculated that a total of 260 EFT new CNS positions would be required as a retention strategy. As the majority of these would already be classified as grade 2, their introduction would require only the salary

difference between the present grade 2 classification and CNS. On current salaries the difference between the mid-range of grade 2 year 3 and CNS is \$172.00 per week. A full year effect of this additional number of CNS positions would be in the vicinity of \$3.32 million.

6.2.1.4 Title of Clinical Nurse Specialist

There is some ambiguity about the title 'Clinical Nurse Specialist'. The definition used in Victoria was consistent with that of NSW, with the exception that the latter specifies that the CNS must 'satisfy the local criteria' (*Public Hospitals Nurses' [State] Award NSW, 1997*).

These definitions are not consistent with the title as used in the international literature (emanating predominantly from the USA and the UK). Castledine (1995) summarised the role of the CNS in the UK as:

a nurse who is able to demonstrate higher levels of clinical decision making, able to monitor and improve standards of care, through supervision of practice; clinical audit; the procession of professional leadership and the development of practice through research, teaching and the support of professional colleagues (p. 265).

Castledine also indicated that the CNS's work with patients must be 'systematic, reflective, analytical, innovative and dynamic'. The overseas literature addresses the issues associated with the terms 'clinical nurse specialist', 'advanced practice nurse', 'nurse practitioner' and 'expert nurse' (Castledine 1995). In a recent article on specialisation in the Australian context, Fairweather & Gardner (2000) highlight the semantic ambiguity of terms by demonstrating that the ANF (1996) definition of 'advanced' level equated with the UK 'specialist' level and that the Australian 'expert' level shared some characteristics of the UK 'advanced level'. There is no equivalent of the Victorian CNS in the overseas literature.

Australian specialist nurses were asked to reflect on their specialist practice in focus groups. Two distinct concepts emerged from the groups: the 'nursing-in-a-specialty' and the 'specialist nurse'. The former more closely resembled the Victorian CNS role. Of interest was the observation that not all nurses working

in a specialty would become specialist nurses simply through working in the area (Fairweather & Gardner (2000), p.31). The specialist nurse was closer to the advanced practice nurses described by Casteldine in the UK.

There is no doubt that the current Victorian CNS position does not reflect the common interpretation of the role. While it does reflect some expertise in practice, it does not capture the advanced level of specialty, nor is it appropriate that advanced practice be rewarded at this level. In order to avoid the ambiguity of title, the Committee recommends that the title be changed to 'Senior Clinical Nurse'. This would be consistent with other health disciplines, where progression according to specified criteria give recognition and status according to qualifications and experience, but do not require advanced levels of practice.

Recommendation 70: That the parties respondent to the *Registered Nurses (Victorian Health Services) Award 1992* work towards a consent award variation, whereby the title CNS be changed to Senior Clinical Nurse (SCN) to more accurately reflect the expectations of the position.

Introduction of CNS within the Extended Career Path

Thus with the development of criteria and change of title, recognition is given to those experienced, qualified nurses and their work is valued by both monetary reward and status. However, the issue is raised as to the long term effectiveness of this position as a retention strategy.

Several written and verbal submissions before the Committee identified three issues associated with the CNS as part of the current career structure. Firstly, the use of the term 'experience' in the definition. As Fairweather & Gardner (2000) stated, specialists need not necessarily develop 'just by working in the area' (p.31). The part of the existing Award definition placing time limits on experience needs to be reviewed in the light of the changes that have occurred in nursing practice since 1992. Secondly, as outlined above, the CNS role needs to be examined against specialist and advanced practice, concepts that have been

continually developing over recent years. The third issue to emerge, particularly through the forums, is the need for ongoing recognition of the CNS position. The Committee has learnt that the common practice is for annual re-application for the position, and there appears to be no transportability of the position across hospitals. The issue of transportability, as well as increments, needs to be examined to assist a long term retention strategy.

The criteria developed above reflect a particular role defined for the CNS. In 1997, NSW reviewed the CNS position and concluded that the classification should be maintained, but to update and clarify the role description to reflect contemporary practice (*NSW Health Department Circular, 28th February 1997*). Strangely, the role of the CNS was described as 'performing (identified functions) at an advanced level competently and consistently'. The criteria set by NSW are at a higher level than the Victorian criteria proposed previously.

South Australia is currently undertaking a review of its career structure with more avenues for the CNS, where progression is based on increased skill and competence, not experience. It has also included the nurse practitioner in its career structure.

The career structure of Victorian mental health nurses already includes the equivalent of the SCN and CNS, and offers clear clinical progression (*Registered Psychiatric Nurses Classification Standards 1997*).

Victoria has not reviewed the CNS position since its inception, nor has it addressed the issue of advanced and expert practice.

The Committee believes it is time for a revision of the clinical career pathway. The pathway, and its associated remuneration bands, needs to recognise the clinical contribution of the current CNC and CNS and to offer a path that will continue to reward the higher levels of clinical expertise developed by clinical nurses, expertise that adds considerably to the quality of care. The CNS, at advanced and expert levels of practice, needs recognition at grades 3 and 4 with the appropriate remuneration. In addition, the career structure should build in a requirement for qualifications in order to practise at these higher levels.

Under any review, the interface between the clinical specialist and consultant and the evolving roles of Clinical Chairs needs to be recognised and articulated. The current CNC descriptions are ambiguous and confuse the roles of specialist and consultant. This review must ensure that the profession 'owns' the new structure if it is to be successfully implemented and should have a wide consultation process built into it.

Recommendation 71: That VHIA, ANF and the Department of Human Services develop a CNS stream within the Registered Nurse Award which ensures that there are CNS positions at grades 2, 3 and 4, and that the definition of the responsibilities of the Grade 3 and 4 be completed by the end of 2001.

Costing

At this stage, the number of those eligible for promotion to grades 3 and 4 is unknown. Working on the assumption that around half would be suitable, the amount of funding required would be based on the difference between the CNS salary and that of a nurse at grade 3A (\$10.00 per week), 3B (\$43.80 per week) 4A (\$89.70) and 4B (\$138.2). If the base of CNS were established at 1,450 EFT, assuming that half would be eligible for such a progression, initially to grade 3 year one, the additional finding required would be between \$0.37 and \$1.6 million in the first full year, with increments each year thereafter through both grades 3 and 4.

It is anticipated that the initial cost of increasing the number of CNS positions to more accurately reflect the current level of experience and qualifications at grade 2 level, and the introduction of CNS positions at grade 3, would require initial funding of \$2.7 to 3.9 million.

Summary

Recognition of experience and qualifications is an essential factor in the recruitment and retention of such nurses to the workforce and the CNS classification is currently being used for this purpose by some health care facilities. The Committee sees this as an important strategy. The CNS classification is one of personal appointment and it is essential that

the principles and criteria for appointment be consistent across the State. The CNS criteria currently relate to the expectations of a nurse at the upper level of grade 2 but there is a need to extend the career path for experienced qualified nurses beyond this level. To this end it is recommended that as a medium term strategy, consideration be given to changing the title of the current CNS to SCN and that a new classification of CNS, which recognises advanced and expert levels of practice, be introduced at grades 3 and 4. In this way, recognition is given to the experienced qualified nurses who have been leaving the profession, which is essential if quality nursing care is to continue to be provided to the people of Victoria.

6.2.2 Clinical Nurse Consultants

The CNC is defined under section (3)(1) of the *Nurses (Victorian Health Services) Award 1992* as:

a registered nurse who is appointed as such to provide a clinical resource, clinical advisory/development role on a full time dedicated basis and undertakes related projects and research and development activities to meet specific nursing needs in one of the following disciplines of infection control, diabetes education, chemotherapy, stomal therapy.

The specialty areas defined in the Award reflected the clinical nursing environment in 1992. Since that time there has been great diversity in clinical specialisation. NSW has addressed this issue by naming the various specialties in which nurses currently practice. However, identification of specialties does not allow for future diversification and the Committee argues that facilities should have the flexibility to appoint CNCs in areas that are considered necessary for the enhancement of nursing practice, and that restriction on specification of specialist areas removed as a matter of urgency.

Recommendation 72: That in order to ensure an appropriate clinical career path for nurses in Victoria, the parties respondent to the *Registered Nurses (Victorian Health Services) Award 1992* remove the current award provision which

restricts CNCs to chemotherapy, stomal therapy, diabetes education and infection control to ensure that the CNC position can be appointed in any clinical area.

The current definition focuses on consultation, rather than a direct clinical function. The relationship between a specialist with a predominantly direct clinical care role and the consultant role that has wider consultation responsibilities must be considered by the group established in Recommendation 71. The descriptions in the current award for CNC were developed at a time when the CNS, as defined in the literature, was not considered. Therefore, the description appears to be a mixture of both the specialist and consultant role. The two roles need consideration and their responsibilities need careful definition.

The Committee notes that the Government has now endorsed the role of Nurse Practitioner, and that funding has been allocated for the implementation strategy. This role is seen as one that further extends the options for the clinical nurse. It will not only contribute to improved nursing care, but by extending the boundaries of nursing, will act as an incentive for strengthening the image of nursing and retaining experienced, qualified nurses in the workforce.

By considering the career path open to clinical nurses at specialist, consultant and nurse practitioner levels, recognition is given to those nurses who wish to develop at an advanced level of practice and to not only to share their expertise, but develop the profession in an extended role, as the need arises.

6.2.3 Qualifications Allowance

The issues surrounding the qualifications allowance are complex. At their core is a recognition of and reward for the effort required to gain a qualification in an area of practice. The options available for such recognition of reward are a qualifications allowance or the position that professional rates of pay should build in the necessity for qualifications for certain levels of practice and should therefore reward in this way. In addition there is a perceived need for non-monetary reward as well. Those advocating a qualifications allowance consider that

completing a postgraduate qualification relevant to their area of clinical practice will keep qualified experienced nurses at the bedside. However, the survey of nurses registered but not working showed that 48% had completed a formal postgraduate nursing course. Thus, the acquisition of the qualification alone appears not to be sufficient incentive to retain nurses at the bedside. In the section below, the arguments for and against a qualification allowance are presented.

6.2.3.1 The Case for a Qualification Allowance

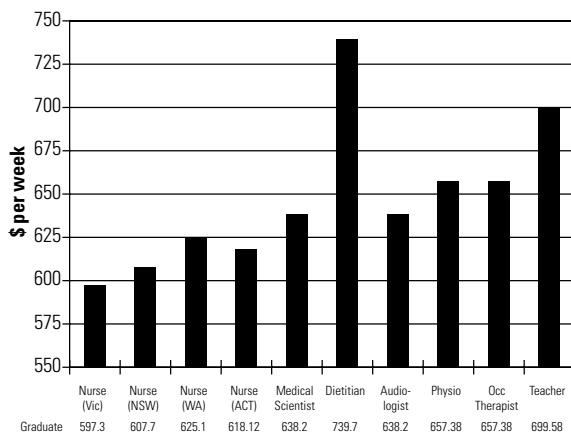
A qualification allowance, paid to nurses who have completed a postgraduate qualification relevant to their area of clinical practice, is viewed by the ANF (Vic Branch) as a strategy that will keep qualified experienced nurses at the bedside. The arguments are based on the history of the qualification allowance for nurses in Victoria, parity with other health professions and the cost of postgraduate education.

Qualification allowance, at 4.5% of the base rate for a certificate and 7% for a diploma (but capped at \$47.50 per week), was paid to Victorian nurses until 1988 when professional rates of pay were introduced into the nurses' award. It is claimed by the ANF (Vic Branch) that nurses were informed at this time that their professional rates of pay would ensure parity with the other health professionals who would also lose their qualification allowance. Currently, the health disciplines still receiving qualification allowance in Victoria are Division 2 Nurses, audiologists, clinical perfusionists, dietitians, pharmacists, medical scientists, speech therapists, occupational therapists and physiotherapists. It is also of interest to note that the current entry salary for nurses is lower than other health professionals who still receive qualification allowance (Figure 8). Currently, no other State or Territory in Australia pays nurses a qualification allowance.

The arguments for the restoration of qualification allowance also relate to the current cost of postgraduate courses. The cost of acquiring postgraduate qualifications has accelerated over recent years. In the 1970s, scholarships were provided for nurses undertaking postgraduate courses at the College of Nursing, Australia. These courses included administration, ward management,

education, public health, operating theatre and critical care. Other clinical courses were offered by the hospitals where the students were also part of the workforce and were thus receiving salary while studying.

Figure 8: Graduate Entry Level Salaries (ANF 2000)



As previously described, during the 1980s there was a gradual transfer of postgraduate education to the higher education sector. The clinical courses were developed largely as result of collaboration between the universities and health facilities. The programs that were offered required the students to reduce to part-time and sometimes to work at a lower grade. Initially places in these courses were funded at the HECS rate. However, reflecting changes in the higher education sector, many became full fee paying places. Data before the Committee shows that currently only 33% are HECS places. The HECS fee is set at \$3,200 and full fees range from \$8,000–10,000. Thus, the students incur two costs, a reduction to part-time employment during the course and the fees—either HECS or full fees. It is, therefore, clear that the cost of postgraduate education has risen over the past two decades.

Those advocating a qualifications allowance see it as a strong motivator for nurses to return to the workforce and to retain those already there. It would reward individual effort, encourage nurses to undertake such qualifications and help offset the cost of the education.

6.2.3.2. The Case against the Qualification Allowance

Doubts are raised as to whether the qualification allowance is a strategy that will

attract and keep nurses at the bedside in the longer term. The arguments against this allowance can be summarised as those relating to equity, cost, career structure and value.

Equity

There are two issues relating to equity—clinical nurses without qualifications, and nurses with qualifications other than clinical.

The major issue addressed by the Committee is the recruitment and retention of experienced, qualified clinical nurses within the Victorian public health sector. The issue of experience versus qualifications is an important one. As described in section 6.2.1, experienced nurses may reach the CNS classification within the award with or without qualifications, and they are rewarded equally. In some cases, the lack of a qualification may be due to the paucity of opportunities for postgraduate study. For example, in the area of acute medical/surgical nursing there is a limited number of courses available (three were offered in 2000), and they tend not to be attractive to nurses. Knowledge and experience may have been acquired through other means, such as short courses, reading and mentoring. In some instances this may have been at considerable cost to the nurse. A qualification allowance would discriminate against those nurses who could demonstrate the competencies of an experienced nurse, but who had not had the opportunity to undertake formal postgraduate qualification or who have acquired the knowledge and skills through other means.

In some disciplines, where qualifications are a prerequisite for a position (as in academia), there is usually a provision for a person without the appropriate qualification to demonstrate the knowledge and skills required for the level—a qualification allowance would not allow for this flexibility.

If the aim of the Committee is to recruit and retain qualified, experienced nurses at the bedside, should the qualification allowance be paid only to clinical nurses? This raises the question of the value of postgraduate qualifications in such areas as management, education and information technology, areas that provide support to experienced qualified nurses at the bedside. The cost to the nurse in

obtaining these qualifications is similar to that of their clinical counterparts. What is the value of these qualifications to the profession? In terms of equity, the qualification allowance should apply to all nurses who have undertaken postgraduate qualifications relevant to their area of practice. Although the primary focus of the Committee is on clinical nurses, consideration should also be given to areas that support the clinical nurse.

Cost of Undertaking Postgraduate Qualifications

As indicated above, there is considerable cost associated with undertaking postgraduate studies. However, there are both HECS and full fee scholarships available for nursing courses, therefore not all nurses have to pay these costs. It is of interest to note that most universities pay the HECS fees for PhD and most Masters by research students, yet the ANF claim suggests a higher qualifications allowance for these qualifications. This rewards the effort and time to undertake such qualifications, but cannot be argued on a financial cost to the nurse basis. An alternative to a qualification allowance would be to ensure that all nurses received assistance with payment of fees through Department of Human Services and health facility scholarships, and that paid study leave be provided while undertaking postgraduate courses. If the qualifications allowance were to be introduced the question should be asked as to whether it is appropriate to divert the monies currently allocated as scholarships to the qualifications allowance, given that a major argument for the qualifications allowance is the cost of the education.

6.2.3.3 Qualification Allowance and Career Structure

A view strongly expressed by the nurses at the forums was the need for recognition of qualifications. The only reward being offered to the nurses was the qualifications allowance. As the alternative of a clinical career structure was not put, the strength for a qualifications allowance is understandable.

Currently, any nurse who undertakes a postgraduate course in a clinical area has the opportunity to apply for the CNS position

when s/he meets the criteria. As indicated above, the definition for this position stipulates both 'postbasic' [*sic*] qualifications and two years experience, or four years experience in the relevant area. Thus, in theory, under the current award the qualified and experienced nurse could attain a higher pay level in two years less than the unqualified experienced nurse. A qualification allowance would further reward those who have undertaken a course but, as indicated above, would not reward those who were unable to do so and who have acquired their competence in other ways.

As was indicated above, there are no further increments for the CNS; it is a personal appointment to one pay point, currently \$70.80 per week more than the highest Grade 2 level. As is argued in section 6.2.1.4, there is a need to recognise the advanced and expert levels of clinical practice by extending the clinical career pathway to grades 3 and 4. Practice at advanced and expert level requires the nurse to demonstrate certain competencies, and qualifications are necessary for such positions. Thus, as suggested earlier, there should be recognition of the advanced and expert clinical specialist with rewards up to grades 3 and 4 and a process established for recognition of qualifications in these positions. In this way, recognition would be given for individual effort and expense associated with the acquisition of a qualification. It would also reward the clinical nurse who wants to remain at the bedside providing a high level of quality care and clinical leadership. Although not all qualified nurses may reach these levels, it would, nonetheless, provide a clear incentive for clinical nurses to remain at the bedside. The reward of incremental progression may have a better chance of keeping qualified experienced nurses at the bedside than qualifications allowance and one pay point. Even if increments were introduced to the grade 2 level, this would not be sufficient to keep the nurse at the bedside in the longer term.

Value of Clinical Role

Another strong theme emanating from the nurses who attended the forums was that their qualifications and expertise be valued not only in a monetary way, but also in less tangible ways. Suggestions given were:

- Input into decision making in the clinical area.
- Respect for their position by management (both nursing and general) and by other health professionals.
- Time to teach, undertake research and be involved in the professional development of other nurses in the unit.
- Time for personal ongoing education.
- Control over personal workload and conditions of work.

Conclusion

Within the Committee there was considerable debate over the issue of qualification allowance. Overall, the arguments were not in favour of a qualification allowance. The issues associated with the current need for a qualification allowance were addressed through the following means. Firstly there was agreement that there should be financial assistance given to nurses undertaking postgraduate courses, as the cost was prohibitive. As indicated in Chapter 5, this cost was given as a reason why not all postgraduate places were filled in 2000.

Secondly there was agreement that the career structure should be changed to allow for progression of a CNS to grades 3 and 4. With this change the qualification allowance would no longer be an issue, as higher salaries and status would offset the cost of such education and also demonstrate clearly the value and recognition that was given to the experienced, qualified clinical nurse. It would also give a longer career pathway. Clearly, a mechanism needs to be established for recognition of qualifications at these levels.

Such a process will take time. Given the debate about a qualification allowance, an interim measure could be introduced to allow the payment of a qualification allowance, until the career structure mechanism is implemented. There was debate in the Retention sub-committee as to the form that such an interim measure should take. Two forms were debated, a bonus payment for one year, paid on a fortnightly basis at \$20 per week (which would mean a bonus payment of around \$1000 per nurse), or the alternative of a payment at a level comparable to other health professionals. The latter option was accepted by the sub-

committee and this option was put to the main Committee (and subsequently accepted).

Recommendation 73: That ANF, HCSUA, VHIA and Department of Human Services establish a suitable mechanism for recognising postgraduate qualifications for nurses within areas of nursing at specific levels within the context of the career structure (the work to be completed by June 2001). Until this mechanism is established and qualifications are recognised in this process, an interim qualifications allowance for nurses should be introduced, similar to that of other health professionals in Victoria for qualifications relevant to the area of current practice.

According to Access Economics, the estimate of nurses with qualifications in the public sector was 11,517. However, the question must be asked as to how many of these qualifications are relevant to the current area of practice. For example, figures from the NBV indicate that only around 25% of midwives who hold this qualification are in current practice. It could therefore be assumed that, with the qualifications allowance restricted to 'qualifications relevant to current practice', the number of eligible recipients would be lower than estimated.

In relation to other health professional groups who currently receive qualifications allowances, Division 2 nurses receive 7.5% for a one-year course and 4% for a six-month course; audiologists, clinical perfusionists, dietitians, pharmacists and medical scientists receive 6.5%; and speech therapists, occupational therapists and physiotherapists receive 7.5%. Thus if the figure of 11,517 were taken, the funding required for a full year effect would be between \$22.7 million and \$24.5 million. However, as indicated above, this is an estimate only as the exact number of potential recipients is not known accurately.

6.2.4. Management

Many nurses, through the various consultative processes, expressed concern about management in the Victorian public health care sector. The Committee considers the effectiveness of nurse managers a critical factor in the recruitment and retention of qualified

nurses in the Victorian public health system. During the progressive restructuring of the public health system in the last decade, the role of the nurse manager has changed as management structures have been generally flattened, with a trend towards erosion of senior level positions and expanded roles at unit level. Unit managers have been given greater budgetary and human resource responsibility while senior nurse managers have commonly lost responsibility for major areas of hospital management.

6.2.4.1 Senior Nurse Management (Grade 7)— Director of Nursing or Chief Nursing Officer

The Committee has heard that the human, capital and fiscal resources have not been sufficient to prevent the situation where unremittingly heavy staff workloads, excessive unpaid overtime, restricted access to education, violent and unsafe workplaces, staff shortages, and the loss of experienced and qualified nurses have become commonplace. The Committee believes it is the responsibility of management to ensure that resources are provided for quality nursing care by experienced, satisfied staff. Fiscal responsibility is essential and the needs of the entire health system must be carefully balanced. However, the aim of any health system is to provide quality care to the community in which it operates. Nurses, which constitute approximately 48% of the public health workforce in Victoria (Department of Human Services Human Resources Branch, March 2000), provide a large proportion of that service.

The erosion of senior nurse manager responsibilities during the restructuring of the Victorian health care system in the 1990s led the Victorian Council of Peak Nursing Organisations (VCOPNO) to issue a position statement to the then Victorian Government on the role of the Director of Nursing in the organisational structure of health services, particularly in relation to budget management (VCOPNO 1997).

There are a number of factors that have contributed to the erosion of the position of nurse manager.

1. The philosophy of some organisations that the generic manager is more effective than one who has experience of the context of the management decisions.

Generic managers are attractive to some organisations because they are perceived to make management decisions with a degree of objectivity, without jeopardising professional loyalties. A counter view is that the nurse manager understands the ways in which the clinical environment is affected by decision making and is more likely to understand the resources required to maintain quality of care and staff satisfaction. However, understanding of the clinical environment alone is not sufficient in the current climate of output-based funding models.

2. Insufficient training/education in modern financial and human resource management techniques of some nurse managers.

Some nurse managers have not had the advantage of education/training to enable them to fully understand modern financial and human resource management issues. This has resulted in the nurse manager either not being directly involved in decisions about resources for nursing, or in making decisions that have shown a lack of understanding and resulted in disadvantage to the nursing workforce. Nurse managers who do possess such knowledge and skills have tended to remain in control of the nursing budget, and have been more successful in achieving the dual aims of quality nursing care in a fiscally responsible climate and high levels of staff satisfaction. One issue brought to the Committee's attention is the tendency of hospitals to manage budgets in the short term to meet specific financial targets, rather than in the longer term. While this is understandable, given the financially precarious state of many hospitals identified in the Ministerial Review of Health Care Networks (Department of Human Services 2000), it has commonly led to a culture of staff attrition which, when resultant recruitment, orientation and agency costs are taken into account, have exacerbated the financial difficulties of many health services.

3. The lack of clear succession policies.

The nurse manager needs to be a mentor to those with whom s/he works. Mentoring and succession planning become difficult when the pool of eligible staff identified for succession diminishes. There is clear evidence that in many facilities, the number of positions at grade 6 and 5 has been reduced. Without a deputy position, succession must be sought from the pool of grade 5 positions that have a management focus. However, after hours supervisors who may not have an interest in a career in management, occupy many of the remaining grade 5 positions in hospitals. Careful attention should be given to this aspect of management.

If nursing management is to be effective in providing the resources necessary for the quality of nursing care that the public is entitled to, then they must have control of the nursing budget and form an essential link in the chain of decision making within the public health facilities. The Committee has heard instances where grade 7 nurse managers (Directors of Nursing) were unable to access information about the budget for the nursing service and were not consulted about budgetary decisions. One submission before the Committee comments that senior nurse managers take on the executive role of dealing with day-to-day issues but are excluded from the high level decision making issues, or are included only as token participants.

American research has demonstrated that when nurse managers are included as decision makers with hospital executives, a range of clinical and human resource indicators show overall benefit to the organisation, particularly improved nurse recruitment and retention rates (Scott, Sochalski & Aiken 1999). The positioning of the nurse leader within the decision making framework of a health care institution is one of the characteristics of the magnet hospital model (see section 2.1.3). In the Australian context, some submissions before the Committee suggest that there is a strong correlation between the management and leadership skills of nurse managers and the health of the hospital, ward or unit team.

Recommendation 74: That the senior nurse manager (however titled) be a member of the hospital executive and have recognised input into resource allocation and utilisation appropriate to the nursing services of the facility.

Little attention has been paid to the education and professional development of nursing managers at top level. There are many postgraduate courses available in financial and human resource management and the Committee believes it is essential in the current climate that nurse managers have such qualifications.

6.2.4.2 Unit Managers

While the role of the top level nurse manager has often been eroded, that of the nurse unit manager (NUM) has been expanded. Devolution of financial and human resources management to the unit level, where the decisions have most impact, is now an accepted part of health system management. The role of the NUM is the lynch pin in any health facility. The workloads, working conditions and morale of the unit depend in large measure on the ability of the NUM, as is the way their management decisions are supported by management at higher levels.

The Committee heard both positive and negative feedback about the NUMs. Where a well educated, caring, committed NUM was in control and was adequately supported by other management, staff were extremely positive. However, the converse was also true and the Committee was told of the difficulty of filling the NUM positions and thus the appointment of nurses who did not have the experience, knowledge and skill to fill the position effectively. The discontent with such NUMs was clear at the forums.

In order to obtain more information on the changing role of the NUM, and to expand further on some of the NUM issues raised in submissions (section 3.10), the Committee convened a representative group of metropolitan and rural unit managers to ascertain their views on the devolution of many management decisions to unit level. The NUMs themselves indicated that the position was a

demanding one. Largely because of the reductions of experienced clinical leaders in the unit, they were required to have a direct clinical role as well as manage the unit and be involved in other professional activities such as quality management projects and research. Some had learned to cope with their workload by allocating 'management days', thus creating an artificial separation in their role.

Most NUMs indicated that they were working excessive unpaid overtime, although they recognised that the position did require some time commitment outside the 'normal' hours. One of the major contributors to excessive workload for NUMs is the lack of administrative support available. In an environment where many clinical units have scant resources allocated to support staff to answer phones, NUMs described the frustrations of routine clerical work such as updating policy and procedures, filing, maintaining an in-tray and answering phones, compounding the already heavy workload.

Those NUMs who were educationally prepared in management and were actively involved in the recruitment and retention issues in the facility were more likely to have established a reasonable workload and skill mix on their unit. They were also more likely to have involved their staff in the unit decisions, to have established clinical leaders and allowed flexible systems such as self-rostering to be adapted to their particular needs. They were also effective in controlling the workloads, particularly through their understanding of the clinical requirements of their unit. They were able to allow time off and reallocate staff when the unit was not busy, and to call in additional staff when workloads increased. For these initiatives, successful NUMs often had support from senior management. These NUMs were also viewed by peers as financially responsible, fighting for more resources where required and with reasoned arguments, yet endeavouring to remain within budgets, without compromising the quality of care. They also considered themselves part of the management team of the facility and had regular contact with other managers.

Such NUMs tended to occupy their position as a result of succession planning, where their

abilities were recognised, and their professional development reflected their chosen career path.

The Committee also heard reports of NUMs who had tried to institute reform in their units but had been stopped by (non-nursing) management.

The Committee considers the role of the NUM to be pivotal in relation to many of the issues that appear to be the cause of discontent and attrition in nursing currently.

As previously indicated, the issue of adequate remuneration for this position was raised frequently as a matter of major frustration. Many NUMs compared their role to management positions in private industry where levels of managerial responsibility were comparable, but where remuneration was not. One issue difficult to resolve is that of the ANUM receiving more than the NUM because the latter commonly work shifts which attract penalty rates, whilst NUMs generally work within core business hours. In a profession where shift work is essential, such issues will remain. A position frequently put before the Committee was that the ANUM position should be redefined and that a deputy unit manager be reintroduced with more clearly defined roles and functions, although there were contrary positions advocating the status quo.

Recommendation 75: That all health care facilities ensure that strategies are in place for succession planning for all levels of nursing management.

Recommendation 76: That nurse managers have input into the budget setting process and have responsibility for its ongoing implementation.

Recommendation 77: That all nurse managers be encouraged to:
(a) Participate on a regular basis in in-service education in general, financial and human resource management.
(b) Pursue postgraduate management and have access to paid study leave.

Submissions from rural and regional facilities drew attention to the difficulty of attracting nurses to become grade 4 NUMs. Several

contributing factors were proposed. Many nurses in rural areas prefer to work on a part-time basis, because of lifestyle factors such as farm commitments (one submission estimated that 80% work part-time). Convention dictates that the NUM position needs to be full-time. While the Committee was made aware of some NUM positions occupied in job sharing arrangements it was put to the Committee, from a variety of sources including the specially convened NUM group, that the position requires a full-time incumbent and should not be offered as a part-time position. However, the Committee is of the view that, in some circumstances, using the principles outlined on 113, job sharing arrangements are appropriate for NUM positions.

Those nurses who may wish to work full-time may not have the necessary education or experience to undertake the NUM role. Further, few opportunities appear available for ANUM positions; hence the potential for succession planning could be limited. In order to recruit nurses into NUM positions and ensure that they are retained, a number of strategies need to be considered. Incentives such as a bonus, a higher salary or salary packaging, training in management and additional funded continuing education opportunities have been proposed as potential strategies. In addition, nurses with potential need to be identified and succession planning and professional development discussed and implemented.

Recommendation 78: That rural and regional hospitals explore strategies to ensure that there is training and development for ANUMs to facilitate succession planning to NUM positions, and that, where appropriate, consideration be given to job sharing within the NUM position.

6.3 Special Issues

6.3.1 Clinical Supervision

Background

Clinical supervision is not a new phenomenon—it has a long history in mental health with conceptual origins in psychoanalytic theory. Since then the model has been adapted to support professional practice more broadly.

In a position paper on clinical supervision, Faugier & Butterworth (1995) note that in social work, counselling and psychotherapy, clinical supervision is understood as a means of protecting the client 'by ensuring that practitioners develop the highest level of skill and the most professional attitudes within the context of a trusting supportive professional relationship'.

In the paper they draw upon a definition developed by Wright which, they claim, is the most useful for the purposes of examining the value of clinical supervision in nursing practice. Wright defines clinical supervision as 'a meeting between two or more people who have a declared interest in examining a piece of work. The work is presented and they will together think about what was happening and why, what was done or said, and how it was handled—could it have been handled better or differently, and if so, how?' (Faugier & Butterworth 1995).

Nevertheless, it is worth noting the caution expressed by Ryan (1998) that clinical supervision 'is a multidimensional, dynamic, developing process (that) defies absolute definition'.

The literature on clinical supervision identifies a range of models. However, most make reference to three dimensions of clinical supervision: formative (teaching or facilitating learning); restorative (giving emotional support and identifying successes); and normative (directing the supervised person and advising on action, with client safety in mind). It is worth noting that the word 'supervision' has been used widely in management literature and in practice to describe managerial control. This definition of supervision concerns only one element of this tripartite model, the normative.

The formative and restorative dimensions of clinical supervision have, by contrast, been promoted widely in the education literature, drawing upon notions such as reflective learning and adult learning. The literature separates clinical supervision from performance appraisal and most authors cite the value of clinical supervision as a support mechanism for health professionals. The nature of this support includes prevention of burnout, increasing the practitioner's sense of confidence and security,

supporting employee personal growth and supporting employees in dealing with job related stress (Ryan 1998). Some authors also raise the issues of horizontal violence and professional rivalry, which can negatively impact on the success of clinical supervision because it requires a collegial culture. However, Ryan argues that 'quality clinical supervision will in itself assist in moving the culture in which it exists toward a more cooperative, learning environment'.

This report makes recommendations about the introduction of clinical supervision for registered nurses in health service delivery in the Victorian public health sector.

Principles Underpinning Implementation of Clinical Supervision

- The purpose of clinical supervision is to help the nurse increase skill in working with patients/residents.
- Clinical supervision is concerned with professional development and support for individual registered nurses and is to be distinguished from performance management and review.
- Clinical supervision is dependent on the quality of the supervisory relationship and requires the supervisor to have undergone training for clinical supervision.
- The supervisor may be either in a more senior position or may be a peer of the supervisee and they may be external to or within the organisation in which the supervise practices.
- The relationship is premised on trust, support, confidentiality and professionalism.
- Participation in clinical supervision is on a voluntary basis.
- The function of clinical supervision is to examine work practices and personal responses of the supervisee to ensure skill development and enhancement of professional attitudes.
- The process of the relationship is developmental, ongoing and includes integration of feedback into practice.

Recommendation 79:

- a) **That clinical supervision for registered nurses be introduced into the public health system as a strategy for retaining experienced, qualified nurses in clinical settings and that each nurse, regardless of full-time or part-time status, will receive two hours per month of clinical supervision time.**
- b) **That funding be provided for the introduction, implementation and evaluation of clinical supervision for registered nurses and that the Department of Human Services take responsibility for the allocation of funds and establish a process for the allocation to health services.**
- c) **That the Department of Human Services evaluate the implementation of clinical supervision.**

The Cost of the Initiative

The manner in which clinical supervision would be organised would be highly dependent on local circumstances, such as roster configurations and overlap time. It is conceivable that most clinical supervision will be performed in the context of current or future available hours, therefore this initiative has the capacity to be cost neutral, depending on the outcome of recommendations related to workload for nurses (section 6.1.1).

6.3.2 The Division 2 Nurse

While the educational issues relating to Division 2 nurses have been discussed in section 5.1.3, in considering the recruitment and retention issues relating particularly to the acute hospital sector, it became apparent to the Committee that there was confusion in the health workforce as to the role of the Division 2 nurse and the employment settings relevant to their training. The Committee acknowledges that the NBV report on medication administration by Division 2 nurses, currently before the Minister for Health, will influence future employment and education trends. The Committee also believes that there is a discrepancy between the aspirations of many Division 2 nurses, who wish for extended practice and to be employed in the acute setting, and the aged care industry, which

perceives the Certificate IV in Health (Nursing) as preparation for nurses solely to enter the aged care sector.

Submissions before the Committee indicate that the image of the Division 2 nurse has fared poorly in the past decade. The relatively low profile of Division 2 nursing in the community and in schools, the lack of exposure to Division 2 nurses by undergraduates and Division 1 nurses, issues surrounding the early application of the traineeship training model, and the trend towards employment in the aged care sector have all contributed to a poor understanding of the role and capabilities of the Division 2 nurse. The Committee is concerned at the apparent under-utilisation of the skills and experience of Division 2 nurses in a variety of settings, and notes the efforts of organisations such as the Victorian Perioperative Nurses Group to pioneer new roles for Division 2 nurses within the acute sector

Recommendation 80: That health agencies be encouraged to consider whether there are opportunities to employ Division 2 nurses in the acute sector in positions currently not filled by Division 2 nurses.

Recommendation 81: That the Department of Human Services considers a campaign amongst Division 1 nurses, undergraduates and the wider health care industry, to promote a better understanding of the role of Division 2 nurses.

6.3.3 The Aged Care Sector

6.3.3.1 Aged Care Funding Issues

Prior to 1987, the public aged care sector received State Government funding to provide short and long term residential care in addition to a variety of rehabilitation services. The latter included long term rehabilitation for patients who had been involved in traffic accidents, those who suffered strokes or those with myocardial infarctions requiring cardiac rehabilitation prior to discharge. The funding allowed hospital management to provide appropriate staffing levels that were adequate to meet the clinical needs of patients.

In 1987, the Care Aggregated Module/Standard Aggregated Module funding model was introduced into the private nursing home

sector. This model was subsequently applied to all public aged care facilities for residential care services including short term respite care, following a State and Federal agreement to transfer responsibility for residential aged care to the Federal Government. The Victorian Government provided a funding top-up to public sector aged care facilities and retained responsibility for rehabilitation services including post-acute care.

Since the advent of the *Aged Care Act 1996*, the funding levels have diminished in real terms due to the 'treasury measure of underlying inflation' formula being applied. This has meant that aged care sector funding is no longer indexed for both wage movements and inflation, which was the case under the previous CAM/SAM funding formula. Workloads in the aged care sector have continued to increase commensurate with increasing resident acuity while the funding continues to decrease in relative terms.

