COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

WEDNESDAY, 27 FEBRUARY 2002

PERTH

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Wednesday, 27 February 2002

Members: Senator Crowley *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Gibbs, Lees, McLucas and Tchen

Participating members: Senators Bartlett, Bishop, Carr, Denman, Evans, Faulkner, Harradine and West

Senators in attendance: Senators Crowley, Gibbs, Knowles and West

Terms of reference for the inquiry:

For inquiry into and report on:

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

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

That the Committee specifically make recommendations on:

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

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

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

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

(v) strategies to improve occupational health and safety.

WITNESSES

Committee met at 8.37 a.m.

O'NIONS, Ms Pamela, Secretary, Association of Paediatric and Child Health Nurses

PHILLIPS, Mr Gary Douglas, Branch Secretary, Western Australian Branch, Australian and New Zealand College of Mental Health Nurses Inc.

SHANLEY, Dr Eamon, Vice-President, Australian and New Zealand College of Mental Health Nurses Inc.

MASTERS, Mr Murray, Chairperson, Community Nurses Special Interest Group

VERRIER, Ms Leanda Tempest, Executive Member, Community Nurses Special Interest Group

BUTT, Mrs Janice, Coordinator Midwifery Education, Obstetric Clinical Care Unit, King Edward Memorial Hospital for Women

FAULKNER, Ms Sharon, Acting Midwifery Director, Obstetric Clinical Care Unit, King Edward Memorial Hospital for Women

CHAIR—Welcome to the Senate Community Affairs References Committee's continuing inquiry into nursing. I would particularly like to thank King Edward Memorial Hospital for Women for its hospitality again. We have been here before and thoroughly enjoyed it. We are very pleased to be back again. I think it is very useful to be able to have our hearings where many of our witnesses either work or are familiar with the terrain, rather than in Commonwealth offices. I appreciate the opportunity for us to be here and thank all of you for attending.

Witnesses are reminded that evidence given to this committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be heard in public but, should you wish to give any of your evidence or answers to specific questions in camera, you may ask to do so and the committee will consider your request. The committee has before it your submissions Nos 479, 753, 794 and 370. Do you wish to make any alterations to your submissions? There being no such request, I will continue.

You may not appreciate this, but the numbering of your submissions, being as high as 794, indicates that we got close to 800 submissions—indeed, we sailed way past that number. There has been a remarkable number of submissions and interest in this inquiry, so we are trying to give as many witnesses as possible the opportunity to appear before the committee. Hence we have chosen this panel style. I appreciate your cooperation in dealing with evidence in this way. I ask each of you now to make a brief opening statement and then we will field questions. If you wish to disagree with each other, that is fine.

Dr Shanley—I am vice-president of the Australian and New Zealand College of Mental Health Nurses. We have been extremely concerned about a number of issues centred on the recruitment and retention of mental health nurses, but there are also quite a lot of other issues in relation to the education and preparation of mental health nurses. As you may be aware, until

fairly recently—about eight or nine years ago—mental health nurses had a separate three-year program. A major issue of concern to mental health nurses has been the creation of the comprehensive system of nursing, whereby mental health nurses have become amalgamated with all the other streams of nursing, producing a generic nurse. This has major implications for recruitment and, indeed, retention.

Many of the campaigns that have been mounted here in Western Australia to recruit nurses have been directed towards the sexier, fashionable end of nursing. The aged care areas and the mental health areas have been largely ignored. In the undergraduate programs, there are a number of what the college would say are disincentives for students to take up mental health nursing. The number of hours that students spend on mental health is quite small—in some cases, their experience in clinical areas is 20 to 30 hours. Quite a number of people are very concerned that students are not being trained and prepared adequately. When students make their choices at the end of their course, they are influenced by their exposure to the clinical area and by attitudes of teaching staff in universities, many of whom have not worked in mental health nursing for 20 or 30 years.

CHAIR—Just take us back to that important point. You were saying that some of the academics have not been in a mental health care institution or mental health area for 20 years or more?

Dr Shanley—Yes. Many of their attitudes and values may be related to the time that they worked in those areas. The underlying problem is that, unlike medicine, the nursing academics very rarely have the opportunity to work in the clinical areas, so there are very few joint appointments. Up until the end of last year I was Professor of Mental Health Nursing. From my point of view, one of the major issues has been that this was one of only three posts in Australia that allowed me to work in the clinical area. All the other nursing posts in mental health are purely academic and seldom convey to students up-to-date modern methods of treatment apart from what they read in books. So the credibility is not as high.

Recruitment into the field is a problem. There are disincentives because of the length of exposure, because of the credibility of the people teaching them and because of their experience. When students do go out into a clinical area, many of them are very concerned about the negative attitudes that exist within the mental health field. Perhaps I can get back to that briefly later on. It is a very complex area, as no doubt you appreciate. The issue of recruitment and retention is not about simply sending a glossy program out to people and expecting them to believe what is stated. When students go into the clinical area, they experience a very different situation.

There has been a decline in the number of people coming into the mental health field from the generic courses. Ideally, it would be useful to have the general population represented within the nursing profession. It would be good to see many more people from ethnic groups and many more males coming into mental health nursing. There are far fewer males coming in. I think there may be one enrolled nurse—I could be wrong—who is from the indigenous population in Western Australia. Those are areas that need to be targeted for recruitment.

Once they have left the undergraduate course and gone into mental health nursing, students in Western Australia undergo a transitional program into the mental health area. This program is

set up by hospitals and may last for six months. This, to my mind, unregulated system of training does not require any minimum standard of performance at the end of the program; it is up to the individual hospitals to determine whether the person is appropriate or not. The education that students get within those programs is not standard, and so there are variations within the various programs, which make it very difficult to determine the level of competence of someone leaving that program.

If somebody did survive that and moved into the clinical area, up until 1999—when I organised two postbasic courses—there were absolutely no courses for mental health nurses in Western Australia other than the course they took when they first qualified. This is absolutely extraordinary because it means that there are people who have spent 30 years in the job, and their three-year program is the only preparation they have had to deal with current issues. That is important from the point of view of somebody who is going to stay within the field. People get a sense of self worth and status from how their colleagues deal with them. It affects how they see themselves. If mental health nurses are not equipped with the skills—and they may obtain competencies outside mental health nursing—they are likely to be considered by their colleagues to be of low status when very often they are the backdrop to the other therapists and doctors who operate within the mental health field.

So there are the issues of status and education. Not least, the quality of the service being delivered by many mental health nurses may not be as competent as it should be. There have been a number of reports to support these particular issues, but they are mainly to do with patients' rights and the quality of care that is being delivered.

There is also no system of support for mental health nurses. All of the occupational groups have some degree of supervision. The supervision I mean is in what psychotherapists may have as supervision—that is, emotional support and skill development. Psychologists, psychiatrists and social workers have clinical supervision. In fact, in the UK all nurses, regardless of discipline—that is, about 700,000 nurses—are entitled to get supervision from their employers or, rather, their employers are expected to provide clinical supervision for them. In the US and all of Australia this has developed on an ad hoc basis in the main, and here in WA there is very little support. So people become burned out and, if you get burned out, then you distance yourself from patients. Individuals who are becoming burned out, in terms of distancing themselves from patients, need to physically get out of the job. There are a number of issues that are probably, I would say, part of the infrastructure of the set-up, and they would require enormous changes to occur within nursing to effect change.

I will give you another example of the type of problem, and that is to do with the career structure. There are disincentives for the level 2 nurse to seek a level 3 position or to go into staff development because they will earn less money. Because of the amount of money they will earn through unsocial hours, there is a disincentive for people to get promotion. So there is a block where individuals are not encouraged to progress in terms of career. About 81 per cent of mental health nurses in WA do not have degrees, so access to university, post basic education or graduate education is not easily available. One of my tasks, as professor of mental health nursing, was to develop programs to get people access to university education. Here in WA there was the problem of resources. Initially that was raised constantly: 'There are no resources to develop these courses.' Because WA is such a small state, the universities were reluctant to put on courses that would see them losing money, and the services were unwilling to fund the

development of courses. They would also lose money because the number of people working in the service would not warrant the resource.

CHAIR—Can I ask you to move toward concluding your remarks because we want to hear from everybody. We have a million questions, but could each of you please restrict the opening bat, the first innings.

Dr Shanley—Sure. There are two issues, which I will cover very quickly. One issue is the inflexibility of services to accommodate staff needs such as providing creches, being flexible in part-time work and issues such as that. The other issue is a more global one. There is no formula to determine the establishment numbers of mental health nursing staff in WA. The numbers that are seen as being required are based mainly on traditional figures. I think they are the main points I want to make. Thank you.

CHAIR—Thank you very much. I think my colleagues and I will hold our questions until we hear from all of you. Who is next?