Further, the public sector has traditionally provided services for patients whom the private sector has been reluctant to accept, such as those residents with exceptionally challenging behaviours. This factor has served to place additional demands on nurses employed in these facilities.

Aged care nursing, until the mid-1980s, was often viewed as the 'Cinderella' of the profession. However, with the increase of postgraduate aged care nursing education opportunities and the development of the role of clinical nurse consultants in areas such as continence management and dementia care, aged care nursing became an attractive clinical area for nurses to work in. It was also recognised that the advantage for nurses in aged care nursing was the ability to have greater autonomy of practice in comparison to other specialist areas. However, due to the funding issues outlined above, these advantages have largely been lost, so that aged care nursing is currently a speciality that has great difficulty in attracting a sufficient number of committed and qualified nurses (Nay & Closs 1999).

While most public sector nursing homes and hostels receive some form of State Government top-up funding, the delivery of care services is

essentially managed under the current arrangements provided for by the Federal Government through the Resident Classification System (RCS) funding tool.

The application of available resources does not necessarily allow for any overlap during the day shift to enable nurses to attend in-service education, and many facilities have reduced the number of nurse educators they employ.

If the aged care sector is to offer nurses the opportunity to practise quality nursing care, then aged care specific education programs need to be provided, to ensure that nurses employed in these health care facilities maintain their skills and engage in contemporary aged care practices.

Recommendation 82: That ongoing in-service education be provided in the public aged care sector (nursing homes and hostels) and that resources be sufficient for this activity.

6.3.3.2 Specialist Positions in the Aged Care Sector

Aged care nursing is recognised as a specialist area of nursing, however it does not attract the same monetary support or interest as other areas of nursing specialty. It is noted that the Commonwealth Government has recently announced its interest in nominating aged care facilities in each State as Tertiary Education Centres.

Whether or not this initiative is finally realised, there are opportunities for the Department of Human Services to identify some of the larger aged care facilities as Teaching Centres of Excellence. The Department of Human Services also has the opportunity to enhance the clinical career pathway for aged care nurses to not only improve the quality of care, but also retain experienced qualified nurses in the clinical area. The Committee's survey of current and desired CNS positions (section 6.2.1.1) showed that there were no CNS positions in the public aged care responses. However, 20.6 EFT positions were identified in response to the question of how many places could be appointed if funding were available. There is, therefore, a need to fund some positions and to establish the number of positions that are required in the aged care sector, consistent with

Recommendation 68 in section 6.2.1.3.

Recommendation 83: That the Department of Human Services collects data relating to the staffing mix in the public aged care sector and, in particular, identifies:

- The number of CNS positions required following the implementation of Recommendation 68 and ensures that this number be used as a basis for the funding of CNS positions.
- The number of CNC positions, especially, but not limited to continence management, and dementia care.
- Nurse Practitioner roles as they are implemented and evaluated as part of the Government's funding of Nurse Practitioner projects.

In addition, recognition needs to be given to specific areas of aged care nursing through the appointment of CNC positions and, as they develop, Nurse Practitioners.

6.3.3.3 Documentation in the Aged Care Sector

One of the criticisms of Federal Government policy both pre- and post-1997 legislative changes, has been the increasing documentation requirements in aged care facilities.

Nurses employed in aged care complain about the time they are required to spend documenting care that has been provided which, they argue, diminishes the amount of time they have to spend on actual resident care.

As these excessive demands appear to be a contributing factor in lowering morale, other alternatives to current documentation requirements should be explored.

Recommendation 84: That the State Government recommend to the Commonwealth Government that the documentation required for Residential Classification Index Tool currently being used in the aged care sector be simplified, so as to reduce the documentation required to allow more time for nurses to deliver direct patient care. The Committee recommends that the Victorian Minister for Health raise this issue at AHMAC to seek the support of other State Governments.

6.3.3.4 Capital Funding in the Aged Care Sector

The Victorian Back Injury Project (Department of Human Services 2000) is undertaking a data collection exercise to ascertain whether demonstrable savings can be made through implementation of no lift policies. The State Government provided \$2 million in December 1998 and a further \$1.2 million in May 2000 for this initiative. While some aged care facilities have gained access to these funds to introduce a no lift policy in specific areas, further funding is required to allow all facilities to adopt the policy across the entire industry.

While there is an up front cost, particularly for the purchase of new equipment, these costs may be recouped within a three to four year period through reduction in time lost, reduction in WorkCover claims, reduction in sick leave and reduction in agency costs as back injuries diminish, although further data will need to be collected to confirm this.

Recommendation 85: That Department of Human Services provides specific funding for the complete implementation of a no lift program in the public aged care sector.

6.3.4 Midwifery

As discussed in section 3.9.3, rural midwifery practice faces specific problems in terms of practitioner support, retention and deskilling. The Committee believes more data needs to be collected on the rural midwifery workforce, in order to monitor overall recruitment and retention trends and the impact of strategies such as the Commonwealth's rural midwifery upskilling program.

Recommendation 86: That Department of Human Services, together with key stakeholders, collects data relating to the recruitment and retention of midwives in rural areas and the implemented strategies be evaluated by Department of Human Services.

This concludes the report of the Committee's deliberations. The remainder of this report contains the various research projects commissioned by the Committee and undertaken by consultants.

Bibliography

- Aiken, L, Smith, H & Lake, E. (1994) 'Lower Medicare Mortality Amongst a Set of Hospitals Known for Good Nursing Care, *Medical Care* 32: 771–787.
- Alspach, J. (1995) *The Educational Process in Nursing Staff Development*, Mosby –Year Book, Inc. Missouri.
- American Nurses Association. (1999) *House of Delegates Summary of Proceedings—Examining the Nursing Workforce (Action Report)*, www.nursingworld.org/about/sum99/workforc.htm
- American Nurses Association. (2000) 'American Nurses Credentialing Center' (Press release), www.ana.org/ancc
- Arnetz, J, Arnetz, B. & Soderman, E. (1998) Violence Toward Health Care Workers: Prevalence and Incidence at a Large, Regional Hospital in Sweden, *American Association of Occupational Health Nurses*, 46 (3): 107–114.
- Australian College of Nurse Management Inc, Australian Nursing Federation (Vic Branch) & Deans Of Nursing Victoria. (1999) *Nursing Workforce Survey 1999*, Australian College of Nurse Management Inc, Melbourne
- Australian Institute of Health & Welfare (1999) *Nursing Labour Force 1998*, Australian Institute of Health & Welfare, Canberra.
- Australian Institute of Health & Welfare (2000) *Nursing Labour Force 1999 – Preliminary Report*, Australian Institute of Health & Welfare, Canberra.
- Australian Labour Party. (1999) *New Solutions—a Healthy Victoria—Mental Health*, Australian Labour Party, Victorian Branch.
- Australian Nursing Federation. (1996) 'Specialisation and Credentialing in Nursing: a Discussion Paper', *The Queensland Nurse* 15 (4): 225–233
- Bassett, J. (1993) *Nursing Aide to Enrolled Nurse: a History of the Melbourne School for Enrolled Nurses*, Melbourne School for Enrolled Nurses, South Yarra, Victoria.
- Bednash, G. (2000) 'The Decreasing Supply of Registered Nurses – Inevitable Future or Call to Action?', *Journal of the American Medical Association* 283:2985–2987.
- Beeman, K, Jernigan, A & Hensley, P.(1999) 'Employing New Grads: a Plan for Success', *Nursing Economics*, 17(2).
- Benner P.(1984) *From Novice to Expert*, Addison-Wesley Pub Co, Menlo Park California.
- Biztrac, Edith Cowan University. (1997) 'Attracting Nurses Back Into the Nursing Workforce', Health Workforce Reform Division, Health Department of WA, Perth.
- Blue, I & Howe-Adams, J. (1992) 'A Program of Educational Support for Multi Disciplinary Health Professionals in Rural and Remote Areas', in *Proceedings of the First National Conference for the Association of Australian Rural Nurses Inc*, University of New England, Armidale, November 27–29 (pp 133–144).
- Blue, I & Kirkbright, S. [1998] *Information Technology and Telecommunications Education Training and Support for Australian Rural Nurses*, Monograph Series, Volume 7.
- Bradley, C. (2000) *Final Report: Research Into the Recruitment, Retention and Role of Rural Enrolled Nurses in South Australia*, Centre for Research into Nursing and Healthcare, University of South Australia.
- British Medical Journal* (2000) 'Canada faces nurse shortage' (news), 330:1030
- Buchan, J & Edwards, N. (2000) 'Nursing Numbers in Britain: the Argument for Workforce Planning', *British Medical Journal* 320: 1067–70 .

- Buchan, J & O'May, F. (1998) 'Nursing Supply and Demand: Reviewing the Evidence', *Nursing Times*, 94(26):60–63.
- Buckley P & Gray G. (1993) *Across the Spinifex: Registered Nurses Working in Rural and Remote South Australia—Final Report*, School of Nursing, Flinders University of South Australia.
- Buerhaus, PI, Staiger, DO & Auerbach, DI. (2000¹) 'Why are Shortages of Hospital RNs Concentrated in Specialty Care Units?', *Nursing Economics* 18(3) 111–116.
- Buerhaus, PI, Staiger, DO & Auerbach, DI. (2000²), 'Implications of an Aging Registered Nurse Workforce', *Journal of the American Medical Association* 283(22): 2948–54.
- Buerhaus, PI. (1998) 'Is Another RN Shortage Looming?', *Nursing Outlook* 46:103–8
- Buresh, B & Gordon, S. (2000). *From Silence to Voice—What Nurses Know and Must Communicate to the Public*, Canadian Nurses Association, Ottawa.
- Canadian Institute for Health Information (1999), 'Canada's Nursing Workforce Ageing, More Nurses Working Part-time', CHIA Directions ICIS 6 (2) www.cihi.ca/direct.
- Canadian Nurses Association. (2000) *Labour Market Integration of Graduates in Nursing in Canada, 1986–1997*, Canadian Council on Social Development, Ottawa.
- Castledine, G. (1995) 'Specialisation in Nursing Comes of Age', *British Journal of Nursing* 4 (5): 295
- Clinton, M. (1999) *Scoping Study of the Australian Mental Health Nursing Workforce*, Curtin University, Perth. (In Press).
- Coffman, J & Spetz, J. (1999) 'Maintaining an Adequate Supply of RN's in California', *Image: Journal of Nursing Scholarship* 31(4): 389–93.
- Commission on Nursing (1998) *Report of the Commission on Nursing – A Blueprint for the Future*, Government of Ireland, The Stationary Office, Dublin.
- Community Services and Health Industry Training Board. (1999) *Medication Administration Assistance Project: Supplementary Report*, Community Services and Health Industry Training Board.
- Considine, G, & Buchanan, J. (1999) *The Hidden Cost of Understaffing: an Analysis of Contemporary Nurses Working Conditions in Victoria*, Australian Centre for Industrial Relations, Research & Training, University of Sydney, Sydney.
- Coordinating Unit for Rural Health Education in Victoria. (1996) *A Vision for the Recruitment and Support of Undergraduate Students to Rural Nursing Practice as a Career*, Coordinating Unit for Rural Health Education in Victoria
- Cramer, J. (1994) 'Finding Solutions to Support Remote Area Nursing', *Australian Nursing Journal* 2(6): 21–25.
- Department of Employment, Workplace Relations & Small Business. (2000) *Australian regional labour markets (90)—March Quarter 2000*, www.dewrsb.gov.au/employment/publications/
- Department of Employment, Workplace Relations & Small Business. (2000) *Skills Shortages*, www.dewrsb.gov.au/employment/publications/skillshortages
- Department of Health & Aged Care. (1998) *Second Mental Health Plan*, AGPS, Canberra
- Department of Health & Aged Care. (2000) *Rethinking Nursing—National Nursing Workforce Forum*, Commonwealth Department of Health & Aged Care, Canberra.
- Department of Health & Community Services (1993) *Midwifery Nurse Labourforce, Requirements & Supply Projections Victoria 1992–2001*, Department of Health & Community Services, Melbourne.
- Department of Health & Community Services. (1993) *Critical Care Nurse Labourforce—Requirements and Supply Projections 1992–2001*, Department of Health & Community Services, Melbourne.
- Department of Health. (1999) *Future Staffing Requirements – the Government's Response to the Health Committee's Report on Future Staffing Requirements*, Department of Health, The Stationary Office, London.
- Department of Health. (1999) *Making a Difference*, Department of Health, London. www.doh.gov.uk/nursestrat.htm

- Department of Health. (1999) *The Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine 17th Report*, Stationary Office, London
- Department of Human Services (1994) *Psychiatric Crisis Assessment & Treatment Services: Guidelines for Service Provision*, Department of Human Services, Melbourne.
- Department of Human Services (2000). *New Millennium, New Practices—Nurses Back Injury Prevention Project Preliminary Results*, Workforce Branch, Department of Human Services, Melbourne.
- Department of Human Services. (1996) *Qualitative Study of the Critical Care Nurse Labour Force—Final Report*, Health Workforce Unit, Department of Human Services, Melbourne.
- Department of Human Services. (1997) *Graduate Nurse Program Guidelines*, Department of Human Services, Melbourne
- Department of Human Services. (1998) *Nursing Recruitment & Retention Taskgroup Report*, Office of the Chief Nurse, Department of Human Services, Adelaide.
- Department of Human Services. (1998) *Undergraduate Nursing Education in Victoria—Psychiatric Knowledge, Attitudes and Skill Requirements for Beginning Level Division One Nurses*, Mental Health Branch, Department of Human Services, Melbourne.
- Department of Human Services. (1999¹) *Evaluation of Nurse Labourforce Planning*, Public Health & Development Division, Department of Human Services, Melbourne.
www.dhs.vic.gov.au/phd/9903084/index.htm
- Department of Human Services. (1999²) *Nurse Labourforce Projections Victoria 1998–2009*, Public Health & Development Division, Department of Human Services, Melbourne.
www.dhs.vic.gov.au/phd/9903083/index.htm
- Department of Human Services. (2000) *Ministerial Review of Health Care Networks – Final Report*, Acute Health Division, Department of Human Services, Melbourne.
- Department of Human Services. (2000) *Victoria—Public Hospitals Policy & Funding Guidelines 2000–2001*, Acute Health Division, Department of Human Services, Melbourne.
- Department of Human Services. (2000) *Victorian Nurse Practitioner Project: Final Report of the Taskforce*, December 1999, Workforce Branch, Department of Human Services.
- Donovan Research. (1998) *Research to Assist the Development of a Campaign to Promote Nursing as a Career*, Health Department of WA, Perth.
- Doyal, L, & Cameron, A. (2000) 'Reshaping the NHS Workforce' (editorial), *British Medical Journal* 320: 1023–4.
- Duffy, E. (2000) 'Profiling the Rural Nurse in Victoria: Implications for Recruitment and Retention' in *Proceedings, Infront Outback*, Toowoomba, Queensland, P 24–26.
- Dunn, D. (1998), Division 2 Undergraduate Education: Difficulties and Triumphs, *Annual State Division 2 Nursing Conference, Victoria* (unpublished conference paper).
- Fairweather, C, & Gardner, G. (2000) 'Specialist Nurse: an Investigation of Common and Distinct Aspects of Practice', *The Collegian* 7 (2): 26–33.
- Faugier, J., & Butterworth, T. (1995) *Clinical Supervision: A Position Paper*, School of Nursing Studies, The University of Manchester.
- Fridkin, S, Pear, S, Williamson, T, et al. (1996) 'The Role of Understaffing in Central Venous Catheter Associated Bloodstream Infection', *Infection Control & Hospital Epidemiology* 17(3): 150–158.
- Gadiel, D, & Riout, L. (1994) *Specialist Medical Workforce and Specialist Service Provision in Rural Areas*, Strategic Human Capital Management, NSW Health, Sydney.
- Gerritson, J. (2000) 'Second Tier Nursing Debate' (News), *Nurses.Co online*
www.nzhealth.co.nz/nurses
- Girvin, J. (1998) 'Speaking out... I Want the Best Qualified Nurses at the Patient Bedside Providing Care', *Nursing Times* 94(20):21

- Glaessel-Brown, EE. (1998) 'Use of immigration policy to manage nursing shortages', *Image: Journal of Nursing Scholarship* 30(4): 323–7.
- Handley, A. (1996) *Australian Rural Nurses: Education, Training and Support: a Literature Review for AARN Inc*, University of South Australia, Whyalla.
- Harris, R. (1992), *Australian Rural Health: a National Survey of Educational Needs*, Graduate School of Health and Medical Science, University of Wollongong, NSW.
- Hastie, C. (2000) 'Dying for the Cause' (online), www.acegraphics.com.au/resource/papers/hastie01/html
- Havens, DS, & Aiken, LH. (1999) 'Shaping Systems to Promote Desired Outcomes: the Magnet Hospital Model', *Journal of Nursing Administration* 29(2): 14–20.
- Hedin, B. (1986) 'A Case Study of Oppression Group Behaviour in Nurses', *Image: Journal of Nursing Scholarship* 18(2) 53–7
- Henderson, V. (1996) *The Nature of Nursing*, Collier-McMillan Ltd, London.
- Hope, J. (1993) 'Continuing professional education for rural nurses – preparing for the future', in the proceedings of the Second National Conference for the Association of Australian Rural Nurses Inc, Deakin University, Warrnambool Campus, November 26–28 [pp33–35].
- House of Commons Select Committee on Health Third Report: *Future NHS Staffing Requirements* (1999), Stationary Office, London.
- International Council of Nurses 'Increasing Violence in the Workplace is a Threat to Nursing and the Delivery of Health Care', (press release 8 March 1999).
- Irish Health & Safety Authority. (1998) *Bullying at Work*, Irish Health & Safety Authority online www.has.ie/osh/bullying.htm.
- Kramer, M. (1990) 'The Magnet Hospitals: Excellence Revisited', *Journal of Nursing Administration* 20 (9): 35–44.
- Malko, K. (1992) 'Policy Development in Rural Health', in *Proceedings of the First National Conference for the Association of Australian Rural Nurses Inc.*, University of New England, Armidale, November 27–29 (pp 33–40).
- Ministry of Health (1998) *Report of the Ministerial Taskforce on Nursing*, New Zealand Ministry of Health, Wellington.
- Moses, E. (1998) *The Registered Nurse Population: Findings From the National Sample of Registered Nurses 1996*, Health Resources & Services Administration, US Department of Health & Human Services, Washington.
- Nay, R, & Closs, B. (1999) *Recruitment & Retention of Qualified Nursing Staff in Long Term Care of Older People*, Department of Human Services, Melbourne (unpublished).
- New Zealand Health (2000) *Non-Practising Nurses and Midwives Report*, New Zealand Health Information Service online www.nzhealth.co.nz
- NSW Health. (1996) *Nursing Recruitment and Retention Taskforce—Final Report*, NSW Health, North Sydney.
- NSW Health. (2000) *Recruitment & Retention of Nurses – Progress Report*, NSW Health, North Sydney.
- Nurse Education Review Secretariat. (1994) *Nursing Education in Australian Universities: Report of the National Review of Nurse Education in the Higher Education Sector 1994 and Beyond*, Nurse Education Review Secretariat, Canberra.
- Nurses Board of Victoria. (1998) *Critical Care Education in Victoria*, Nurses Board of Victoria, Melbourne.
- Nurses Board of Victoria. (1999) *Annual Report 1999*, Melbourne.
- Nursing Review* (June 2000), 'Time for NZ to Address the Growing Nursing Shortage' (news).
- Oulton, J. (1998) 'International Trade and the Nursing Profession: International Trade in Health Services, a Development Perspective', *Proceedings of the United Nations Conference on Trade & Development*, Geneva, Switzerland.

- Pante MA (1999) *Thrown in at the Deep End: Psychiatric Nurses Attitudes to Educational Preparation for Clinical Practice*, Health & Community Services Union—Victorian #2 Branch, Melbourne.
- Perrone, S. (1999) *Violence in the Workplace*, Australian Institute of Criminology Research & Public Policy Series No 22, Australian Institute of Criminology, Canberra.
- Pew Health Professions Commission. (1995) *Critical Challenges: Revitalising the Health Professions for the Twenty-First Century*, Centre for the Health Professions, San Francisco, California.
- Pittman, L, & Rogers, T. (1990) 'Nursing: a Culturally Diverse Profession in a Monocultural Health System', *Australian Journal of Advanced Nursing* 8: 30–38.
- Productivity Commission. (1998) *Commonwealth/State Service Provision – Report on Government Services*, AGPS, Canberra
- Queensland Health. (1999) *Ministerial Taskforce—Nursing Recruitment and Retention*, Queensland Health, Brisbane.
- Quine, L. (1999) 'Workplace Bullying in a NHS Community Trust: Staff Questionnaire Survey', *British Medical Journal* 318: 228–232.
- Reid, NG. (1986) 'Nursing Manpower – the Problems Ahead', *International Journal of Nursing Studies* 23:187–197.
- Russell, LR, Gething, L, & Convery, P. (1997) *National Review of Specialist Nurse Education*, Commonwealth Department of Employment, Education, Training & Youth Affairs, Canberra.
- Ryan, T. (1998), 'Clinical Supervision in Mental Health Nursing',
- Scott, JG, Sochalski, J, & Aiken, L. (1999) 'Review of Magnet Hospital Research: Findings and Implications for Professional Nursing Practice', *Journal of Nursing Administration* 29(1): 9–19.
- Shamian, J, Hagen, B, Hu, T & Fogarty, TE. (1994) 'The Relationship between length of Stay and Required Nursing Care Hours', *Journal of Nursing Administration* 24(7/8):52–8.
- Shindul-Rothschild, J, Berry, D & Long-Middleton, E. (1996). 'Where Have All the Nurses Gone?', *American Journal of Nursing* 96(11): 25–39.
- Snell, J. (1997) 'They're banking on You ...the Use of Agency and Bank Staff', *Nursing Times* 93(7): 24–26.
- Spencer, J, Bull, R, Martin, E, et al (1998) *Roles and Responsibilities of Education Providers, Education Training and Support for Australian Rural Nurses*, Monograph Series, Volume 4.
- Spring, NM, & Stern, MB. (2000) 'Nurse Abuse? Couldn't Be ! Intraprofessional Abuse and Violence in the Workplace', *Nurse Advocate*, www.nurseadvocate.org/nurseabuse.html.
- Tang, KC, Duffield C, Chen, X, et al (1999) 'Nursing as a Career Choice: Perceptions of School Students Speaking Arabic, Serbo-Croatian, Spanish, Turkish or Vietnamese at Home', *Australian Health Review* 22 (1): 107–121.
- The Australian*, 20 July 2000 'Heartbroken Nurses Lose Numbers Game' (news).
- Torrance, C, & Wilson, M. (2000) 'Magnet Hospitals – the Truth Behind the Concept', *Nursing Review*, July 2000.
- Trades Union Congress. (1999) *Violent Times: Preventing Violence at Work*, Trade Union Congress, London
- Victorian Council of Peak Nursing Organisations. (1997) *Position Statement – the Position of Director of Nursing in the Health Services Organisational Structure*, Victorian Council of Peak Nursing Organisations, South Warrandyte.
- While, A, & Blackman, C. (1998) 'Reflections on Nursing as a Career Choice', *Journal of Nursing Management* 6(4):231–237.

Appendix One—Terms of Reference

The purpose of the Committee is to provide advice to the Minister for Health on workforce matters in relation to the registered nurse workforce (including general nurses, psychiatric nurses and the Division 2 nurses) and, in particular:

- I. To review local, national and international experiences and measures to address nurse recruitment and retention.
- II. To consider a range of strategies for improving recruitment and retention of nurses, through a process of consultation with relevant bodies and organisations in Victoria and with Commonwealth Departments. Areas to include:
 - A. Undergraduate recruitment.
 - B. Undergraduate educational programs and clinical practice opportunities.
 - C. Access to continuing education.
 - D. Access to refresher courses.
 - E. Particular needs for rural and regional Victoria.
 - F. Workplace reform.
 - G. Work role reform opportunities.

And without limiting the generality of the above to:

- Examine the effectiveness of other State Government's publicity programs to attract students into undergraduate nursing programs with a view to introducing similar media campaigns into Victoria.
- Examine any recent research available regarding nursing shortages and to consider any additional questions that may be included in the annual research conducted by the Australian Institute of Health and Welfare.
- Ascertain what is appropriate health agency support, monitoring and supervision for new graduates.

- III. To examine the impact of the current education and registration frameworks on availability of specialised nurses.
- IV. To identify and prioritise effective short, medium and longer term strategies to remedy the current situation and prevent shortfalls in Victoria in the future.
- V. To develop costed action plans in the context of government policy for priority areas.
- VI. To advise the Minister for Health on matters requiring attention to be taken to the Victorian Minister responsible for Education and Post Compulsory Education, and to the Commonwealth Minister for Health and Aged Care.
- VII. To establish sub-committees, working groups as necessary.
- VIII. To prepare an interim report for the Minister for Health by 30 April 2000, which should give special consideration to postgraduate education, and a final report by 31 August 2000.

Appendix Two—Committee Membership

Nurse Recruitment and Retention Committee		Coopted Sub-Committee Members	
Emeritus Professor Margaret Bennett—Chair	Retention Sub-committee	Ms Naomi Corlett	Attraction and Recruitment Sub-committee
Ms Jan Brownrigg (from July 2000)	Education Sub-committee	Ms Donna Dunn	Education Sub-committee
Ms Andrea Dennis	Attraction and Recruitment Sub-committee	Ms Kate Gray	Education Sub-committee
Mr Alwin Gallina	Attraction and Recruitment Sub-committee	Ms Wendy Lewis	Retention Sub-committee
Ms Denise Guppy	Retention Sub-committee	Ms Cheryl Nicholson	Education Sub-committee
Ms Jill Linklater	Chair—Retention Sub-committee	Professor Judith Parker	Retention Sub-committee
Ms Belinda Morieson	Retention Sub-committee	Ms Leanne Raven	Retention Sub-committee
Associate Professor Pauline Nugent	Chair—Education Sub-committee	Ms Hannah Sellers	Attraction and Recruitment Sub-committee
Ms Margaret Ormerod	Attraction and Recruitment Sub-committee	Ms Kylie Smith	Attraction and Recruitment Sub-committee
Associate Professor John Rasa	Retention Sub-committee	Ms Kim Sykes	Education Sub-committee
Ms Victoria Southgate	Retention Sub-committee	Dr Sue Turale	Education Sub-committee
Ms Ann Turnbull	Chair—Attraction and Recruitment Sub-committee	Mr Dan Weeks	Attraction and Recruitment Sub-committee
Mr Paul Waterson	Education Sub-committee	Ms Sue Williams	Retention Sub-committee
Ms Kairsty Wilson	Education Sub-committee		
Ms Sue Wylie (to July 2000)	Education Sub-committee		
Project Team			
Ms Karen Carmichael			
Mr Geraint Duggan			
Mr Peter Carver			
Mr Gerard White			
Mr Graeme Doidge			

Appendix Three—Quantitative Survey of Registered, Non-Working Nurses

Nursing Return to Work Survey FINAL REPORT

A report of 2,089 self-completion surveys
with nurses who are registered but currently not working.

Prepared for

Nurse Recruitment & Retention Committee
Department of Human Services
Melbourne Victoria

June 2000

CAMPBELL
RESEARCH  CONSULTING

Contents

1. Executive Summary	119
1.1 Key Characteristics	119
1.2 Workforce Status	119
1.3 Reasons for Not Working as a Nurse	119
1.4 Barriers to Return to Work	120
1.5 Factors Influencing Return To Work	120
2. Conventions Used in This Report	121
3. Background	121
4. Research Objectives	121
5. Methodology	122
6. Results	122
6.1 Division of Registration	122
6.2 General Background Information	122
6.3 Employment Attitudes	125
6.4 Seeking Employment as a Nurse	129
6.5 Returning to the Nursing Profession	136

Index of Tables

Table 1: Terms and Acronyms	121
Table 2: Division of Registration	122
Table 3: Division of Registration by Age Group	123
Table 4: Type of Nursing Course by Division of Registration	125
Table 5: Division of Employment	125
Table 6: Current Work Status by Division of Registration	126
Table 7: Current Work Status by Age	127
Table 8: Factors for Leaving Nursing by Division of Registration (Average Score)	128
Table 9: Factors for Leaving Nursing by Age (Average Score)	128
Table 10: Factors for Leaving Nursing by Current Work Status (Average Score)	129
Table 11: ‘Other’ Factors for Leaving Nursing by Age	129
Table 12: Active Employment Seeking by Current Work Status	130
Table 13: Reasons for Not Seeking Employment as a Nurse	131
Table 14: Reasons for Not Seeking Employment as a Nurse by Current Work Status	132
Table 15: Influential Factors for Not Seeking Employment by Division of Registration	133
Table 16: Influential Factors for Not Seeking Employment by Age	133
Table 17: Influential Factors for Not Seeking Employment by Current Work Status	134
Table 18: Factors Rated as Important in Returning to Work by Division of Registration	136
Table 19: Factors Rated as Important in Returning to Work by Age	137
Table 20: Area of Nursing Likely to Work by Division of Registration	137
Table 21: Area of Nursing Likely to Return to Work by Age	138
Table 22: Area of Nursing Likely to Return to by Current Work Status	139
Table 23: Desired Area of Nursing by Division of Registration	139
Table 24: Desired Area of Nursing by Age	140
Table 25: Desired Area of Nursing by Current Work Status	141

Index of Figures

Figure 1: Registered Nurses by Age Group	122
Figure 2: Place of Residence	123
Figure 3: Registrations in Other States	123
Figure 4: Average Years Since Graduation	124
Figure 5: Formal Post-Basic Nursing Courses across All Divisions	124
Figure 6: Nursing Courses by Division of Registration	124
Figure 7: Employment of Registered Nurses	125
Figure 8: Current Work Status	126
Figure 9: Influential Factors for Leaving the Nursing Profession	127
Figure 10: Seeking Employment as a Nurse	130
Figure 11: Seeking Employment by Division of Registration	130
Figure 12: Influential Factors for Not Seeking Employment	132
Figure 13: Influential Factors for Not Seeking Employment by Geographical Location	134
Figure 14: Factors Rated for Importance in Not Finding Employment in Nursing	135
Figure 15: Factors Rated Important for Not Successfully Obtaining Employment by Division of Registration	135
Figure 16: Factors Rated as Important for Not Obtaining Employment by Age	136
Figure 17: Factors Rated as Important in Returning to Work	136

Appendix

Appendix A Return to Work Nursing Survey

1. Executive Summary

This report summarises survey information on the attitudes, beliefs and behaviour of registered nurses who are currently not working in the nursing profession.

A total of 3,626 surveys were mailed. Altogether 2,089 responses were received by 23 May 2000. The response rate of 58% is exceptionally high for a mail survey indicating the high level of interest by nurses.

1.1 Key Characteristics

- Nearly all (96%) nurses who are registered but are not currently working are women.
- Most (71%) have worked as a Division 1 nurse for an average of 19 years.
- Seven in ten (68%) are middle aged (30–49 years).
- There was a high proportion from non-metropolitan Victoria (46%) and a small proportion resident (4%) or registered (6%) in other states.
- These are nurses with substantial experience in the nursing workforce. The majority (60%) have completed some post basic nursing training. Most commonly (22%) the training was in midwifery. There is a wide spectrum of other specialities but less than 10% of the sample reported qualifications in critical care, advanced nursing, community health, gerontology education and management.

1.2 Workforce Status

- Nearly all Division 1 and Division 3 nurses had worked full-time while only 73% of Division 2 nurses had worked full-time.
- Fewer than one in five (16%) nurses who indicated they were not working at the time they completed the registration survey indicated that they were working in May 2000. This suggests that a segment of the non-working registered nurse population has a dynamic or flexible relationship with the workforce.
- The finding that a substantial minority (close to one in three) of nurses not currently working had also worked part-time during their career supports the dynamic relationship. The relative high proportion of this population who have worked part-time suggests that, over their substantial workforce experience, part-time work was an option for nurses.
- Most commonly the population of nurses

who reported not working at the time of registration had abandoned the nursing workforce, at least temporarily, or were working in an area other than nursing.

- 40% were not working in May 2000.
- 20% were working in an area other than nursing.
- 11% were on extended leave.
- Only 12% indicated that they would not seek employment as a nurse again.

1.3 Reasons for Not Working as a Nurse

- The most important reasons given by those not working were:
 - Increased workload.
 - Conditions of work.
 - Satisfaction with nursing.
- Family commitment also received a high rating.
- Working conditions and lack of experience were important for younger nurses as were finding a job in another area and returning to study. Sickness, injury and redundancy packages were more important for older nurses who also rated organisational restructure and inadequate hospital funding higher than their younger counterparts.
- Just over one in ten (12%) indicated they would not return to the nursing workforce. The reasons differed by age group.
- Registered nurses, excluding those already working as a nurse, were asked to rate the importance of a list of influential factors for not seeking employment. The four highest rated factors included:
 - The workload is too heavy.
 - Commitments in other areas (family).
 - Lack of recognition.
 - Working conditions are poor.
- Older nurses were most likely to give retirement (33%) or injury/illness (19%) as a reason.
- Middle-aged nurses were most likely to identify working/studying in another area (34%), poor career satisfaction (23%), family responsibilities (17%) and a negative work environment (16%).
- Younger nurses were most likely to identify poor career satisfaction (39%), working/studying in another area (28%), negative work environment (22%) and poor salary (22%).
- Registered nurses in Division 1 and Division 2 reported different influential factors for not seeking employment than registered nurses

in Division 3.

Division 1 and Division 2 rated:

- No access to child care.
- Commitments in other areas (family).
- Employment prospects are better elsewhere.
- Opportunities for promotion are limited.
- Pay is inadequate, higher in importance than respondents in Division 3.
- Conversely, Division 3 rated 'working conditions as poor' and 'difficulty in finding a job' higher in importance than respondents in Division 1 and Division 2.
- Non-metropolitan Victorian registered nurses rated higher on factors, including:
 - Commitments in other areas.
 - My practical experience is inadequate.
 - Difficult to find a job.

1.4 Barriers to Return to Work

- The two most important factors for not finding successful employment in nursing were:
 - There are limited job opportunities.
 - It is difficult to find a job in my locality.
- Division 1 nurses rated higher importance for 'difficult to find a job in my preferred speciality', than both Division 2 and Division 3.
- Division 2 nurses rated higher importance for 'inadequate hospital funding' than both Division 1 and Division 3.
- Younger registered nurses rated 'I lack practical experience' higher than middle-aged and older registered nurses.
- Older registered nurses rated 'there are limited job opportunities' higher than middle and younger registered nurses.

1.5 Factors Influencing Return To Work

- The five most important factors influencing return to work for those not working as a nurse were:
 - Working conditions.
 - Flexible rosters.
 - Employment opportunities.
 - Professional development.
 - Training opportunities.
- The main types of nursing identified as

likely areas for return to work were:

- Gerontology (27%)
- Agency/Casual (27%)
- Mixed medical and surgical (21%).
- These were closely followed by community health (18%), surgical (13%), and midwifery (12%).
- Area of work was analysed by Division of registration which found that:
 - Division 1 nurses are likely to work in community health (20%)
 - Division 2 nurses are likely to work in gerontology (44%)
 - Division 3 nurses are likely to work in mental health/psychiatric (85%).
- Age differences were evident for the area of nursing the participants would return to, for instance:
 - Younger and middle-aged nurses were likely to work in agency/casual (30% and 30%)
 - Older nurses were more likely to work in gerontology (38%).
- Respondents who were working in the health arena were more likely to report that they would return to work in the 'community health' area (24%).
- Respondents working in other areas (not health related), reported that they would likely return to work in the agency/casual area (32%).
- Registered nurses on leave were also likely to return to work as a nurse in the agency/casual area (25%).
- Respondents who are not working at all reported they would most likely return to work in the area of gerontology (30%).
- Respondents were asked what area of nursing they would like to work in if appropriate training were accessible. The three main areas reported were:
 - Community health (26%)
 - Midwifery (18%)
 - School children's health (16%).

2. Conventions Used in This Report

The results of the Nursing Survey have been analysed by Division, region and age.

Only statistically significant differences at the 95% confidence level have been reported.

2.1 Reading the Tables

- The tables identify the relevant survey question in the header.
- The base for each table is identified under the left-hand column of the table.
- The base on which percentages are calculated for each column is given in parentheses under the column header.
- Alphabet letters in lower case represents significant levels at the 5% level (95%), and letters in upper case represent significant levels at the 10% level (90%). The corresponding capital letters for comparison may be found in the column header (example table below).

Category	DIV 1 A	DIV 2 B	DIV 3 C
Yes	45 ^b	3	46 ^b
Don't Know	42 ^c	67 ^c	6

In this example above, respondents who answered:

- ‘Yes’, Division 1 (column A) and Division 3 (Column C) was significantly different at the 95% confidence level than Division 2 (Column B).
- ‘Don’t know’, Division 1 was significantly different at the 90% confidence level compared to Division 3.
- ‘n/a’ means that the particular cell is not applicable and no result can be reported.
- ‘-’ means that the responses for the cell were too low to provide a percentage.
- Subtotals are right justified and printed in parentheses.
- Percentages are rounded to the nearest whole number.

2.2 Reading the Graphs

- The relevant survey questions are identified in the graph header.
- The base for each graph refers to the total number of responses upon which the percentages have been calculated. This is identified under the left-hand corner of the graph.

The following terms are used in this report:

Table 1: Terms and Acronyms

NBV	Nurses Board of Victoria
Division 1	Nurses registered in Division 1
Division 2	Nurses registered in Division 2
Division 3	Nurses registered in Division 3
AIHW	Australian Institute of Health & Welfare
Younger Nurses	aged between 20 years of age to 29 years of age
Middle Nurses	aged between 30 years of age to 49 years of age.
Older Nurses	aged 50 years and older
CR&C	Campbell Research and Consulting
NRRC	Nurse Recruitment & Retention Committee

3. Background

There is currently a shortage of registered nurses in Victoria. The Victorian Government has established a task force to identify factors that can address the shortfall of nurses. There is a substantial number of nurses who are registered but not working. To identify factors that can encourage registered nurses to rejoin the workforce, the Nurse Recruitment and Retention Committee (NRRC) commissioned Campbell Research & Consulting (CR&C) to conduct confidential self-completion survey of nurses who indicated they were not working at the time of last registration.

4. Research Objectives

The objectives of the research are to identify:

1. Characteristics of the estimated 14,000 registered nurses who are currently not working.
2. The reasons to why registered nurses have left the nursing profession.
3. The factors that will influence registered nurses to return to the nursing profession.

5. Methodology

The sample was drawn from the responses to a survey distributed by the NBV on behalf of the Australian Institute of Health & Welfare (AIHW). Strict protocols were developed to ensure the confidentiality of respondent details:

- The survey was mailed by the NBV to nurses who, when renewing registration, indicated they were not working as a nurse.
- No names, addresses or personal information was provided by the NBV to CR&C.
- A passive consent process was used—refusal was through non-response.

Respondents were advised that no identifying information was reported, however some respondents specifically asked to be identified and attached lengthy detailed responses.

A total of 3,626 surveys were mailed. This sample included a proportion of nurses on extended leave which will act as a de facto control group, and understand the preconceived notion that nurses on maternity leave do not always return to nursing. Altogether 2,089 responses were received by 23d May 2000. The response rate of 58% is exceptionally high for a mail survey indicating the high level of interest by nurses.

6. Results

An initial 3,626 surveys were posted to prospective participants. Response rate was successful with a total return rate of 2,089 surveys.

6.1 Division of Registration

Most respondents (71%) were Division 1 nurses (Table 2).

Table 2: Division of Registration

Division	(2,089) %
Division 1	171
Division 2	225
Division 3	32
No response	2

6.2 General Background Information

The majority (96%) of the sample were females. This did not differ across age groups, Division of registration or geographical region. This finding is consistent with the nurse register as a whole.

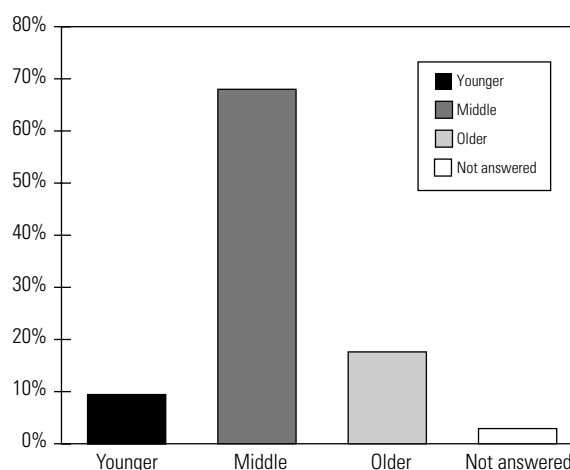
The sample was analysed by three age groups, younger, middle and older (Figure 1) with:

1. The majority of the sample (68%) from the middle age group (30-49).
2. Two in ten (20%) respondents aged 50 years of age and over (older).
3. One in ten (10%) respondents aged between 20 and 29 years of age (younger).

Age was calculated from year of birth.

Figure 1: Registered Nurses by Age Group

Q5 Your year of birth?



Base: 2,089

The majority of nurses (71%) were registered in Division 1.

Older nurses were more likely to be registered as Division 1 (Table 3).

Eight in ten (81%) of older nurses were registered in Division 1 compared to seven in ten (72%) of the younger, middle age group.

A very small proportion of all age groups were registered as Division 3 (Table 3).

Table 3: Division of Registration by Age Group

Q2: In which Division of the Register maintained by the NBV are you currently registered?

Division	Younger (20-29yrs) (203) %	Middle (30-49yrs) (1,416) %	Older (50yrs & Over) (432) %
Division 1	72	68	81
Division 2	23	29	16
Division 3	2	2	1

Note: Of the total sample, 38 respondents did not respond.

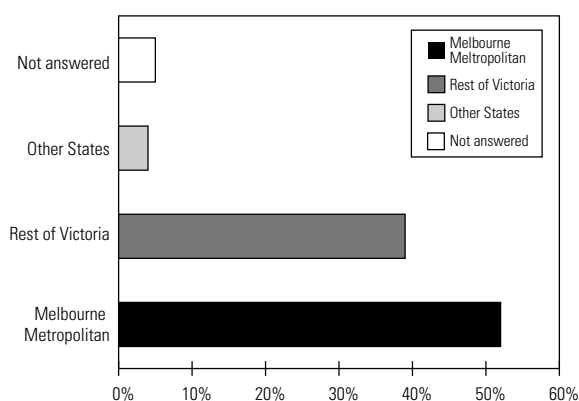
Note: The small proportion of participants in Division 3 is consistent with the total number registered by the NBV.

Place of residence is relatively distributed throughout Victoria (Error! Reference source not found.Figure 3), with:

- Five in ten (52%) respondents residing in the Melbourne metropolitan area.
- Four in ten (39%) respondents residing in non-metropolitan Victoria.
- A small proportion (4%) of respondents living in other states of Australia.
- A small proportion (5%) of respondents not indicating their permanent place of residence.

Figure 2: Place of Residence

Q7: What is the postcode of your permanent place of residence?



Base: Total sample (2,089)

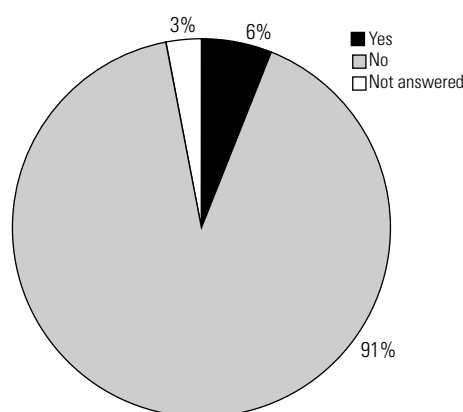
Victorian registered nurses are unlikely to be registered in another state.

Nine in ten (91%) respondents were not currently registered in another state or territory other than Victoria (Figure 3). A small proportion (6%) indicated that they were registered in another state, and 3% of respondents did not answer this question.

Figure 3: Registrations in Other States

Q4: Are you currently registered in another state or territory?

Base: Total sample (2,089)



6.2.1 Years of Registration

Nurses registered but *not* working had been registered on average for 18 years.

Years of registration is a function of age, with:

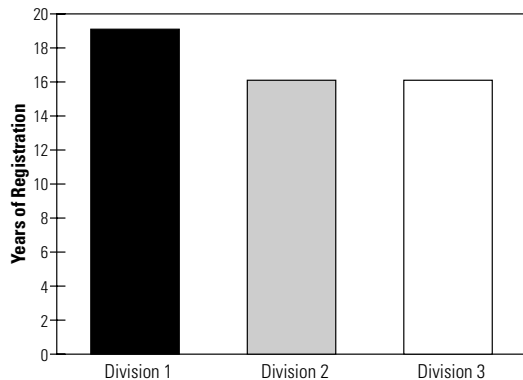
- Younger nurses registered for an average of six years.
- Middle aged nurses registered for an average of 15 years.
- Older nurses registered for an average of 33 years.

Division 1 nurses have more years of registration than nurses in Division 2 and Division 3.

Overall, Division 1 nurses (average of 19.1 years) report having more years of registration than both Division 2 (average of 16.1 years) and Division 3 (average of 16.1 years) nurses.

Figure 4: Average Years Since Graduation

Q6 *What year did you first register as a nurse?*



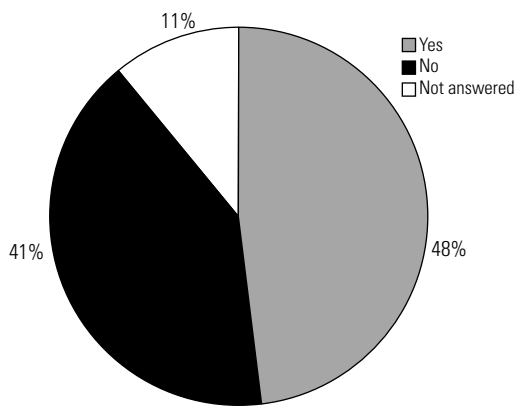
Base: Total sample (2,089)

6.2.2 Completion of Formal Post-Basic Nursing Courses

Five in ten (48%) nurses had completed a formal post-basic nursing course and four in ten (41%) nurses had not (Figure 5).

Figure 5: Formal Post-Basic Nursing Courses across All Divisions

Q12 *Have you completed any formal post basic nursing courses such as Grad Dips, Grad Certs, Masters?*

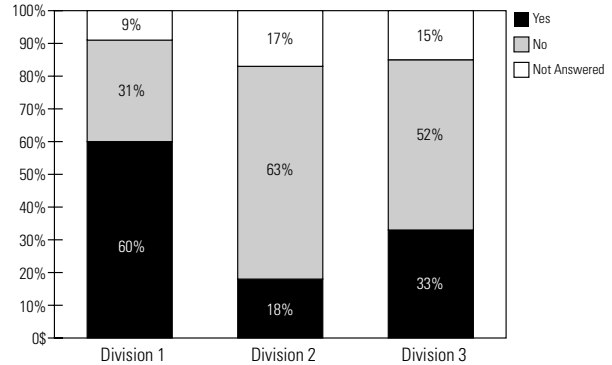


Base: Total sample (2,089)

Division 1 nurses are more likely to complete formal nursing courses than Division 2 and Division 3. Division 2 (65%) and Division 3 (52%) nurses were more likely to have not completed formal post-basic nursing courses (Figure 6), than Division 1 nurses (31%).

Figure 6: Nursing Courses by Division of Registration

Q12 *Have you completed any formal post-basic nursing courses such as Grad Dips, Grad Certs, Masters?*



Base: Division 1 1,478
 Division 2 531
 Division 3 33

Note: Of the Division 1 nurses, 29% had completed at least a midwifery course.

Completion of formal nursing courses was a function of age, where:

- Three in ten (34%) younger registered nurses reported the completion of a formal nursing course.
- Five in ten (54%) middle age nurses had completed a formal nursing course.
- Six in ten (62%) older nurses had completed a formal nursing course.

6.2.3 Type of Formal Post Basic Nursing Course

Midwifery is the most commonly completed post-nursing course.

The most common formal nursing course reported by the total sample was midwifery (22%), this was followed by critical care (6%). Midwifery remained the most common nursing course for all three age groups.

Midwifery also remained the most common nursing course (Table 4) for Division 1 (29%) and Division 2 (4%)(sic), however mental health was the most common nursing course for Division 3 (18%).

Table 4: Type of Nursing Course by Division of Registration

Q12: Have you completed any formal post basic nursing courses such as grad dips etc?

Course Type	Total (2,089) %	Division 1 (1,478) % A	Division 2 (531) % B	Division 3 (33) % C
None	36	31	65 ^A	52 ^A
Midwifery	22	29 ^{BC}	4	6
Not Answered	11	9	17 ^A	15
Critical Care	6	8 ^{BC}	1	0
Advanced Nursing	5	6 ^B	2	3
Education	4	5 ^B	1	9 ^B
Community Health	3	5 ^B	1	3
Administration/ Management	3	4 ^B	1	3
Maternal & Child Health	3	4 ^B	1	0
Gerontology	3	4	2	3
Perioperative	3	4 ^B	1	0
Coronary Care	2	3 ^B	0	0
Accident & Emergency	2	2 ^b	1	3
Mental Health/ Psychiatric	2	2	1	18 ^{AB}

Note: Percentages add up to more than 100% because of multiple responses.

Note Alphabet letters A, B, C represent significant levels.

6.2.1 Employed as a Registered Nurse

Nearly all respondents (98%) indicated that they had been employed as a registered nurse, while a very small proportion (1%) responded that they had never been employed.

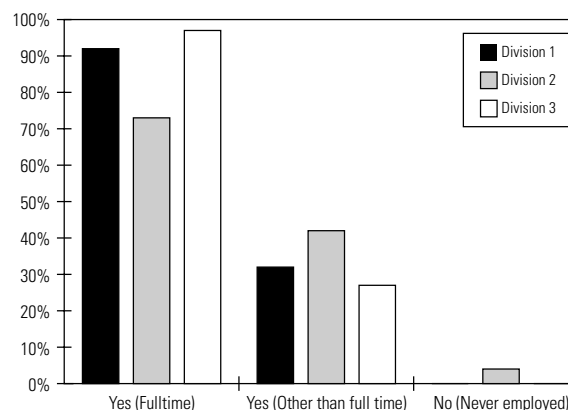
There was no difference by age or Division.

Division 2 nurses are less likely to work on a full-time basis than Division 1 and Division 3 nurses.

Some nurses indicated that they had worked as a registered nurse on a full-time and/or other than full-time basis. Division 2 nurses (73%) were less likely to work on a full-time basis than both Division 1 (92%) and Division 3 (97%). However, Division 2 nurses (42%) are more likely to work 'other than full-time' (for instance part-time, casual) compared to Division 1 (32%) and Division 3 (27%).

Figure 7: Employment of Registered Nurses

Q9: Have you ever been employed as a registered nurse?



Base: Division 1 (1,478)
Division 2 (531)
Division 3 (33)

6.2.2 Division of Employment

Nurses who had been employed as registered nurses were asked to indicate which Division they were employed in. Most nurses worked in their Division of registration, however some did work in other Divisions (Table 5).

Table 5: Division of Employment

Q10 In which Divisions were you employed?

Registered Division	Division 1 (1,473) %	Division 2 (628) %	Division 3 (42) %
Employed in Division 1	97	5	25
Employed in Division 2	9	97	0
Employed in Division 3	1	0	91

Note: Percentages add up to more than 100% because of multiple responses.

Note: Some respondents have been employed and registered in more than one division, which illustrates multiple responses. This is due to the previous structure of the nursing training system where Division 1 students could work as Division 2 nurses as part of their education.

6.3 Employment Attitudes

A key objective of the current study was to identify the reasons why registered nurses left the nursing profession. In this section of the report, survey information will identify specific characteristics of the nurses who have left the profession and reasons that led them to their

decision. This section begins by analysing the total sample by current work status.

6.3.1 Current Work Status

While the sample was drawn from nurses who indicated they were not working as a nurse in the registration survey, a substantial proportion (16%) were in fact working.

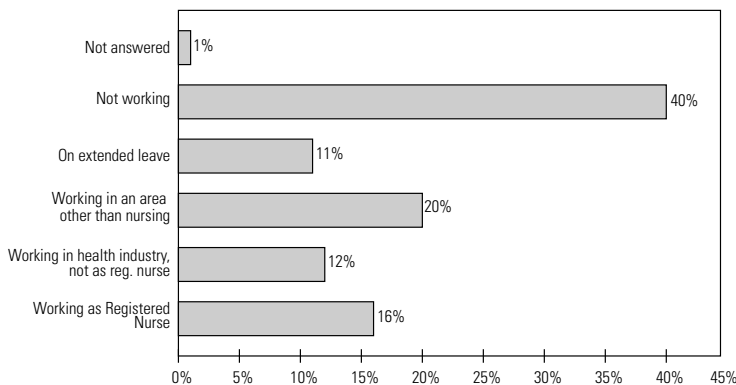
Four in ten registered nurses were not working at all.

Of the total sample (Figure 8):

- 16% of respondents were working as a registered nurse.
- 11% of respondents were on extended leave.
- 12% of respondents were working in the health industry, but not as a nurse.
- 20% of respondents were working in an area other than nursing.
- 40% of respondents were not working at all.

Figure 8: Current Work Status

Q1: Which of the following best describes your current work status?



Base: Total sample (2,089)

Note: The sample included respondents who were on extended leave in order to determine the preconceived notion that nurses on maternity leave do not always return, and secondly to act as a de facto control group.

Division 1 and Division 3 registered nurses are more likely to be working as a 'nurse' than Division 2 registered nurses.

'Current work status' was analysed by Division of registration (Table 6) and it was found that:

- Division 1 (17%) and Division 3 (21%) nurses were more likely to be working as registered nurses than Division 2 nurses (13%).

- Division 1 nurses were also more likely to be on leave (14%) than both Division 2 (7%) and Division 3 nurses (3%).
- Division 2 nurses (27%) were more likely to be 'working in another area other than nursing' than Division 1 (18%) and Division 3 (21%).
- Across all Divisions of registration there is consistency between respondents reporting that they were not working.

Table 6: Current Work Status by Division of Registration

Q1 Which of the following best describes your current work status?

Current Work Status	Division 1	Division 2	Division 3
	(1,478) % A	(531) % B	(33) % C
Working as registered nurse	17 ^b	13	21
Working in health, but not as a registered nurse	11	15 ^a	9
Working in an area other than nursing	18	27 ^a	21
Not working (on leave)	14 ^{bc}	7	3
Not working	40	37	45

Note: Alphabet letters A, B, C represents significant levels.

Younger registered nurses are more likely to be working as a nurse than middle aged and older registered nurses.

'Current work status' was also analysed by age (Table 7), which found that:

- Younger nurses (25%) are more likely to be working as a registered nurse than both middle (17%) and older (8%) registered nurses.
- Younger nurses were also more likely to be working in a 'health-related field but not as a registered nurse' (16%) and 'taking extended leave' (17%), than older registered nurses.
- Older nurses (57%) are more likely to be not working at all compared to younger (19%) and middle (37%) aged registered nurses.

Table 7: Current Work Status by Age

Q1 Which of the following best describes your current work status?

Current Work Status	Younger (203) %	Middle (1,416) %	Older (432) %
	A	B	C
Working as registered nurse	25 ^{BC}	17 ^C	8
Working in health, but not as a registered nurse	16 ^C	12	11
Working in an area other than nursing	23	20	20
Not working (on leave)	17 ^C	13 ^C	4
Not working	19	37 ^A	57 ^{AB}

Note: Alphabet letters A, B, C represents significant levels.

Registered nurses in non-metropolitan Victoria are less likely to be working compared to registered nurses in metropolitan Victoria.

There are small differences between registered nurses residing in metropolitan Victoria and non-metropolitan Victoria for current work status. Registered nurses residing in non-metropolitan Victoria (42%) are significantly more likely to be 'not working' than metropolitan registered nurses (38%).

6.3.2 Reasons for Leaving Nursing

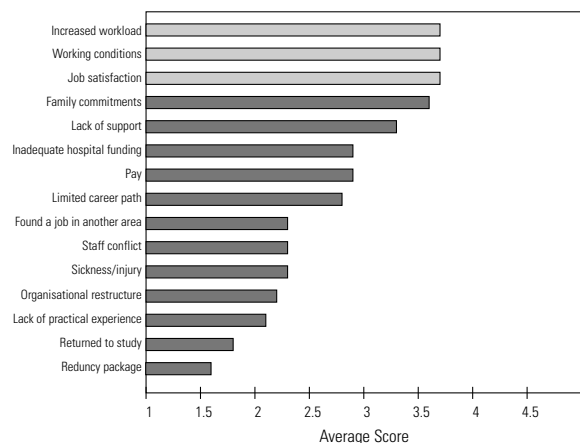
The three main reasons why nurses stopped working in the nursing profession (Table 8) were:

- Job satisfaction
- Working conditions
- Increased workload.
- These were closely followed by family commitments and lack of support.

Figure 9: Influential Factors for Leaving the Nursing Profession

Q15 Thinking about why you left work in nursing, how important were the following factors?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Sample 1,790 (excludes participants working as a nurse)

Key differences between Divisions of registration for reported 'factors' for leaving nursing (Table 9) included:

- Across all Divisions of registration, factors such as 'increased workload' and 'working conditions' were rated as the most important factors for leaving the nursing profession.
- Division 2 nurses significantly placed greater importance on many factors compared to Division 1.
- Factors such as family commitment, lack of support, and organisational restructure were rated consistently across all Divisions.

Table 8: Factors for Leaving Nursing by Division of Registration (Average Score)

Q15: Thinking about why you left work in nursing, how important were the following factors?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Division 1 (1,227) Average A	Division 2 (461) Average B	Division 3 (27) Average C
Working conditions	3.7	3.7	3.8 ^a	4.1
Increased workload	3.7	3.7	3.9 ^a	3.6
Job satisfaction	3.7	3.6	3.8 ^a	3.8
Family commitments	3.6	3.6	3.6	3.6
Lack of support	3.3	3.3	3.3	3.5
Pay	2.9	3.2 ^a	3.0	
Inadequate hospital funding	2.9	2.8	3.1 ^a	2.9
Limited career path	2.8	2.5	3.3 ^a	2.8
Sickness/injury	2.3	2.3	2.5 ^a	2.2
Staff conflict	2.3	2.2	2.3 ^a	2.7
Found a job in another area	2.3	2.1	2.6 ^a	2.7
Organisational restructure	2.2	2.2	2.3	2.7
Lack of practical experience	2.1	2.0	2.4 ^a	2.2
Returned to study	1.8	1.8	1.9 ^a	1.8
Redundancy package	1.6	1.5	1.7 ^a	2.0

Note: Alphabet letters A, B, C represents significance levels.

‘Job satisfaction’, ‘working conditions’ and ‘increased workloads’ are factors rated as highly important for leaving the nursing profession across all age groups. Within particular age groups:

- Older registered nurses rated factors such as sickness/injury, redundancy package, inadequate hospital funding and organisational restructure higher than both middle and younger nurses.
- Younger nurses rated ‘lack of practical experience’, ‘working conditions’, ‘return to study’ and ‘found a job in another area’ higher than both middle and older registered nurses as contributing factors for leaving the nursing profession.
- Younger and middle registered nurses rated family commitments, pay and limited career path higher in importance for leaving the nursing profession than older registered nurses (Table 9).

Table 9: Factors for Leaving Nursing by Age (Average Score)

Q15: Thinking about why you left work in nursing, how important were the following factors?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Younger (152) Average A	Middle (1,176) Average B	Older (400) Average C
Job satisfaction	3.7	3.8	3.7	3.7
Working conditions	3.7	4.0 ^{bc}	3.7	3.6
Increased workload	3.7	3.8	3.7	3.9 ^b
Family commitments	3.6	3.3 ^c	3.9 ^{ac}	2.6
Lack of support	3.3	3.4	3.2	3.4 ^b
Pay	2.9	3.1 ^c	3.0 ^c	2.5
Inadequate hospital funding	2.9	2.7	2.8	3.1 ^{ab}
Limited career path	2.8	3.0 ^c	2.9 ^c	2.2
Sickness/injury	2.3	2.3	2.1	3.0 ^{ab}
Staff conflict	2.3	2.3	2.2	2.5 ^b
Found a job in another area	2.3	2.9 ^{bc}	2.3 ^c	1.9
Organisational restructure	2.2	1.9	2.1	2.9 ^{ab}
Lack of practical experience	2.1	2.6 ^{bc}	2.1	2.0
Returned to study	1.8	2.1 ^{bc}	1.8 ^c	1.5
Redundancy package	1.6	1.4	1.5	1.9 ^{ab}

Note: Alphabet letters A, B, C represent significance levels.

There are some significant differences between registered nurses residing in metropolitan Victoria and non-metropolitan Victoria. Nurses residing in metropolitan Victoria placed more importance on the following factors for leaving the nursing profession than registered nurses residing in non-metropolitan Victoria:

- Lack of support
- Job satisfaction
- Working conditions
- Increased workload
- Pay
- Limited career path
- Returned to study
- Organisational restructure
- Inadequate hospital funding.

6.3.3 Factors for Leaving Nursing by Current Work Status

The main factor (Table 12) rated as important for respondents who are not working was family commitments (average score 4.0). This was also the main factor for people on leave (average score 4.4). The main factor for leaving nursing for people working in a health job (but not as a nurse) was 'job satisfaction' (average score 4.0). This was the highest rated factor in terms of importance for people working in another area (average score 3.9).

Table 10: Factors for Leaving Nursing by Current Work Status (Average Score)

Q15: Thinking about why you left work in nursing, how important were the following factors?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Working			Not Working	
	Total	Health	Other	Leave	Not
	(1,760) Average	(249) A	(422) B	(225) C	(826) D
Job satisfaction	3.7	4.0 ^{CD}	3.9 ^{CD}	3.5	3.6
Working conditions	3.7	3.9 ^D	3.9 ^D	3.7 ^D	3.5
Increased workload	3.7	3.7	3.9 ^{ACD}	3.7	3.6
Family commitments	3.6	2.6	3.0 ^A	4.4 ^{ABD}	4.0 ^{AB}
Lack of support	3.3	3.4 ^D	3.4 ^D	3.4 ^D	3.1
Pay	2.9	3.1 ^E	3.0 ^E	3.0 ^E	2.8
Inadequate hospital funding	2.9	2.9 ^{CD}	3.3 ^{ACD}	2.6	2.7
Limited career path	2.8	3.3 ^{BCD}	3.1 ^{CD}	2.7 ^D	2.4
Sickness/injury	2.3	2.1	2.2 ^C	2.0	2.5 ^{ABC}
Staff conflict	2.3	2.3 ^C	2.2	2.0	2.3 ^D
Found a job in another area	2.3	3.7 ^{BCD}	3.2 ^{CD}	1.6 ^D	1.4
Organisational restructure	2.2	2.3 ^C	2.4 ^{CD}	1.9	2.2 ^C
Lack of practical experience	2.1	2.2 ^C	2.2 ^C	1.9	2.1 ^C
Returned to study	1.8	2.2 ^{CD}	2.0 ^{CD}	1.7	1.5
Redundancy package	1.6	1.6 ^C	1.5 ^C	1.4	1.7 ^{BC}

Note: Alphabet letters A, B, C & D represents significance levels.

Note: In table headers 'Health' refers to nurses working in the health arena but not as a nurse, 'Other' refers to nurses working in an area other than nursing, 'Leave' refers to nurses who are on leave from nursing and 'Not' refers to nurses not working.

Two in ten respondents who identified 'other' factors for why they left the nursing profession were related to:

- Structural change
- Other employment functions
- Retirement
- Factors not related to nursing (Table 11).

Table 11: 'Other' Factors for Leaving Nursing by Age

Q15: Thinking about why you left work in nursing, how important were the following factors?

'Other' Factors	Younger (152) %	Middle (1,176) %	Older (400) %
Structural change	7	6	14
Other employment functions	5	5	4
Retirement	1	1	1
Unrelated to nursing	3	3	3
No other factor mentioned	84	84	76

6.4 Seeking Employment as a Nurse

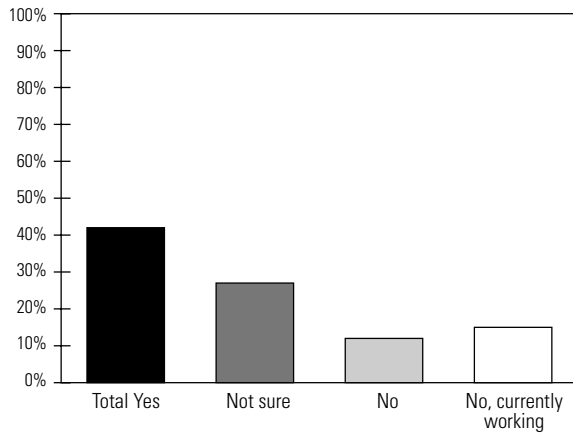
Three in ten registered nurses were unsure whether they would seek employment as a nurse.

Of the total sample:

- Four in ten (42%) respondents will seek employment as nurse.
- Three in ten (27%) respondents were unsure whether they would seek employment.
- One in ten (12%) respondents indicated that they would not seek employment as a nurse.
- 15% of respondents indicated that they would not seek employment as a nurse because they were already working.

Figure 10: Seeking Employment as a Nurse

Q11 Do you think you will actively seek employment as a nurse?



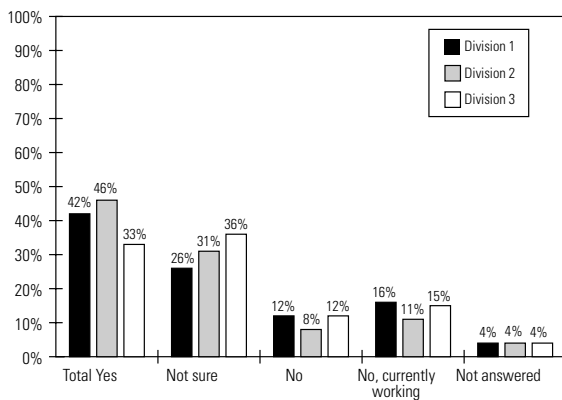
Base: Total sample (2,089)

Seeking employment as a nurse did not differ between Divisions of registrations for 'total yes' (Figure 11). There were significant differences for:

- 'Not sure' between Division 2 (31%) and Division 1 (26%)
- 'No' between Division 1 (12%) and Division 2 (8%).

Figure 11: Seeking Employment by Division of Registration

Q11: Do you think you will actively seek employment as a nurse?



Base: Division 1 (1,478), Division 2 (531), Division 3 (33)

There was some age differences for seeking employment, which included:

- Older registered nurses (19%) are less likely to seek employment than younger (43%) and middle (49%) aged registered nurses.

- Older (40%) and middle (24%) aged registered nurses are more likely to be 'not sure' about seeking for employment than younger registered nurses (18%).

No differences were found between registered nurses residing in metropolitan Victoria and registered nurses residing in non-metropolitan Victorian in terms of seeking employment as a nurse.

6.4.1 Intentions To Seek Employment by Current Work Status

Nearly two in ten (16%) registered nurses who are currently working as a registered nurse (16%) reported that they were seeking employment as a nurse (Table 12).

Five in ten (51%) non-working registered nurses will at some stage seek employment as a nurse. Three in ten (32%) non-working registered nurses were unsure whether they would seek employment (Table 12).

Respondents who were:

- working in a health related field, but not as a nurse (16%);
- working in a other area (14%); and
- not working at all (15%);

were more likely not to seek employment as a nurse, compared to respondents on leave (6%) (Table 12).

Table 12: Active Employment Seeking by Current Work Status

Q11 Will you actively seek employment as a nurse?

	Working			Not Working		
	Total (2,089) %	Nurse (333) %	Health (253) %	Other (425) %	Leave (240) %	No (827) %
Total Yes	42	23	32	34	67	51
Not sure	27	2	35	42	12	32
No	12	0	16	14	6	15
No, currently working	15	60	16	9	10*	0

* Respondents do not intend to seek employment because they considered themselves on leave from their current employment.

6.4.2 Reasons for Not Seeking Employment as a Nurse

The main reasons for not seeking employment (Table 13) included retirement (18%), poor career satisfaction (17%), working in another area (19%) and family responsibilities (12%).

Table 13: Reasons for Not Seeking Employment as a Nurse

Q11b: If you DON'T INTEND to seek employment, please tell us why?

Factor	Total (242) %	Younger (18) %	Middle (100) %	Older (121) %
		A	B	C
Working/studying in other area	19	28	34 ^c	7
Retirement	18	0	0	33 ^{AB}
Poor career satisfaction	17	39	23 ^c	8
Family responsibilities	12	17	17 ^c	7
Negative work environment	12	22	16 ^c	8
Injury/illness not work related	11	6	3	19 ^b
Excessive work load	9	6	9	9
Poor salary	7	22	12 ^c	0
Work related stress/burnout	5	0	4	5
Heavy workload	5	0	6	4
Not answered	5	11	3	7
Hours of work	4	11	8	0
WorkCover injury/illness	4	0	2	7
Age	4	0	1	7 ^b
Lack of staff	3	6	4	2
Child care	2	0	4 ^c	0
Stress/burnout not work related	2	0	3	1
Lack of suitable/available positions	1	0	1	2

Note: Percentages add to more than 100% because of multiple responses.

Note: Alphabet letters A, B, C represents significance levels.

Previously, it was discussed that older nurses were more likely not to seek employment than younger and middle aged nurses. As Table 13 suggests older nurse do not seek employment because of:

- Retirement (33%)
- Injury/illness (19%)
- Excessive workload (9%).

Middle and younger nurses do not seek employment for reasons such as:

- Poor career satisfaction (23% and 39%)
- Poor salary (12% and 22 %)
- Negative work environment (16% and 22%)
- Family responsibilities (17% and 17%).

One in ten (12%) of the total sample reported that they would not actively seek employment (Table 13). These respondents mainly consisted of registered nurses who were already working but not as a nurse and registered nurses who were not working at all.

Influential factors (Table 14) for registered nurses who are not looking for work included:

- Retirement (30%)
- Injury/illness (17%)

Registered nurses working in the health arena but not as a nurse reported the influential factors to be:

- Poor career satisfaction (33%)
- Working/studying in another area (40%).

The factors reported for nurses working in another area included:

- Negative work environment/conditions (24%)
- Working/studying in another area (36%).

Table 14: Reasons for Not Seeking Employment as a Nurse by Current Work Status

Q11b: If you DON'T INTEND to seek employment, please tell us why?

Factor	Working			Not Working	
	Total (242) %	Health (40) %	Other (59) %	Leave (14) %	No (127) %
		A	B	C	D
Working/studying in other area	19	40 ^D	36 ^D	7	7*
Retirement	18	0	3	7	30 ^{AB}
Poor career satisfaction	17	33 ^D	20	7	12
Family responsibilities	12	3	5	50	14 ^{Ab}
Negative work environment	12	2	24 ^{BC}	0	11
Injury/illness not work related	11	3	3	14	17 ^{AB}
Excessive workload	9	8	10	0	9
Poor salary	7	5	15 ^D	0	4
Heavy workload	5		5	0	4
Not answered	5	5	8	0	5
Work related stress/burnout	5	3	2	7	6
Hours of work	4	8 ^D	8 ^D	0	2
WorkCover injury/illness	4	5	2	14	4
Age	4	0	5	0	6
Lack of staff	3	5	3	0	2
Child care	2	0	2	0	2
Stress/burnout not work related	2	0	3	0	2
Lack of suitable/available positions	1	5 ^{no}	0	0	1

Note: Percentages add to more than 100% because of multiple responses.

Note: Alphabet letters A, B, C & D represents significance levels.

* Respondents are studying in an area other than nursing.

6.4.3 Important Factors for Not Seeking Employment in Nursing

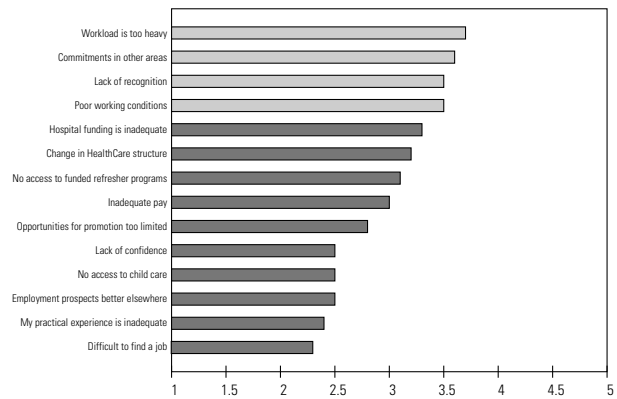
Registered nurses, excluding those already working as a nurse, were asked to rate the importance of a list of influential factors for not seeking employment. The four highest rated factors included:

- The workload is too heavy
- Commitments in other areas (family)
- Lack of recognition
- Working conditions are poor.

Figure 12: Influential Factors for Not Seeking Employment

Q17 How important are the following factors for you not actively seeking employment in nursing?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Sample 1760 (excludes participants working as a nurse).

Registered nurses in Division 1 and Division 2 reported different influential factors for not seeking employment than registered nurses in Division 3 (Table15).

Division 1 and Division 2 rated:

- No access to child care
- Commitments in other areas (family)
- Employment prospects are better elsewhere
- Opportunities for promotion are limited
- Pay is inadequate, higher in importance than respondents in Division 3.

Conversely, Division 3 rated 'working conditions as poor' and 'difficulty in finding a job' higher in importance than respondents in Division 1 and Division 2.