Ms O'Nions—I am sorry; I am not very well prepared for this, so I will give you a very brief summary as I see it. Our concerns from the paediatric perspective are that nurses are comprehensively trained with very limited paediatric experience within their course, but they can then work in the paediatric area, which is a specialised field within itself. As to the encouragement for people to pursue further qualifications in paediatrics, because it is not recognised as a specialty area, there is no financial compensation for doing the course, so there is a financial cost involved in further education and there is no allowance at the end of the day. It is also not a requirement for a promotional position within the organisation, within paediatrics, so it is of concern that it is not recognised and valued as a requirement to progress in the area of paediatrics and paediatric nursing.

A lot of the comments are similar across-the-board with recognition, recruitment, retention and education. Once you are not working unsociable hours then financially it is not as beneficial. In the undergraduate courses the paediatric component is very minimal. More than 50 per cent of the children nursed in Western Australia are nursed outside of Princess Margaret Hospital so there is certainly a concern there of lack of people with paediatric experience caring for these children. Again, it is not a criteria for employment at Princess Margaret or for promotion. I think a lot of your concerns are reiterated.

Ms Verrier—I would say that in a lot of what Dr Shanley said, if you take out 'mental health' and put in 'community health', we would have similar issues. With community health, especially over the last 10 years, it has become quite obvious that we have been underresourced. The service has been allowed to run down. I suppose one thing that I am not sure that the others have said is that the loss of senior community nursing positions has really hit us quite hard. There have been increased work pressures, as I am sure everyone else has had, basically to do more with less. There have been continuing funding cuts creating attraction and retention problems, especially in the remote and rural areas. There is a major problem out there.

The important issues that we see as a way to help remedy these situations are, firstly, to create a senior community nursing position within the health department—that would be looking at strategic leadership for the whole state of WA; we have been very fragmented as a result of the

last 10 years—secondly, to create a clinical chair in community health nursing which would provide that link between universities and the industry; and thirdly, to give community nursing the inspiration, vision and direction that we have lost and, finally, to bridge that theory-practice gap. To add to what Dr Shanley was saying, I actually work part time. I have two jobs, one is part time in Curtin University as a lecturer in the undergraduate program and the other is part time with Swan Health Service in community health nursing. My background is child health nursing. There is no recognition for that, there is no joint appointment.

CHAIR—There is no recognition for what?

Ms Verrier—For the fact that you are working across both fields: theory and practice. You sort of wonder if that is valued. There is some rhetoric about university and industry partnerships but when it comes down to it you sort of wonder. That is where we need to create that strong leadership. We would expect that, if you have that strong leadership, a number of strategies could be put in place addressing work force issues, some of which Eamon brought up, such as the concern about the attraction and retention of staff, once again especially in rural and remote areas. This could be done by providing assistance for ongoing education for postgraduate and higher degrees and by establishing a postgraduate diploma in community health nursing through that university-industry partnership.

One thing with the undergraduates, and I see this with semester 6s—I teach in family nursing practice which is child health, maternal health and paediatrics and also in the Community Health Nursing Practice Unit—is that the students are so keen when they understand the philosophy of primary health care, community development and what community nursing is all about. They go through their graduate program when they finish nursing. There is no second-year grad for community health nursing so they do not have an entry into that field of nursing and then—excuse me, all the hospital people here—sometimes that primary health care philosophy in community development sort of gets beaten out of them going through the normal system. I do apologise to the hospital people, but it is something that we really do need to build up again. Years ago we would have a six-week orientation to actually get the philosophy of primary health care into people's practice. That is all gone now, it is lost, so we do not have that. People can be employed into a school, for instance, as a registered nurse with no background in community health and no education in community health. It really does put the schools at a disadvantage.

CHAIR—Did you describe the students as 'semester 6s'?

Ms Verrier—I am sorry; I mean students towards the end of their nursing education. Where I teach there are seven semesters. In semester 3, they learn about primary health care; in semester 6 they do community health nursing practice. They have one more semester and then they are out in the work force. I have forgotten where I was up to.

CHAIR—You were up to where a number of the students go, for example, to a school as a registered nurse with no—

Ms Verrier—Yes. There is no transition and sometimes the nurses just have to pick it up as they go along. That is not an ideal position at all, and it also applies to continuing professional education for those already in the system that are struggling. As I said, we have been allowed to

run down over the last 10 years and there has been no input. We are getting trickles. A few new programs are coming out now, but there is a lot of damage that needs repair. All these proposals will require increased funding and I think that is probably where a lot of the problems stem from.

CHAIR—Thank you. And last but not least, Ms Faulkner.

Ms Faulkner—I represent the Obstetric Clinical Care Unit of King Edward Memorial Hospital. I will let Janice start because she is the educationalist.

Mrs Butt—I would really like to restrict my comments mainly to initial recruitment and education, although I am clearly aware that there is a nursing education review in progress at the same time. The first statement that I would like to make is that we do believe midwifery is quite separate to nursing, as is internationally recognised. On listening to my colleagues, it is clear to me that in many ways, despite a critical shortage of midwives worldwide at the moment, we are actually quite fortunate in having been recognised as a distinct profession. I would like to see more recognition of that within Australia, as would our organisation and the professional colleges.

We do not have a particular problem with initial recruitment in terms of numbers. Midwifery is a popular entry for those who have completed undergraduate nursing programs. The difficulty for the recruitment is more to do with the fees that are associated with postgraduate diploma courses now. King Edward has had a long association with midwifery education. We were the last hospital to cease educating midwives last year. In that respect, we have been fortunate in fostering fairly strong collaborative relationships with the universities. I have a joint appointment between Curtin University and this hospital which has been formally recognised, for which I am very thankful. It allows my colleagues and me to still have a very close association with clinical practice, and I would agree with Dr Shanley and the others that that is particularly important for the strength of the interface between education and practice.

Whilst the midwives in Western Australia at the present time are all prepared, having gone through nursing programs, certainly as a hospital we are very supportive of the direct entry option for midwifery. Western Australia has a number of difficult geographical locations in terms of nurses working only as midwives, but at this hospital we already have a number of midwives on staff who are direct entry midwives. However, we have had to recruit them actively from the United Kingdom and perhaps we will do the same from New Zealand, which has moved almost totally to direct entry midwifery.

We do not see direct entry as being the only option; we would like to encourage nurses, as well as non-nurses, to enter midwifery, and we would like to see more widespread options available around Australia. It is starting this year in a very small fashion, but I am sure it will increase. We are not so sure about the double-degree option, which I am sure has been mentioned in a number of instances. We would like to see some formal evaluation from that initial program which is at La Trobe University in Victoria. At this stage, we do not believe midwifery will be adequately represented in that program.

I have already referred to the cost of midwifery education. One of the strategies that should be subject to ongoing evaluation—we have attempted to do this in Western Australia, and we

would like to see this further formalised around Australia—is concurrent employment for midwifery students. We pay the students to be here. This hospital pays the students for some of their study time, as well as much of their practice time. The hospital, individually, has decided to do that. The Australian Nursing Federation, in consultation with the government, presented the enterprise bargaining agreement last year, which, for the first time has a clause within it that requires midwifery students to be paid in the public sector. That has not been well implemented. It has been a very difficult transition from the intent of the clause to the implementation of the clause and that is being addressed by the Department of Health, albeit a bit late. It is starting to make a difference. The private sector has also been very supportive of paying midwifery students. We do not want to see a transition back to the old apprentice style of preparation of midwives. We see this as a reasonable option to help students to gain sufficient clinical practice and to survive the 12 months of an $8,800 full fee-paying course for a postgraduate who will receive no further remuneration as a midwife than they would have done as a nurse.

We are very supportive of re-registration and refresher programs in midwifery. The Department of Health has, in this state, been very supportive in providing funding for the last couple of years. However, this year we have had a bit more of a fight on our hands to get the money. It is very difficult to get people to come back into midwifery if they are expected to give up a job that they already have to undertake a re-registration or a refresher program in that area. So we have been actively trying to promote funded programs or part-funded programs. The numbers are small, but it is certainly a good way of trying to get the work force back into the midwifery area.

One final comment, and one of the most exciting, is that we are about to reach a consensus between two universities that provide midwifery education—Edith Cowan University and Curtin University—and this hospital, to provide a professor of midwifery who will be located at the hospital and funded by the hospital, but who will be an academic appointment to both universities. We see that as a very exciting way forward for midwifery in this state. It will be a first, in terms of the intricacies of that appointment. In recognition of Dr Shanley's earlier comment, there is non-graduate entry to the postgraduate diploma in midwifery in both universities of this state. Those nurses without degrees, albeit quite a small number in our population, do have an opportunity to enter postgraduate programs in our discipline.

Ms Faulkner—I would like to talk about the strategies to retain midwives in the work force and to attract midwives back into the profession. One thing that really needs to be done is a manpower planning model for midwifery, to predict midwifery numbers and also to look at midwives' workloads and to make them more manageable. We do not really know how many midwives we require. As the average age of a midwife is now 43, we need to be looking at replacement. As Janice said, we have 24 fully funded places here. We used to train 30 per year at King Edward Memorial Hospital for Women. That was probably not enough then, so we are still not reaching the full numbers required for midwives in the state. However, we do not really know, because nobody has ever done any proper planning in this area. Midwifery needs to be marketed as a real career choice for nurses and school leavers of both genders. As Janice said, we like the choice, but we would support a direct entry program here. We have implemented in this hospital—but we would like to see more implementation here and everywhere else—midwifery-led models of care, so that midwives can completely fulfil their roles. This is for normal pregnancy and care. I know it has been alluded to before, but midwives require financial reward and suitable career pathways. One of the things about recruiting UK midwives is that they are quite disappointed at our pay scales. They get paid much more in the UK than

quite disappointed at our pay scales. They get paid much more in the UK than registered nurses. One of the reasons for this is probably that they are much more autonomous over there and they have many more midwifery-led models of care. We would like to go in that direction as well.

CHAIR—Thank you all very much. Senator Knowles, would you like to start the questions?

Senator KNOWLES—Dr Shanley, could I ask you to elaborate a little on what you were saying about mental health nurses being held in fairly low esteem. To be honest, I would have thought it would have been the reverse.

Dr Shanley—In terms of popularity of disciplines, it is the least popular—I correct that, aged care is probably less popular. But mental health nursing is unpopular. I think that we are reaping the legacy of neglect within the system here in WA because, as I said, the people who are coming into mental health nursing did the initial three-year degree and afterwards there had been no postbasic courses. As somebody who has lived and worked most of my life outside WA, I find it absolutely extraordinary how a system could operate in that way.

Regarding the image of mental health nursing, there have been a number of reports made on patient care, and many of the mental health nurses were identified as having quite custodial attitudes. Their therapeutic interventions were criticised because of the lack of them. They were there to contain, to control, to keep safe and secure. I am not saying that all mental health nurses are like that, but there is a culture. When naive undergraduate nurses come into a culture in which there is a large degree of burnout—as I said, because the staff have not been looked after by the system—they will see insensitivity and indifference, and sometimes neglect, and then they will throw their hands up and say, 'This is not an area I would like to work in. I would like to work where I can deal with children or work in theatre or work in more exciting areas of nursing.' So there are quite a number of disincentives in that area. Yes, the status of mental health nursing is very low.

Senator KNOWLES—Ms O'Nions, you were also talking about the training for paediatrics; I realise that there are a whole range of things. Would you mind putting on the record some of the fundamental differences between general nursing and paediatric nursing?

Ms O'Nions—The catchphrase is 'children are not little adults.' There is a huge difference between a child and an adult anatomically, physiologically, behaviourally and psychosocially—and all of those criteria are so important when nursing children. It is unfortunate that a lot of thought is that children are little adults and we can treat them just the same—that we can have the same staffing ratios and you do not need specialist skills to look after them—when they are completely different. Psychosocially and developmentally that very much needs to be taken into account so that we practise atraumatic care and we practise family centred care. We are part of that child's journey and the family unit is the most important thing: recognising and incorporating that into our practice. The enormous physiological differences that impact on our care cannot be underestimated. Children are very different: their presentation is different, the diseases that they are susceptible to are different and you will not see them in adults. Adult experience does not prepare you adequately for nursing children.

Senator KNOWLES—The fact that they cannot tell you what is wrong with them, to start with—

Ms O'Nions—It is a big point.

Senator KNOWLES—It is a big hurdle to start with, isn't it?

CHAIR—I should resist telling you this but I am going to succumb to temptation. I was once in the children's hospital, for reasons that do not matter, and I heard a nurse who had recently come from the larger hospital say to a two-year-old sitting up in bed just about to burst into tears, 'Are there any magazines I can get you, dear?' I did not believe I'd heard it; it was just delicious.

Senator KNOWLES—I think the people who treat children are remarkable, almost in the same way that I think vets are remarkable, because in neither case can patients tell you the depth of the problem or where it hurts or anything else. I do not particularly mind who answers this next question and a few of you might want to have a crack at it. In recent times, what has happened to the funding levels in the state: the pay structures, the incentives, the improved clinical training, rural recruitment and all of those things that are important?

Mrs Butt—I will answer regarding midwifery, purely rural midwifery primarily. We were fortunate five years ago to gain quite a large RHSET grant to provide midwifery education specifically to rural nurses. We have always provided education, but nurses have generally had to come away from their home towns to the city to undertake their program. Curtin University does have a distance learning option, and has had one for some time, but did not have the clinical practice arena in the city area to provide at least a component of complex care.

That rural program has proved to be extremely successful, and in four years we graduated about 20 midwives who came from the rural areas—they were selected by their rural hospitals largely—and undertook their program with a component here at King Edward. We supported them with free accommodation and a clinical practice component that was precepted. All of those nurses, on entering midwifery, were guaranteed positions as midwives in their local communities and were required—although with little legal intent—to remain as midwives for 12 months after they completed their course. Every one of them did.

In our collaboration with the universities, since the completion of the hospital based course, we are trying to continue to promote that quite actively. However, the RHSET funding has now finished. We have been lucky in encouraging health services to put in some extra dollars to help their students to complete the course. The EBA, which I alluded to earlier and which was our major change in pay and conditions last year for nurses and midwives in Western Australia, has at least recognised midwifery quite separately in terms of some remuneration.

CHAIR—Just a small point of clarification: what funding?

Mrs Butt—RHSET stands for Rural Health Support Education and Training; it is a Commonwealth grant.

Dr Shanley—Up until recently, the situation with regard to mental health nursing was fairly standard in that very few extra resources were made available. In fact, this year the $100,000 that had been allocated over the last seven or eight years for scholarships for mental health nursing has been totally removed and so is no longer available this year.

CHAIR—State or Commonwealth money?

Dr Shanley—That is state money. That has been used elsewhere within the Department of Health without any forewarning, so whatever small incentives there were in the way our resources were available seem to be further reduced.

Ms Verrier—Basically there has been a reduction in funding for community health nursing. Pre health service integration, which happened in about 1993, community health had its own budget. Post health service integration, our budget came from the hospital for the health service we were in. Obviously the funding was going to go to the acute services, not the preventative services, because that is really what we are on about.

Out of that, we also lost the funding for the level 4s/5s, which are the senior nursing positions. We lost staff development positions. We also lost generalist community nurse positions because, for example, the staff development nurse at the hospital then covered community, the diabetes nurse at the hospital then covered community, and even the well elderly came under 'extended care' in the hospital. But, with that, the hospital does have a focus more on acute, not preventative, services. I think hospitals try really hard to include preventative services, but in the community we are dealing with well people—we are trying to keep them out of hospital. So our funding was just sucked up by others.

Senator KNOWLES—None of you has commented on pay structures, which I think is an interesting issue. Pay structures have been a real problem, haven't they, because it is an issue linked to retention and so forth and so on? Maybe we could look at the issue of pay structures.

I would also like to look at the issue of recruitment, particularly recruitment at schools. Lots of kids are encouraged to go off to university to do this or that, but to me it seems that something as vital as nursing is not necessarily getting the profile and the status that it deserves at that career guidance end.

Ms Faulkner—That is right.

Senator KNOWLES—Do any of you have any experience of what is happening there and what emphasis has been placed on trying to get young men and women into the profession?

Ms Verrier—Years ago, community health had what they used to call school resources. We had a program where community health nurses, child health nurses, went into the schools to teach high school students about mother care and various things. We would use that as a way of having a link to a school to tell them about nursing and especially about child health and school health nursing. As well, the school health nurses were in the schools all the time. It was an avenue to encourage schoolchildren into our profession. However, the school resources have now gone. There is no program or it is on an ad hoc basis where the schoolteacher of a class is interested in getting the child health nurse in to speak or, if there is time, the school health nurse comes along. Some school health nurses might have to cover up to 20 primary schools, so it is very difficult to give time to recruiting school children.

Senator KNOWLES—Are you saying that there is no formal career guidance emphasis on nursing at all anymore?

Ms Faulkner—A couple of years ago the government did fund quite a big program but, as Eamon said, it was to the acute end of nursing. Midwifery or paediatrics could have been alluded to because there was a baby in an isolette in one of the pictures. The program gave the message that it is exciting to be a nurse and that type of thing, but it was only for a short space of time. Also, the universities have open days where you can have a stall and promote your area of specialty. But there is no constant, sustained approach that I know of that may attract school leavers. The universities have their brochures and they are usually quite well done, but we are competing with a lot of different faculties and I think it is an area that we really need to push more. We need to market ourselves better, particularly in the areas of paediatrics, mental health and midwifery to make them career choices.