Table 15: Influential Factors for Not Seeking Employment by Division of Registration

Q17 How important are the following factors for YOU not actively seeking employment in Nursing?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Division 1 (1,227) Average A	Division 2 (461) Average B	Division 3 (27) Average C
The workload is too heavy	3.7	3.6	3.6	3.9 ^{AB}
Commitments in other areas (family)	3.6	3.4 ^c	3.9 ^{AC}	2.6
Working conditions are poor	3.5	3.5	3.5	3.7 ^B
Nurses do not receive enough recognition for the work they do	3.5	3.7 ^c	3.5	3.5
Hospital funding is inadequate	3.3	3.1	3.3 ^A	3.5 ^{AB}
Change in the health care structure	3.2	2.7	3.1 ^A	3.6 ^{AB}
No access to funded refresher programs	3.1	3.0	3.1	3.1
The pay is inadequate	3.0	3.3 ^c	3.1 ^c	2.7
Opportunities for promotion are limited	2.8	3.2 ^{BC}	2.9 ^C	2.5
Employment prospects are better elsewhere	2.5	3.0 ^{BC}	2.5 ^c	2.1
No access to child care	2.5	2.6 ^c	2.9 ^{AC}	1.2
Lack confidence	2.5	2.8 ^{BC}	2.5	2.4
My practical experience is inadequate	2.4	2.7 ^{BC}	2.4	2.4
It is difficult to find a job	2.3	2.3	2.3	2.5 ^B

Note: Alphabet letters A, B, C represents significance levels.

Registered nurses from the middle age group rated most influential factors higher than both younger and older registered nurses (Table 16).

Table 16: Influential Factors for Not Seeking Employment by Age

Q17 How important are the following factors for YOU not actively seeking employment in Nursing?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Younger (152) Average A	Middle (1176) Average B	Older (400) Average C
The workload is too heavy	3.7	3.6	3.8 ^A	3.3
Commitments in other areas (family)	3.6	3.6	3.5	3.4
Working conditions are poor	3.5	3.5	3.6	3.4
Nurses do not receive enough recognition for the work they do	3.5	3.5	3.7 ^A	3.6
Hospital funding is inadequate	3.3	3.3	3.5 ^A	3.4
Change in the health care structure	3.2	3.1	3.4 ^A	3.2
No access to funded refresher programs	3.1	3.0	3.3 ^A	3.3
The pay is inadequate	3.0	2.9	3.3 ^A	2.6
Opportunities for promotion are limited	2.8	2.7	3.2 ^A	2.8
Employment prospects are better elsewhere	2.5	2.4	2.7 ^A	2.2
No access to child care	2.5	2.5	2.5	2.1
Lack confidence	2.5	2.5	2.4	2.6
My practical experience is inadequate	2.4	2.4	2.6 ^A	2.1
It is difficult to find a job	2.3	2.2	2.5 ^A	2.4

Note: Alphabet letters A, B, C represents significance levels.

Registered nurses residing in metropolitan Victoria significantly rated higher on the following factors (Figure 13) than registered nurses residing in non-metropolitan Victoria:

- Workload is too heavy
- Lack of recognition
- Poor working conditions
- Hospital funding is inadequate
- Inadequate pay
- Opportunities for promotion are limited.

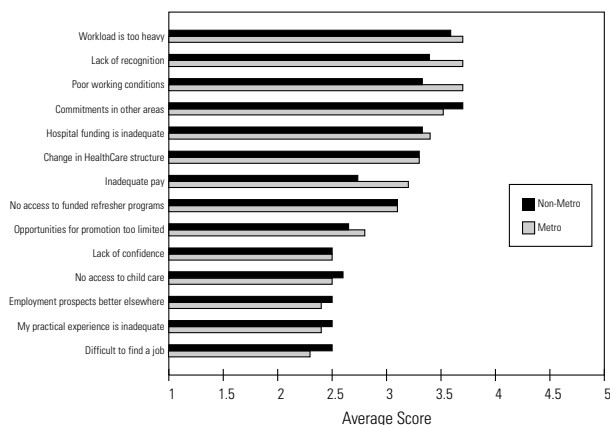
However, non-metropolitan Victorian registered nurses rated higher on factors, including:

- Commitments in other areas
- My practical experience is inadequate
- Difficult to find a job.

Figure 13: Influential Factors for Not Seeking Employment by Geographical Location

Q17 *How important are the following factors for YOU not actively seeking employment in Nursing?*

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Metro (908), Non-Metro (695).

Respondents who are working rated different factors higher in importance than respondents who are not working (Table 17). For instance, registered nurses who are working, but not as a nurse, rated factors higher, including:

- Pay is inadequate
- Working conditions are poor
- Employment prospects are better elsewhere.

However, respondents who are not working rated higher on factors such as, commitments in other areas (family) and no access to child care, than respondents who are working.

Table 17: Influential Factors for Not Seeking Employment by Current Work Status

Q17 *How important are the following factors for YOU not actively seeking employment in nursing?*

Factor	Working			Not Working	
	Total (1,760) Average	Health (249) A	Other (422) B	Leave (225) C	No (826) D
The workload is too heavy	3.7	3.8	3.7 ^C	3.5	3.6
Commitments in other areas (family)	3.6	2.6	3.1 ^A	4.2 ^{ABD}	4.0 ^{AB}
Working conditions are poor	3.5	3.8 ^{CD}	3.7 ^{CD}	3.3	3.4
Nurses do not receive enough recognition for the work they do	3.5	3.8 ^{CD}	3.7 ^{CD}	3.5	3.4
Hospital funding is inadequate	3.3	3.4 ^C	3.6 ^{CD}	3.1	3.2
Change in the health care structure	3.2	3.1 ^C	3.3 ^{AC}	2.8	3.2 ^C
No access to funded refresher programs	3.1	3.0	3.2 ^{AC}	2.7	3.2 ^C
The pay is inadequate	3.0	3.3 ^{CD}	3.2 ^D	3.0	2.8
Opportunities for promotion are limited	2.8	3.3 ^{BCD}	3.0 ^{CD}	2.7	2.5
Employment prospects are better elsewhere	2.5	3.1 ^{CD}	3.0 ^{CD}	2.2	2.1
No access to child care	2.5	1.9	2.2 ^A	3.6 ^{ABD}	2.7 ^{AB}
Lack confidence	2.5	2.3	2.4 ^C	2.1	2.6 ^{ABC}
My practical experience is inadequate	2.4	2.5 ^C	2.5 ^C	2.0	2.5 ^C
It is difficult to find a job	2.3	2.2 ^C	2.3 ^C	1.9	2.4 ^{ABC}

Note: Alphabet letters A, B, C & D represents significance levels.

One in ten registered nurses mention 'other' important factors for not actively seeking employment. These important factors included health and safety, employment conditions, negative attitudes and the redundancy process.

6.4.4 Barriers to Obtaining Employment in Nursing

All respondents, except those employed as a nurse, were asked to rate the importance of a list of factors relating to the barriers in obtaining successful employment.

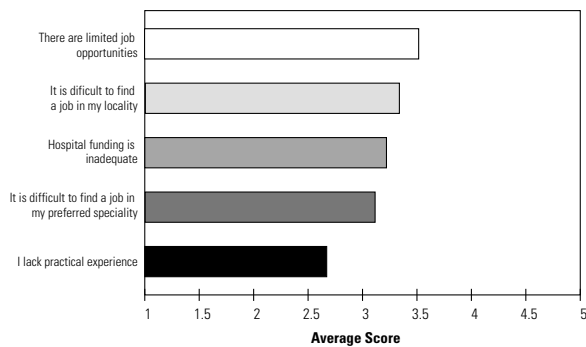
The two most important factors for not finding successful employment in nursing were:

- Limited job opportunities
- It is difficult to find a job in my locality.

Figure 14: Factors Rated for Importance in Not Finding Employment in Nursing

Q18 If you have been seeking employment in nursing but have not been successful, please circle the number that identifies how important the following factors are:?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Sample 1760 (excludes participants working as a nurse)

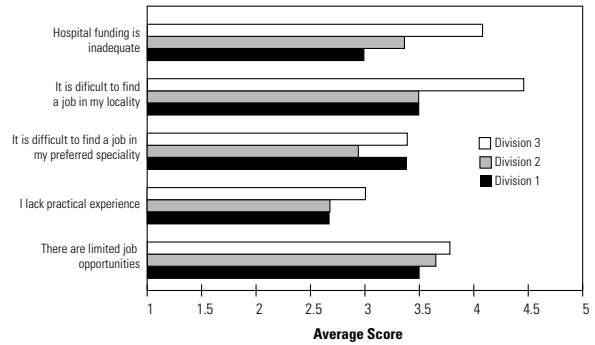
There were only two significant differences between Division of registration for the factors rated as important in not finding employment in nursing (Figure 15). These included:

- Division 1 nurses rated higher importance for 'difficult to find a job in my preferred speciality', than Division 2.
- Division 2 nurses rated higher importance for 'inadequate hospital funding' than Division 1.

Figure 15: Factors Rated Important for Not Successfully Obtaining Employment by Division of Registration

Q18 If you have been seeking employment in nursing but have not been successful, please circle the number that identifies how important the following factors are:?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Division 1 (1,227), Division 2 (461), Division 3 (27)

Note: Division 3 consists of a relatively small sample, therefore interpret this finding with care.

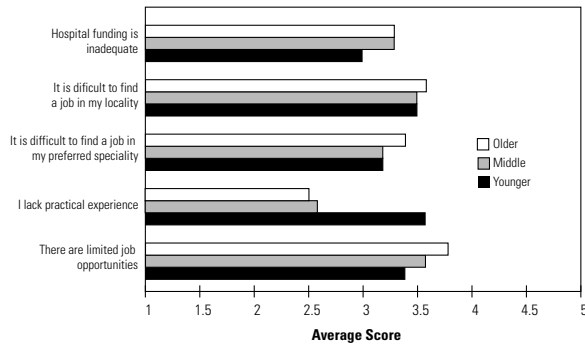
There were only two significant differences between age groups for the factors rated as important in not finding employment in nursing (Figure 16). These are:

- Younger registered nurses rated 'I lack practical experience' higher than middle age and older registered nurses.
- Older registered nurses rated 'there are limited job opportunities' higher than middle and younger registered nurses.

Figure 16: Factors Rated as Important for Not Obtaining Employment by Age

Q18 *If you have been seeking employment in nursing but have not been successful, please circle the number that identifies how important the following factors are:?*

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.



Base: Younger (152), Middle (1176), Older (400)

Two significant differences were noted between metropolitan respondents and non-metropolitan respondents with factors rated as important for not obtaining employment as a nurse. These include non-metropolitan registered nurses rating higher importance on:

- There are limited job opportunities.
- It is difficult to find a job in my locality.

6.5 Returning to the Nursing Profession

One of the main objectives of the current research was to determine the factors that will influence registered nurses to return to the nursing profession. This section explores survey information regarding this objective, and begins by analysing the important factors that contribute to respondents' decision to return to work in nursing.

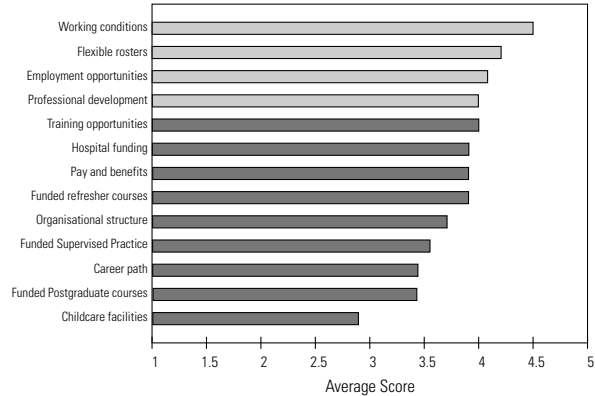
6.5.1 Influential Factors in Returning to Work

Respondents regarded all factors highly important (Figure 17), however the three 'stand out' main factors rated as important in returning to work as a nurse included:

- Working conditions
- Flexible rosters
- Employment opportunities.

Figure 17: Factors Rated as Important in Returning to Work

Q16 *If you decided that you wanted to return to work in nursing, how important are the following factors?*



Base: Sample 1760 (excludes participants working as a nurse)

Division 1 and Division 2 nurses rated most factors relating to returning to work as significantly higher in importance than Division 3 (Table 18). Division 1 nurses did rate 'organisational structure' higher in importance than both Division 2 and Division 3.

Table 18: Factors Rated as Important in Returning to Work by Division of Registration

Q17 *If you decided that you wanted to return to work in nursing, how important are the following factors?*

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Division 1 (1,227) Average A	Division 2 (461) Average B	Division 3 (27) Average C
Working Conditions	4.5	4.5	4.5	4.4
Flexible rosters	4.2	4.4 ^c	4.4 ^c	3.7
Employment opportunities	4.1	4.2 ^c	4.1 ^c	3.9
Training opportunities	4.0	4.1 ^c	4.0 ^c	3.8
Professional development	4.0	4.1 ^c	4.0 ^c	3.7
Funded refresher courses	3.9	3.9	3.9	3.8
Hospital funding	3.9	3.9	3.9	3.9
Pay and benefits	3.9	4.2 ^c	4.0	3.6
Organisational structure	3.7	3.5	3.7	3.8 ^{AB}
Funded supervised practice	3.6	3.8 ^c	3.6 ^c	3.5
Funded post graduate courses	3.4	3.6 ^c	3.5 ^c	2.9
Career path	3.4	3.8 ^{BC}	3.5 ^c	2.6
Childcare facilities	2.9	2.9	2.8	2.8

Note: Alphabet letters A, B, C represents significance levels.

Middle aged registered nurses placed higher importance on many factors compared to younger registered nurses (Table 19). These include:

- Training opportunities
- Employment opportunities
- Funded refresher courses
- Pay and benefits
- Career path.

Table 19: Factors Rated as Important in Returning to Work by Age

Q17 How important are the following factors for YOU not actively seeking employment in Nursing?

1 = Not at all important, 2 = Not too important, 3 = Important, 4 = Very important, 5 = Extremely important.

Factor	Total (1,760) Average	Younger (152) Average A	Middle (1176) Average B	Older (400) Average C
Working conditions	4.5	4.5	4.5	4.5
Flexible rosters	4.2	4.2	4.3	4.5
Employment opportunities	4.1	4.0	4.3 ^a	4.2
Training opportunities	4.0	4.0	4.1 ^a	4.1
Professional development	4.0	3.9	4.0	3.8
Funded refresher courses	3.9	3.8	4.0 ^a	4.3
Pay and benefits	3.9	3.9	4.1 ^a	4.0
Hospital funding	3.9	3.9	3.9	3.9
Organisational structure	3.7	3.7	3.7	3.6
Funded supervised practice	3.6	3.6	3.6	3.9
Funded postgraduate courses	3.4	3.4 ^b	3.2	3.3
Career path	3.4	3.3	3.6 ^a	3.7
Child care facilities	2.9	2.9	2.8	2.8

Note: Alphabet letters A, B, C represents significance levels.

6.5.2 Area of Nursing Likely to Work

Participants were asked which area of nursing they would like to work in if they returned to work as a nurse. The three most reported areas were:

- Gerontology (27%)
- Agency/casual (27%)
- Mixed medical and surgical (21%).

These were closely followed by community health (18%), surgical (13%), and midwifery (12%).

Area of work was analysed by Division of registration (Table 20), which found that:

- Division 1 nurses are likely to work in community health (20%)
- Division 2 nurses are likely to work in gerontology (44%)
- Division 3 nurses are likely to work in mental health/Psychiatric (85%).

Table 20: Area of Nursing Likely to Work by Division of Registration

Q13 If you were to RETURN TO WORK AS A NURSE, in which area of nursing would be likely to work?

Area of Work	Total (1,760) %	Division 1 (1,227) % A	Division 2 (461) % B	Division 3 (27) % C
Gerontology	27	21	44 ^A	15
Agency/casual	27	26	34 ^A	26
Mixed medical and surgical	21	20	27 ^A	7
Community health	18	20 ^b	13	33
Surgical	13	14	12	0
Midwifery	12	15 ^b	5	0
Medical	11	10	15 ^A	4
Rehabilitation	9	6	17 ^A	4
Management	8	10 ^b	2	15
Perioperative (including operating theatre and recovery)	7	8 ^b	3	0
Not answered	7	8 ^b	5	0
Accident and emergency	6	7 ^b	4	0
School children's health	6	7 ^b	4	4
Paediatric	5	5	6	0
Mental health/psychiatric	5	4	6 ^A	85
No specialty	5	3	10 ^A	0
Oncology	4	4	4	0
Critical care/intensive care	4	5 ^b	2	0
Maternal & child health	4	4 ^b	2	7
Coronary care	3	4 ^b	1	0
Gynaecology	3	3	3	0
Net Mixed medical & surgical, surgical, and medical*	45	44	54	11

Note: Percentages add up to more than 100% because of multiple responses.

Note: Alphabet letters A, B, C represents significance levels.

* Response consists of three combined categories namely medical & surgical, medical, and surgical

Age differences were evident for the area of nursing the participants would return to (Table 13), for instance:

- Younger and middle aged nurses were likely to work in Agency/casual (30% and 30%)
- Older nurses were more likely to work in gerontology (38%).

Table 21: Area of Nursing Likely to Return to Work by Age

Q13 *If you were to RETURN TO WORK AS A NURSE, in which area of nursing would be likely to work?*

Area of Work	Total (1,760) %	Younger (152) % A	Middle (1176) % B	Older (400) % C
Gerontology	27	15	24 ^A	38 ^{AB}
Agency/casual	27	30 ^C	30 ^C	20
Mixed medical and surgical	21	25 ^C	24 ^C	11
Community health	18	13	18	18
Surgical	13	22 ^{BC}	15 ^C	6
Midwifery	12	5	14 ^{AC}	10
Medical	11	16 ^C	12 ^C	8
Rehabilitation	9	9	9	10
Management	8	5	8	9
Perioperative (including operating theatre & recovery)	7	7	7	6
Not answered	7	5	7	11 ^{AB}
Accident and emergency	6	10 ^{BC}	6 ^C	4
School children's health	6	8	6	5
Paediatric	5	9 ^C	5 ^C	3
Mental health/psychiatric	5	9 ^C	6 ^C	3
No specialty	5	7	5	5
Oncology	4	4	5	3
Critical care/intensive care	4	5 ^C	6 ^C	1
Maternal and child health	4	5	3	4
Coronary care	3	3 ^C	3 ^C	1
Gynaecology	3	1	3	3
Net Mixed medical & surgical, surgical, and medical*	45	63	51	25

Note: Alphabet letters A, B, C represents significance levels.

Note: Percentages add up to more than 100% because of multiple responses

* Response consists of three combined categories namely medical & surgical, medical, and surgical

Some notable differences of area of work were reported between metropolitan and non-metropolitan nurses. These included registered nurses residing in metropolitan Victoria:

- To work in surgical (15%) and agency/casual (31%) more than registered nurses residing in non-metropolitan Victoria (11% and 24%).
- To work in community health (16%) and gerontology (21%) less than registered nurses in non-metropolitan Victoria (21% and 34%).

Differences between respondents who are working and not working, in terms of the nursing area they would likely return to work to, were evident from the survey information (Table 22). These included:

- Respondents who were working in the health arena were more likely to report that they would return to work in the 'community health' area (24%).
- Respondents working in other areas (not health related), reported that they would likely return to work in the agency/casual area (32%).
- Registered nurses on leave were also likely to return to work as a nurse in the agency/casual area (25%).
- Respondents who are not working at all reported they would most likely return to work in the area of gerontology (30%).

Table 22: Area of Nursing Likely to Return to by Current Work Status

Q13 *If you were to RETURN TO WORK AS A NURSE, in which area of nursing would be likely to work?*

Area of Work	Working		Not Working		
	Total (1,760) %	Health (249) %	Other (422) %	Leave (225) %	No (826) %
		A	B	C	D
Gerontology	27	24 ^c	27 ^c	17	30 ^{ac}
Agency/casual	27	24	32 ^{ac}	25	27
Mixed medical and surgical	21	17	24 ^{ad}	16	23 ^{ad}
Community health	18	24 ^{bcd}	19 ^c	11	18 ^c
Surgical	13	12	14	11	15
Midwifery	12	7	12 ^a	12	14 ^a
Medical	11	12 ^c	11 ^c	6	13 ^c
Rehabilitation	9	12 ^c	9 ^c	3	10 ^c
Management	8	16 ^{bcd}	10 ^c	4	5
Perioperative (including operating theatre & recovery)	7	7	7	9 ^d	6
Not answered	7	8 ^{bd}	3	23 ^{abd}	5
Accident and emergency	6	9 ^d	7 ^d	7 ^d	4
School children's health	6	4	8 ^c	4	6
Paediatric	5	4	6 ^c	3	6 ^c
Mental health/psychiatric	5	9 ^{bcd}	5	4	4
No specialty	5	6 ^c	7 ^c	2	6 ^c
Oncology	4	4	8 ^{acd}	3	3
Critical care/intensive care	4	6 ^d	5 ^d	8 ^d	2
Maternal and child health	4	2	3	2	4 ^{ac}
Coronary care	3	3	3	2	3
Gynaecology	3	2	4	2	3
Net mixed medical & surgical, medical, and surgical*	45	41	49	33	51

Note: Alphabet letters A, B, C & D represents significance levels.

Note: Percentages add up to more than 100% because of multiple responses

* Response consists of three combined categories namely medical & surgical, medical, and surgical

6.5.3 Desired Area of Nursing

Respondents were asked what area of nursing they would like to work in if appropriate training were accessible. The three main areas reported were:

- Community health (26%)
- Midwifery (18%)
- School children's health (16%).

The main areas reported by Division of registration (Table 23) included:

- Division 1 and Division 2 nurses would like to work in community health (25% and 30%).
- Division 3 nurses would like to work in mental health/psychiatric (30%).

Table 23: Desired Area of Nursing by Division of Registration

Q14 *If appropriate training were accessible to you, which of the following areas would you consider working in?*

Area of Work	Total (1,760) %	Division 1	Division 2	Division 3
		(1,227) %	(461) %	(27) %
		A	B	C
Community health	26	25	30 ^a	22
Midwifery	18	19	18	19
chool children's health	16	16	18	11
Not answered	16	19 ^b	9	11
Mixed medical and surgical	13	9	25 ^a	22
Maternal and child health	12	13	12	7
Gerontology	11	11	13	19
Surgical	10	7	18 ^a	7
Accident and emergency	10	10	11	4
Agency/casual	9	8	11 ^a	19
Cardiothoracic	9	9	11	11
Management	9	11 ^b	5	15
Oncology	8	7	11 ^a	4
Rehabilitation	8	6	15 ^a	7
Perioperative (including operating theatre & recovery)	8	7	13 ^a	4
Paediatric	8	6	15 ^a	7
Medical	6	5	10 ^a	7
Mental health/psychiatric	6	5	8 ^a	0
No specialty	6	5	7	15
Coronary care	5	5	4	0
Critical care/intensive care	5	6	4	0
Gynaecology	4	4	6 ^a	4
Neonatal/intensive care	4	4	5	4
Renal	3	3	3	7
Net Mixed medical & surgical, surgical, and medical*	29	21	53	36

Note: Alphabet letters A, B, C represents significance levels.

Note: Percentages add up to more than 100% because of multiple responses

* Response consists of three combined categories namely medical & surgical, medical, and surgical

Younger nurses would like to work in midwifery (26%), middle aged nurses would like to work in the area of school children's health' (20%), and older nurses would like to work in the area of community health (24%) (Table 24).

Table 24: Desired Area of Nursing by Age

Q14 *If appropriate training were accessible to you, which of the following areas would you consider working in?*

Area of Work	Total	Younger	Middle	Older
	(1,760) %	(152) % A	(1,176) % B	(400) % C
Community health	26	23	27	24
Midwifery	18	26 ^{BC}	20 ^C	10
Maternal and child health	16	9 ^{BC}	14 ^C	5
Not answered	16	1	15	23 ^{AB}
Mixed medical and surgical	13	14 ^C	15 ^C	8
Cardiothoracic	12	9	11 ^C	5
Gerontology	11	8	9	21 ^{AB}
Surgical	10	14 ^C	11 ^C	4
Accident and emergency	10	21 ^{BC}	10 ^C	4
Agency/casual	9	8	9	10
Neonatal/intensive care	9	10 ^{BC}	5 ^C	2
Management	9	7	10	9
Oncology	8	8	9 ^C	5
Rehabilitation	8	9	7	10
Perioperative (including operating theatre & recovery)	8	13 ^C	9 ^C	5
Paediatric	8	15 ^{BC}	9 ^C	3
Medical	6	8	7	5
Mental health/psychiatric	6	10 ^{BC}	5	5
No specialty	6	5	5	8 ^B
Coronary care	5	5 ^C	6 ^C	2
Critical care/intensive care	5	11 ^{BC}	6 ^C	2
Gynaecology	4	1	5 ^{AC}	3
School children's health	4	13	20 ^{AC}	8
Renal	3	5 ^C	3 ^C	1
Net Mixed medical & surgical, surgical and medical*	29	36	33	17

Note: Alphabet letters A, B, C represents significance levels.

Note: Percentages add up to more than 100% because of multiple responses

* Response consists of three combined categories namely medical & surgical, medical, and surgical

There were only two differences between metropolitan and non-metropolitan nurses in reporting the area of nursing they would like to work in. This included:

- Non-metropolitan nurses (15%) reported higher on gerontology than metropolitan nurses (9%).
- Metropolitan nurses reported higher for management (10%) than non-metropolitan nurses (7%).

Registered nurses who are:

- Working in the area of health (but not as a nurse) (31%) and those working in other areas (27%) would like to work in community health.
- Respondents who are not working (21%) would like to work in the area of midwifery.
- A proportion of nurses who are on leave (32%) did not indicate what area they would like to work in (Table 25).

Table 25: Desired Area of Nursing by Current Work Status

Q14 If appropriate training were accessible to you, which of the following areas would you consider working in?

Working Not Working					
Area of Work	Total (1,760)	Health (249)	Other (422)	Leave (225)	No (826)
	%	%	%	%	%
		A	B	C	D
Community health	26	31 ^{CD}	27 ^C	21	25
Midwifery	18	12	16	16	21 ^{ABC}
School children's health	16	8	15 ^A	16 ^A	19 ^{AB}
No specialty	16	8 ^C	6 ^C	3	6 ^C
Not answered	16	17 ^B	11	32 ^{ABD}	14
Mixed medical and surgical	13	11 ^C	17 ^{AC}	6	15 ^C
Maternal and child health	12	7	10	14 ^{AB}	15 ^{AB}
Gerontology	11	12 ^C	3 ^C	7	12 ^C
Surgical	10	10 ^C	9 ^C	5	12 ^C
Accident and emergency	10	13 ^D	12 ^D	10	8
Agency/casual	9	7	10 ^C	5	10 ^C
Cardiothoracic	9	11	11	8	9
Management	9	15 ^{CD}	13 ^{CD}	7	7
Oncology	8	5	13 ^{ACD}	6	7
Rehabilitation	8	10 ^C	9 ^C	4	8 ^C
Perioperative (including operating theatre & recovery)	8	10 ^C	9	6	8
Paediatric	8	7	10 ^C	4	9 ^C
Medical	6	8 ^C	7 ^C	2	8 ^C
Mental health/psychiatric	6	8 ^C	5	3	6
Coronary care	5	3	5	5	5
Critical care/intensive care	5	7	6	5	4
Gynaecology	4	2	5 ^C	2	5 ^{AC}
Neonatal/intensive care	4	2	4 ^A	6 ^A	5 ^A
Renal	3	2	3	2	3
Net Mixed medical & surgical, surgical, and medical*	29	29	33	13	35

Note: Alphabet letters A, B, C & D represents significance levels.

Note: Percentages add up to more than 100% because of multiple responses

Appendix Four—Qualitative Survey of Registered, Non-Working nurses

Nursing Return to Work Survey Qualitative Report

A Qualitative Report of Nurses' Responses to
Open-Ended Survey Questions

Prepared for

Nurse Recruitment & Retention Committee
Department of Human Services
Melbourne Victoria

June 2000

CAMPBELL
RESEARCH & CONSULTING

Contents

1	Executive Summary	145
1.1	Family	145
1.2	Injury and Illness	145
1.3	Work Conditions and Remuneration	145
1.4	Employment Opportunities and Training	145
1.5	Professional Recognition	145
1.6	Job Satisfaction and Other Careers	146
2	Background and Objectives	146
2.1	Research Design	146
2.2	Reading this Report	146
3	The Common Themes	147
4	Family	147
5	Injury and Illness	148
6	Work Conditions and Remuneration	149
7	Employment Opportunities and Training	150
8	Professional Recognition	152
9	Job Satisfaction and Other Careers	152
10	Conclusion	153

1. Executive Summary

- This report summarises the qualitative component of a survey of 2,089 registered nurses, currently not working in the nursing profession, to better understand reasons for leaving, as well as barriers to returning to nursing.
- A detailed report of the quantitative results is reported separately.
- Responses to six open-ended survey questions are analysed here according to common themes. These questions asked include:

Q11. *If you don't intend to seek employment, please tell us why?*

Q15. *Thinking about why you left work in nursing, how important were the following factors?*

Q16. *If you decided that you wanted to return to work in nursing, how important are the following factors?*

Q17. *How important are the following factors for YOU not actively seeking employment in nursing?*

Q18. *If you have been actively seeking employment in nursing but have not been successful, please circle the number that identifies how important the following factors*

Q19. *Is there anything else you would like to say to the Nurse Recruitment Retention Committee that you think could influence nurses to return to the workforce?*

- This report summarises six key themes identified by the 2,089 registered nurses responding to the survey.

1.1 Family

- Combining family with nursing is a serious concern for registered nurses who have the responsibility to care for family members.
- Nurses do not perceive that their profession provides flexible shifts and appropriate child care facilities to accommodate family commitments.

1.2 Injury and Illness

- Respondents reported both work related and non-work related injuries as barriers to returning to work.

- *Work related* injuries and illnesses are perceived to be a result of poor working conditions (heavy workloads and understaffing).
- A lack of support by management was noted when injuries and illnesses occurred.
- After an injury or illness has incurred, nurses often feel unable to return to work due to the lack of alternative duties.
- Injured and sick registered nurses want to nurse but feel the inflexibility of the workplace and their employers are barriers to gaining suitable employment.

1.3 Work Conditions and Remuneration

- Registered nurses reported that work conditions and their duties were not rewarded with adequate remuneration.
- Many respondents feel exploited because they do not receive their entitlements, such as meal breaks and overtime.

1.4 Employment Opportunities and Training

- Division 2 nurses reported a sense of displacement with the introduction of Personal Care Attendants (PCAs), and there is a lack of opportunities to increase their qualifications.
- Division 1 nurses feel that Division 2 nurses are being employed before themselves because they have a lower salary.
- Most registered nurses reported that they want to attend further training and education, but not at their expense, especially when salaries do not increase with further training.
- Both hospital trained and university trained nurses feel that university graduates lack practical experience, thereby compromising their ability to work on the ward or obtain employment.

1.5 Professional Recognition

- Nurses perceive they receive little respect and recognition for their skills.
- Respondents believe a lack of respect is evident by the poor remuneration they receive.

1.6 Job Satisfaction and Other Careers

- Job dissatisfaction is created by overlapping factors such as non-family friendly environment, lack of flexibility of working hours, poor working conditions, injury, illness, displacement and lack of recognition.
- In addition, job dissatisfaction is enhanced with the lack of time available to 'care' for patients, as well as increased administration workloads.
- Due to continued poor job satisfaction, many registered nurses have changed career direction.

2. Background and Objectives

Campbell Research & Consulting was commissioned by the Nurse Recruitment and Retention Committee to develop a profile of registered nurses who are currently not working as nurses.

A survey instrument was developed to provide detailed information of why nurses continue to register as nurses, but not work as nurses. In addition, nurses were asked what would entice them to return to the nursing profession. A separate report provides a detailed analysis of the survey implementation and quantitative reporting of the survey information as at May 2000.

The current report intends to provide a qualitative account of six open-ended questions from 2,089 returned surveys and detailed letters returned by respondents with the survey.

2.1 Research Design

The survey research design is described in the Nursing Return to Work Survey, Quantitative Report.

For this qualitative report, six open-ended survey questions asked registered nurses for their thoughts on leaving and returning to the nursing profession:

- Q11. If you don't intend to seek employment, please tell us why?*
- Q15. Thinking about why you left work in nursing, how important were the following factors?*

Q16. If you decided that you wanted to return to work in nursing, how important are the following factors?

Q17. How important are the following factors for YOU not actively seeking employment in nursing?

Q18. If you have been actively seeking employment in nursing but have not been successful, please circle the number that identifies how important are the following factors

Q19. Is there anything else you would like to say to the Nurse Recruitment and Retention Committee that you think could influence nurses to return to the workforce?

Survey respondents provided extensive comments to these questions, and many provided additional letters, several pages long. The nurses were grateful to be given the opportunity to speak and their responses have been coded into similar groups to provide summaries. These summaries will be presented as separate common themes that became evident when responses of each question were coded.

2.2 Reading this Report

Verbatim responses of registered nurses were detailed and broad ranging. Quotes are reported to illustrate the breadth and depth of responses to particular survey questions. Verbatim responses are not reported for categories where percentages are less than 5% unless the response holds importance for understanding the current issues at hand.

This report provides details of the quotes illustrating the context of the responses to provide depth of understanding of the nurses' point of view.

Disclaimer

Please note that in accordance with our Company's policy we are obliged to advise that neither the Company nor any member nor employee undertakes responsibility in any way whatsoever to any person or organisation in respect of information set out in this report, including any errors or omissions therein arising through negligence or otherwise however caused.

3. The Common Themes

The responses to the open-ended questions have provided a rich pool of data generated from the realms of the nursing profession. In summarising this data it became apparent that no matter what question was asked some common themes prevailed. These themes are central to providing insight to the two research objectives, namely, why registered nurses left the nursing profession and what would encourage them to return.

This report has been written to tell a 'story' about respondents' views, and has been generated from nurses' verbatim responses. A summary at the end of each theme will give a clear understanding of the areas that need to be addressed in the nursing arena.

The common themes discussed are:

- Family
- Injury and Illness
- Work Conditions and Remuneration
- Employment Opportunities and Training
- Professional Recognition
- Job Satisfaction and Other Careers

4. Family

When respondents were asked why they stopped working in the nursing profession one of the main responses was family commitments. The additional information provided in the open-ended questions clarifies the problem nurses' face combining family with their profession.

Concerns about combining family with nursing are determined by the family as the main priority in the nurses' life. This may be young children or ill family members:

I would love to return to nursing but family commitments make it impossible.

I intend to be a full-time mother to my 12-month old baby. She comes first.

Disappointed with the nursing profession and I am a full-time mother

Illness in the family, too difficult to maintain work commitments.

Employment conditions, in particular hours of work, are problematic to registered nurses with family commitments:

I do not want to leave my children home at night.

Inflexible and unsympathetic rostering of the nursing workforce undermines the importance of family commitments.

I left nursing to have my two children and to care for them at home. I would like to return part-time but there are no available positions and most workplaces are not family friendly.

As well as a lack of 'family friendly' shifts, the absence of suitable child-care, especially for single parent families is frequently discussed. Hours of work are not flexible and have detrimental affects on mothers who need to seek out care for their family:

Nurses with young families, particularly mothers, need permanent part-time rosters in order to organise child care.

Hated working different shifts all the time. Can't raise a family like that. Child-care has to be a permanent arrangement.

I have children, and there are a lack of positions where I can work one to two shifts a week on a regular basis.

The importance of this rather complex relationship between family, shift work and lack of suitable child care in the nursing profession becomes particularly problematic when registered nurses with family commitments actually want to nurse. They find that the barriers are too overwhelming:

More shifts or mother friendly opportunities should be available. If I could I would be back at work now, but I can't see how I can do it with my children and no spontaneous care. My family comes first, so I am rapidly losing my skill, my career.

Regular evening and weekend 'on call', frequent overtime and low staffing levels were a regular part of my working life. However, with two small children at home, despite a desire to return to part-time theatre work, I really desired a more family friendly position.

The fundamental problem for registered nurses is that the nursing profession does not cater for those employees or potential employees who have families. This is a serious concern considering that the majority of respondents are of child bearing age. Some nurses offer suggestions to rectify the problems discussed.

Be aware that job sharing would be appealing for nurses with school age children. A lot of women don't want to work full-time and raise a family.

Provide a better package for nurses returning from Maternity leave, for instance the combination of shorter working hours, flexible hours to fit in with child care, and the ability to maintain a career path.

No 'on call' and minimal over-time.

The solution is provision of child care and more flexibility in rosters:

I think child care and flexible rosters are so important as most women are mothers and some are single parents.

Flexible hours of work to cater for single parents with school aged children.

Unfortunately some feel that the nursing profession is no career choice for individuals who wish to have a family in the future. This is summarised by one respondent:

It seems ludicrous in the extreme that nursing invests so much time, money and resources in the training of motivated and dedicated young nurses, predominantly female. These nurses usually consolidate their practice and then seek further education, experience and qualifications before ultimately taking leave from work to have a family. So, here, we have a very valuable asset being allowed to deteriorate due to difficulties in returning to a system that does not allow flexibility and support for those trying to maintain professional standards, and juggle the demands of a busy family. Trying to find consistent and reliable child care becomes too difficult at times and at the end of the struggle, it does not seem worth it as the cost of child care ultimately takes most of the wage. There seems little incentive for those once motivated, qualified and experienced to persist in their chosen career.

The responses for this theme captured a revolving problem felt by many registered nurses. These nurses indicated that poor flexibility in rosters and lack of suitable child care or the effects of rosters on child care commitments made nursing an impossible career path to follow. Many respondents wish to nurse, but could not perceive how to combine nursing with family commitments under the current nursing health care system.

5. Injury and Illness

Many respondents reported injuries or illnesses that were both work-related and non-work related. The reasons why nurses leave work and do not return reflects an inflexible profession that does not allow nurses to continue to work by attending to alternative duties.

While some injuries did not occur at the workplace, most did. This raises many issues about the working conditions of the nursing profession:

What nurse doesn't end up with a crook back for the rest of their lives.

I am burnt out after ten years ... fed up with deplorable hours.

I love nursing, but it seemed that every nurse I knew had a back injury from excessive and physically demanding workloads.

I sustained a permanent work injury contributed from poor equipment, staff shortages, heavy work load and poor working conditions.

If nurses' workloads were less and hospital resources were increased (staffing and equipment) perhaps nurses would not feel so exhausted and 'burnt out'. This has put me off nursing all together.

Older nurses especially feel that the demands of nursing are too excessive. Some of these respondents have decided to retire early rather than risk injury or continue working in a stressful industry:

I am close to retirement and do not wish for any more injuries.

Too tired and drained from nursing, decided to retire.

I am 64 years of age and tired.

Respondents who had work-related injuries and illnesses reported that there was a lack of support from their employer when they were injured:

In my first year of nursing, I hurt my back. I reported this to my employer, however nothing was done about it. I was not aware of my right of WorkCover. I am disappointed and I doubt I'd ever go back.

A lack of support was also reported by many respondents after the injury or illness has occurred (irrespective whether work-related or not). These registered nurses would like to come back but feel the workplace is not prepared for them and the managers are not willing to offer alternative duties:

I was very disappointed at the treatment by my employer after I sustained my injury. I am sure that after receiving such a permanent injury there must be something I am capable of doing. However, I was told not to come back to work. We have been through the courts and it has been settled, but still I am not welcomed back at work.

As I use a walking stick it is very hard to find employment to suit my qualifications and experience. I am a disabled nurse, ex-nurse.

There is no support or program for a person returning to work after a injury.

I have cystic fibrosis and I am presently unable to work due to this health condition.

The combination of excessive workloads and the inability to provide adequate duties for injured or sick workers have sent some registered nurses into other non-nursing careers:

I am now in a job which is much more gentle on my body and stress levels.

Work-related injuries are a by-product of the duties expected of nurses. Once injured or sick, there are few support mechanisms to aid their recovery and return to work. Respondents report problems potentially leading to injury (work conditions) which dissuades them from continuing work. Also, nurses report a lack of support if injured as a barrier for them to return to nursing.

6. Work Conditions and Remuneration

Unsatisfactory work conditions and remuneration were important factors for leaving the nursing profession. Remuneration refers to the tangible benefits gained from working (for example, salary and leave entitlements). 'Work conditions' is a broad term used to refer to:

- The duties performed by the nurse
- The environment in which the duties are performed
- The management under which the duties are conducted.

Together, work conditions and remuneration have a dynamic relationship, which ultimately contributes to nurses leaving the profession and not returning.

Some nurses reported the current climate of the nursing profession is very discouraging:

I would never return to work whilst the public health system is in such a mess.

I have had a gutful of being treated as inexperienced or obstructive when my advice is ignored because I am only a nurse.

When the Standards Monitoring Team visited the Nursing home at which I worked every resident was given or made sure that they had a toothbrush, hair brush, soap, shampoo etc. These items were then taken away and put back into storage after the visit at the management's request.

No amount of money or pay increase is worth having to work in such discouraging and unsupported conditions. When care and compassion for workers and patients is dispensed with, the term 'nursing' becomes obsolete. Robots will do the job quite adequately.

I was told by my boss in the last restructure that nurses are overpaid. He was a professor on about \$180,000 pa.

Many respondents believe that the remuneration received is not adequate for the work conditions they endure:

The amount of money earned does not fit the job description. We get physically, mentally and verbally abused and come away with less than a telephone company employee who sits on their bottom answering phones. It's ludicrous.

Physical and emotional demands of nursing are too high when compared to the low wages and lack of professionalism in the industry.

I have come to realise how suppressed your opinions become and how low your remuneration is for such a physical and mentally demanding position.

Registered nurses reported that they were not given appropriate compensation for doing overtime, excessive workloads and sometimes not receiving their award benefits:

I would stay back at least half an hour overtime every shift due to the heavy workload. I was never paid for these extra hours, nor was I offered any remuneration.

Nurses are treated like slaves. There is no recognition of our right to a meal break. We are expected to work a full day, then be on call and forced to work the next even though we were called out during the night. My employer stopped paying penalty rates for working the day following overnight call-outs.

As usual a female dominated industry receives little recognition and the rewards are poor.

One respondent suggests work conditions and remuneration in the nursing profession have not moved with the times like other professions:

I am unable to understand why conditions for nurses do not resemble those of the police, who also do shift work and deal with the public, but with conditions (holidays, superannuation), which are light-years ahead of those in place for nurses.

Work conditions and remuneration seems to be an inverse relationship ... the pay for the amount of responsibility, hard work, pressure and risk to personal happiness (mental health) do not balance the equation. Registered nurses believe they do not receive benefits from their employers that reflect the work they do.

7. Employment Opportunities and Education

Nurses' responses highlighted a tension between employment and education across Divisions. Division 2 nurses reported that there is no accessible education path to increase their training to the level of Division 1. Additionally, Division 2 nurses felt that their career is being taken from under their feet with the introduction of Personal Care Assistants (PCAs).

Division 2 seems to be an unwanted registration. Pseudo caring certificates are undermining Division 2. There is also a lack of recognition of Division 2 registration when applying to upgrade (sic) to Division 1 nursing courses.

Lack of education for Division 2 nurses to become Division 1 nurses.

Lack of opportunities for Division 2 nurses to work out of the nursing home structure.

Funded refresher courses for Division 2 nurses will become extinct with PCAs taking their positions.

In the aged care sector nurses are being replaced by PCAs.

As a Division 2 nurse, there are not many jobs available as the PCAs can do the same job.

Conversely, Division 1 nurses feel they have to accept less money because Division 2 nurses are being employed for jobs originally done by Division 1. A similar situation is evident for Division 2 nurses and PCAs:

Division 1 nurses jobs are not being protected, therefore we receive lower pay due to the competition with other divisions.

Most Division 2 positions go to PCAs for less money.

We are leaving nursing (Div 2 Nurses) because there is no chance to advance nor is our ability recognised and our pay is less than a factory worker or a PCA yet we have a qualification.

Some nurses feel discouraged from furthering their education as it is a personal expense and does not result in a salary increase. This leads to less experienced staff working on the wards:

Lack of funded staff training results in inexperienced staff. Staff want to learn more but should not have to pay for it from their own money.

An inadequate quota of qualified and experienced staff results in stressful and unsafe work environment, especially in critical care.

Lack of support with regard to education. No nurse educators for nursing staff especially for new and junior staff. Therefore the workload on experienced staff is excessive.

I am required to work some days in areas where I had little or no training.

Unrealistic/unreasonable expectations of nurses knowledge, expertise and skill with the absence of continuing education.

Nurses feel their employment opportunities are limited due to either a lack of practical experience and/or preferred employment positions:

I have spent five years at university and received excellent results. However, I have found it impossible to find a permanent position in my chosen field because I lack practical experience. This has destroyed my self-confidence. I work in mostly agency positions, which has not been satisfying. Now I am at home with a baby and I am concerned where my future in nursing is.

The only work available is in aged care nursing, which I do not find challenging enough.

Because of PCAs, Division 2 positions are now only available in aged care.

Agency is the only option for someone of my practical experience.

Further, registered nurses living in rural areas report limited access to job opportunities and training:

Living in isolated area, no job opportunities.

Rural women have limited opportunities and many expenses.

There are no courses for Division 2 nurses to become more educated, especially in rural areas.

The rural area I'm now living in appears to have a policy of 'in house jobs', therefore jobs that may be appropriate to me are not advertised publicly. I have no knowledge of vacant positions.

A tension between hospital and university educated nurses appears in nurses' comments. Both parties are dissatisfied with the lack of practical experience of university trained nurses:

After doing my graduate year, I vowed never to return to nursing. Apart from earning more money as a telemarketer, I did not want to be abused for my lack of practical experience because I was university trained.

Lack of self esteem caused by ridicule of hospital trained nurses, I am university trained.

In some institutions there is undue pressure for hospital trained nurses to get their nursing degree. There has to be a balance of the two training systems.

Nurses who completed hospital-based training have double or triple certificates and many years' of experience should not be discriminated, just because they do not have a diploma or degree. They are all registered nurses and that is all that matters. This issue is a major factor for many nurses leaving the profession and must be addressed.

I would suggest that serious consideration be given to undergraduate nurse education—there needs to be much more time spent on clinical placements as I have worked with a number of new graduates who have discovered after their three years at university that they dislike nursing. This is not a matter of apportioning blame, but simply of giving undergraduates much more "hands-on" experience, so that they develop practical ability along with theoretical knowledge.

Registered nurses want to be educated and learn more practical skills. In turn, workloads may be decreased and employment opportunities may be available for others:

Emphasise free refresher courses and on-site education. Have 'hands on' nurses as managers because they understand the practicalities.

Training and education is an issue for further inquiry. Funded courses would be desirable as most nurses wish to learn and improve their skills. However, nurses do not want to pay for these courses unless they perceive it will lead to increased remuneration. In addition, nurses want to be able to work in their chosen nursing area after the completion of these courses.

8. Professional Recognition

Nurses perceive they receive little respect and recognition for their skills. Nurses' comments about this issue reflect a great degree of disappointment:

Lack of opportunity to practice nursing with autonomy. Nurses are capable of making their own nursing judgement. We are not just doctors' handmaidens or hospital dogs.

Listen to what the nurses tell you, not the CEO and certainly not the government, none of whom have any grasp of the true needs of ongoing health care.

My career adviser in high school summed it up perfectly—if you want to be a professional and treated as one, do occupational therapy, not nursing.

Nurses need to have professional recognition with continuous opportunities for further education and professional status, remuneration make us independent practitioners not a slave.

Nurses over the age of 50 years have been treated badly in the last 8–10 years. They feel unwanted, lack respect from senior staff and their experience is not valued.

Morale is very low amongst nurses, and the way the workload is organised, staff tend to have to "compete" to access resources/equipment rather than working as a team.

The devaluing of nursing, as a profession is a part of economic rationalism. Nurses feel that humanity has been removed from their profession:

Employers should be recognising their nurses for the valuable work they do, and begin to treat staff as people, not just numbers on a computer.

Nurses need to be valued more for what they do with better pay conditions and improved management (very poor quality at the moment). The economic rationalist approach has taken the heart out of the health care settings.

Nurses are turning away from their profession due to lack of respect, money and support from governing bodies, such as the Nursing Board. Other professional areas are attracting nurses' attention away from nursing because of the way they are treated.

As a solution, nurses are asking for increased respect, support and remuneration:

Nurses provide essential service in the community for very little return and support. Look after nurses and they will look after you.

Nurses will come back to work when it is seen that people are more important than money.

9. Job Satisfaction and Other Careers

A non-'family friendly' occupation, lack of flexibility, poor working conditions, injury, illness, displacement and lack of recognition will ultimately lead to poor job satisfaction. In effect poor job satisfaction will lead registered nurses 'who were once inspired' to begin careers in areas that offer more than a career in nursing.

Job dissatisfaction is created by a multitude of factors previously discussed but also clearly linked to understaffing, inability to spend time 'caring' for patients, and increased administration workloads:

There is very little job satisfaction due to poor nurse/patient ratios, impossible cost cuts and difficult rosters. It is not possible to give good care any more.

I have lost what little faith I had left in the medical profession to actually help sick and injured people to help themselves. Nursing is now a job for conformists, scapegoats and non-questioners. I no longer fit into these categories (thankfully!). I thought that nursing was unethical.

Nursing now seems to be orientated around administration. There is more emphasis on what is written than what is actually done for the patient. Give us the time to put caring back into nursing.

Nursing now seems to be so administratively important, there is more emphasis on what is written than what is actually done for the patient. I know reports are very important. It seems that the solution is more nurses per patient—give us time to put the caring back into nursing.

I didn't know the culture of loving care had been replaced by a culture of pseudo entrepreneurialism.

More emphasis required on basic nursing care and documentation to be kept to a minimum to enable the care to be carried out.

More clinical staff may help unnecessary duplication of paper work. If I wanted to be a secretary, I wouldn't have chosen a career I have loved—Nursing.

Many nurses feel patient care now comes second to paperwork. Originally, nursing was a hands on job. These days, patients lose valuable time on care because staff are busy filling in forms to get the much deserved funding we need.

In summary, registered nurses are looking toward other careers due to poor job satisfaction and stressful working conditions in the nursing profession. The feelings expressed identify overlapping problems:

It is very tempting to abandon nursing for other professions where stress is lower and management support is higher.

I'm now in a job which is much more gentle on my body and stress levels. Work conditions are excellent in comparison, and my trainee wage with this job is more than I ever earned in my 10 years of nursing. I have no desire to return to nursing. I kept my registration just on the off chance that if conditions change I might nurse again.

I have undertaken studies in a completely different field, for a job which gives me far greater personal satisfaction and pleasure than I found in nursing.

My current job is so much better.

I have no desire to nurse again. I have kept my registration on the off chance that I may nurse again, but I doubt it very much. There are too many better opportunities out there for women. I can see that there will be a huge shortage of nurses in the future.

10. Conclusion

The themes discussed are the most prominently expressed opinions of the respondents. Many comments reflect a combination of themes, especially respondents who attached additional letters to their survey.

Many registered nurses expressing discontent and frustration with the nursing arena commented that this survey was long overdue. Nurses were also thankful for the Nurse Recruitment and Retention Committee for taking interest and allowing them to 'speak out':

Thank-you for the opportunity to comment on the survey. I would volunteer more information if needed.

I feel very concerned about the current nursing conditions and was very grateful that this survey arrived in the post last week.

Others articulated that the survey was not enough to make change, and what was required was a further in depth account of personal experiences in the nursing domain.

I really do not think that this type of survey will provide sufficient information to develop profound change in the recruitment and maintenance of the nursing profession.

There is no singular reason why nurses continue not work, but rather a multitude of factors that seem to be common to most participants. The consensus of respondents' opinions are that nursing no longer has a focus on 'caring' and interacting with those who are in need.

Many survey participants believe that nursing is now an unsatisfactory profession because of excessive workloads, physical and mental strain, unpleasant work environment, poor salaries, and lack of compassion. For these reasons nurses choose not to work until they can begin to refocus on caring for patients with a more humanistic approach.

Keeping registration is largely seen as a financial safety net. If conditions change in the nursing arena, many would consider returning to work as a registered nurse.

Appendix Five – Report of the Open Consultation Forums

Nurse Recruitment and Retention Committee

Issues Arising from Public Forums in June 2000: An Overview

Prepared by URCOT,

July 2000

Contents

Executive Summary	157
Introduction	158
Issues Affecting Recruitment and Retention	158
1. Education	158
2. Resources and Workloads	159
3. Workplace Change	160
4. Nursing Management	160
5. Pay, Role and Career Issues	160
6. Balancing Work and Life Priorities	161
7. Quality Issues and Community Perceptions	162
Conclusion	163

Acknowledgements

This report has been prepared by Dr Bruce Wilson, URCOT. It is based on data gathered at Public Forums of nurses, which were facilitated by Bruce Wilson and Robyn Dale. Thanks are due to the members of the Project Team who assisted with the organisation and the conduct of the forums, to Professor Margaret Bennett and Ms Ann Turnbull, members of the Committee who chaired the Forums, and to all the nurses who attended and contributed to the Forums, or otherwise submitted their feedback in writing.

Executive Summary

- This document reports on the issues arising from the public forums targeted at nurses employed at Grade 4 and below, conducted at four metropolitan and six rural sites on behalf of the Nurse Recruitment and Retention Committee.
- Compared with the reports from each of the individual forums, this report presents a more thematic and interpretative account, seeking to understand some of the underlying issues that shaped the comments made in the forums.
- The Committee obviously faces a considerable challenge in addressing the issues of concern to nurses. There are a range of complex factors that shape the structure and resourcing of the health industry, as well as the social context from which its workforce is drawn.
- The economic and cultural forces shaping nurse recruitment and retention will be difficult to address through public policy alone, especially when resources are limited. However, recognition of the complexities will be important in gaining support from the various stakeholders for the more specific initiatives that governments can take.
- In every forum, participants raised a considerable number of issues about nurse education, including undergraduate, postgraduate and refresher programs. Underpinning many of these comments was a fairly deep-seated resentment at the imbalance between a clear expectation and pressure for nurses to be pursuing ongoing education, and the minimal support provided in relation to leave or money.
- Nurses have been affected very severely by the reductions in resources for general patient care in the health care environment.
- Workplace change in the health care system appears to have been driven by alterations to funding arrangements, rather than a focus on work processes.
- At several forums, there was substantial criticism of nurse management. Put simply, nurses believed that there was a lack of support and respect from management.
- Nurses felt that they were underpaid and accordingly undervalued.
- Nursing is a highly gendered occupation and many of the women who participated in the forums raised issues that reflected their concerns about balancing work and other responsibilities.
- Many nurses have suffered a crisis of identity and loss of faith in their capacity to deliver what is expected. Questions about the underlying issues of leadership, identity and quality of care also need to be addressed.

Introduction

This document reports on the issues arising from the public forums targeted at nurses employed at Grade 4 and below, conducted at four metropolitan and six rural sites on behalf of the Nurse Recruitment and Retention Committee. The forums were introduced by members of the Committee, and attended by between 27 and 165 people. Nurses from all Divisions and all Grades were represented at one or the other of the forums. Evidence was recorded publicly on a whiteboard; and participants were invited to respond to a set of questions in writing during the forum, and to hand them to the facilitator if they felt that their views were not expressed adequately during the forum.

On a few occasions the forums were taped. Reports were prepared from each of the forums, summarising the issues and their implications for recruitment and retention.

While most of the forums were held in health care environments, nurses from various locations attended. These included nurses from inpatient and from community health settings, from agencies and from the Royal District Nursing Service. Quite a few nurses drove considerable distances from other centres or health care environments to attend the forums conducted in rural settings.

This document presents an overview of the major themes and issues that have emerged from the forums. While the reports from each of the individual forums has been organised around the particular Terms of Reference of the Committee which had featured prominently in the forum, this report presents a more thematic and interpretative account, seeking to understand some of the underlying issues which shaped the comments made in the forums.

Issues Affecting Recruitment and Retention

The forums were conducted in an open manner, with participants being encouraged to take up any aspect of the Committee's Terms of Reference. Where possible, the discussion was managed to bring some coherence to the dialogue and, on other occasions, people were prompted to address particular topics that had

not yet been considered. Specific prompting questions were used to explore apparent contradictions or ambiguities and to bring greater depth to the insights being generated. At times, the forums generated considerable passion, even anger, and a sense almost of desperation in relation to the need for change. At other times, the mood was quieter and more questioning about possibilities for change.

Another perhaps tentative observation about the forums might be that the geographic location and the quality of the health care environment seemed to influence the nature of the discussion and the positive or negative nature of the contributions. In general, nurses in the rural and more modern health care environments had more to say about the professional issues under consideration by the Committee, whereas industrial issues tended to have more prominence in the metropolitan and older sites.

The Committee obviously faces a considerable challenge in addressing the issues of concern to nurses. There are a range of complex factors that shape the structure and resourcing of the health industry, as well as the social context from which its workforce is drawn. The economic and cultural forces shaping nurse recruitment and retention are difficult to address through public policy alone, especially when resources are limited. However, recognition of the complexities will be important in gaining support from the various stakeholders for the more specific initiatives that governments can take. Some of these complexities are raised in the following discussion of the issues.

1. Education

In every forum, participants raised a considerable number of issues about nurse education, including undergraduate, postgraduate and refresher programs. Many of the issues were quite specific, referring to practical problems such as the costs of various courses, geographical access, number of places, and difficulties in getting study leave.

Underpinning many of these comments was a fairly deep-seated resentment at the imbalance between a clear expectation and pressure for nurses to be pursuing ongoing education, and the

minimal support provided in relation to leave or money. It was not uncommon for nurses to indicate that undertaking a postgraduate qualification had cost them up to \$20,000, in course fees, foregone income and travel costs, with one nurse claiming as much as \$50,000 had been spent in obtaining her qualifications. Their resentment was exacerbated by the lack of any acknowledgement by their employers, monetary or even professional, once they had completed the qualification.

Balancing the resentment about costs was the recognition that the health industry was subject to rapid change, especially in relation to medical research and the introduction of new technologies. Many nurses were positive about the importance of continuing to build their expertise, so that they were well equipped to support new forms of treatment for patients.

It seemed that this situation was more difficult for rural nurses rather than metropolitan. Rural nurses were concerned about the quality of continuing education in rural areas (did they get educational support equivalent to those in the city), and the general commitment to providing continuing education.

Undergraduate education was a source of considerable angst, manifesting itself in two key issues. Firstly, the general lack of clinical experience available to student nurses, with the consequence that they were clearly unprepared for employment as independent nurses on the wards. The second issue was the implications of students undertaking broadly-based curricula, rather than offering the opportunity for specialisation through a specialist direct entry model.

These two issues reflect a continuing underlying tension between the commitment to university-based programs which provide the theoretical base for nurses to develop an independent professional identity, and health care-based experience, which provides a much more practical grounding for nurses to work with patients. It reflects different visions about the role of nursing in the health industry.

Much of the criticism of university-trained nurses was based on their lack of readiness to take a full load immediately they were employed as graduate nurses. In the current

circumstances of limited resources, health care providers find it difficult to provide appropriate supervision and support for graduate nurses. Even though they might be ready to learn how to apply their expertise, once employed in a health care environment, they still need a phased period of induction and support. This can be a source of additional pressure on established nurses, given the demands of the current working circumstances. There was some concern that new graduates are too much at risk of encountering incidents that would undermine their confidence forever.

A similar philosophical difference arose in relation to psychiatric nurses, who were concerned about the lack of opportunity for students to experience psychiatric clinical settings during their undergraduate studies. They felt that it meant that graduate nurses were completely unprepared to work in psychiatric settings, threatening the supply of nurses to what they regarded as a quite distinct field, requiring specialist training.

2. Resources and Workloads

All the forums provided evidence that nurses have been affected very severely by the reductions in resources for general patient care in the health care environment. There were a number of dimensions to this issue.

Firstly, the cost constraints meant that there were simply not enough nurses to provide a decent quality of patient care. Nurses repeatedly told stories about how they were unable to do the little things, such as help patients to eat, to clean their teeth, to wash, that had always been part of the care provided. Secondly, in some cases, there were insufficient resources to supply basic equipment or medicines, such as pillows or ventilators.

Unit managers are seen sometimes to be preoccupied with containing costs rather than addressing quality of care issues. Perhaps more seriously, in the absence of there being enough staff, junior staff were being pushed to senior levels without the education or the experience required to respond appropriately to the circumstances which they might have to deal with.

While some health care environments have

adopted particular strategies designed to provide a more strategic and objective basis for allocating nurse workloads (such as the Trendcare patient dependency tool), they did not appear yet to have won the confidence of nurses. While there were some who felt that these technologies were a step in the right direction, they did not provide a comprehensive framework for assessing the range of tasks expected of nurses.

3. Workplace Change

Based on the views expressed in the forums, workplace change in the health care system has been driven by alterations to funding arrangements, specifically casemix, rather than a focus on work processes. This has meant that cost containment has been the focus, with wards being merged and spans and layers of management being restructured so that workplace relations are being reordered. It appears that much of this change has been undertaken without recognition of the importance of the ward relationships to nurses, and without any consultation or other initiatives to draw on their expertise..

As workplace reform has had this focus, there has been a corresponding failure to review even simple work practices (such as basic observations) that might have been in place for many, many years. While there have been occasional experiments with various kinds of staffing structures, there has not been any serious commitment to the kind of process redesign which might significantly improve nurses' working environment, and achieve greater efficiencies in health care systems.

From comments made in some of the forums, workplace change has not typically involved a challenge to the underlying power relations in the health care systems. This has meant that the medical dominance of doctors continues to control nurses' working environment and professional practice, without adequate recognition of the potential role which nurses could fulfil (as independent practitioners, for example), given the benefit of their increased educational standing. In some rural settings, in particular, nurses expressed some concerns about the ways in which their services were used by doctors, given an ambiguity in the

management of public and private health provision.

In these circumstances, it seems that many nurses are saying that they can see few benefits for them emerging from the kind of workplace reform that has occurred over the past decade. It seems that the love of nursing is not sufficient to balance the consequences of all of the forced changes in the profession.

4. Nursing Management

At several forums, there was substantial criticism of nursing management. Put simply, nurses believed that there was a lack of support and respect from management. This was exemplified in comments about the lack of consultation by management with nurses over proposed changes in the workplace. It was felt that nurses' expertise was often simply ignored. There was little open communication from health care management, and nurses regularly encountered decisions which, in their view, did not demonstrate an understanding of the value of bedside nursing.

Increasingly, it was felt that even those managing the nursing workplace had insufficient understanding of the pressures nurses were experiencing, and failed to represent nurses' interests adequately in management forums. Many nurses felt that management had unrealistic expectations of nurses, given the resources available.

Given the kinds of changes that have occurred in the health system over the past decade, it would seem that a range of management decisions and strategies have been poorly founded. Irrespective of the pressures that managers have been under themselves (and many of these were noted also in the forums, especially workloads), some key principles in managing staff constructively appear to have been neglected.

5. Pay, Role and Career Issues

At the core of the consultation process, nurses felt that they were underpaid and accordingly undervalued. The pay issue was raised in different ways and terms. For example, one participant made the blunt assessment that the relativities had declined, making other careers more attractive. Another view was that the way

in which pay and career options were structured gave nurses no incentive to pursue a nursing career.

Even more simply, the pay was not enough compensation for the work nurses were expected to put in. There was a widespread view that nurses had been expected to assume increased responsibilities that had been matched by little or no financial recognition.

There was some discussion about the effectiveness of the restructured professional career structure, specifically the opportunities associated with Clinical Nurse Specialists (CNS). In most cases, the CNS positions were valued as a tangible means of providing a career option for nurses who wished to stay at the bedside. However, a number of issues had arisen in almost all sites. These included the difficulties in gaining access to CNS positions. In some cases, it appeared that appointments had been curtailed as a means of reducing cost structures, while in others, there was a perception that some parts of the health care environment were neglected in the allocation of CNS positions.

For those who were successful in gaining the appointments, it was sometimes felt that the workload was excessive, and that they were expected to give up too much of their own time on project activities. There was some ambiguity also about how decisions about project topics were made, and about the use of the project results. Another constraint was that if a nurse wished to change their employment, he/she would have to reapply for a CNS position in the new organisation. While the CNS positions were accepted as a positive step in the right direction, there was still a widespread view that there needed to be a clearer career structure for clinical nurses.

As mentioned previously, there was significant concern about the lack of recognition of postgraduate qualifications, especially given the investment that nurses, and sometimes the health care environments, had to make in acquiring the qualifications. It was generally a source of considerable disquiet that nurses could not gain any direct career benefit from their studies.

There do appear to be a range of tensions underlying these discussions. Many nurses appear to have views about career structures that imply a clear maintenance of a hierarchy in pay and status, even in bedside nursing, at a time when most organisational change is promoting flatter structures and forms of career planning which involve lateral movement as much as vertical.

On the other hand, nurses' expectations that they should get additional compensation for gaining additional qualifications is quite consistent with the implementation of flatter structures, providing that they are relevant to a nurse's work performance. Perhaps a more thoughtful approach to resolving these tensions could be promoted within the context of a more open and inclusive discussion about workplace reform.

One other dimension of the debates over career structures again concerns different views on the balance between general and specialist nursing. While psychiatric nurses were the most vocal in promoting the need to recognise the special circumstances of that nursing field, there was a more general debate about the extent to which nurses should be encouraged to specialise, especially given the pace and increasingly (technologically) sophisticated dimension of medical treatments.

Rural nurses were alert to this debate, but felt that in many rural health care environments, nurses had to be generalists. While they might still develop specific areas of expertise, they had to be able to deal with any circumstances that presented themselves.

6. Balancing Work and Life Priorities

While balancing work and life is an increasingly important issue in many industries, it has particular significance for nurses. Nursing is a highly gendered occupation and many of the women who participated in the forums raised issues that reflected their concerns about balancing work and other responsibilities. This was especially important in rural areas, where a very high proportion of the nursing workforce was employed part-time.

There were some important consequences. For many participants, it was apparent that nursing was their second priority, possibly being undertaken to add a second wage to the family income. They suggested that improved access to child care, and to car parking, would make a return to nursing after having had children that much easier.

They also raised issues about the structure of shifts, showing some interest in shorter shifts, and greater flexibility in shift times (more choices than the standard eight or ten hour shifts). It should be noted, however, that the question of shift structures was debated in a very heated fashion. Many participants felt that the various modifications to shift structures almost always meant that an additional burden fell on the shoulders of the ongoing full-time nurses, especially in relation to paperwork, and other less desirable tasks. There was some discussion about the potential value of self-rostering. While some small, stable teams had managed their rosters themselves, the general mood about these arrangements was cautious and most participants were inclined to expect difficulties in self-management amongst larger groups of staff.

Many nurses clearly experienced considerable stress in combining a commitment to their paid employment with the flexibility to spend time in caring for their children. On several occasions, it was apparent that it was very difficult for some nurses to resolve these issues. One particularly moving response was given when the following question was asked:

Facilitator: 'When I asked about working and the stresses affecting your life, there was energetic nodding; tell me what that was about?

A nurse: 'I'll tell you. I've got a nine-year-old who won't go to school because he hasn't done his homework. He hasn't done his homework because I'm not there to help him. I'm not there because I am here, working. I am staying at work later—there are fewer staff and other things need to be done. When I ring work from home, my kids say that I would rather be at

the big house than the little house. I need to ring the big house because I am worried about a dying patient. I feel the tensions from both houses. I can't give my children what they need because I am here.' (Ballarat).

These tensions need to be managed, and there are very few resources available in health care environments to provide the extra support for those people who struggle with these kinds of uncertain responsibilities. It would be much easier for this nurse if she could leave the hospital knowing that her patients would continue to be cared for with the same attention that she herself would provide. However, she cannot, partly because of a lack of other experienced nurses, and partly because of staffing levels.

This issue is a very good example of the complex interaction that can occur between the professional domain of nursing and the broader social context from which the predominantly female workforce is drawn.

7. Quality Issues and Community Perceptions

Taken together, many of the difficulties faced by nurses in the current environment lead to considerable concern about their capacity to provide the quality of care which they want to give, and community perceptions about the health system and the nursing profession. The great majority of the written responses provided in the forums indicate the extent of nurses' commitment to caring for people, and to serving the community. Many entered the profession because they saw it as a respected role.

The current crisis in health care has generated a much deeper problem for nurses than is reflected in the obviously practical problems that result from a lack of resources. When you put the following problems together, many nurses are left wondering whether they can provide the level of care they had always understood, from the earliest days of their training, to be their obligation, and to which they still aspire. These problems include:

- Fewer nurses to share the workload.
- Roster allocations which mean that nurses have more disjointed connections with particular wards.
- A structure of funding which has led to many patients being in hospital for shorter stays (and leaving before they are clearly well).

An important dimension of nursing is managing relationships with patients, responding to their social and personal needs and offering a measure of dignity in spite of the consequences of illness. This is very hard to manage in the current environment, with the consequence that many nurses have suffered a crisis of identity and loss of faith in their capacity to deliver what is expected.

This tendency is reinforced for many nurses by their experiences with community reaction. This is not just their sense that their contribution to health is not adequately recognised or valued in community opinion, it is manifest in their very direct experience of aggression and abuse on the wards (especially in accident and emergency situations). Both patients and family members blame nurses for having to wait for treatment, or for any other reason that has disrupted their expectations in regard to immediate 'customer' service. And this might come when nurses are already exhausted from their workloads, perhaps even at the end of a double shift that they have worked because there are simply no other nurses available. These circumstances seem to result from a pattern of unrealistic expectations and to reflect a lack of respect from the community, even in rural areas.

The workplace violence which results from public aggression are matched to a significant degree by 'horizontal' aggression amongst nurses themselves. While this is much less likely to be physical, it can nevertheless be just as demanding on the personal resources of nurses who are already stretched to the limit.

Conclusion

The issues that emerge in the discussion about providing an appropriate quality of care do reflect a significant under-resourcing of health services. However, it is also the structure of health care that has changed. Nurses have been almost systematically excluded from making an effective contribution to the direction of change (the lack of consultation in the workplace reform process), and have suffered also from a very significant lack of leadership in understanding and exploring how the role of nursing is changing. What are the professional expectations of nurses in providing an outstanding quality of care in the contemporary health system, and how can they be resourced to deliver? This question appears to be central to the challenge facing the Committee.

The great majority of respondents said that they would not encourage people to enter or return to nursing until there had been significant changes made. Some did support increased promotion of nursing in order to influence public opinion about nursing. Others were prepared to offer quite specific and practical suggestions that would enhance the prospect of remaining in nursing, and of attracting nurses to return. Some of the practical suggestions unquestionably offer sound ideas about career structure, education, nursing management and, fundamentally, about pay.

Appendix Six – Report of the Focus Group Consultation

Nurse Recruitment and Retention Review



Executive Summary

Qualitative focus group research was conducted in July 2000 among nursing students and the current and lapsed nursing workforce. The research sought to gain, first hand, issues and considerations impacting on recruitment and retention of nurses.

There is a perception among nurses that it is, quite simply, becoming harder to do their job. The pressures of increased acuity of care, inadequate staffing numbers and lack of support systems have become the realities of nursing. Added to this is perceived inadequate remuneration and limited career paths. Not surprisingly, a high proportion of nurses report that, within the next 5–10 years, they will either leave or scale back their participation in the profession. This intention is expressed uniformly across the various nursing segments researched.

There is a clear sense by many of being ‘trapped’ in their jobs. We suspect departure rates from the profession may in fact be higher if perceived exit barriers (or barriers to switching) were lower. Many nurses are clearly dissatisfied, but stay in the profession simply because they see no way out (that is, they are unsure of what else to do or earning potential elsewhere).

Finally, there is a feeling among nurses of being isolated in term of their grievances:

- Nursing management does not champion their cause for improved conditions and recognition for their contribution.
- The public generally has limited understanding or appreciation of nurses’ role/working conditions.
- Government continues to cut health funding, with any shortfalls expected to be ‘picked up’ by nurses.
- The issues/concerns expressed in the groups have all been said before and there has been no resolution.

Each of the above reinforces the strong perception among nurses of being undervalued. It is clear from this research that the current levels of departure from the industry are only likely to increase if measures are not taken to address the range of issues outlined above. In particular, the issues that impact on nurses’ fundamental ability to perform their jobs is a clear priority for action.

Remuneration is the tangible recognition of your contribution to the workplace. Thus, when discussing remuneration, the issue for nurses is bigger than just a salary gap. The concern is the fundamental belief that nurses are undervalued.

Contents

1. Introduction	168
1.1 Background	168
1.2 Research Objectives	168
1.3 Research Method	168
1.4 Respondent Profile	169
2. Detailed Findings	170
2.1 Role of Nursing	170
2.2 Overall Satisfaction with Nursing as a Career	171
2.3 Key Reasons for Departure from Nursing	178
2.4 Nursing Advocacy	178
2.5 Future Intentions	179
3. Segment Findings	180
3.1 Grades 2/3 Nurses	180
3.2 Division 2 Nurses	182
3.3 Midwives	184
3.4 Mental Health Nurses	186
3.5 Graduate Nurses	189
3.6 Undergraduate Students	191
3.7 Community Nursing	194
3.8 Agency Nurses	195
3.9 Unregistered Nurses	197
3.10 Rural vs City Nursing	200
4 General Recommendations	201
5. Appendix—Discussion Guide	

1. Introduction

1.1 Background

The number of nurses working in Victoria has been declining at an increasing rate, with the nett loss in 1998 alone being some 2,700 nurses (source – Department of Human Services Nurse labour force projections 1998–2009). While the actual numbers are at a sufficient level to meet current demands, there are very real distribution problems in some geographic and specialty areas.

In response to concerns relating to practice patterns and supply projections, the Victorian Government has introduced a number of initiatives to bolster the industry.