Senator KNOWLES—I would like to raise another issue. I have been looking through the program today and I do not see that we have anyone from rural nursing. Ms Verrier, you might be able to answer this question. I have been plugging away here for a number of years, across governments of both colours, for greater status in housing in rural communities. For example, we do not ask the local policeman to go and share a house with six other people; we do not ask the local teacher to do the same thing. Why is there something unique about nurses, who are working odd shifts and yet have to go and live with other nurses?

Ms Verrier—Absolutely.

Senator KNOWLES—I have belted my head against a brick wall because it is not a Commonwealth responsibility; it is a state one. Where are we at in that little quest?

Ms Verrier—It is one of those issues that go on. As a remote area nurse, I lived in a caravan for two years with the Bidjadanga community. I was lucky because I had an airconditioner, so I was pretty happy. They do not expect rural nurses to be married, so they provide single accommodation and single beds.

Senator GIBBS—Single beds!

Ms Verrier—Absolutely. It is a continuing issue. I was involved in the Council of Remote Area Nurses many years ago when I was working in rural areas. That issue has been on the table for a very long time. Once again it comes back to funding.

Senator KNOWLES—I understand that. I get a bit grumpy with the state governments about that. It is not a question of funding when it comes to a police officer or a teacher—

Ms Butt—Or a doctor.

Senator KNOWLES—or a doctor. Why is it a question of funding for a nurse, who invariably does the whole kit and caboodle anyway as doctors come and go in country areas? Are you currently pushing for that at all? Is there any proposal on the table?

Ms Verrier—With the last EBA—and correct me if I am wrong here—I could not be entirely positive, but I am sure that it was on the table as part of looking at how we can improve the lot of rural and remote area nurses by having adequate housing and what have you. So it has been on the table; I am not sure of the outcome though.

Mr Masters—It has been improved in the last five years. Places like Jigalong now have regular houses with things that work. Prior to that, repair and maintenance was a major problem. But it is the other conditions that are a problem, for example, the basic pay scale. Why would you go to a remote community to earn $30 an hour and work a 60- or 70-hour week?

CHAIR—Can I just ask where Jigalong is?

Senator KNOWLES—It is an Aboriginal mission.

Mr Masters—It is in the Pilbara, on the edge of the Central Desert.

Senator KNOWLES—It is in the very far north, out to almost the Northern Territory border.

CHAIR—I understand. I thought it was probably that, but thanks for that indication of distance.

Mr Masters—It is relatively close compared to the Kimberleys, but it is still 14 hours drive.

Senator KNOWLES—I am not just looking at those remote communities with this problem. I swing through fun-filled places like Halls Creek and Fitzroy Crossing—all those places that are very difficult to get to. It is not as though you can go down town to the local disco every week, or anything else. There are not a lot of things that can be done there. I think it is something that everyone has to stay on the warpath over if we are going to attract people to the bush, because it is the pay thing, it is the housing thing and it is the travel thing—being able to come home and see family or whatever else as well. All I have ever looked at is putting them on an equal plateau with teachers and doctors.

Mr Masters—I totally agree with you; you are absolutely right.

Mr Phillips—I speak from my experience of working some years back as a health building inspector before I started nursing. In the local community doctors have status with the shire council: it provides housing and bends over backwards to give them anything to keep them there. When it came to nursing, the attitude was, 'Oh well, they are just women. They can come and go as they please.' That was the attitude. I know because I worked for the shire council.

That is an area we have not done anything about. From a mental health point of view, we have found that we have had to work so hard to do something here in the metropolitan area that we have not got beyond that. But we are very conscious of our college members who live in Broome and Derby or even just the outer wheat belt. They get no support; they are the only person there. There is a psychiatrist who might fly in once a month, but otherwise they are it. If somebody goes mad in the local area, they have to go and deal with the whole thing. They are the only one there so they also have no colleagues to talk to. Who is going to go there, especially when you have not even got a house. If you have a house, at least you can go inside and shut the door.

Senator GIBBS—I would just like to expand a bit on the conditions and, particularly, the wages. Dr Shanley, you said that 81 per cent of nurses who work in the mental health care area

do not have degrees. You mentioned the initial three-year degree. If you do a three-year degree what happens then—are you an EN or an RN?

Dr Shanley—It is not a three-year degree; it is three years of hospital training.

Senator GIBBS—It is training?

Dr Shanley—Yes. The vast majority of people did that. It is still a state registration qualification but it was done through colleges or schools of nursing that were locally based. Most of the mental health nurses in Western Australia had received that sort of training.

Senator GIBBS—So they are then registered nurses?

Dr Shanley—They are registered mental health nurses. There was quite a separate registration. It was a three-year course geared specifically towards preparing people for registration as a mental health nurse.

CHAIR—Were they part of a different union?

Mr Phillips—Yes.

CHAIR—I thought that was the case; it certainly is in South Australia too. Which union covers them in Western Australia?

Dr Shanley—I am not sure what you mean by union.

Senator WEST—Is it ANF or—

CHAIR—Or is it NHU; which one is it?

Mr Phillips—It used to be a separate union, WA Psychiatric Nurses Association. That is now defunct, and we come under the ANF. One of the controversies is that WAPNA, even though defunct, has a seat on the Nurses Board representing mental health; we do not, as a college. We have been lobbying for it for years.

CHAIR—In South Australia there are separate unions.

Senator GIBBS—Are the pay structures for nurses who work in mental health different from the pay structures for those who are working in a general hospital or, indeed, in these other areas—obstetrics, paediatrics et cetera?

Mr Phillips—It was a separate career structure but, at the moment, it seems to be in chaos.

Senator GIBBS—Is it basically the same amount of money?

Mr Phillips—Yes. We have lost a lot of conditions from going into an overall one, but we have gradually got them back. That was based on working in a big psychiatric bin, where a lot

of the emphasis is. I trained under the old apprenticeship system of three years. There has been no incentive for me—in terms of pay structure—to do anything else. I could sit there on my bum and be there until I retire. Personally, because I was interested in the forensic side and other sides, I have gone and gotten my own education, in some ways, and that is where we are at.

Looking at the whole structure, when it comes to wages, I work as a clinical nurse in the Armadale Health Service, which is outer suburban. My clinical nurse specialist, who is above me, actually earns less than me because she works Monday to Friday. She has the responsibility of looking after the inpatient unit in the aged mental health area and of looking after the clinic, which looks after outpatients. We, as a new service, have tried hard to get skills so that we go beyond just locking a person up, to put it crudely, and can look at other options. We have found that there is no place where we can do further education, like cognitive behavioural therapy, unless we do our own stuff.

The new nurses coming through are registered to work in those areas. They are quite skilled and they have a lot of education, but it is the practical issues of being with a person who is very distressed and very unwell. How do they deal with that? They are frightened of them, because they have had no experience. I can say from working in Graylands, which is the big hospital here, and also in our own service, it has taken us as registered nurses a lot of time to support them to come in—mainly because, when you talk to them, they have not had experience of what it is like. When it came to the campaign for nurses that was referred to before, we, as mental health nurses, felt very insulted that not a word was said about our side. We see the whole basis of living as this: if you are mentally well, a lot of other physical stuff falls into place. That is not taken into consideration. I work in the forensic service in the prison as well as in a local service now—I work on the mental wellness and then the other bits.

Senator GIBBS—I understand that, Mr Phillips. I know it must be a very difficult area to work in. In this report, we talk about level 2 nurses. I am trying to establish what a level 2 nurse is.

Mr Phillips—A clinical nurse, level 2.

Senator GIBBS—It says here 'reluctant to seek promotion to Level 3.' Is level 3 a staff position or is it paid by the hour?

Mr Phillips—No. Level 3 is a position of being in charge. It is called a clinical nurse specialist in this state. They work Monday to Friday—

CHAIR—Why do they get less pay?

Mr Phillips—Because of the penalties and everything else; because they work the three shifts.

Senator GIBBS—Sorry?

Mr Phillips—They do not get penalties or anything else.

Senator GIBBS—So they work a set-hour week.

Mr Phillips—Yes.

Senator GIBBS—The level 2 person does not work a set-hour week; therefore, you get paid more money.

Ms O'Nions—I get paid by the hour, but the clinical nurse who is going to be working shiftwork on Saturday will accrue shift penalties and weekend penalties. So, at the end of the day, they get paid more.

Senator GIBBS—Right.

CHAIR—Who gets paid more?

Ms O'Nions—The clinical nurses.

Dr Shanley—The lower level.

Ms O'Nions—By working from Monday to Friday, even though the hourly rate is slightly higher, it does not compensate for losing shift penalties.

Senator GIBBS—It is higher at level 3. So there is really no advantage to progress in that particular field.

Ms Verrier—Some of you might correct me if I am wrong. When professional rates came in many years ago, we went to the different levels. Before professional rates for community nursing—I think it applied to mental health as well—our pay rate was higher than that for hospital nurses. That was to help attract nurses into community nursing. Community nurses do not get penalty rates because they do not work shift work.

Senator GIBBS—So basically it balanced out?

Ms Verrier—Yes.

Senator GIBBS—You got more for your base rate and that balanced out because you did not get the penalties.

Ms Verrier—That is right.

Senator GIBBS—Are you all now on the same pay structure?

Ms Faulkner—Yes.

Senator GIBBS—Do you all have the one union?

Ms Faulkner—Yes.

Senator GIBBS—Which one is that?

Mrs Butt—It is the Australian Nursing Federation. Our current enterprise bargaining agreement managed to secure an allowance for specialised training. It is a one-off allowance. It is three per cent of the base salary and you have to have worked in the speciality area for 12 months. To take midwifery as an example, most of the midwives currently are nurses. Once they enter midwifery and they work as a midwife for 12 months, they can get a one-off three per cent payment on their base salary. That is the sum total of recognition for their extra qualification. There is no continuation of any special payments. As Shani alluded to, in the United Kingdom midwives are paid generally at higher rates than nurses throughout the country are. That is an agreement reached through having a separate union for midwives, which does not exist in Australia.

Senator GIBBS—No, I know. Senator Crowley and I certainly know the struggle of midwives. We have travelled the country extensively. Are you all happy with your pay or do you want more?

Ms Verrier—No, we are not.

Senator GIBBS—You are all underpaid.

Ms Faulkner—I am one of the level 3s normally. I am in an acting position at the moment, but the level 2s in my area get up to $300 a fortnight more than me.

Senator GIBBS—Is that right!

Ms Faulkner—Yes, depending on what shifts they work.

Senator WEST—And the buck stops with you?

Ms Faulkner—Yes. I am actually a clinical midwifery manager—that is my substantiated position. I am in charge of the clinical standards, plus staffing.

Mrs Butt—It is actually quite difficult to encourage level 2s to even act in your position at a level 3 for a short period of time, because they recognise straight off that there is increased responsibility. There is a lot of work to do out of hours and you receive less pay for it. They are generally not keen to do it.

Senator GIBBS—Why would they be keen to do it? You have all the responsibility and you are not being paid for it. We have here a scale of teaching hours at the West Australian School of Nursing for a start: nursing, 157 hours; psychiatry, 171 hours. It goes on to the Edith Cowan University: nursing, 19 hours; psychiatry, 18 hours, which seems pretty appalling. At Curtin University of Technology: nursing, 16.5 hours; psychiatry, 51.5 hours. Is this particular course at the West Australian School of Nursing still going or has it been replaced?

Mr Phillips—No, it has been replaced by a university educator.

Dr Shanley—That was the hospital school. It was the hospital training that 81per cent of the current mental health nurses had undertaken.

Mr Phillips—That is where you worked in the hospital in blocks of six weeks or eight weeks—more of an apprenticeship system.

CHAIR—This is a question I wanted to ask. It says at table 1:

Psychiatry and Mental health nursing. Content of Program Currently Received in the Preparation of Students to Work as Registered Nurses in the Mental Health Field.

All I put beside that was a big question mark, with a 'please explain what on earth those figures mean'.

Dr Shanley—It meant that, within the comprehensive scheme of training, the students were given that number of hours in the classroom related to mental health nursing and mental health psychiatry. The figures should also contain the time spent in the clinical area. There were two lots of hours.

CHAIR—It is on page 14 of your submission, Dr Shanley, and it is completely unintelligible to me.

Senator GIBBS—When we go over to page 15 we have 5,000 hours as opposed to 96 and 60.

Dr Shanley—Tell me what it is that you are having problems with.

CHAIR—I am not sure how I compare the West Australian School of Nursing figures of 157 and 171 with those for Edith Cowan, which are 19 and 18.

Dr Shanley—In terms of mental health nursing, in the previous hospital training students received 157 hours in the classroom compared to 19 hours in the classroom in Edith Cowan University. In the Curtin university, 16.5 hours were spent in mental health nursing. In terms of general issues of psychiatry, the figures in the West Australian School of Nursing are 171 hours in general issues such as the conditions of schizophrenia and depression—which is what all that means—compared to 18 hours in Edith Cowan and 51 hours in Curtin. The point of pointing out those figures is that, compared with a three-year course which is preparing people to look after individuals with a mental illness, under the old apprenticeship system the amount of time spent in the classroom was far greater—it was nine or 10 times as much as is currently received.

Senator GIBBS—How are we going to address this problem? Do you think that we should go back to the apprenticeships?

Dr Shanley—Absolutely not. I think one of the really attractive things about the comprehensive scheme of training is that people who go into mental health nursing are not socialised into a culture within the mental health system, which tends to be custodial. They bring the general population culture into mental health nursing. From that point of view it is very attractive. I would see the way forward as having this transition course: when somebody

finishes the comprehensive course, then they will do a period of time under supervision of some description, preparing them to work independently. So I would like to see that transition period formalised into having minimum standards and being accredited by the university, even through an internship. Individuals will get a lot more clinical practice, but it will be much more educationally oriented.

Senator GIBBS—You say in your report that students experience the attitudes of people who have not worked in the mental health system for quite a while. Let us face it: that system has changed quite a lot. How are you going to address that? How can governments address that?

Dr Shanley—The major issue seems to be almost naive in its simplicity; putting it into practice may be very much more difficult. The simplest way of solving that problem is the subsequence of joint appointments—that is, the university paying half a salary and the service paying half a salary, but an individual will have a responsibility for education, research or whatever as well as the clinical practice, the hands-on. In that way you would have teaching informing practice and practice informing teaching, whereas at the moment you have two separate groups of people.

To my mind, people who call themselves nurses who work in universities teaching nursing but do not practise should be called ex-nurses. For example, if I were a footballer and became a manager or a coach of a football team, I would stop being a player—I would become a manager or a teacher. So you have the people who practise continuing to practise and the people who teach having little contact with the practice. People around this table have proved the exception, and I think maybe that is partly why they are here, in that they have a lot of motivation in representing their organisations. But the majority of people who work in universities do not have a clinical input, and I think that is really detrimental for loads of reasons, not least in terms of mental health, in that it is conveying a culture to the students.

Senator GIBBS—I would like to have one query answered for my own curiosity. In Western Australia are mental health hospitals attached to regular hospitals as a mental health unit or do you actually have asylums? I ask this because, where I live, we have about four, although we have closed one down and it will become part of Queensland university in Ipswich. They are pretty gruesome places, particularly Wolston Park, which is in the electorate where I have lived all my life.

Dr Shanley—In WA there is only one freestanding hospital for the whole of the state and that is Graylands Hospital that Gary referred to. There is the development of individual units or wards attached to general hospitals—that is a more recent development. Within the remote and rural areas, there have been problems where individuals have become mentally ill. Many of them have had to be taken to Perth, and to go by the Royal Flying Doctor Service they would have to be drugged up and strapped in. For people who are from our indigenous population it is very distressing to have that experience and then end up in a large psychiatric hospital where the knowledge of, and information about, the culture of the individual is scant. So there is a recognised need within the service to develop in-patient facilities more locally based. Within the metropolitan area most of the large hospitals have got mental health units attached to them.

CHAIR—We are coming to the end of our time, I am sorry. I appreciate that there is so much information that you have got that we would welcome but I do want to give Senator West the opportunity to question.

Senator WEST—I have to fess up, Dr Shanley, I am an ex-nurse. I still have current registration but I have not been near a ward for a long time. What would it cost me and what would be my ability and options here if I came to Western Australia and wanted to go back and practise and do a refresher? I have got general nursing, midwifery, mothercraft and a Diploma in Community Health Nursing. What are my options to actually get refresher courses, what is it likely to cost me and how long is it likely to take before I actually get salary?

Mrs Butt—I think it depends on how long you have been out of practice.

CHAIR—Say, 20 years.

Senator WEST—It is 30 years since I have practised in midwifery.

Mrs Butt—Therefore it would be more than a refresher—and that is the reason I asked that question. A renewal of registration program would be required in Western Australia. Anybody who has been out of practice for five years or more is required to renew their registration not just to refresh, which is unlike some other states. You would need to complete a renewal of general registration program. Most of those are provided at Curtin university and at a number of hospitals and in combined groups.

Senator WEST—How are they taking up those?

Mrs Butt—They vary. The hospitals run courses. I am not from general nursing. My understanding is that most of them are relatively short in terms of the theory component with about four weeks clinical practice. The university program—and Leanda would probably know more than me—is usually undertaken on a modular system and takes up to 12 months.