These include:

- An extra \$26.9 million spent over four years on a recruitment and retention package to address the shortage of nurses in the hospital system.
- The establishment of the Nurse Recruitment and Retention Committee (NRRC) to urgently report on issues contributing to the current shortages.

In preparing their submission to the Minister for Health, the NRRC is seeking direct input from nurses on issues perceived to be having an impact on the industry. Hence, this proposal is in response to a request for target market research focusing on the areas of education, attraction and recruitment and retention of nurses in the State.

1.2 Research Objectives

The overall objective of this study was to provide the NRRC with specific and comprehensive feedback on nursing issues across the State as perceived by existing and undergraduate nurses.

The research was required to identify/understand, across all nursing categories, the:

- Drivers (or motivations) for becoming a nurse.
- Ongoing motivations to stay in nursing.
- Expectations (or needs) from a career in nursing— what role do they play in community, what value does the community place on their profession?
- Satisfaction with the nursing profession.
- Appeal of, and/or satisfaction with, specialty areas.
- Perceptions of differences in practising in metropolitan and rural areas.
- Perceptions of reasons for leaving the profession; and
- Specific actions or steps required to increase retention rates (probe beyond remuneration and working conditions).

1.3 Research Method

Qualitative focus groups were conducted on the basis that they were the most suitable avenue for covering the breadth of issues surrounding nurse recruitment and retention.

In total, eight categories were identified for inclusion in the study:

1. Grade 2/3 nurses (Divisions 1 & 3)
2. Division 2 Nurses
3. Mental health nurses
4. Midwives
5. Graduate nurses (mid-graduate year)
6. Undergraduate students
7. Agency nurses (metropolitan only)
8. Unregistered nurses (metropolitan only)

Given the focus on both metropolitan and rural issues, each of the above segments (with the exception of agency and unregistered nurses) were covered in both regions to enable comparison and contrast on the range of nursing issues.

Given the skew in nursing numbers towards Divisions 1 to 3 (and in particular, Division 1) the numbers of groups among this segment were boosted relative to other categories.

The table below summarises the group structure:

Number	Category	Location
1.	Grade 2/3 nurses	Metropolitan
2.	Grade 2/3 nurses	Metropolitan
3.	Division 2 nurses	Metropolitan*
4.	Mental Health nurses	Metropolitan
5.	Midwives	Metropolitan
6.	Graduate nurses	Metropolitan
7.	Undergraduate students	Metropolitan
8.	Agency nurses	Metropolitan
9.	Unregistered	Metropolitan
10.	Grade 2/3 nurses	Rural
11.	Division 2 nurses	Rural
12.	Mental Health	Rural
13.	Midwives	Rural
14.	Graduate nurses	Rural
15.	Undergraduate students	Rural

* Two separate mini-groups were conducted – One group with hospital educated Division 2 nurses and another with TAFE educated Division 2 nurses

Metropolitan groups were conducted at a Research Facility in Elwood, Melbourne between 12 – 27 July 2000. Rural groups were conducted in Shepparton between 18–19 July and in Ballarat on 25 July with undergraduate nurses.

Each group lasted approximately 1.5–2 hours and contained up to nine respondents. An incentive was paid to each respondent for attending.

Key Recruitment Criteria for each segment was:

- Grade 2/3 nurses (Divisions 1 & 3):
50:50 Grade 2 vs 3, 50:50 community vs hospital-based.
- Division 2 Nurses:
50:50 community vs hospital-based. Mix of hospital educated and TAFE educated.
- Mental health nurses:
Work predominantly as mental health nurse.
50:50 community vs hospital-based.
Mix of those who were initially educated as mental health nurse vs specialised later.
- Midwives:
Practicing midwives only. 50:50 community vs hospital-based.
- Graduate nurses (mid-graduate year):
In 1st year of study.
- Undergraduate students:
In 3rd year of study.

- Agency nurses: Work full-time as agency nurse. Mix/ cross-section of nursing categories.
- Unregistered nurses: Have allowed nursing registration to lapse (either consciously or by default).

1.4 Respondent Profile

A total of 107 nurses participated in the focus groups across Melbourne, Shepparton and Ballarat. The majority of nurses were female (n=95), with just over one in ten respondents being male (n=12).

Division 1, 2 and 3 nurses worked in a spread of organisations, including:

- The Alfred Hospital
- Goulburn Valley Health
- Mercy Hospital for Women
- Monash Medical Centre
- Royal Children's Hospital
- St George's Hospital
- St Vincent's Hospital
- Wangaratta and District Base Hospital
- Western Hospital, Footscray

Mental health nurses worked in the following organisations:

- Doveton Community Care
- Dandenong Hospital
- St Vincent's Hospital
- Melbourne Health – Royal Melbourne Hospital
- Goulburn Valley Base
- Numurkah District Hospital

Midwives worked in the following organisations:

- Moorabbin Birthing Centre – Monash Medical Centre
- Frankston Hospital

Undergraduate nurses attended the following universities:

- Monash University
- LaTrobe University
- University of Ballarat

Agency nurses worked with the following agencies:

- Medistaff
- Care Nursing Agency
- Code Blue
- Staffing Australia

Participants came from a broad geographical section of Melbourne (and surrounding areas for the rural groups). Where available, suburb of residence can be separately supplied.

Drop-Out Rates

Initial recruitment for the groups targeted nine people per session, in order for eight to attend (an expected drop-out rate of one per group is the norm in market research). However, after the first few sessions, the drop-out rate for this project was significantly higher than the norm, with early groups averaging only six attendants.

When later investigated, the vast majority of respondents who failed to attend reported last minute changes to rosters or having to stay back and work overtime as the reason for non-attendance. Of note, this encroachment of work into private life is widely mentioned in the groups as an issue for nurses.

A few were unable to attend due to unforeseen family circumstances. Specifically, two people contacted had sick children and another had a family member in an accident.

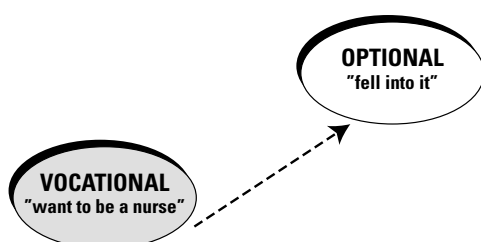
2. Detailed Findings

2.1 Role of Nursing

Initially in each of the groups an understanding of motivations to become a nurse are probed. This section provides interesting insights into the extent to which people are aspirationally attracted to the profession (as opposed to 'it's a job').

The research reveals that nursing is more likely to be an optional career choice (that is, chose this in preference to something else, but not particular desire to become a nurse), rather vocational.

Why Are People Attracted to Nursing?



The majority of people fell into nursing rather than actively selecting it as their career choice. For most it was 'something to do' and appealed on the basis of not being a desk job. For those who had been in nursing longest, it is often described as one of limited options available to them (most in their peers either became teachers or nurses). There was at least one person in each group who had family in nursing (often a mother) which influenced their choice.

More recently, since nursing has become a degree, there are those who choose nursing as an entry point to another profession (that is, had the university entrance scores for nursing, but not their preferred profession).

Nursing initially appeals for a variety of factors:

- Portability—you can travel within Australia as well as worldwide and will always find work as a nurse
- Security—perception that there are always jobs available in nursing. Additionally, there is a perception of transparent entry and exit barriers to nursing (that is, can leave for periods of time, for example to have a family, and can easily return).
- Flexibility—in terms of shiftwork (although it is also a negative aspect of nursing).
- Rewards of helping people.
- Being paid from the first day of training in the hospital system.

Why Do People Remain in Nursing?

When discussion of ongoing motivations for staying in nursing is explored, it is clear that the 'shine' has gone off many of the factors detailed above. Significantly, many nurses describe themselves as being 'stuck in a rut' and lacking vision or motivation to change careers. Additionally, there is a perceived loss of income (at least for a transition period) when you change careers.

Hence, for a majority of nurses, retention to date is more to do with barriers to exit rather than satisfaction with or commitment to the profession.

Specific barriers to exit include:

- While base salaries in nursing come under criticism, there is still an expectation that to change careers they will need to return to 'entry level' salaries. These are expected to be significantly less than current salaries (this is typically a barrier for nurses who have been in the profession for 5–10+ years).
- The cost of education (both in terms of financial outlays and loss of income while studying) is also a significant barrier to changing careers, hence they stay in current roles.
- Many are unsure what else they would do (most are not interested office/ desk jobs or working in a shop).

The discussion at this stage in the groups is not all negative, participants are able to suggest various upsides to a career in nursing which has sustained them during the years. These are explored in more detail in the following section (that is, positives of nursing).

What Are Perceptions of Nursing Among the Community?

Many feel that there is a general lack of understanding of nursing. This is not just among the general public but even among families and friends. *'How can you do that job?'* is a common reaction people receive. It is acknowledged that once people have been in hospital or had a close friend/ relative in hospital they are much better at understanding.

A number still feel that nurses are perceived as 'Florence Nightingale' types. Although this is a positive impression for people to have, it is increasingly unrealistic in today's environment. Nursing is no longer about personal care—there is no time to rub backs or sit chatting on beds. It is felt that older generations in the population, in particular, have this image, which makes them more demanding patients who are typically dissatisfied when they experience the nature of care in hospitals today.

Those who see the image of nurses to be positive overall still acknowledge the potential of the media to report on negative incidents and harm this image. An incident in Shepparton a couple of years ago was raised as being heavily reported by the media and the nursing profession is still recovering from it.

Most feel that expectations of nurses are high, and rising. The public is becoming more demanding as knowledge about health issues and awareness of patient rights increases. This is not just confined to nursing, however, comment is also made that doctors are no longer perceived by patients as God.

More demanding stakeholder expectations is mentioned across all segments of nurses, with the main issues raised being:

- Management deliverables (that is, making more demands on nurse outputs).
- Patient 'rights and responsibilities' creating a potentially adversarial environment. The concern for nurses in this regard is the perception that emphasis is placed on patients rights (to the detriment of nurse rights), rather than their responsibilities.
- General increase in public's assertiveness (translating to more difficult and demanding patients to care for).

Some feel that the low entry mark for nursing degrees is harming its image. Although training involving a degree is seen as positive in terms of raising the profile of nursing, the low entry level creates a public perception that: 'It's an easy way to get a degree'.

There was some feeling in the rural groups that the community, in fact even other nurses, may see nurses from the country as less skilled, particularly if someone has only ever worked at one hospital. Specific issues include:

- Less exposure to acuity of care (and hence capacity to manage high acuity patients is less).
- Unless utilised, 'advanced' skills tend to lapse.
- Typically more generalist than specialist.

2.2 Overall Satisfaction with Nursing as a Career

Overall there are low levels of satisfaction with nursing. There are a number of positive aspects of nursing and it is these positives which tend to attract people to the profession initially. However, the positives of nursing are offset by the reality of the daily grind of working as a nurse. Overall, the positives are clearly outweighed by the negatives.

2.2.1 Positives of Nursing

The reported positives of a career in nursing reflect many of the initial motivations for entering the profession. Portability and flexibility are the most commonly mentioned benefits. Significantly, while both attributes are perceived benefits of the profession, both also have an impact on the 'stability' of the workforce (in terms of staffing levels and skills mix).

The following key positives of nursing are raised spontaneously across all groups:

- **Flexibility of hours:** shiftwork and the ability to work part-time.
- **Portability:** nursing is a transferable skill (both within Australia and worldwide). Australian nurses also feel that they are generally well respected worldwide.
- **Job security:** it is perceived that nursing is a profession where there will always be jobs, providing security for trained nurses (particularly important for those with financial responsibilities).
- **Personal contact and interaction:** working with people (this is one of the key attractions of nursing over other professions).
- **Making a difference:** using your skills to have a positive impact on people's lives.
- **Appreciation:** when you receive thanks (note: gratitude and positive reinforcement is mentioned in the context of patients; management are criticised for their lack of encouragement).

Other less frequently mentioned positives:

- Interesting and varied work ('no two days are the same').
- Nursing can be exciting or pose a challenge, for example in emergencies, or when you diagnose a condition before medical staff.
- Teamwork is also mentioned in most segments as a positive aspect of working in nursing, that is working towards a common goal and pulling together to help one another out. At the same time, there is a concern that the teamwork approach has become more fragmented in recent years.
- There are a number of different speciality areas from which nurses can select.
 - Some see this as a positive as individuals should be able to find something they

like among the options available.

- Those with a speciality tend to feel more skilled and confident in their roles
- Some mention that health knowledge and access to health information can be useful for situations outside the work setting, for example if children are sick.
- Grade 2/3 city nurses comment on in-service hospital training as a positive. New product training and updates on therapeutics, in particular, are mentioned as the most beneficial forms of training.

2.2.2 Negatives of Nursing

Poor remuneration and burdensome working conditions are main areas of dissatisfaction highlighted across all groups. Coupled with these is the 'bigger picture' issue of limited career path (particularly in the clinical setting).

Overlaying these concerns is the perceived negative attitude of nursing management.

There was a great deal of discussion about the negatives of nursing in the groups. When specific reasons for departure from the industry are later probed, it is clear that the majority of negatives raised also act as drivers for departure. Hence, each of the areas of concern detailed in this section is also applicable to the later section on departure rates.

Remuneration

Remuneration is typically one of the first issues raised when the negatives of nursing are probed. It is the 'yardstick' by which they measure their value. Nurses are quite vocal in expressing a perceived mismatch between their contribution to health care and their compensation. Perceived poor remuneration provides yet another indication to nurses that they are not valued by management.

Specific areas of dissatisfaction with remuneration are summarised below:

- Numerous references are made to other professions (mainly business) to contrast the disparity between nurses remuneration and other 'professions'. Salaries for nurses are seen to be significantly lower than the earning potential of other professionals (beyond the initial graduate level transition).
- To the same point, nurses' salaries are perceived to be 'capped', with remuneration

based solely on **salary**. It is the perceived norm in other professions for remuneration to comprise each of the following:

- Base salary (fixed rate of pay regardless of on-the-job performance or contribution)
 - Skills recognition (an additional component to base salary reflecting skill set and skills upgrades)
 - Performance review (recognition of contribution to the working environment either by way of salary increase, bonuses or some other tangible incentive).
Nurses perceive that not only are they denied skills recognition and performance reviews, but that base salaries do not meet workplace demands.
- It is also felt that salaries in nursing do not reflect the level of responsibility nurses have. Nurses feel that they work with the constant pressure of having people's lives in their hands but receive no recognition for it.
 - Without shiftwork, nurses salaries are commented as being very low. Nurses begrudge having to make long term lifestyle sacrifices (shiftwork) to earn a liveable salary.
 - There are seen to be insufficient tax deductions available. Uniforms can no longer be claimed, child care and parking costs are also mentioned (should be deductions)
 - Many have high levels of unpaid overtime. Nurses are often 'expected' to finish shifts late but are not recognised for this extra time (this may be half an hour extra per shift, which quickly adds up over time).
 - Once a certain level of experience is reached, salaries do not shift, regardless of additional training or expertise brought to the workplace. As commented by one Melbourne nurse ... 'I've been on the same pay for 10 years'
 - The ANF public sector claim is referred to as addressing specific pay issues among nurses (although specific elements or details of the claim are not discussed).

Workloads

Although there are clearly issues with remuneration in nursing, it is not unexpected that salaries would be a focal point when areas of dissatisfaction are probed (regardless of

industry). While nurses are clearly concerned about compensation, the more compelling issue for them is workload (and the associated stress).

When explored in the groups, nurses report various contributing factors to increased workloads and stress levels in the workplace:

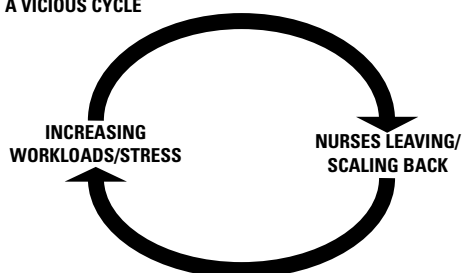
- The emphasis on cost reduction by hospital management has resulted in lower staff levels and higher patient ratios. All groups refer to patient loads of at least six, even eight patients to one nurse (where four is seen as an acceptable level).
- All nurses felt that their hospitals were short-staffed (some commented on being particularly short-staffed at night). There were also some comments that skill mixes on shifts were often poor. Agency nurses and/ or graduates replacing full-time staff, in particular, put extra burden on units.
- Increased acuity of patients is a significant issue. Turnover and earlier discharge of patients has resulted in higher maintenance inpatient care, while nurse to patient ratios have not decreased commensurately (and in fact have reportedly increased).
- There is also recognition that problems will continue into the future as a result of the ageing community (it will place increasing pressure on already limited beds).
- Nurses feel that they can no longer do their jobs properly. They often leave feeling that they did not do as much as they could have, or should have, done. This results in feelings of disappointment and low job satisfaction.
- There is seen to be no downtime anymore. If it is a slow shift someone will be sent home (to save costs). On the other hand, if someone is sick the others are often expected to just cope with one less staff member.
- A concern from Division 1 and 3 nurses is the increasing use and reliance upon agency and nurse bank to top up low staff numbers. Specific issues include:
 - a resentment that management regularly pays the higher rates required for bank and agency nurses, when they are so cost-focused in all other aspects
 - a belief that agency nurses are less productive than hospital staff since they are not familiar with the ward

- a perception that agency nurses have a 'pick and choose' mentality, positioning themselves as elitist
- Hence, some permanent nurses feel that agency nurses have an adverse impact on the morale of permanent staff on the ward and would prefer that bank nurses are used instead.
- Rosters are seen to regularly change and working overtime is common (and often unpaid). As mentioned earlier in the report, a number of the respondents reported a change in shift or having to stay on at the end of a shift as reasons for being unable to attend the groups. This lack of control over hours adds to nurses' feeling of not being respected by management.
- There is also an issue with time in-lieu and annual leave. Time in-lieu, in particular, is felt not to be encouraged or easy to take. Annual leave may even be refused (one rural participant hadn't had leave in two years despite claiming she had asked for it several times).
- Working conditions are seen to have a very real and detrimental impact on nurses over time (and with age). The physical nature of the job and the demands of shift work are commonly spoken of as wearing nurses down. Burn-out is regarded as inevitable.

In summary, workloads have increased in reality while staffing levels have not kept pace with on-the-job demands. As stress levels in the workplace increase, burn out rates accelerate, either forcing nurses out of the industry or to scale back their participation (that is, work part-time).

The concern for longer term maintenance of staffing levels is that as participation rates decrease, workloads for incumbents will increase thus resulting in the vicious cycle as illustrated below.

A VICIOUS CYCLE



Management Attitude (Lack of Support)

Nurses frequently referred to 'management' during the groups. They were generally referring to Nurse Unit Managers and Directors of Nursing. It is acknowledged that Government funding and CEO support is essential in implementing change, but the day-to-day responsibility is seen to lie with Unit Managers and Directors of Nursing. Nurse Unit Managers in particular are perceived not to be fighting hard enough for better working conditions for nurses—they are seen to be on 'management's' side.

There is a general feeling that research has been done before and nothing has changed as a result. Management is seen not to listen or admit the problems that exist in the nursing industry. Hospital managers are seen to have become businessmen who are focused on costs and are puppets to government.

There are a number of elements that are perceived to contribute to inadequate support from management:

- Managers are seen to now follow an academic stream and have become removed from the reality of nursing today. Even those who started out as nurses act in a way which makes current nurses think that 'they seem to have forgotten what it was like'
- Hospital management is perceived to care only about money and cutting cost. This translates into high patient ratios and highly stressful working conditions (as discussed previously).
- It is felt that there is no people focus by management. This lack of focus applies to both patients and staff, as neither is receiving adequate treatment/ support in the current environment.
- There is seen to be no recognition of the stress staff are under and denying of basic rights, such as the opportunity to take time in-lieu or annual leave.
- There are no formal performance appraisals in place for nurses. Hence, no feedback or encouragement mechanisms along with no basis for which to reward high performance levels.
- There is no support on a day-to-day basis, let alone in more serious situations. Nurses feel isolated in circumstances where they

would expect to have the support of nursing management. Examples cited include management siding with patients with no regard for the nurse's perspective if there is a complaint. Mention is also made of expecting no support if more serious matters (for example, litigation) arise.

Higher Expectations

- It is felt that expectations of nurses from the public have increased in recent years. Consumers are generally more informed, including in health matters. More informed patients are increasingly demanding in terms of the standard of care they expect.
- This is contrary to the lower standard of care that nurses feel that they are able to offer in current working environments. Patients easily become impatient with what they believe to be hospital inefficiencies and blame nurses for a lower standard of care.

Working conditions and the lack of management support, combined with higher expectations from the public, contribute to considerable stress in the workplace.

Lack of Career Path

- Bedside nurses in particular feel that their career options are limited. It is felt by some that there is a perception in the industry that bedside nurses are under-achievers and there is thus no career path for them.
- There is a common perception that once you reach clinical nurse specialist there is nowhere to go except 'management'. Similarly with some specialities it is perceived that after five years the only advance you can make is into management.
- Many seem unclear about exactly what management does (one group mentioned that roles should be more clearly defined so that management is not so 'alien' / separate). However, it is generally associated with administration, which does not appeal to a majority of nurses. Interaction with people is a positive aspect of nursing for most; the reason they are nurses is because they don't want a 'desk job'.
'The further up in nursing you move the further you move away from patients'
- Many of those who had been nursing for more than a few years, felt that they had lots

of rotations and exposure to different areas when they were training but since then they have been 'stuck' in one area/ role.

- Division 2 nurses are clearly seen by all to have a limited career path, with fewer and fewer options outside of aged care (see Division 2 section).
- There is some feeling among those who have been nursing for some years that nursing was once a good career choice but isn't any longer.

Perceived lack of career opportunities is an issue, as nurses do not have a long term view of their future in nursing. In particular, among bedside nurses, there is a perception that there are deliberately limited opportunities. A sense of reaching a ceiling early in careers (eg 5–10 years) leaves many considering options outside (bedside) nursing.

Education

Education is another key area of dissatisfaction, evoking much comment in the groups. There is not a particular issue in terms of courses being available with a number of courses/options for further education seen to exist (except for Division 2 nurses—see section below). However, there is clearly an issue with nurses accessing education due to both cost and time barriers. In particular, lack of management support is regarded as a primary barrier to further education.

- Lack of support consists of three main facets:
 1. No assistance towards the cost of courses (actual course cost is significant and time off required to study means a loss of income).
 2. Minimal study leave available (nurses expect that they will not get study leave. Shepparton Div 2 nurses pointed out there is one day/ fortnight study leave for their unit, which covers 50 staff.
 3. Lack of recognition at the end (no thanks/congratulations, not recognised in review processes, no monetary recognition, no promotional opportunities).
- Although concerns are raised about the cost of study, it is generally the unpaid time off work that is seen as the greatest cost.

Vocational-based education appeals to nurses on the basis of not having to take time off (minimise loss of income).

- Study leave is mentioned in terms of a per unit allocation of only one day/fortnight. Where a unit has someone who is studying they can take the allocation for the entire unit. There is a perception of issues of access to this leave (not equally awarded to different levels).
- There is a clear perception that other professions receive assistance, both time and cost outlays, to do further education, as well as being financially rewarded once they have completed education.
- There is a further barrier to education in rural areas as many courses are in Melbourne. Travel to Melbourne requires time and cost (particularly when at night and overnight accommodation is required).
- The paradox is that, in spite of offering no support for education, management is perceived to put pressure on nurses to up-skill.
- Midwives differed from other groups in terms of having a greater number who had pursued further education, as midwifery is now a postgraduate qualification. Midwives, as a group, appeared more motivated than other nurses (see midwife section below). We believe that generally higher levels of on-the-job satisfaction may help to reduce or overcome the perceived barriers to further education.

Respondents are quite specific in saying that they want to pursue further education and that the barriers that exist are a real concern for them. While access to education is clearly desirable, it is possible that its aspirational appeal is elevated due to difficulty of access. Specifically, education acts to bolster individual confidence as well as provide evidence of recognition when sponsored (even in a small way) by management.

Hence, it is potentially an 'easy target' to provide more evidence of management lack of support for nurses. Having said this, it is quite clear from the groups that current access is totally inadequate to meet the needs and demands of the nursing workforce.

In-Service Education

Hospital-based education was raised initially by some groups when discussion turns to education. There is typically positive feedback on this level of education. There were, however, a few access issues raised across the groups:

- Night shift workers are not catered for as education is typically during the day (and neither are night shift staff compensated to attend day time sessions). This is seen to demonstrate a basic short-sightedness of management, that is, not catering to the needs of a sizeable segment of the workforce.
- Sometimes not everyone in the hospital is made aware of education sessions (mentioned by Division 1 nurses in particular; seemed to be a result of hospital hierarchy/politics).
- Training for new equipment/technology is often by the equipment's manufacturer, meaning nurses receive only a positive view (not warned of possible problems).

Lifestyle Cost

- The hours of nursing are unsociable (nights and weekends) and impractical for mothers with children as child care facilities do not offer extended hours for shift workers.
- Nursing is seen to become more difficult with age. It is felt that as you get older the physical nature of the work and the hours (particularly night shift) have a greater impact.

Age aside, the lifestyle cost of shiftwork is seen to wear nurses down and is reported in the groups as a major reason for leaving the profession or working fewer hours.

University Educated Nurses

- There is clearly a feeling among current nurses that graduates are ill-prepared when they come out of the nursing degree. They are seen by many to be a stark contrast to the 'old hospital trained' nurses: *'We were value for money from Day 1...we expect them to have more practical skills'*
- Expectations are that graduates should deliver from day one. This is clearly an issue as expectations are not in line with what the course delivers (the course is not structured to do this).

- The reality is that graduates are having to deliver from day one due to staffing shortages on most wards (graduates report inconsistent access to supernumerary status). This creates problems as wards or units feel the strain of having graduates who are clearly not able to act in that capacity. This is further compounded by the knowledge many nurses have of the 'graduate levy' (reportedly \$15,000) paid to hospitals while graduates are in transition from study. The current scenario provides further evidence to nurses of management's lack of respect for staff (that is, disregard for protocols and an expectation that experienced staff will cope with any skills gap).
- Many of the more experienced nurses begrudgingly work with graduates. There is a feeling that '*graduates can't do anything*'. There can also be problems if it becomes obvious that graduates are unsure about what they are doing, which subsequently upset patients. The extra burden graduates pose in their first year is causing genuine concern, even animosity among some more experienced nurses.
- Undergraduate courses are seen to be too academic by existing nurses. Although they do include clinical training, it is not seen to adequately prepare graduates for their first day in the ward. Many request a return to the hospital-based 'training' regime.
- Graduates themselves agree that there are gaps in their preparation for the workforce. (See graduate section for more detail.)
- Undergraduates also feel unprepared for the clinical placements and request more placements to better prepare them for their graduate year. However, they have an expectation that support will be forthcoming in the wards if required (as things stand, the reality is likely to be very different).

Risk of Litigation

Litigation is mentioned by a number of nurses as something which is constantly '*hanging over their heads*'. There is felt to be an increased trend towards it as well as an increased risk of mistakes with the pressure they are now under. One nurse commented '*You are being judged all the time*'.

There was a heightened sense of litigation in Shepparton groups where there had been litigation at the local hospital.

Lack of Facilities

Hospitals are seen to offer inadequate facilities for their nursing staff. Specific shortcomings include:

- Lack of child care facilities generally and also the hours of operating are inadequate to meet the needs of shift workers.
- Parking around hospitals can be quite expensive and is regarded as unsafe for women leaving hospitals late at night.
- Poor staff kiosks/canteens, however this is a reasonably low priority.
- Access to facilities is reportedly limited outside business hours. This is regarded as demonstrating management's lack of understanding (or care) regarding the needs of afternoon and night shift workers.

Health Risks

- Back injury is mentioned by many as a relatively common injury among nurses. Support in the instance of injury is felt to be poor. WorkCover is seen to be inadequate and there is no post-injury support.
- There is also a perceived risk of infectious diseases (relatively minor issue).
- There was some mention of physical violence in the workplace in emergency care, psychiatric and community nursing.

Horizontal Violence

- Comments relating to horizontal violence are isolated across the groups, but exist. The term was referred to in one group (grade 2/3 nurses) to describe segregation or breakdown in working relationships resulting in inequitable treatment. Specific references include:
 - A feeling by a small number of nurses that there were hierarchies within hospitals based on where you had trained. Information was not felt to be shared by all (believed that some withhold information on the basis that it is power). Lines of communication were also not seen to open to everyone.
 - One example given was 'selected' access to information about in-service education sessions.

- Some other groups raised a general lack of 'togetherness' among nurses. It is felt that there is a clear hierarchy in hospitals, particularly the gap between medical staff and nursing staff, but in addition to this some perceive there to be a real sense of rivalry among nurses at the same level. That is, 'rivalry among people who should be your peers' (comments about this were made across different nursing segments).
- There is also recognition of intolerance by some older nurses towards graduates and undergraduates. The observation was made in one group that 'we eat our young' to highlight the attitude of some nurses.
- Mention is also made of instances where staff will call in sick to avoid particular individuals, placing undue burden on other staff members.
- Some acknowledge that bitchiness and rivalry is the nature of a predominantly female based industry, however it is also felt that the way nursing works today is contributing to this (people are assigned their patients and have to focus on getting everything they need done for their patients). Hence, there is no time to consider the needs of co-workers when working under these pressures.
- Doctors having a lack of respect for nurses is something mentioned in several groups. This attitude has improved over time as doctors 'status' with the public has changed (public now more questioning) but it is still an issue. Nurses feel frustrated when doctors won't acknowledge their views or are subject to patients trusting the doctor's word over their own.
- Some do still feel that there is a sense of teamwork and that people do offer to help each other out (for example at the end of a shift). This image is certainly an appealing aspect of nursing but the reality today seems to be that nurses are becoming increasingly fragmented and somewhat isolated in their roles.

Rate of Change

- The pace of technology and other changes was mentioned. Change itself is seen as a positive but some felt that change was not managed well—you have to make the effort to keep up you get left behind.

2.3 Key Reasons for Departure from Nursing

As mentioned previously, all of the negatives discussed above can be reasons for people leaving nursing. It is most likely that it is a combination of negative factors that cause nurses to leave the profession.

Overall, when asked to prioritise negatives, poor remuneration and working conditions are the two factors named most often as reasons for departure from nursing. As stated earlier, working conditions appear to be the more powerful motive to adjust work status or leave the profession.

One Shepparton respondent summarised the reason for people leaving by commenting 'It is the powerlessness of it'. This powerlessness is a combination of poor working conditions, higher and higher patient loads with no recognition or support from management, and increasingly difficult patients to deal with. That is, higher levels of stress combined with no recognition or support. **All these factors combine to make nurses feel under-valued and unsatisfied with their careers.**

Barriers to entering nursing in the first place were also discussed. Overall, nurses (particularly those who have been nursing for some time) felt that there were many more alternatives out there for women these days. Nursing does not compare well when you compare the pay and the hours to other industries. They also feel that when they selected nursing it was a good career choice but these days it lacks a career focus.

2.4 Nursing Advocacy

When responsibility for dealing with departure issues is probed in the groups, the over-riding responsibility, or lack of advocacy, is assigned to nurse management. Additionally, nurses themselves believe they need to take more of the initiative.

The point is well summarised by a comment in the groups that nurses 'are their own worst enemies'. The fact that they continue to put up with conditions and continue to 'cope' under pressure and in times of short-staffing (most of the time) sends the wrong messages back to management.

At the same time they also believe that there have now been a number of investigations into conditions in nursing and as yet they have seen no tangible outcomes. There is cynicism that this project will be any different. It is generally felt that there is a reluctance to admit the issues in the industry and until this admission is made it is unlikely that any improvements will be seen.

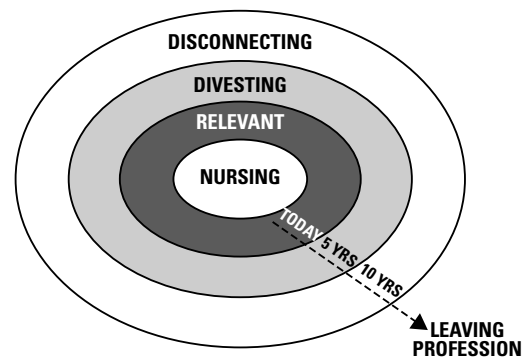
It is felt that there needs to be a change in the attitude of 'management'. When discussing management during the groups, nurses generally refer to Nurse Unit Managers and Directors of Nursing. Nurse Unit Managers in particular are seen to have a responsibility for speaking up for nurses and in most cases are not living up to this responsibility. It is felt that those beyond Unit Manager level are out of touch with the reality of today's wards. They need to become closer to the coalface and gain a true understanding of nursing. It is felt that only then will they be able to offer genuine support.

For change to occur it is acknowledged that Government must lead the way (with an increase in funding an obvious requirement). Change will also have to be supported by all levels of hospital management.

2.5 Future Intentions

Of concern, the proportion of nurses who are positive about their future in nursing is small (less so for midwives and psychiatric nurses). When asked their future intentions, most intend to either scale back their participation, or plan to leave altogether within the next 5–10 years.

This point is illustrated in the graphic below depicting the current sentiment, or attachment, of nurses to their profession. While nursing has been, or is, relevant to their context today for a majority of nurses, the trend is to be divesting responsibility within the next five years and to be somewhere else (that is, disconnected) within the next ten years.



There is a high proportion of nurses who expect to be working part-time within the next five years. The bulk of nurses we spoke to fall into this category. In reality not all will have this option available to them (mainly due to financial considerations). However, the extent of desire to scale back participation in the nursing workforce is obviously a concern. We believe it is clear evidence of the dissonance that currently exists with the profession.

Nurses seem no longer prepared to give so much of themselves. The lifestyle cost of nursing full-time is not worth it when there is little or no perceived reward. Some feel that they will physically be unable to handle the workload in the future, others feel emotionally burnt out.

Some nurses intend to move to agency nursing in the next few years. Although it is recognised that it doesn't have the same job security, agency is perceived to have the key advantages of higher salaries and control of your working hours (including the ability to work part-time if desired).

There is a segment of nurses who intend to remain in nursing but move away from the bedside. Becoming community nurses is the most logical option for this group to pursue. Being out of the wards, having more autonomy, working one-on-one with patients and having more regular hours are the appeals of community nursing.

There is a segment that intends to leave nursing to move into an associated health profession. There is a general perception among nurses that they have a transferable skill; many seem to believe this skill extends into other health areas. Some who have tried moving into what they see as an associated health field have discovered that this may not be as easy as it sounds.

Psychiatric nurses and midwives are less likely than other nurses to report an intention to leave nursing. There is some trend towards part-time nursing, as in other segments, but the majority see themselves in the same role, or at least still in their specialty, in the future.

Some of those who intend to leave nursing altogether plan to move into totally different roles. Business is mentioned several times as an alternative.

Those leaving intending to leave altogether included a few of the males we spoke to. We believe that there could be an issue where nursing is being depended on for sole income in a household. Current salaries are encouraging breadwinners to look elsewhere.

Amongst the agency nurse group there were a couple who were sales representatives for pharmaceutical companies and worked agency nursing only part-time for extra money.

There could possibly also be a negative image association with men and nursing which makes them less likely to continue to 'put up with' the poor conditions. (One respondent mentioned the surprised and disparaging reactions he got when saying he was a nurse to other males).

3. Segment Findings

3.1 Grades 2 / 3 Nurses

Three focus groups (two in Melbourne and one in Shepparton) were conducted among Grade 2/3 nurses. In total, 23 Grade 2/3 nurses across a range of speciality areas were included in the research.

Compared with other segments, the tone among Grade 2/3 nurses is relatively negative. There is a real issue with bedside nurses who are fed up with their roles and lack of career progression. There is a clear issue with

maintaining the interest and motivation of bedside nurses.

On the whole, the views of Grades 2/3 nurses are reflective of the range of issues covered in section 2 of this report. Many of the characteristics of, and issues for, Grades 2/3 nurses applied across segments, that is to nursing as a whole. Any issues specific to Grades 2/3 nurses are covered in this section of the report.

Career Progression

When career prospects are raised in the groups, the focus is on clinical or 'bedside' nursing. Clinical nurses feel particularly strongly. The lack of perceived career path for clinical nurses is seen to send the message that you are not ambitious if you stay bedside. There is a very real sense that if you are career-oriented, you will regard clinical nursing as transitory. That is, you won't go far by staying at the bedside.

Additionally, it is felt that there is nothing between the wards and management (administration). Most do not want to move away from the wards as they do not want to lose the people aspect of their jobs. Management is essentially seen by Grades 2/3 nurses as to shuffle paper. There is a general lack of understanding of exactly what management does but it is seen as very different and unappealing by most.

Beyond career path, there is the issue of job stimulation if you have been in the one role for a long time. Grades 2/3 nurses feel that when they first start out as a nurse, a number of rotations occur which provide exposure to different areas. However, once they have been nursing for more than a few years they get 'stuck' in one area or role.

Clinical nurses are feeling stale and bored as a result of limited variety in their role and opportunities for progression. This is clearly an issue as it is a reason for leaving the industry.