Ms Verrier—They are stopping that program because the hospitals are now offering courses free, so why would you pay for a refresher course when you could go to a hospital and get it free?

Senator WEST—But still get salary—

Ms Faulkner—No. It is not necessarily free.

Mrs Butt—It depends. At this moment, because we have got such an acute shortage, the health department has provided funding for the last few years to assist nurses and midwives to re-register. Once you had completed a re-registration in nursing, if you chose to re-register in midwifery, that would be another course. This hospital is currently the only provider of renewal of registration in midwifery. We provide the course as distance learning or as attendance mode. Again, there is a requirement for clinical practice once the theory has been completed. Currently that costs applicants $600 per person. Up until this year we have had health department funding to support nurses wanting to go back into midwifery so it has not cost them anything.

Ms Verrier—You could not practise in child health, because there is no refresher course in child health. The child health programs were stopped at the end of last year. The PMH course then got emergency funding to run over the next 12 months, but we had nothing after that.

Senator WEST—What if I were interested in mental health, but do not have any mental health qualifications?

Mr Phillips—There is a six-month refresher course at Graylands Hospital. It costs $2,000. You have to go there in your own time. People can do a certain amount of clinical experience at Graylands, where they are attached to a ward for one or two days a week. Outside of that, it is very limited. There is nothing for community mental health. We are part of an integrated health service in the region and there is no provision for people to come in and gain experience. I work with someone who has been through the system. She trained 18 years ago, married, had a family and has now come back, and she has found a whole new world. Six months were initially enough to refresh her, but she has since, on her own initiative, had to find out how to upgrade her skills in counselling and in various therapies that she wants to run. But she has had to do this herself.

Dr Shanley—Because the $100,000 was withdrawn this year from the scholarships, people applying for registration will have to fund themselves, but there is some funding available for them in the mental health area.

Senator WEST—In paediatrics, how would I go back to being an early childhood nurse in the community?

Ms O'Nions—In the community, there is no refresher program. There is a family-child health program. You would have to do the whole course. We run a refresher program that is a four-week block, but it is not a re-registration program. If you were coming back into nursing, you would have to do a re-registration course and, if you had previous paediatric experience, you could then do a refresher course. But you would have to re-register.

Senator WEST—There seem to be some obstacles put in the way—for three of the four specialties here—of encouraging back women who have gone off and had families, which is a fairly traditional thing to do. Now that the kids are leaving the nest, these women want to go back to work for intellectual stimulation—and not to work full time—and there seem to be some serious impediments in the way of attracting them back. If I did all that and got back, what sorts of shifts and working conditions would I be expected to work under? Would it still be rotating day and night shifts? Would I get any choice or any flexibility, to fit my family needs?

Ms Faulkner—You get some flexibility, but it is very difficult because we do need to have service requirements.

Senator WEST—Babies like to be born at all sorts of weird hours of the day and night.

Ms Faulkner—Sure, but most areas—and correct me if I am wrong with regard to other hospitals—would have a request book and everybody would put their requests down. If there was a real need, you would write it in red and you would make sure that the rostering person knew about it. In most cases, we really try to give everybody their requests. Child care can be a

problem, and that is recognised. But at the end of the day you do need staff in morning, noon and night, and sometimes that cannot be arranged. However, I think mental health might have rotating rosters.

Senator WEST—Would I have to work a 40-hour week, or could I work part time, a couple of days a week?

Ms Faulkner—Part-time work is very common now and people are allowed to do it. I remember even 10 years ago you had to wait in line to get part time. But now if people want to do it they are given it, because we know people will leave otherwise and we will be in a worse state with the shortage of staff than we are already. We do have some requirements for a level 2 position. They need to work at least five shifts a fortnight, otherwise the position really cannot fulfil its extra responsibilities. Not many level 3 positions are part time. Some could be, but a ward manager would find it extremely difficult to work part time. So part time is definitely available. People can work night duty if they want to, but we find that is extremely unpopular.

Senator WEST—It used not to be, 30 to 35 years ago.

Ms Faulkner—We do not tend to do job-sharing here, but that should be an option if you would like to do it. It is not popular. It has not been something that has been progressed in this hospital. The other thing that has happened is we have 12-hour shifts now. Some people like that, some people do not—as long as you can get somebody who does the 12-hour day or the 12-hour night. The team midwifery rosters are nearly all 12-hour shifts. A lot of the nurses, but not all of them, like that because they get more free time.

Mrs Butt—That is their choice.

Ms Faulkner—It is a choice thing.

Mrs Butt—That is probably something that has changed. If the clinical staff can come up with a system that is more flexible but meets their needs, I believe most hospitals would be keen on looking at such a scheme.

Ms O'Nions—The flexible rosters are trying to balance the need to have your staff there when you need them while allowing for personal preference in shift. There are incentives to have flexible working hours, but it is a very difficult thing to do. It is not possible to accommodate everyone's special needs, such as 'I really like to drop the kids off at school and pick them up'. Also, we do not have as many people as we had in the past who want to do permanent nights, which is a bit of a shame. So the expectation is that, if you are a permanent staff member—whether you be part time or full time—you will rotate onto night duty. In some areas that is very frequent, like two weeks in six. So it is a very quick rotation through and that is a very common thing—four weeks of days and two weeks of nights.

Senator WEST—I am sorry, I will not be working for you.

Ms O'Nions—So we are seeing a lot of people doing casual and agency work because then they can choose the hours and the days that they want to work. That is the consequence.

Mr Phillips—In mental health—the service I work for—we try to be flexible, but there are problems. I was the only male for six months. We have recruited two more from England and, of course, they come from a very different set-up. We try, in the interests of equity, to ensure that everybody does a bit of night shift, but there are four nurses who have families, so we are very flexible when it comes to school holidays, picking up kids and that sort of thing. In fact, we want to keep our staff so we try as much as we can to fit in with them. So far it has worked very well; nobody has left after 12 months—that is the length of time we have been open.

Ms Faulkner—Can I just clarify one thing about the difference between level 2 and level 3 pay. I said it was $300, but it is between $100 and $300 a fortnight. I have seen a $300 difference, which raised my eyebrows. It is possible to get that but it is probably more between $100 and $300. I would like to clarify that.

Senator WEST—So if I went back and actually did all that, I would get no recognition as we used to in the old days? A couple of you here might be old enough to remember them. We used to get recognition for our certificates and our length of time.

Ms Faulkner—That changed when we went to professional rates. I refer to those of us that did, say, a whole lot of certificates and also those of us who went from the old hospital-based training, spent the money, went to university, changed, got our degrees and did postgraduate degrees. Once we went to professional rates, everybody got the same pay. Those who just did the hospital system, those who were coming through the university system and those of us who had X number of certificates and university degrees all got the same pay.

Senator WEST—So there appears to be no recognition—

Ms Faulkner—except for that recent three per cent, which was a one-off payment.

Mr Phillips—Yes.

Ms O'Nions—And that does not support further education on top of that. That is a one-off payment, so if you then proceed to a master's degree, you get no payment for that.

Senator WEST—A master's degree is going to cost you. What do you have to pay up-front for that?

Ms O'Nions—A postgraduate degree is about $6,000.

Mrs Butt—A master's degree is about $8,000 to $10,000.

Senator WEST—What about a PhD?

Mrs Butt—At most universities you can get that for free—if you get that far—because the honest truth is that it is more of an accolade for the universities.

Senator WEST—But master's degrees are now a dime a dozen sort of thing.

Mrs Butt—It is not actually at this stage because people cannot afford to do it, but certainly many people are capable of doing it.

Senator WEST—Yes.

CHAIR—Can I solve some of our problems by asking each of you to provide to the committee, if it is not a major task, actual figures of how much nurses qualified in your area get when they first finish university and go into the work force. What are the levels that they rise up? What are they called? What is the scale of pay? Include any other variations of that sort. I think we have found out why a level 2 nurse earns more than a level 3, but it is not clear to me how much a first-year working nurse is getting. Is it $23,000?

Mrs Butt—About $45,000.

Ms Faulkner—No, it is not that much. Could we approach our human resource department and get the scales emailed over, and give you a copy?

CHAIR—Yes, at your leisure, and not a major PhD thesis but just some information. The other thing is that we have some information, but we are also aware that it is different from state to state; it is clearly different from the heading of 'nurse category' in this state. It is going to be interesting for us to try and get a handle on it. I think the pay is important, as in Senator Knowles' interesting question of what is being told to students to encourage them to go into a profession. If you discover that if you become an accountant you are going to make $100,000 but if you become a nurse you will be scrabbling around on $30,000—and with no chance of improving it—you would be a drongo to be a nurse, wouldn't you? And the students in schools are not drongos; they work it out very quickly.

The other thing is that our inquiry is from the Commonwealth's point of view. Clearly, a lot of what is helping people to do nursing is the terms and conditions, and they are matters of fact for the state. So we get this nonsense where you might get a lot of people doing nursing, but then they will not work as nurses because they get more pay being a flight attendant or something. We appreciate that they are state matters and that we are trying to look particularly at where the Commonwealth is responsible. If you have any further information that you can add—I do not think you need to because most of it is written down here—in particular on the issue that Senator West raised, which is the cost of re-registration or re-training, please do so. I am going to just quickly flip through a couple of pages where we will get some answers on the record if we can, in the very short time here, but otherwise take them on notice. Dr Shanley, on page 15 you say:

(i) a case should be put to the Department of Employment, Education and Training (DEET) that an additional period of time be added to the comprehensive undergraduate program facilitating greater learning in mental health nursing, and students exempted from HECS fees ...

Is there anything further to that? Do you mean to cover the transitional period?

Dr Shanley—As indicated, that was one of a number of options.

CHAIR—Are the undergraduate programs exempt from HECS? I would not have thought so, so I am not at all sure what you mean by 'exempted from HECS'? Do you mean 'included in HECS', so that the students do not have to actually pay up front or out of pocket for their transitional or immediately post-undergraduate continuing education?

One of the things I find interesting about nursing is that people are compelled quite often to do necessary postgraduate education and they have to pay for it straight away because, under the current educational funding, only the base degree is HECS liable. I wondered if you could explain what you meant by 'exempted from HECS'. I did not think they were exempted.

Dr Shanley—Can I get back to you?

CHAIR—Please, that would be helpful. Also, could you give me a few words on paragraph (ii), which states:

(ii) the current transitional program (graduate program) should be converted to an internship with supervision ...

Can you drop us a few lines on what difference that would make? Do you mean it would cost less or do you mean it would be differently supervised in the institution?

Dr Shanley—Okay.

CHAIR—Thank you very much. I will put this on the record so we can make sure that Ms O'Nions gets the question. Page 4 states:

... the minimum standards established and recommended by the Australian Confederation of Paediatric and Child Health Nurses (ACPCHN, May 1999) have not been adopted ...

Who would do the adopting? Would it be the state government or the nurse educators? That is not necessarily a question for you, but we could see that Ms O'Nions gets to follow that one up.

The section headed 'Current availability and cost of paediatric and child health specialist nursing courses in WA' on page 8 has a lot of information about paediatric nursing programs. It states:

Princess Margaret Hospital offers a Certificate in Paediatric Nursing (12 months) at no cost to students. Students are employed as part of the hospital FTE.

But you can go on through these things and there are costs of $7,200. How many people are picking up that kind of course?

Mrs Butt—Very few go on to complete that course.

CHAIR—I should imagine. And is this money necessarily up-front, so people would have to borrow?

Mrs Butt—Yes. All postgraduate specialty courses have up-front fees. The postgraduate diploma in nursing, specialising in paediatric nursing, is available at the university and the students can choose to enrol in that alongside being part of the paediatric program at Princess

Margaret Hospital. Clearly, very few do because they will gain the specialist qualification from the hospital and be able to practise in the paediatric setting but will not be able to have a nominated postgraduate diploma.

CHAIR—Are there any scholarships that cover these positions?

Mrs Butt—Yes, the Department of Health provides scholarships each year for nursing and midwifery. Dr Shanley was probably referring to those in the mental health areas having been withdrawn. Certainly in midwifery we have been quite successful, with scholarships being awarded for many years. Our criticism is that they are not enough and there is a requirement through our Department of Health, which we have actively lobbied against, that the nurses have to have worked as nurses for two years, preferably in the public health system, before they are eligible for the scholarship for midwifery and other specialties. I believe that is a disincentive. We attract people to midwifery very soon after general nursing, a significant number of them only having done general nursing because they want to be midwives, so they cannot get there any other way. Currently, probably 50 per cent of our midwifery students would not qualify for those scholarships. Despite active lobbying of the health department, they have refused to remove that criterion.

CHAIR—Are you only lobbying the health department—which I presume is that of Western Australia?

Mrs Butt—And the minister of this state.

CHAIR—Is there any lobbying of the federal minister for education?

Mrs Butt—There has been in the past in relation to the HECS issue. Postgraduate midwifery again we believe, because it is an initial registration into that discipline, should attract HECS. The federal government has declined to consider midwifery as a special case and there has been active lobbying, both state and federal, in relation to that from the professional associations, the universities and the health industry.

CHAIR—I wanted to know what 'advanced standing' meant: 'Completion of the certificate in paediatric nursing offers advanced standing.' Does that mean three unit credit towards—

Mrs Butt—It is credit towards the postgraduate diploma.

CHAIR—What is a 'JDF'?

Mrs Butt—A job description form.

CHAIR—Thank you very much. I love letters that I cannot understand—a job description form. I have to say that I finished up not clear about what courses are continuing and what courses are closing. How would you advise that we might get a map? Should we contact the state department on what courses are available for nurses, and where, across all fields?

Mr Masters—That would be an interesting exercise. One of the issues for us is that there are very few strategic positions, so that would be a very interesting exercise. We could create something for you, but again we would be bringing it all together. It would be interesting to see how the health department was able to manage that.

Mrs Butt—That is just the Nurses Board of Western Australia. The Nurses Board of Western Australia does have an up-to-date list of accredited courses—that means registration courses, recognised postgraduate courses and recognised re-registration programs—but there are many other programs that they would not be able to comment on.

CHAIR—It would seem to me that this might be one other reason why the students that Senator Knowles raised concern about would be a bit flummoxed. Certainly, sitting here listening I am a bit flummoxed. It may well be that that is another effective disincentive. The submission says:

> At present there are few opportunities within community health nursing to develop professionally with an increment progression ceiling set very low at level 2.4 clinical nurse...

I do love the language of bureaucracy. What is an 'increment progression ceiling set very low'? Does it actually mean what I understand it to mean? Could you please explain it in simple language.

Ms Verrier—Clinical nurses in community health enter at level 2 and on increments they go up to level 2.4. We have a lot of nurses that are sitting on increment level 2.4, which we will give you in the pay rates—

CHAIR—Which is effectively a salary increase?

Ms Verrier—That is it.

CHAIR—And after that they are stuck?

Ms Verrier—And they go nowhere—yes.

CHAIR—I wanted to ask you about one last thing—and maybe because of time I should ask you if you would take it on notice and write me only five lines and, if not, 10, but certainly not a thesis. All of you have been adamant that you do not want to go back to the apprenticeship scheme, but all of you, one way or another—particularly Mrs Butt, I think—have talked about the value of having nurse students being paid. This is a very subtle distinction in my mind. There has also been a very big case for closer association between the institution where people are practising and the institution where they are being educated. Are any of you actually advocating that? Certainly, if there were a professor of mental health who is actually based in an institution—did you tell us that, Dr Shanley?

Dr Shanley—Yes, there was a joint appointment.

CHAIR—then this seems to me to be interestingly the same. I would love to know how it is different from the old world, where education was provided in the institution and people were

paid while they were working as students at whatever level. How is this different from going back to the old apprenticeship scheme?

Dr Shanley—Do you mean whether the current situation is different from the old apprenticeship scheme in terms of the relationship between the institutions?

CHAIR—No. If you are taking student midwives and you are actually paying them because they are doing the work of nurses and studying—that is, they are effectively being students and working and being paid for their student work time—how is this different from the old apprenticeship scheme?

Mrs Butt—I think the difference—and I can only speak for midwifery—is that the equality of the partnership between industry and the university, certainly in the midwifery field, has meant that we have discussed the clinical component of the course to a much greater extent than we would have done perhaps in the past. Whilst they are paid, they are not necessarily always part of the work force; we actually pay students to be supernumerary for a considerable amount of the time. That is very different to what we were able to produce before. I would say that it is not perfect, and I think it has met a need of people not being able to complete their education without the payment. However, the feedback from the students has generally been very positive; and it is a much more realistic preparation than they were perhaps getting previously, because practice was very fragmented and they were actually working full time in another nursing capacity to achieve the ultimate goal of being a midwife—which I do not think is the right way to survive.

Ms Faulkner—The rural sector really like it, too, because they were very concerned about having recently graduated midwives with very little clinical experience being the only midwife on duty in the rural area.

CHAIR—One of the reasons that has been put to us in the past about why there is a shortage of nurses is that you no longer get paid when you go straight in—you have to go and do that university thing—and that is a kind of cultural step that a lot of people do not want to take or are not comfortable taking. But you are all adamant that you are not advocating any return at all to the old apprenticeship scheme?

Ms Faulkner—Definitely not.

Mrs Butt—There are some similarities.