Speciality Areas

Those who had specialised tended to feel somewhat more satisfied than others. Overall specialties are seen to have the advantage of providing a sense of security (nurses feel more secure when they have a particular skill). Some

also feel that there is a greater sense of togetherness among specialist staff, bound by a common interest and 'membership' to a skill set.

It was also generally acknowledged that you can reach a ceiling within specialities *'Five years in a speciality and there is nowhere to go'*

When motivations for choosing different specialties are probed, reasons are varied and dependent on someone's particular interest. For some, being in a specialty was more by accident than design. The comment is made several times that they chose the first specialty that came along in order to get out of what they were doing. A few examples of specialty based appeals include:

- Intensive Care was seen to have the advantage of being fast paced, exciting and an area where you were able to focus more (fewer patients, often one-on-one). The challenge of working with technology is mentioned by a number of the younger nurses in this field.
- Surgical/Theatre was seen as a less intense area, which appeals to some (others find it less exciting/ stimulating). It is appreciated for having more 'normal' hours, particularly day surgery.

Beyond these two specialties, it was difficult to draw out particular drivers or attractions to the range of specialty areas in nursing.

Key Issues Facing the Industry

As highlighted in Section 2, working conditions is a key issue facing nurses today. Grades 2/3 nurses are especially vocal about working conditions, with the range of concerns raised reflecting those outlined earlier.

Grades 2/3 nurses feel that there has to be a general change in the attitude of management to improve the situation. There is a perceived distance between management and the reality of nursing today. It is felt that managers now follow an academic stream and that even those who were once nurses 'have now forgotten what it was like'. Management is seen to offer no genuine support to nurses 'they don't give a damn'.

Interestingly, Grades 2/3 seemed very aware of one another's income. While other nursing segments complained about remuneration, they did not discuss pay amounts. Grades 2/3 nurses seemed to know rate of pay and income level associated with all positions in nursing (\$50,000 was most commonly mentioned as the ceiling for salaries for bedside nurses). This transparency in salaries is a frustration for some nurses who feel that regardless of on-the-job performance or commitment, 'you are paid the same as the person working with you'.

The Way Forward

When actions or steps to retain more nurses in the profession are probed, the immediate focus is on increased remuneration. When we explore remuneration more fully, it becomes clear that salary is an issue, but recognition of performance is the underlying need.

Of similar importance are poor working conditions, which are perceived to have escalated as a result of management's actions (and inaction). There is widespread endorsement that management needs to become more in touch with the reality of nursing today and stop being *'puppets to government'*. Nurses would like to see the focus revert from a focus on costs back to people (patient and staff). Lowering patient ratios is the most immediate step that needs to occur here.

Other, less widely recommended, steps or actions arising from the Grades 2/3 nurse groups include:

- Clinical nurses would like more exposure to different areas. They would like to have a number of rotations providing them with the opportunity to work in different areas and on different wards.
- Reduce working hours to a maximum 32 hours a week. This is commented as more feasible for shiftworkers.
- Some claim that they should have eight weeks annual leave. The current six weeks makes up for missing public holidays but does not compensate for the extra stress of nursing compared to other professions.

The Future

Almost all Grades 2/3 nurses included in the research intend to scale back their participation in the nursing workforce in some way over the next 5–10 years. For many, this means hoping to work part-time. Those nursing for more than five years perceive that there is a limit to their future in nursing (boredom is a key factor after five years, with no prospects for change). Quite simply, they are unprepared to keep giving themselves (at least full-time) to a profession that gives them little back in return.

3.2 Division 2 Nurses

Overall, the views of 19 Division 2 nurses were included in the research. The research was conducted across three groups: one rural and two metropolitan mini-groups. The mini-groups were split by type of education, with one group comprising TAFE educated hospital nurses and the other comprising nurses who had been educated in the hospital system. While the mindset across the two Melbourne groups was quite distinct (with TAFE educated nurses more likely to be seeking or actively studying for Division 1 registration) there is a consistent perception of how this segment of nurses is treated in the system. Hence, the views of Division 2 nurses are reported together in this section. Additional comment is made towards the end of the section referring specifically to views of TAFE educated nurses where they are atypical from other Division 2 nurses.

The mood among Division 2 nurses was, largely, depressed. They have a low feeling of self-worth due to the perception that they are being 'squeezed out' of the profession, at least for areas outside aged care. Nurses as a whole feel under-valued, however Division 2 nurses feel even more so than others. The issues are the same for both metropolitan and rural nurses.

Perceptions of Division 2

There is a general feeling among some Division 2 nurses that public perception is more negative than for nurses as a whole. For example, when patients realise the limits of their responsibilities they reportedly behave differently towards them: '...they know you

don't give out medication...therefore believe you must be less qualified in some way'.

There is a feeling among some Grades 2/3 nurses that Division 2 nurses are generally respected by other nurses but not by other health care workers. A comment made by a Grade 2/3 nurse is that Division 2 nurses are 'seen as the working class of nursing'.

Some Grades 2/3 nurses are positive about Division 2 nurses and point out that there are some very experienced Division 2 nurses who are good to work with. At the same time, however, there is the perception among Division 2 nurses that some Division 1 nurses are not happy having them on the ward. Division 2 nurses regard this disposition as either stemming from an elitist attitude, in the case of some graduates, or purely territorial for others. The fact that Division 2 nurses cannot administer medication (and hence add to the Division 1 nurse's workload) is also expected to be a frustration driving Division 1 nurses' attitudes. This frustration is equally shared by Division 2 nurses.

Limitations of the Division 2 Role

The nature of the responsibilities that Division 2 nurses have is recognised as a limitation by all (Division 1 and Division 2 nurses). The fact that they are not able to administer any drugs, even a panadol, is seen as ridiculous by some. Not being able to check medications is also frustrating. Division 2 nurses report having to interrupt workflows to find a Division 1 nurse to administer medications as a frustration when both nursing divisions are under pressure to fit everything into their work day. This latter concern is most potent in situations where Division 2 nurses are called in from nurse bank or agency to replace a Division 1 shift.

The role of Division 2 nurses regarding medications is not consistent across Australian states. Victorian Division 2 nurses believe that Division 2 nurses in other states are able to administer medication. This causes confusion and some resentment.

Limitations of the Division 2 role are exemplified by the following comments made within Grades 2/3 groups:

- *'I continually have to find things for them to do'*
- *'I feel sorry for them'*
- *'It's becoming harder and harder for them to be of help given the more acute nature of patients these days.'*

The Future of Division 2 Nurses

There is a perception among all nurses that Division 2 nurses seem to be being 'squeezed out', with the only opportunities being in aged care. For some, this is a highly unattractive longer term option. Division 2 nurses largely feel they are being forced out of (more interesting) general nursing and are also excluded from most courses that allow them to gain additional skills. This means that there is no incentive for them to develop themselves. It is felt that they have no career path or direction, which is resulting in low motivation levels and poor attitudes among some. There is a minority who report working in environments that are more progressive and stimulating in terms of different work tasks and wards. This has more to do with the attitude of management and equality of access to resources in their specific workplace

Division 2 nurses see no career path to exist for them, with fewer and fewer opportunities outside aged care available to them. For example, midwifery had been taken away as a course option. There are still some courses they can do, such as a diabetes course, but the cost is a barrier, study leave is almost impossible to get, and there is a feeling of 'what is the point really?' (no recognition at the end).

Those already working in nursing homes are feeling particularly frustrated. They believe hospitals offer greater diversity, job satisfaction and higher remuneration. The aged care environment is generally described as 'depressing', especially for younger nurses.

On the whole, Division 2 nurses feel that 'they are phasing us out' and as a result (management) offer no support. Rural Division 2 nurses felt that there were even fewer opportunities for them in the country.

The Threat Posed by PCAs

Personal Care Attendants (PCAs) are regarded as a threat to Division 2 nurses, particularly in community-based nursing in the aged care

sector. There is resentment that PCAs come out after an eight-week training course able to perform most of the functions, and indeed with greater job responsibilities, than Division 2 nurses who are educated for 12 months.

Other segments of nurses are also concerned about the level of responsibility that PCAs have after such a short training period, particularly the ability to administer medication. Melbourne Grade 2/3 nurses commented that they would rather Division 2 nurses were performing the roles that PCAs are taking on *'we're getting PCAs doing things they shouldn't'*.

One recently trained Division 2 nurse felt friction with older PCAs when she began work as they seem to view her and any new ideas or knowledge as a threat. It was noted that it will be more difficult to attract people to Division 2 these days as PCAs are out there with more flexibility and responsibility, earning the same money after an eight week course.

The Way Forward

Division 2 nurses raise the key issues of remuneration and workloads (as discussed in the main section of the report). However, they do have some very specific issues to do with their responsibilities and future in nursing, as discussed below.

Ideally Division 2 nurses want a career path. They are resentful that management is *'paying them no attention'* and continues to further limit their options, for example, taking courses away. As the situation stands today, Division 2 nurses point out that it is obviously a segment in decline, which is unlikely to attract new entrants.

They at least want to be given more scope in the areas they work in. For example, the ability to administer simple drugs like panadol, or the authority to check medications on their own. Victorian nurses are seeking clarity on the issue, particularly from the perspective that they believe this is already permitted in other states.

In addition to increased responsibility, Division 2 nurses say they would like more opportunities to work in different areas and to feel like they are actually working as a nurse. Working as a perioperative theatre nurse was

suggested by one, where they could function as a theatre technician. There is resentment that they are being forced into aged care and they clearly want the option to remain in other areas, such as acute care.

There needs to be clarification of the role of PCAs. Division 2 nurses would like PCAs to be prevented from performing the same tasks '*they are taking our jobs!*'

Division 2 nurses would like to see a reduction in the amount of paperwork they have to process so that they can get back to a focus on patient care.

The Nurses Board of Victoria is suggested as having primary responsibility for addressing the issues discussed above (seen as responsible for all sectors of nursing).

The Future

For some Division 2 nurses becoming a Division 1 nurse is aspirational, but the barriers to change are perceived to be excessive: loss of income while training being the greatest.

When asked about their futures, most of those who have been nursing for some time are likely to stay as is. There is almost a sense of resignation about their futures.

A small, more ambitious, segment is actively seeking opportunities outside clinical nursing, for example community nursing.

TAFE Educated Division 2 Nurses 'Upgrading' to Division 1

The attitude of TAFE educated nurses is quite different from hospital educated nurses. For many of the former, Division 2 is a transition to Division 1 (a function of representation at our focus groups possibly). For some, the limitations of Division 2 nursing had forced them to take up further study. For others, Division 2 was always going to be part of their progression to Division 1. These nurses were typically much younger than hospital educated nurses.

TAFE Courses

Overall, among all Division 2 nurses there is a strong sense that TAFE courses are focusing on aged care. It is believed that the course has very

few weeks in hospitals and much more time in nursing homes. This makes it very difficult initially when Division 2 nurses come on to the wards. Division 2 nurses identify that a transition period would be very useful, ideally in the acute sector to expose them to more than aged care.

Nurses would expect to be educated during the transition period (less than full salary may be acceptable) and would like to be supernumerary throughout this period.

3.3 Midwives

We spoke to 10 midwives in total, with one metropolitan and one rural group. Overall, midwives were clearly the most positive of all segments towards nursing. They did still raise general industry issues, such as workloads and remuneration, but their tone was much more positive and their intentions for the future were to remain in midwifery.

There were some issues that came up specifically among rural midwives (see below).

A Positive Speciality

The positive views appear to be due to the nature of midwifery. Unlike general nursing, midwifery is not about helping people who are sick, to the contrary, most patients are typically excited about having a baby. Essentially, midwifery is a much 'happier' environment to work in. Midwives cite this as a key positive of the speciality and something which keeps them in the speciality.

As well as working in a more positive environment, the midwives we spoke to also felt privileged to witness new lives and guide women in such an important part of their lives. In addition, and importantly, they feel that they have more autonomy and greater decision making power than general nurses. They have their own patients who they look after throughout the birth (without a doctor looking over their shoulder). Midwives clearly distinguish themselves from general nursing and the consensus is that they would never go back to general nursing.

Midwifery is seen to be an emotional area in which to work, related to the protracted intensity of care during labour. However, the

emotional benefit or satisfaction associated with a successful birth was seen as greater than satisfaction achieved in general nursing. This satisfaction was seen to offset the emotional strain of the job.

Undergraduates and graduates also perceive midwifery in a positive light with many hoping to specialise in it eventually. There was some mention of it being quite difficult to get into to due to its popularity.

The metropolitan midwives seemed to have a greater sense of teamwork and togetherness than other nursing segments (Moorabbin birth centre in particular seemed to emit this feeling). This was not the case in the rural group, where there were issues with some feeling uncomfortable with other members of the team (sense of competition etc).

Doctor Relationship Issue

Nurses generally say that there were some issues with the relationships with doctors if asked. They generally believe that doctors think they are superior and treat them with a lack of respect. However, relationships with doctors seemed to be somewhat more of an issue to midwives and was raised spontaneously by some as a negative of their roles. Midwives with many years of experience, in particular, find it frustrating when a young doctor contradicts their treatment approach. Both the rural and metro groups felt that doctors, on the whole, do not give them the respect they deserve. Specific examples include:

- Metropolitan midwives mentioned that doctors can place things in a different way and tend to focus on all possible abnormalities (fear of litigation), which can cause confusion and concern among patients.
- There was an issue among rural midwives as they felt that they have autonomy only up until the birth itself, at which point a doctor steps in and takes over. They clearly find this unsatisfying as they feel they do all the hard work along the way but are denied responsibility at the end, for the key moment of birth.

Access to Education

Further education is more common among midwives than other sectors. They seem less concerned with the barriers of time and cost. They acknowledge there is no tangible recognition of further qualifications; for them self-satisfaction is enough motivation.

Additionally, rural midwives are clear that they would like the general patient overflow into midwife wards to stop altogether. If it is to continue, perhaps some internal general nursing refresher courses would help them feel more confident with general patients.

Rural De-Skilling Issue?

Rural midwives did not feel disadvantaged in terms of the births that they were exposed to. If a birth was known to be difficult in advance, the patient may be sent to Melbourne, but this happens rarely. Goulburn Valley Hospital is a large hospital and receives most of the births in the surrounding area so they experience a wide range of situations.

Midwives also point out that experience goes beyond the birth itself. Goulburn Valley Hospital has rotations every two months between the three areas of antenatal, delivery and postnatal care, which provides midwives with variety and exposure to the different areas.

There is a lack of exposure to critical care of young babies in rural areas. This is an issue for one rural midwife who is considering moving to pursue this (she is one of the few who does not have family ties in the area, which will make it easier for her to leave).

Midwifery units in some smaller country hospitals have been closed due to a problem attracting staff. This hasn't been an issue for any of the midwives we spoke to, however, they mention it. It is not perceived as a threat to them given the size of Goulburn Valley Health.

The Way Forward

In spite of having a relatively positive perspective, midwives still mention a consistent set of concerns driving nurses from the profession. Their views, for the most part, are reflected in Section 2 of this report.

One concern going forward for rural midwives is the ability to feel empowered in all aspects of their role. This means preventing doctors from performing tasks that midwives can (most notably delivery of babies).

The Future

In line with the higher levels of motivation and job satisfaction among midwives, few are intending to leave the speciality. Many talk about doing further training and specialising within midwifery.

Their career is in midwifery.

3.4 Mental Health Nurses

Two focus groups were conducted among mental health nurses from three Melbourne-based and one Shepparton mental health facility.

Mental health nurses are passionate about their area of specialty, with reported intentions to remain in the specialty higher than retention among the general nursing workforce.

Significantly, however, burn-out is becoming a key driver for leaving the clinical area.

Additional to this is the accelerating pace of burn-out in the inpatient setting.

Perception of Specialty

Mental health nurses regard themselves first and foremost as being in the field of psychiatry, commonly referring to themselves as 'psych nurses'.

- And within this field ... they are nurses.
- For many in the groups, mental health nursing was their career choice (rather than nursing per se).
- Having said this, there are still a reasonable number who entered via the general nursing stream and then specialised. Over time, they too have come to regard their specialty area as offering them something different to, / or more than, general nursing.

When perceptions of the specialty among the broader community are probed, there is consensus that the public largely misunderstands mental health and that the segment is suffering general image problems. The media is highlighted as fuelling misinformation. Additionally, the role of nurses

in this segment is also regarded as misunderstood, with public perceptions ranging from 'martyrdom' through to 'nurse Ratchett' (from the movie 'One Flew Over The Cuckoo's Nest').

Motivations to Nurse in Mental Health

A majority of mental health nurses in the research cite an interest in the field of psychiatry as an initial motivation for becoming a nurse (that is, the initial attraction is not to the general field of nursing).

In both metropolitan and rural mental health groups, **teamwork** is reported as an appealing aspect of mental health nursing. The emphasis on teamwork is stronger in this specialty than other nursing segments included in the research. The strength of relationship, or bonding, with co-workers is perceived to be fuelled by the stress of working conditions in their specialty.

Another appealing aspect of nursing more widely mentioned in mental health than other groups is the sense of **personal reward or results**. Mental health nurses see themselves as being responsible for longer term care and maintenance of patients and results can be slow and hard won. Hence, a strong sense of satisfaction when positive outcomes are evidenced. Community / case managers in particular comment on the personal reward felt from making a difference in people's lives.

Nursing Issues

In the main, mental health nurses report a similar set of issues and workplace impediments as the broader nursing populace (that is, work load, remuneration, career path, shift work, access to education).

There are, however, a few particular areas where discussion in the mental health groups was more emotive than in other groups. It is worth re-stating these issues.

Workload

As with other nursing segments, the increasing workloads and acuity of care are significant issues that have an impact on the ability of mental health nurses to effectively deliver the level of care deemed appropriate.

Respondents cite many examples of increasing workloads beyond manageable levels, while at the same time the administration content of their work is rising relative to patient contact hours. This is resulting in greater levels of dissatisfaction with job content and role. Specifically, the quality of time that can be spent with any one patient suffers as the workload increases. Typical comments among mental health nurses include:

- *'You simply don't have time ... you feel as though you are going from crisis to crisis'*
- *'Ideally a case manager's load should be 20 cases. We manage up to 37'*
- *'The contact you have with patients gets less and less while you try to manage the admin stuff and paperwork while also negotiating with other agencies and referrals'*

Increased workload is seen to be the largest contributor to burn-out in the workforce, which is also reported as the major cause for nurses leaving the bedside (and leaving the profession). Mental health nurses perceive that burn-out and stress levels are higher in their specialty than in general nursing, due to:

- Patient conditions more emotionally draining.
- Can be more physically demanding.
- Changing nature of patient illnesses/increased complexity (beyond traditional mental health areas into drug addiction, homelessness, and so on).

A few comments typifying burn-out within the specialty include:

- *'I love psych nursing, but I just can't handle the stress levels I have been carrying for the last five years anymore. I feel that I am tired of life being so tough. I live to work at the moment and I want to get on with my life'*
- *'I think psych nursing is actually depressed. I now just go to work and do my job – stuff training, stuff politics.'*

While workload is widely mentioned across the groups as a very real barrier to accessing education, mental health nurses feel especially strongly about taking time off in the knowledge that co-workers will be under additional stress. As commented in the Melbourne group 'you feel guilty about abandoning the ward'.

Career Path

A flat and diminishing career path was mentioned in both mental health groups. The closure of larger psychiatric institutions and their absorption into the community is singled out as a contributing factor in lack of career path. Specifically:

- Loss of a career structure previously accessible in the hospital setting (a perception that more opportunities/layers are available to nurses in this setting).
- Flattening of levels within the specialty.
- Coupled with a breakdown of nursing responsibilities, with aspects of their job now being absorbed by allied health professionals and non-government organisations.

This '**de-skilling**' leaves many mental health nurses with a strong feeling of being undervalued by the system. Typical comments reflecting attitudes towards de-skilling include:

- *'The landscape looks very different now ... we direct traffic rather than drive cars'*
- *'It has made it less attractive. You start to think 'why should I come to work''*
- *'There are things we used to be able to do, now you can't – or you can't do them easily. Everything is being referred out, so we lose the skill' Psychotherapy is a specific example cited.*

As with general nursing, a flat career structure for clinical nursing is also identified, along with unnecessarily heavy workloads being deemed the 'reward' for promotion in the current environment:

- *'There is no promotional structure for someone who wants to pursue a clinical channel ... They introduced the clinical nurse consultant, but you are expected to carry a 0.5 case load, which is 20 clients in our setting, as well as be accountable for the professional standards of 90 nurses for the other half of your time. It's ridiculous.'*
- *'If you want to progress, you need to move into direct care.'*
- *'The really good nurses move onto community because of the structure and job satisfaction. Here (in the ward) you burn out very quickly and there is no incentive to stay in terms of career structure'*
- *'There is no mobility within the structure'*

Entry Level Requirements

For some, the feeling of being under-valued is further reinforced by recent changes to the entry requirements for mental health nursing via the bachelor of nursing program (rather than a specialist psychiatric nurse training).

Specific comments include:

- *'It took me three years to train for this job. Now a student does a few weeks clinical and they're expected to be ready to handle patients'*
- *'The new system genericises patient treatment and de-values the patient experience ... doing a unit in communication skills in a degree programme is useless if it's with a non-psychotic person'*
- *'The majority of graduates are in their early to mid-twenties. They have no life experience ... psych is all about people intervention'*
- *'This triggers a shift ... psych nursing was once a specialty, but it's not anymore. Anyone with a basic comprehensive degree can walk in and do it after a few weeks of psych exposure'*

Interestingly, undergraduates have a perception that the mental health component of their course is high (possibly to the detriment of other, 'more useful', areas such as pharmacology). At the same time, there is recognition among undergraduates that even if they don't go into the mental health specialty, they still need a certain set of skills to handle and diagnose patients who come through the mainstream system.

Dilution of Specialty

A significant concern among longer serving nurses (10+ years) is the perceived dilution (and hence devaluing) of their specialist role over time. Specific examples of this include:

- Decreased input into patient care (due to a combinations of other professions taking over aspects of their role as well as increasing workloads making it impractical to spend time with patients).
- Aspects of their role are being contracted to non-government organisations.
- Increased role of allied health in their profession.
- Less time allocation per patient (for example, time pressures to have assessments done in short time frames—expected that patients will be 'stamped with a condition' in one hour).

Leadership

While also raised in other segments, the issue of leadership and a united front for nurse issues seems to be more strongly championed among mental health nurses. Part of this may be due to the skew in the Melbourne group towards more experienced specialist nurses, who have had longer to consider the macro issues facing the profession (rather than a focus on micro issues that can be all-consuming).

Specific reference is made to the profession and, in particular, mental health nursing, as:

- Having no solid leadership
- Rudderless
- Fragmented
- Impotent (no one taking particular interest in nursing issues within psychiatry).

The comment is made in the groups that the next level of reporting for mental health nurses is a social worker. Without a Director of Nursing to champion nursing issues, many feel there is inadequate consideration being given to nursing issues, contributing to the disintegration of their specialty. Furthermore, the absence of a dedicated senior nurse is perceived as devaluing the role within the specialist field. Interestingly, while mental health nurses perceive a Director of Nursing would make a difference in fighting for the rights of nurses, in other focus groups, this level of management comes under direct attack for the lack of their commitment to the nursing workforce (that is, seen as siding with management and bureaucracy).

These factors are said to stem from the de-institutionalisation of mental health and a shift away from working in large hospitals. The institutions at least provided a career path.

As with many other nursing segments, the compromises outlined in this section translate to a disintegration of patient care, thus impacting the degree of fulfilment nurses have with their job (that is, left with a feeling that they could do more for the patient if different access to resources).

The Way Forward

When prompted, mental health nurses suggest a number of courses of action to address issues raised. Some of these are listed below:

- Graduate placements in acute inpatient units to be supernumerary. This would provide graduates with greater opportunity to learn and foster a more supportive environment from co-workers (that is, more inclined to take the time to help with development).
- Solid leadership—to address the perceived setbacks since de-institutionalisation. What is sought is someone to *'hold the reins and fight for the nursing cause in a very competitive environment'*
- The creation of dedicated nurse management positions is to be a step in the right direction in terms of the value of nurses in the new organisational structures.
- The HACSU Public Sector claim is mentioned in the groups as addressing the range of issues that have an impact on mental health nurses and desirable outcomes.

When **responsibility** for dealing with departure issues in the profession is probed, mental health nurses are more likely than other segments to attribute blame to hospital CEOs and the Minister for Health. That is, responsibility for policies that impact on working conditions and patient care is aimed higher than the nursing hierarchy (which is where blame tends to rest among other nursing segments).

The Future

As with other nursing segments, mental health nurses are also looking for working options in the future that reduce stress levels and give them access to better quality of life. Unlike other segments, there is less reported intent to scale back hours of work (although this is certainly aspirational), with expectations being of a move away from bedside to roles that give them greater autonomy and control over their working lives. Some areas they are pursuing for the next 5–10 years include:

- Community nursing
- Academia (in mental health area)
- Early retirement (at 55 years).

3.5 Graduate Nurses

Two focus groups of graduate nurses were conducted: one in Melbourne, with graduates representing five different hospitals and

covering a range of specialist rotations (from paediatrics to psychiatric); one in Shepparton, with graduates employed at the local hospital. Of the 15 graduates spoken to, three had previously been Division 2 nurses.

Overall, graduate nurses are pleased to finally *'be out there'* working, but are now discovering the realities of being a nurse: long hours, physically demanding, mentally challenging, pressures of time and resource management.

Significantly, after a relatively short exposure to clinical practice, their reported intent is in line with other nursing segments researched in terms of expectations for the future: for the majority, their career beyond the next five years is out of bedside nursing!

Perceptions of a Career in Nursing

Graduates' reasons for entering nursing are not dissimilar from the various motivations reported across the spectrum of nursing segments. Essentially, the main drivers are:

- Career benefits (for example, portability, flexibility, security).
- Vocational (for example, always wanted to be a nurse; family heritage).
- By default (for example, unsure of what direction to take, ended up in nursing; by accident, not what originally intended to do).

Regardless of initial motivation for becoming a nurse, there is a common thread in terms of it being *'bigger'* than they expected (that is, a bigger commitment). For some, there was a sense coming into the graduate year that they had *'made it'* and were now nursing. The reality has been ongoing study and a heavy schedule to meet workplace expectations (that is, full patient load).

When prompted, the perceived downsides and reasons for departure rates from the profession, as volunteered by graduates, is on par with other more experienced nurses. After six months of working, they have begun to experience first-hand some of these downsides, including:

- Lack of social recognition (the community is regarded as still not giving nurses the same degree of recognition as graduates' peers in other industries).

- Remuneration (the comment was made by a previous enrolled nurse that, after three years of study, she now earns three cents an hour more than before study).
- Physical working conditions (long days, busy, heavy work).
- Mental stress (dealing with peoples lives and with death).
- Shiftwork (and the impact on social life).

Graduates have already come to the conclusion that you can only do this for so many years.

Perceptions of Preparation for Nursing

Reinforcing the views held by more experienced nurses, graduates (in hindsight) regard themselves as being ill-prepared for clinical placements. Graduates included in the research were all mid-year. Hence, by this time they feel they have gained confidence and are starting to appreciate what it is to be a nurse (that is, it's stressful, hard work and shift-based).

Specific comments regarding preparation for work include:

- *'Uni doesn't prepare you for working or the realities of being a nurse ... I didn't realise it would be such hard work'*
- *'When you do your clinical placements at uni, you work day shift. That's nothing like the way you actually work when you're a nurse. You really need to be exposed to shift work sooner than grad year'*
- *'I didn't think it would be such physical work ... it is, after all, a female dominated industry'* (comment by Melbourne-based male)

Perceptions of Graduate Year

Nursing Support

On balance, the perception of working relationships is of a cooperative, supportive relationship between graduates and other nursing staff. However, there are a number of grievances raised across both groups that are specific to graduates. Namely:

- A perception that they *'get the butt end'* of the roster (Saturday night and Sunday morning). The rationale is argued that graduates are cheaper to pay to do these shifts than other staff.
- Decreased staff on wards results in potential for graduates to be given menial tasks

(perceived as easier than investing time in training when under pressure).

- Some perceive that graduates (and agency nurses) are given the more high acuity patients.
- Younger staff are regarded as more *'sympathetic'* (that is, they know what it's like to be a grad), but some older staff are perceived to judge without getting to know your skill level, for example: *'you're a grad ... you'll do pans!'*
- The term *'nasty nurse'* was used in the Melbourne group to describe the demeanour of nurses worn down by the ongoing stress in the workplace (that is, cranky, unsupportive). The consensus is that steps need to be taken, since none of them wants to become a nasty nurse!

At the end of the day, there is a sense that the onus is on the graduate to make the most of their transition year and to seek support and assistance when needed. To do so requires a certain level of confidence (that is, to not be afraid of asking).

Rotations

When satisfaction with career choice is probed, it is clear that graduate placement (institution) and choice of specialties can have an impact on perceptions. It is noted that some hospitals (and units/staff within them) are better equipped than others to manage graduate needs and provide appropriate support for their development.

About one-quarter of graduates express dissatisfaction with the program to date, with negative feelings stemming from a combination of choice of specialties as well as a difficulty with staff and management. Specific comments include:

- *'I don't feel I'm getting enough exposure to different areas of nursing'*
- *'On my first placement they didn't know what to do with me ... I tidied up pamphlets'*

In the main, graduates are satisfied with placement and optimistic that at least one of their rotations will have longer term appeal to them. The program at the Royal Children's was singled out in the Melbourne group (both by those in the program and other attendants at the group) as being innovative and supportive

of graduates' needs. Specifically, the program appeals because it has:

- Three rotations, each of four months (rather than two rotations of six months each). Preference drivers include: opportunity to be exposed to another specialty area; six months can be a really long time if discover don't like the specialty; four months is enough time to determine how you feel about the specialty and to consolidate skills in the area of practice.
- A mentoring program.
- Generally supportive staff.

There is strong support for more than two rotations in the graduate year. A fear of being 'boxed' into a specialty area early in their career is mentioned several times. As discussed in the groups, the graduate year is important in terms of consolidating nursing skills, but also gaining exposure to and choosing a specialist area. The access to only two areas in Shepparton (general ward and rehabilitation) is seen as not offering enough stimulation or choice. A concern specific to the rural group is the perceived limited options in rural areas (you can study a specialty area, but may not get a position in it).

Third year placements during the undergraduate program are also commented on as playing a role in choice of specialties (and subsequent graduate placements).

The Way Forward

Addressing issues contributing to workload is a major target in terms of actions or steps to retain nurses in the workforce. Graduates can 'see the writing on the wall' in terms of burn-out and lifestyle sacrifice as they progress through their career.

Specific suggestions are also made in terms of better preparation for the workplace. The emphasis is on longer clinical placements throughout the undergraduate degree, both to consolidate workplace skills and to greater appreciate the physical and emotional demands of the job and shift work.

Options described in the groups include:

- Longer placements (a four-week minimum to consolidate specialty and to generally 'fit' into the ward).
- Requirement to work shifts during placements (from 1st year) to appreciate

sooner, rather than later, the impacts of shift working on the body and lifestyle.

- Blocks of 'permanent' employment, working 2-3 days a week for approximately six months. The suggestion is made that these shifts be paid.

In a similar vein, graduates would like to see initiatives to assist both the candidate and the hospital deciding if they are right for the job earlier on. For example, placements sooner during 1st year along with interviews with hospital.

Graduates are also seeking stronger commitment from hospitals participating in graduate year programs to support their transition to the workforce. Specific suggestions include:

- Strict application of supernumerary status (not just on their first rotation).
- Provision of in-service training to other nurses imparting basic teaching skills (how to 'show' rather the 'do' when working with graduates) and tolerance for graduates within particular nursing segments (nurses trained in the old system).

The Future

Across both groups, a majority of respondents expect to have left bedside nursing within the next 10 years. Barriers to bedside nursing include:

- Physical fatigue or burn-out.
- Mental burn-out or need a change.
- Opportunities for promotion lie outside of bedside.
- Salary cap (especially for the few males who felt compelled to earn higher *incomes* 'to support a family'. One was proposing to follow a career path into academia).

3.6 Undergraduate Students

Two focus groups of undergraduates in the nursing program were conducted: one with students from La Trobe and Monash in Melbourne and another with students from Ballarat University. Of the 13 students spoken to, three had previously been Division 2 nurses.

Undergraduates are optimistic about career prospects, although, a majority do not see themselves in the clinical environment beyond an initial consolidation of skills period (up to five years).

Students are anxious and excited about starting their graduate year, however they believe their nervousness and questioning of ability to 'cope' is not dissimilar from that of any other student finishing an undergraduate degree and about to enter the unknowns of the working world.

Overall, the undergraduate degree program is regarded as having provided students with an academic framework and principles of nursing. However, they are vocal in their call for increased clinical contact throughout the course to consolidate skills learned in the curriculum and better prepare them for the realities of working as a nurse.

Perceptions of a Career in Nursing

The primary motivation for studying nursing is fairly evenly split among three key drivers:

1. Nursing is a vocation or a career of choice, as typified in the following comments:
 - *'want to give something back'*
 - *'I've always wanted to be a nurse – I love helping people'*
2. Nursing is an option (no particular desire to be a nurse, but a convenient and reasonably attractive option at the time). Typical explanations of this motive include:
 - accessibility (entry score)
 - know people who are nurses (family or friends) so *'just fell into it'*
 - it was a choice between nursing or teaching or some other career.
3. Nursing as a **stepping stone** to something else.
 - These students entered the nursing undergraduate program as a means of increasing their university eligibility to other degree programs that they did not qualify for. Significantly, the intent on entering the program was to switch at the end of first year, but all subsequently decided to see the degree through once they had some exposure to the profession.

Undergraduates' expectations of a career in nursing are not dissimilar to graduates and other nursing segments and include:

- Career benefits (portability, diversity, options).
- Flexibility (day-to-day flexibility, shiftwork as well as lifestyle, taking time off for children / travel etc).

- Desirable skill set (for own benefit or family as well as attractive to employers if want to change careers).

When perceptions of the expected downsides are probed, undergraduates are typically aware of the range of working concerns voiced by other nursing segments. Of note, Melbourne respondents appear to be slightly more aware or familiar with the range of issues and the intensity of impact on future nursing work life.

There is a sense among undergraduates that the community's perception of nursing is slowly changing for the better. The degree qualification is believed to be elevating nursing status to a '**profession**'. Although, undergraduates acknowledge that there is still a gap between the regard held for degrees in medicine and law as compared with nursing (which is more likely to be paralleled with teaching).

Despite this, undergraduates are quick to defend the robust academic format of the degree, commenting that nursing is in fact one of the more difficult undergraduate programs (work load, degree of content difficulty), further supported by the high drop-out rates in first year.

Perceptions of Course

As eluded to above, students rate the undergraduate nursing degree as being highly intensive in its academic content, with a commensurate drop-out/failure rate by the time someone graduates.

Specific feedback on a year-by-year basis is provided below, however, some overall observations of the course are worth noting first. Specifically:

- The most widespread criticism of the program is the limited clinical content and the lag in making '*first contact*' with the hospital environment.
- The intensity of study throughout the program is criticised, especially in second year.
- Off-campus educators are also mentioned as not necessarily providing as much support (or encouragement) as sought.
- Generally speaking, however, undergraduates believe they have appropriate support mechanisms when on clinical placements.

- In terms of curriculum, there are several suggestions requesting increased emphasis on pharmacology and pathology. A number of students felt that there was an imbalance between these subjects, which are seen to have important and widespread application in all fields of nursing, compared with psychiatry, which is a specialist field, but has greater weight of content.
- There is mixed reaction to the *'holistic'* focus adopted in the degree programs. Specifically, the course philosophy is reported as *'treating the whole patient'*. While this approach is endorsed by students, many are coming to realise that this is not the reality of how nursing is practised. The suggestion is made that either the focus needs to shift, or at least a more balanced representation of how nursing is administered in practice needs to be presented. In practice, it is perceived that nursing is task-focused rather than patient-focused. Excessive patient loads are seen to be a major contributor relating to the necessity for a task-oriented approach in practice.

First Year

When reaction to the program is probed, the initial discussion is consistently about the level of clinical contact. Within this context, the first year of study comes under most attack. Specifically, undergraduates' perceptions of first year are:

- High drop-out rates (especially after the first clinical placement; but also during other times of the year as some students come to recognise that nursing is not the career for them).
- It is generally regarded as the *'lightest load'*, hence suggested opportunity to include some of second year curriculum in first year to lighten the load in subsequent years.
- Timing of clinical placements is too late in the year (that is, three months into the course). They want to get out and experience nursing sooner.
- Clinical placements in aged care facilities are met with mixed reaction. While it is seen as a *'safe environment to let undergraduates loose in'*, it is also regarded as potentially misrepresenting the challenges and diversity of nursing. The comment is also made that

some students may drop-out in first year because they get the *'wrong impression'* of nursing after this first placement.

- Drop-outs in first year are also attributed to the usual undergraduate motives, such as don't want to put the effort into study; want a year off to experience life before further study; want to earn money; academic failure.

Second Year

Second year is regarded as the toughest year in the program due to the volume of subjects to get through. It is also when the majority of students really embraced nursing and became more focused in their studies. Factors driving these perceptions include:

- First *'acute care'* placement and sense of excitement regarding placements.
- A chance to consolidate learning (put the theory into practice).
- The failure rates in second year are perceived to be high (with three respondents out of 13 having repeated second year). These are regarded as testimony to the intensity of the program.
- In spite of the heavy on-campus work load, there are still calls for longer placements in second year as well as a preference for placements to in some way relate to the curriculum (although recognise this is impractical for the number of students around the State).

Overall, second year is regarded as the **year of empowerment** (albeit via a *'sink or swim'* philosophy).

Comments typifying reactions to second year include:

- *'I'm in it now ... I'm a nurse'*
- *'Everything fell into place for me in second year .. it was much more nursing focussed'*
- *'It was difficult, full-on and unnecessarily stressful'*
- *'It's much more intense than first or third year .. it's probably also heavier than a lot of other degrees'*
- *'A lot of people fail second year'*

Third Year

There is an almost self-congratulatory feel to having made it to third year. As summed up by one Ballarat participant: *'if you make it to third*

year you really want to be a nurse – you're a winner'. While continuing to be a full workload, there is a sense of the pressure easing off compared to second year, with more of an emphasis on consolidating learning.

On balance, third year is regarded as the **year of responsibility**; when you begin to feel a readiness to take on nursing in practice.

Next Year

When expectations of their preparedness for the upcoming graduate year is probed, the majority express some apprehension. The apprehension centres around:

- The unknown.
- Being fully responsible for a human life.
- Accountability for 6–8 patients.
- Support mechanisms are not in place to the extent of the undergraduate program.
- Will they retain theory in a practical context (time lag from studying subject to actually having to implement learning).

While apprehension is reported as not specific to nursing (that is, all final year students feel some anxiety about going into the wide world), there is a definite question in students' minds about their capacity to 'get the job done'. This is not so much related to the demands of the job (such as workloads or shift work), but refers to their ability to apply their nursing skills. Hence, the repeated calls for more clinical contact throughout the course to exhibit to themselves (and the nursing workforce) that they are prepared and able to nurse as well as to consolidate skills as they are learned in theory.

When the computer match list is explored in the groups there is limited discussion, but general endorsement of the recruitment process. While some regard it as a 'bonus' (that is, other professions don't get this sort of entree to the workforce), others comment that the reality is you still need to go through the normal job interview process anyway, so it has limited appeal. Additional comments include the possibility of completing more than four options, especially if you are applying to highly sought after positions.

The Way Forward

There is widespread endorsement in the groups for earlier exposure to the clinical environment

as well as earlier detection of 'fitness' for a career in nursing. Some suggestions for **earlier detection** of 'fit' with nursing included:

- Work experience before going to university.
- Interviews or briefings by hospital staff to give a grounding in 'nursing' (including day to day tasks; career prospects).
- Open days and hospital tours to get a feel for the work environment.
- Earlier placements in first year (as early as the first week on campus).
- Exposure to 'real' wards (not just aged care, which can be deflating and misrepresentative of what nursing has to offer).

The Future

Similar to graduate nurses, the expectations among undergraduates is that bedside nursing has a limited shelf life. Many are expecting to spend no more than the required period of time to consolidate their skills before exploring other options, such as:

- Nurse management
- Academia
- Related health.

Having said that, there is less of an expectation of leaving the profession or scaling back participation (part-time) in the medium term (five years) for undergraduates compared with other nursing segments.

3.7 Community Nursing

Across the groups, there was representation of community nurses in each of the segments researched. While community nurses also acknowledge and support the views of institutional nurses, there appears to be a greater sense of on-the-job satisfaction among this segment of nurses.

Both institutional-based and community nurses perceive a number of advantages to working in community. The key benefit to most is an increase in autonomy. Community nurses see themselves as sole nurse practitioners who make their own decisions. They enjoy the challenge of being responsible for their own actions. Doctors are involved only in abnormal circumstances, which gives community nurses a sense of autonomy and independence: *'There is no one looking over your shoulder'*

Another significant benefit is perceived to be the one-on-one relationships they have with patients. They feel that they spend more time with patients (in their own home), which allows them build greater rapport and trust. At the same time, patient loads are also commented as prohibitive to spending time. Mental health nurses working in community were most vocal about this issue.

Community nursing also appeals on the basis of not being 'stuck on the ward'. They are out and about, usually with a car provided for them. The more regular hours are also appreciated: *'It feels more normal'*

There are some downsides mentioned to community nursing. Autonomy also means accountability. Having sole responsibility for patients means being accountable (and solely liable) in the case of any mishaps.

For some, community nursing is also regarded as lonely, from the point of view of not establishing close working relationships with colleagues.

Another negative mentioned was the threat of physical violence. This is seen as a potential risk for female nurses working alone in the community and entering people's homes (this has been experienced by one community nurse).

The concern was also raised regarding some neighbourhoods being dangerous when travelling in a vehicle brandishing 'community nurse'. As commented by one nurse, 'this is an advertisement saying 'drugs on board'.'

On balance, community nursing is clearly aspirational to a large number of nurses, with this being one of the more widely mentioned preferences for the future. For those feeling (or expected to be) burnt-out from time spent on wards, community nursing is regarded as somewhat of a panacea.

3.8 Agency Nurses

The research included one group of agency nurses, comprising nine respondents who currently live and work in Melbourne.

The decision to work for an agency is based on a greater level of flexibility and financial reward. Nurses who register with agencies also

appear to find permanent nursing positions unappealing due to politics, rosters, workloads, stress levels and the inability to combine work with study and family commitments.

Attractions to Nursing

Agency nurses report similar initial attractions to the profession as other nursing segments. Agency nurses have a real desire to care for people, and appear to enjoy the level of contact they have with their patients. Nursing is also seen to offer flexibility for those who relocate (intra or interstate), and offers vast and varied employment opportunities. Gaining employment does not seem to be an issue for the profession generally, as it is well known that shortages exist.

Many nurses report joining the profession as a matter of default, having received a low Tertiary Entrance Rank at the completion of their secondary education.

Overall the profession is seen to be rewarding, with nurses taking pride in being able to *'make a difference'*.

Attractions to Agency Nursing

Nurses are generally attracted to Agency nursing for four main reasons:

- Greater flexibility
- Greater remuneration
- Dissatisfaction with permanent nursing positions
- Perception of decreased stress levels.

There are many facets to the flexibility of agency nursing. Agency nursing is flexible for those with family or study commitments, and allows nurses to *'escape the roster'*. There is a strong sense that agency nurses can 'pick and choose' between shifts, with as many as six shifts being offered at any one time. Enrolling with multiple agencies appears to be the norm.

Agency nursing allows those who are studying the ability to gain experience (undergraduates) or *'keep skills up'* (Division 2 nurses studying for Division 1, or those doing Masters). For instance, when studying their undergraduate degree, students are able to join an agency and work as a nursing assistant. During the study years, agency nursing is viewed as being *'good for the CV'* and there is a sense that it *'helps to prepare you'* for the realities of nursing. This is

seen to be particularly beneficial given that many undergraduate nurses worry about the responsibilities of nursing. For these nurses, agency nursing is an avenue for exploring different areas and to *'test the water before getting a permanent job'*. Many undergraduates report that they are likely to stay with an agency for the duration of the graduate year and beyond (in addition to full-time employment at the completion of study).

Consistently, agency nurses state that salaries are higher within the agency structure. There is seen to be a hierarchy in pay rates, with agency topping the list, Bank coming in second, and regular nursing at a distant third. There is also a perception that different agencies offer different rates of pay, whereby pay is equated with reliability (some agencies that pay highly are perceived to be somewhat unreliable, with last minute cancellations of shifts).

Many nurses are attracted to agency nursing due to dissatisfaction with regular permanent nursing positions. Nurses are frustrated by the rigid rostering systems adhered to by permanent staff, increased stress levels and the exposure to internal politics. Permanent nurses also have to contend with staff shortages, high expectations, unpaid overtime and constant *'running around'*. In most cases these frustrations can be avoided or felt to a lesser extent in an agency position.

For those nurses with personal commitments such as family or study, agency is clearly the preferred employment option. Examples were sighted, whereby changes in the employment of a spouse resulted in the family re-locating. In cases such as this, agency employment allows for fast reinstatement in employment, while avoiding lengthy interviewing processes associated with permanent positions.

Agency nurses also claim to have been attracted to agency nursing due to the perception of lower stress levels. Agency nurses generally believe they feel much more in control of their shifts, and take pride in the fact that they can choose not to go back to a hospital if they dislike the patients or staff – *'we can walk away at the end of a shift and never go back if we don't want to'*. Agency nurses also believe they can reduce stress simply by

managing their own hours. By managing their own hours they are able to avoid becoming overworked and worn out.

It should be noted that while there are many attractions to agency nursing, many nurses refrain from this type of employment due to a preference for stability and continuity of care.

Issues for Agency Nurses

While agency nurses easily identify the advantages of agency employment, there are issues, however, that remain. These can be summarised as follows:

- Instability
- Lack of team environment or support structure
- Working conditions
- Agency nurse reputations within the profession
- Barriers to continued training and education.

The instability of agency employment is felt initially by graduate nurses, however this is seen to subside as graduates learn to enjoy the greater flexibility that agency nursing offers. In some instances, graduate nurses choose Bank over agency for added stability. More experienced agency nurses have the view that new graduates shouldn't work for agencies—they believe the transition is hard enough without moving around hospitals.

By the very nature of agency nursing, nurses acknowledge that there is a lack of exposure to a team environment. Given that a particular placement may only be (at the very least) for one shift, agency nurses are unable to form closer working relationships with other staff members and patients (*'friends on the ward'*). For many this is seen to be beneficial (that is, leaving problematic colleagues/patients behind), but others miss peer group support or continuity of patient care.

The working environment that agency nurses are exposed to is very much *'fend for yourself'*. Agency nurses find that orientations are virtually non-existent, simple introductions are not given and generally very little assistance is offered by the permanent staff. The overall feeling that is derived from this is that *'nurses do not care for each other'*. Many agency nurses

talk about how they need to introduce themselves and *'pick out someone who is resourceful and helpful'*.

Agency nurses appear to be somewhat concerned about the reputation they have within the profession. There is a concern that the interviewing process is not stringent enough within the agencies themselves, and the actions of a few nurses are ruining the credibility of the group as a whole. Division 2 nurses in particular talk about the difficulties they face working within the agency structure; they believe there is a perception that *'they do not know what they are doing'*.

While it is generally accepted that further education and training is available, agency nurses believe that barriers do exist. Further education is seen to be expensive, both in monetary terms and in the opportunity cost of time away from work. Many also report that there is very little incentive to undertake further education when it is not recognised in remuneration. Agency nurses believe that further education is both expected and encouraged by the profession (and many are willing to participate), however, there is a general consensus that the barriers (that is, costs) are too great.

While there are issues for agency nurses as mentioned above, it is important to note that the positives of agency nursing far outweigh the negatives.

How Agency Nurses See the Nursing Profession

There are many issues facing the nursing profession generally, as identified by agency nurses. These include:

- Problems in aged care
- 'Disgruntlement' in profession
- Nurses leaving the profession.

The problems identified with aged care relate largely to privatisation. Agency nurses believe that cost cutting is contributing to heavier workloads ('only need one registered nurse for 60 beds'). There is a perception that Division 1 nurses have been forced to leave, while *'cheaper'* PCAs are being hired. This is clearly an issue for Division 2 agency nurses.

Agency nurses are also aware of 'disgruntlement' within the profession. It is felt that nurses do not stick together and bitchiness and rivalry is rife. Many believe this is a factor of a predominantly female-based industry, while others believe it is a factor of the working environment, that is high levels of stress, high workloads and insufficient pay rates.

Agency nurses recognise that nurses are leaving the profession. It is generally believed there are many contributing factors for the increase in departures from the profession. Burn-out due to staff shortages and associated stress levels, coupled with disgruntlement and dissatisfaction with pay rates, appear to be the main contributing factors as seen by agency nurses.

The Way Forward

The issues facing agency nurses are quite similar to the general issues facing the profession as a whole. The way forward as seen by agency nurses, involves the following actions:

- Increased funding
- Reduce workloads—staffing on patient numbers is ineffective, when different patients require different levels of care.
- Recognition of study—encourage further study by paying accordingly.
- Bonuses/rewards—to keep staff motivated.
- Tax deductions—previously available tax deductions have been taken away. Should be allowed to claim shoes, stockings and uniforms as tax deductions.
- Need professional recognition.

The Future

Quite clearly, the future for agency nurses is not back in health institutions, it is largely away from nursing, with many actively studying for entry into other professions, such as business, travel industry and information technology.

3.9 Unregistered Nurses

The research included one group of unregistered nurses, comprising seven respondents who currently live and work in Melbourne. There was a mix of unregistered Division 1 and Division 2 nurses in the group.

Unregistered nurses appear to have either made a conscious decision to exit the profession entirely (a minority) or they have moved horizontally into related fields, such as pharmacy, pathology, community or research. In spite of this career decision to leave traditional nursing, many nurses state that they initially did not wish to forfeit their registration. However, due to confusion regarding registration requirements, and little guidance from the Victorian Nurses Board, there is wide belief that unregistered nurses are in some ways 'forced' to lose their registration. While not all unregistered nurses wish to reapply for registration, there is a proportion that do wish to reapply at some point in the future—these nurses identify barriers to reapplying and claim to be uncertain about the necessary requirements.

Attractions to Nursing

Despite making a conscious decision to discontinue registration or losing registration due to circumstance, unregistered nurses speak fondly about initial attractions to the profession. Many describe a natural want to care for people, and the flexibility of working hours, such as nights and weekends. It is, therefore, not surprising to find that many unregistered nurses remain in a nursing related field, such as pharmacy assistants, pathology, research nursing, drug therapy, community work.

Reasons for Discontinuing Registration

Various reasons are given for discontinuing registration. Of those who have made a choice to leave, many speak of being dissatisfied with the quality of care given while nursing, and the frustration of not being able to give the level of care required due to time shortages and cost cutting (*'no time to sit on the bed'*). Other nurses describe wanting regular '9 to 5' jobs, or simply a change of pace and describe their deregistration as a conscious decision. Of those who did not actively decide to leave, the loss of registration appears to be the result of moving into a related field, and experiencing one of the following:

- Related field not recognised for registration, for example, research nursing.

- Difficulty in completing minimum number of shifts to maintain registration (while working in another job).
- Confusion over what is required to maintain registration.

Unregistered nurses appear to display a level of 'sadness' that they no longer hold their registration – *'one part of your life is over when you let your registration go'*. At the same time, however, there is a perception that unregistered nurses remain nurses and *'they can't take it away from me'*.

The general view of unregistered nurses is that they would prefer to maintain their registration, to have nursing to fall back on. There are, however, cost barriers to maintaining registration.

Many unregistered nurses talk about the financial cost of registration. There appears to be some discontent with the fact that nursing is the only profession that requires compulsory registration. There also appears to be issues with the fact that registration is not transferable between states. For those unregistered nurses who are working in related fields (where registration is not required) maintaining registration is *'paying for something you're not using'*.

Generally, the belief of unregistered nurses is that the Victorian Nurses Board does not make it clear what is required to maintain registration, or reapply for registration. There is a strong sense that the Board does not stipulate the hours required (to maintain registration) and there is a widespread belief that the Board is reluctant to send information. The overall attitude of these nurses towards the Board is *'thanks for nothing'*.

As most unregistered nurses are working in related fields, many have tried to maintain registration while working in new positions for a period of time. However, during this time, nurses encounter difficulties in completing shifts when working full-time. Some nurses also describe being hesitant about doing odd shifts due to concerns about their own skill levels (*'...concerned that my skills aren't up to date'*).

Factors Contributing to Career Move out of Nursing

Whether a conscious decision to leave, or simply a desire to move into a related field, there is a common set of drivers that appear to be contributing to a career move out of nursing. These can be summarised as follows:

- Internal politics
- Working conditions
- Working conditions in nursing homes
- Career development issues.

Possibly the most often mentioned contributing factor for nurses leaving the nursing profession is internal politics. This is typically described at two levels: politics between nurses and politics between nurses and other medical staff, such as doctors and surgeons. The former would appear to be of greatest concern within the profession. In a similar way to other segments of nurses, unregistered nurses take the view that nurses do not support nurses. This can be summarised by the following quote *'...we are in a caring profession, yet we do not care for each other'*. There is also a widely held belief that nurses themselves are contributing to the retention issues within the profession – *'nurses have a lot to answer for nurses leaving'* (that is, lack of mutual respect and support for one another). The main issues appear to be high levels of stress, no recognition or support and *'dictation from the hierarchy'*. To a lesser extent, unregistered nurses describe a 'power play' with doctors and other medical professionals.

Unregistered nurses also see working conditions contributing to nurses leaving the profession. This covers a spectrum of problems, including remuneration (unpaid overtime and general perceptions of low pay rates compared to other professions), budget cuts and staff shortages, increased workloads and burn-out. Unregistered nurses also report the fact that they are caring for *'sicker patients'*, a factor of high patient turnovers and shorter hospital stays. This again contributes to levels of exhaustion. Overall the issues facing unregistered nurses with regard to working conditions are relatively consistent with other nursing segments.

Remuneration is also seen to be contributing to the retention issues in nursing. Unregistered nurses believe that the salaries in nursing do not reflect the level of responsibility required or the workloads.

Many unregistered nurses report the working conditions in nursing homes as a reason to leave the profession. As quoted by an unregistered nurse: *'...in aged care you work like a dog, get treated like a dog and get paid like a dog'*. Many nurses cite examples of heavy workloads as the result of cost cutting or *'cutting corners'*. As quoted by another unregistered nurse: *'...one nurse may be required to give 40 showers in a morning'*. Unregistered nurses believe these working conditions are quite common in aged care.

Finally, unregistered nurses believe that career development issues are also contributing to nurses leaving the profession. There is a general perception that the nursing career path leads away from patient care and toward administration (an unfavourable direction as seen by many, and particularly by Division 1 nurses). This career path is perceived by unregistered nurses to be limiting for those who want to continue in *'hands on nursing'*. Further, unregistered nurses do not see this situation improving. It is believed that documentation will become more and more important, and nurses in management will be required to take on more administrative duties. One unregistered nurse said that this will lead to *'...stagnation in career development and increased resentment'*. Those nurses who were hospital educated prior to deregistration believe that their careers are even more limited. That is, *'...there is nothing in between ward nursing and administration, unless you do community work'*.

What Would Entice Unregistered Nurses Back to Nursing?

Despite the majority of unregistered nurses working in related fields, it is quite clear that these nurses are not interested in returning to conventional nursing at least in the short term. In spite of this, however, many are interested in reapplying for registration either to provide themselves with work cover in their current position, or as a back up should they decide to return to more traditional nursing at a later date. Those nurses not interested in reapplying for registration (minority) stated that they would *'like to have the choice of a flexible refresher course'*.

What Is Known about Reapplying for Registration?

Generally unregistered nurses are not entirely clear on what is required to reapply for registration. One unregistered nurse was quoted saying *'...I would like to go back to nursing, but I don't understand what is required'*.

Those unregistered nurses who have preconceived ideas about what is involved, believe it very much *'depends on your circumstances'*. Generally unregistered nurses talk about a refresher course with a *'combination of hands-on and theory'*, with the ratio depending on past experience and how long you have been unregistered.

Barriers to Completing a 'Refresher Course'

All unregistered nurses acknowledge that real barriers exist to completing the required 'refresher course' for registration. These barriers include:

- Expensive
- Time consuming
- Not suited to everyone
- Limited access to information regarding refresher courses and costs.

When unregistered nurses describe the expense of refresher courses they talk about both the monetary expense, '\$3,000', as well as the pay sacrificed, that is, perception of some nurses that refresher courses involve unpaid training or *'slave labour'*.

Time also appears to be a barrier for unregistered nurses completing a 'refresher course' for registration. One unregistered nurse was quoted saying *'13 weeks full time is demanding'*. Those nurses with family commitments appear most likely to see time as a barrier – *'...a big inconvenience for my family'*.

There is a strong sense among unregistered nurses that currently refresher courses are not relevant or suited to everyone. For example, *'a hospital placement is not relevant to everyone'*, that is, those not wanting to return to ward nursing.

Access to information and costs on refresher courses is a barrier for many considering registration. Nurses report instances of phoning the Victorian Nurses Board only to receive very little assistance – *'...they don't send you information'*.

How Unregistered Nurses View Training (Generally) in the Nursing Profession

It is perceived by unregistered nurses that education and training is not readily available in hospitals, however they also state that it *'does vary by hospital'*. Those nurses who have been exposed to training comment on *'having to pay for it'*. The overall view is that a nurse's professional development is left to the individual. That is, there is *'no appraisal, no guidance as to what you are best suited to, not much supervision and no debriefs'*.

The Way Forward

Unregistered nurses believe many actions are required to prevent nurses leaving the profession. These actions include:

- Increase funds to hospitals, increase staff numbers and reduce the patient ratio. Allow for greater flexibility, that is, shorter shifts.
- Attempt to change attitudes and encourage teamwork. Run courses to encourage bonding and communication. Encourage brainstorming and conduct a SWOT analysis.
- Need to clearly define roles. Nurses need to understand the 'hierarchy' and the opportunities for career development.
- The profession needs to acknowledge that there are problems.
- Education needs to be available, accessible (cost and time) and recognised in remuneration.

Unregistered nurses believe that implementing these actions should be a 'collaborative effort' among stakeholder groups.

The Future

Unregistered nurses see their future in health-related fields rather than in a clinical setting. These nurses have essentially 'moved on' from the clinical. Removal of barriers to re-registration is unlikely to entice them back into nursing.

3.10 Rural vs City Nursing

Overall there were remarkably few differences between the city groups (Melbourne) and the rural groups (Shepparton and Ballarat).

Living outside the city is referred to as a lifestyle choice. Rural nurses are there because that is where they want to be. Nursing is

secondary to that; it is a job that they can do where they have chosen to live. Almost all the nurses we spoke to in Shepparton and surrounding areas were there due to ties with the area. Many were born and bred there and had family still in the area.

There were some issues with rural midwives. They were frustrated with having to take on general patients and felt a lack of empowerment when doctors step in for delivery of babies. (See Midwives section for further detail).

De-Skilling Issues

On the whole nurses in rural settings feel that they receive exposure to a wider range of situations and in that sense have a wider skill-set (certainly a broader working knowledge) than their city counterparts. Few felt that their skills were less than city nurses, more so slightly different in nature.

There was some feeling among nurses in Shepparton that nurses from the country may be seen as less skilled. This view is thought to exist among nurses and even among rural nurses themselves. If someone has only ever worked at one country hospital people tend to think of them as less experienced than other nurses.

There were some isolated comments about a lack of exposure to certain areas:

- One woman had done an IV course and needed to do a certain number of IVs per month as a post-course requirement (she was finding keeping that number up difficult).
- One midwife would like to specialise in neo-natal care but neo-natal units are limited to bigger cities.
- One feels that she has become less skilled in paediatrics in a rural setting.

There is a perception among graduates and undergraduates that opportunities are greater in Melbourne in terms of exposure to the diversity of nursing.

4. General Recommendations

For all recommendations outlined in this section, there is also the fundamental issue of funding. Many raise this as a prerequisite for improvements in the future. There must be greater funding available as well as a willingness to spend it 'fixing' some of the issues. This willingness is seen to rely on an admission of the issues that exist in the industry by the Government and hospital management.

When discussing issues, nurses tend to 'blame' those closest to the 'grass roots' (Nurse Unit Managers in particular). However, when asked who is responsible for implementing changes, most believe that changes must come from the top (government) and then need to filter down through levels of management. This means hospital CEOs, Directors of Nursing, down to Nurse Unit Managers, who must be acting on behalf of their staff (generally not perceived to be the case currently).

Although remuneration came up clearly in all groups as a priority, we believe that there is a need to recognise nurses in many dimensions, as the issues extend far beyond just pay. Other actions, such as improving working conditions, facilities and career opportunities are less tangible forms of recognition than money. (We feel that remuneration is likely to reduce in significance once other factors have been improved).

This final section of the report makes recommendations based on the proposed actions raised in the groups. There is no consideration given in this section as impacts of these recommendations on other segments of health care or for funding initiatives.

ISSUE

Remuneration

RECOMMENDED ACTION

Remuneration is raised by all nursing segments as a major area of dissatisfaction and opportunity to increase industry retention.

In terms of specific actions, the current ANF public sector pay claim is generally viewed positively, particularly for its recognition of the need to achieve parity between remuneration for nursing and other professions (acting on it would be appreciated by the industry).

Salary 'packaging' is recommended as a way of both recognising nursing for its professional status (that is, compensation is based on more than just wages) and to provide incentive for nurses to up-skill. Specifically, consideration should be given to the following areas of remuneration:

- Review base salary movements for nurses who choose to remain at bedside (specifically, create more levels/tiers for salaries to increase after more than five years—perceived to be the cap).
- Introduce a skill recognition where nurses upgrade qualifications. This should extend beyond specific skills related to specialist area (but remain relevant to nursing).
- Performance reviews should be introduced (or enforced if they do already exist) with an emphasis on providing support and motivation to develop careers (rather than just focusing on evaluating delivery of day to day tasks).

Workloads

Lower patient ratios should be a priority. They are attributed to high levels of job dissatisfaction (stress levels, feeling that you're not keeping pace or performing job adequately, concern for patient care etc) and regarded as a key factor in burn-out and subsequent departure from the industry.

Nurses request a ratio of one nurse to every four patients (perceived by some as the recommendation in the ANF pay claim).

If this is not realistic, there should at least be an attempt to ensure no more than six patients (up to eight is currently quite common).

Lack of career path

There needs to be a clearer career path for nurses. In particular for bedside nurses. Revisit the number of levels for bedside nurses (consider increasing them).

There should be more opportunities to move around departments/ wards if possible. Many request this as a means of making their roles more interesting.

As highlighted in the remuneration recommendations, formal performance reviews are worth implementing.

Division 2 nurses require special attention. Clearer communication of career opportunities and strategic intent (vis a vis the role of Division 2 nurses) needs to be clarified.

Both of the initiatives above should increase motivation, which may increase intentions to remain in nursing.

Access to Education

While paid study leave is clearly attractive, simply being able to access education, even without paid leave is the greater barrier to not pursuing more study.

Where funds are made available, equitable access to funds should be put in place. We would recommend a set amount of paid study leave per person (not per hospital unit) to ensure all staff members have equal access.

Some sort of additional financial incentive is required for rural nurses who need to attend Melbourne courses, for example, amount towards travel and accommodation expenses.

In-service training also needs to be reviewed to ensure that there is equal access to all staff (including permanent night shift workers).

Graduate preparation

Multiple entry points to graduate degree should be considered:

- Tertiary entrance score
- Hospital-based interview
- Observation/ work experience (ideally).

There needs to be an accurate impression given about nursing to applicants and they need to be interviewed to assess their suitability and commitment to the degree.

Within the degree there should be more clinical placements, starting from early in first year, and less time between each (consider 2 days/ week).

Set in place education programs:

- To manage expectations hospital staff have of graduates' capabilities at different stages of transition.
- To ensure staff are trained in basic teaching communication to develop (rather than suppress) graduates on-the-job.

Ensure graduates are given the supernumerary time that they should be during their first year working. This should help improve attitudes of more experienced nurses towards graduates.

Facilities



Provision and appropriate access to facilities:

1. Parking (secure parking)
2. Child care (hours matched to shifts)

Fragmentation



There is opportunity to improve the working environment for some nurses who feel tension between nursing staff and towards management.

Clearer role definition of management function may assist.

It is suggested in the groups that staff development days may also be of value to improve team bonding in a non-stressful environment.

Community perception



A public education campaign to address the misinformation about nurses is also recommended within the groups.

Appendix Seven – Submissions Received

1. Organisation Submissions

Alfred Hospital
Angliss Health Service
Australian Association of Maternal & Child Health Nurses
Australian & New Zealand College of Anaesthetists
Australian & New Zealand College of Mental Health Nurses
Australian Diabetes Educators Association Ltd
Australian College of Critical Care Nurses
Australian College of Midwives Inc (Victorian Branch)
Benalla & District Memorial Hospital
Ballarat Health Service Barwon Health
Bendigo District Nursing Service
Bendigo Health Care Group
Box Hill Hospital
Caritas Christi Palliative & Aged Care Services
Casterton Memorial Hospital
Caulfield General Medical Centre
Colac Community Health Services
Day Surgery Special Interest Group
Djerriwarrh Health Services
Dunmunkle Health Services
East Gippsland Institute of TAFE
East Wimmera Health Service
Echuca Regional Health
Enrolled Nurses Special Interest Group (Victoria)
Far East Gippsland Health & Support Service
Freemasons Hospital
Gippsland Southern Health Service
Goulburn Ovens Institute of TAFE
Goulburn Valley Health
Kerang & District Hospital
Australian Medical Association
Kyabram & District Hospital
La Trobe University (Mildura Campus)
LaTrobe Regional Hospital
Lorne Community Hospital
Mansfield District Hospital
Maryborough District Health Service
Maryvale Private Hospital
Masada Private Hospital
Mayfield Education Centre
Melbourne Clinic
Mildura Base Hospital
Mildura Private Hospital
Mount Alexander Hospital
Mount Alvernia Mercy Hospital
North West Health Mental Health Program

North Western Health
Otway Health & Community Services
Palliative Care Victoria
Peninsula Health Care Network
Peninsula Private Hospital
Peter James Centre
Royal Australasian College of General Practitioners
Royal District Nursing Service
Royal Talbot Rehabilitation Centre
Royal Victorian Eye & Ear Hospital
Rural Northwest Health
South Gippsland Hospital
South West Healthcare
Southern Health Care Network
St George's Health Service
Sunraysia Institute of TAFE
Swan Hill District Hospital
Swinburne University of Technology
Tallangatta Health Service
Terang & Mortlake Health Service
Victorian Association of Health & Extended Care
Victorian Healthcare Association Ltd
Wangaratta District Base Hospital
Western District Health Service
Wodonga District Hospital
Wodonga Institute of TAFE
Yarram & District Health Service
Yarrawonga District Health Service

2. Individual Submissions

A Johansson-Wong
A Ferguson
A Watts
K Greig
L Cassar
M Smyth
P Mayne
S Kernaghan
M Lees
D Shillabeer
M Henshaw
I Royce
M Buschmann

Appendix Eight – Survey Instruments

During the life of the Committee, several survey instruments were generated. Due to space constraints these instruments will be made available on request. Please direct such requests to:

Geraint Duggan
Nurse Policy Branch
Policy & Strategic Projects Division
Department of Human Services
GPO Box 4057
Melbourne Vic 3000

Appendix Nine – Training and Development Grant Details

The Training and Development (T&D) Grant was established as a part of the acute casemix funding system. It is a specified grant and similar grants are made for medical and allied health. The Grant for the acute sector is broken down as follows:

Table A: Acute Training and Development Grant

Medical	\$62 million
Nursing	\$23 million
Allied Health (including undergraduates)	\$5.5 million
Medical and Nursing Undergraduates	\$9 million

Table B: Acute Training and Development Grant—Nursing Component Breakdown

Program	Total Allocation	Nurses Supported	Per Capita rate (2000)
Graduate Nurse Program	\$11.4 million	903	\$12,626
Postgraduate Program	\$6.5 million	562	\$11,573
Postgraduate Midwifery	\$1.4 million	121	\$11,573
Continuing Education	\$4 million	N/A	N/A

Aged Care and Sub-Acute Grant

The aged care and sub-acute T&D Grant is similar in structure to the acute grant and the overall funding allocation is around \$5.1 million. Although the nursing streams broadly conform to the criteria used in the acute grant outlined above, and is used in public sector facilities, the overall emphasis of the grant reflects the strategic priorities of the aged care and sub-acute workforce (particularly aged care, palliative care and rehabilitation).

Table C: Aged Care and Sub-Acute Training and Development Grant

Medical	\$2.1 million
Nursing	\$1.9 million Allied
Health	\$0.59 million

Table D: Aged Care and Sub-Acute Training and Development Grant—Nursing Component Breakdown

Program	Total Allocation
Graduate Nurse Program	\$1.2 million
Postgraduate Program	\$0.78 million

Background

The nursing component of the Grant was established for two reasons: the need to recognise and provide funding for specialist hospital post-registration programs already in existence, and the need to compensate hospitals for employing new graduates whose contribution to patient care was less than that of an experienced registered nurse.

Initially, a ‘best guess’ estimate of the cost of the specialist programs was made and a per capita amount established. Each hospital received funding for specialist and graduate nurse programs based on its number of students. The graduate nurse per capita amount was based loosely on the cost of half a salary for a new graduate plus on costs. Over time, these per capita grants have been adjusted to reflect the more accurate costing information available.

In addition to the above allocations, ‘A’ and ‘B’ hospitals—those with the most beds—all receive an additional allocation of 10% of their T&D Grant for supervision of medical and nursing students. Allied health student support is paid to all hospitals, based on student clinical placements for the previous year.

The funds available in the nursing T&D Grant remain constant with the addition of any CPI adjustments. However, changes within the allocation of the funding are made from time to time. In summary, changes to funding since the inception of the Grant have been an increase in the per capita allocation for specialist programs, a decrease in the per capita allocation for

graduate nurse programs, and the creation of the continuing education program.

Programs

Graduate Nurse Program

In September 1997, the Department of Human Services published the first in a series of papers reviewing components of the nursing T&D Grant. This led to the establishment of agreed guidelines for the provision of graduate nurse programs in Victoria, and apply to Victorian acute care and aged care public institutions (Department of Human Services 1997). Pilot schemes have also been run in the community sector, while there is no government funding provided for programs run in the mental health and private sector, including nursing agencies. Graduate nurse programs remain popular with nurses and competition for places is strong.

Criteria

The programs must be offered full-time with pro rata payment during 2000 for those programs not full-time. The intent is not to fund part-time positions in 2001 unless approval is granted by the Department of Human Services. Hospitals introduced part-time programs as a cost saving means and full-time work was found generally to be unavailable to graduates. Part-time programs are considered by the Department of Human Services to be a disincentive to undertake nursing, that is, to have a negative impact on attracting persons into nursing if full-time work is not available on completion of studies. Department of Human Services does not support the underemployment of graduates while a nursing shortage exists.

Courses must adhere to the graduate nurse program guidelines (Department of Human Services 1997).

Hospital must participate in the computer match program.

No fees are to be charged to graduates applying, undertaking or completing graduate nurse programs.

Clinical educator to be dedicated to program.

Postgraduate Programs

While this program is currently under review it has been designed to compensate hospitals for the clinical experience component of students undertaking postgraduate nursing courses. In addition, the program funds a residual hospital-based critical care course.

Criteria

Course must be at postgraduate level.

Hospital must provide clinical component of postgraduate course. Course must require a minimum of 24 hours per week clinical component with a dedicated nurse educator (or part-time equivalent).

Funding is provided for equivalent of full-time course.

Where students are undertaking courses on a part-time basis over two years, funding equivalent to that for full-time will be paid in the first year of the course. No funding will be provided in the second year of the course.

Midwifery (Postgraduate) Program

The criteria are broadly the same as the postgraduate program above. In addition, there is a fixed number of hospitals receiving an allowance of \$9,995 per student due to historical agreements reflecting old course structures.

In another funding model, funding was introduced at \$3000 per student midwife to whom a minimum of 50 days clinical placement per academic year is provided by hospitals. Pro rata payment may be provided to hospitals providing placements of less than 50 days to a large number of students.

Continuing Education Program

This program is a submission-based funding round where business plans are submitted to the Department of Human Services for continuing education and professional development. All submissions are funded from a fixed \$4 million pool, so that the more hospitals apply the less funds are available for individual hospitals. Rural and regional hospitals are assisted in business plan submission development by Department of Human Services Regional offices and they are

encouraged to form consortia or joint programs. Many of the programs seek to teach nurses functional skills acquisition in areas such as information technology, customer service and management. Others run courses in specialties such as critical care, oncology and renal nursing in variable forms from workshop-based formats to short courses with exit examinations.

The program imposes a considerable administrative burden on hospitals and the Department of Human Services. The current funding split is metropolitan hospitals \$2.2 million and rural and base hospitals \$1.8 million.

Criteria

Business plans are assessed centrally and are judged on set criteria such as a needs analysis, evaluation methodology and financial acquittal statements.

All Victorian acute hospitals have submitted business plans or have been covered by consortia arrangements with other hospitals.

Undergraduate Teaching Allowance

This allowance is allocated proportionally to teaching hospitals according to casemix, that is, the greater the casemix funding the larger the teaching allowance. This allowance is only allocated to hospitals that have undergraduate nursing and medical students (as allied health undergraduate funding is separately funded on an output-based model) and is not tied to any other criteria (such as the number of students or the number of clinical placement days).