CHAIR—I take your point. If there is anything further you would like to add for the committee on that, that would really be very helpful. We have the problem we have always: there is far too much that is interesting and far too short a time to get it onto the record. If there is anything that we have missed and you really are burning to tell us, I would be very happy if you would just put that on a bit of paper and, given that you are all frantically busy, please, do not give us theses, and if it is not easy to get, drop us a line and say, 'It's not easy, but you might try here.'

Senator WEST—May I ask for a definition, please, from my community colleagues? What is 'JDF'?

Ms Verrier—Job description form.

CHAIR—That one clearly slipped through the net. Thank you all very much for attending here today and for your efforts in making excellent submissions and helping us.

Proceedings suspended from 10.15 a.m. to 10.34 a.m.

BETTS, Ms Jillian Alice Evelyn, Acting Level 4 Community Nurse Consultant, Swan Health Service

BURNS, Ms Yvonne Evelyn, Coordinator Nursing (Hospital), Swan Health Service

CATTERMOUL, Ms Moyra, Acting Director of Nursing, Swan Health Service, and Hospital Program Manager

HENDRICKS, Dr Joyce, Coordinator Staff Development, Swan Health Service

BISHOP, Mrs Toni, Chairperson, Peak Nursing Council WA

FINN, Mr Michael Philip, Treasurer, Australian and New Zealand College of Mental Health Nurses (ANZCMHN) Inc. (WA Branch)

GLUYAS, Mrs Heather, Director of Nursing and Acute Services, Rockingham Kwinana District Hospital and Murray District Hospital

CHAIR—Welcome. Thank you for your submissions. The committee prefers all evidence to be heard in public but, should you wish to give any evidence in camera, you may ask to do so and the committee would give consideration to your request. I need to remind you, without any implications, that the evidence you give will be protected by parliamentary privilege but the giving of false or misleading evidence may constitute a contempt of the Senate. The committee has before it your submissions, Nos 450, 750 and 173. Do you wish to make any alterations to the submissions? I now ask you to make an opening statement and then take questions from the committee. As I understand it, there should be three groups, so could I ask you to give a precis of your submission and then we will have more time for questions.

Mrs Bishop—The Peak Nursing Council firmly supports the concept of tertiary nursing education courses and not a return to the pseudo apprenticeship system of the past, which obviously follows on from your previous session, from comments that we heard. The focus of nursing for both registered and enrolled nurses has changed from institutional based care to a much broader scope that encompasses the institutional care together with preventative and community care. Nurses need to have knowledge and experience based on primary health and wellness approaches, as well as that which is specific to acute and aged care sectors. Access to clinical experience is a concern, particularly here in WA, with less bed numbers and a smaller population. Returning to hospital based programs would not overcome this issue as students would need extensive time away from the primary hospital to gain all the relevant required experience. Particularly in the cases of enrolled nurses, it could very well limit them to being able to practice in only one area, such as aged care. Funding, as always, is a major issue. The majority of strategies suggested in any review of nursing education and work force needs will require increased budgets.

Documentation in aged care is an area of major concern to all involved. Nurses are spending far too much time completing forms and reports which are repetitive, simply to obtain funding. This is not seen as nursing and it prevents these staff members from actual delivery of care which is their primary role. This is given as one of the major reasons why nurses are not staying

with or entering aged care. In the opinion of nurses, this funding model needs to be reconsidered very quickly.

We are very happy to discuss other issues identified in our submission with you. All of these issues have been brought up in everybody else's submissions, I am sure. In the *Hansard* report that you have on your web site, you have identified them in your discussions. Out of most of them, I think the education and aged care topics are those that are the primary Commonwealth focus. The rest of them tend to be more state driven.

CHAIR—Thank you. I now invite the Rockingham-Kwinana representatives to make their opening statement.

Mrs Gluyas—Thank you for the opportunity to give evidence to this inquiry. This statement represents a consensus of the views of the senior nursing staff at both of the hospitals. Just to give you some background—because they are a bit different to the metropolitan hospitals—Rockingham-Kwinana is an outer metropolitan secondary hospital which deals with about 30,000 emergency presentations and approximately 8,000 admissions per year. The Murray District Hospital is a small rural hospital 40 minutes away from Rockingham, and it has 30 beds. The senior nursing staff from these sites give a slightly different focus—from a regional and rural perspective—to the metropolitan hospitals.

In our written submission, we have tried to articulate strategies which we truly believe would make a difference to the recruitment and retention of nurses. In brief, they deal with things such as clinical support for students and graduates; government and organisational support for ongoing education; the impact on the mental and physical health of long-term rostered and rotating shiftwork on a work force who are mainly women with other family roles and responsibilities; and, finally, the powerlessness of nurses, the majority of whom work at the coalface of the health service industry but who have little influence on health service planning or the decision making on how health services will be resourced to deliver care.

It is difficult to summarise our submission in a short statement. However, I would like to report from a recent study that was carried out in the US in 2001. I believe this study catches the essence of what we hope to do in our written submission. It involved 43,000 nurses from 700 hospitals in the USA, Canada, Germany and the UK. The results of the survey when collated showed that what was required to recruit and retain nurses are health institutions which value nurses and their contribution, health institutions which have personnel policies and working conditions comparable to nonhealth workplaces, health institutions which offer career opportunities and lifelong learning and workplaces which offer flexible work schedules.

Interestingly enough, there are groups of hospitals in the US which offer these very things, and they are called magnet hospitals. They undergo an accreditation process against set criteria similar to the process used by the ACHS in Australia. Characteristics of these hospitals are that they demonstrate management support for nursing, they have structural flatness, there is a decentralised decision making, there is self-governance, there is the availability of self-rostering flexibility and, most importantly, there is nurse autonomy, nurse influence in policies and support of education. These magnet hospitals are able to recruit and retain nurses at a high rate than other hospitals, and we should remember that in the USA they have the same recruitment and retention problems that we do. They are able to demonstrate better outcomes for patients as

well. I would put forward the proposition that it is time to pilot the magnet hospital concept in Australia. Once again I thank you for this opportunity and I am happy to take questions on our submission.

CHAIR—Do magnet hospitals draw nurses of steel? I would like to think so. You made a comment that I think we might want to come back to and I will give you notice of the question, and that is nurse satisfaction is a better outcome for patients as well. I ask the representative of the Swan Health Service to now speak.

Ms Cattermoul—We welcome the opportunity to address the Senate inquiry. We commence by giving a brief outline of our service. The Swan Health Service provides a comprehensive range of services that span across the hospital and extend into the community. Our main focus is on primary and secondary care services. The health service and nursing service is managed in three key program areas of primary health, mental health services and hospital program. Nurses in the mental health program provide care for patients in acute adult in-patient facilities, in the elderly in-patient services and also in a range of specialist and community services.

Nursing in the hospital program covers the 24-hour emergency department, maternity services, a medical department, a small paediatric unit, a range of surgical services and aged care and rehabilitation service. Our nurses working in primary health program focus on prevention promotion in the key areas of child health, services to children and their families in primary and secondary schools and in a range of other community based services, examples being parenting, immunisation and Aboriginal health.

The health service is situated approximately 20 kilometres from the central business district of Perth. It serves the local communities and, importantly, a significant number of our staff live in the nearby community. The paper and recommendations submitted in 2001 represent the views of senior nurses from across the three program areas and from a variety of backgrounds and specialties, as previously outlined.

While the health service commends changes and initiatives already in place to address the nursing shortage and nurse education, the recommendations in the paper were put forward to highlight issues that were not fully addressed in, or by, the system. In summation of the Swan Health Service paper, and in addition to the Nurses Agreement and the recommendations outlined in the Western Australian Department of Health's *New Vision, New Direction* document, senior nurses from Swan Health Service highlight the following matters for consideration: the Swan Health Service supports the retention of university based education and suggests that each university be attached to a group of hospitals or health services, both teaching and non-teaching, to build loyalty to an institution and thereby increase retention rates; the adoption of a model of nurse education which exposes nurses to clinical areas earlier in degree courses; the provision of training and payment of on-site preceptors to increase the confidence of undergraduates in the transition to registered nurse; remuneration and fee exemption options for nurses undertaking postgraduate studies in specialty areas and, additionally, the development of combined employment and study options, thereby allowing staff to earn an income while training; the development of appropriate systems to monitor and identify safe work loads; adequate resourcing for nurses working in the community, in particular for mental health and primary health; an increase in staff development positions and clinical support, on the floor, in all areas, to support the educational needs of staff in a complex and

dynamic health industry; and additional administrative support for nurse-led projects and clinical nurse managers.

Importantly, nurses enjoy, and gain job satisfaction through, interacting with their clients and patients, and a lack of support services and increases in patient case workloads will decrease the amount of time nurses are able to spend interacting with clients. Similarly, workload monitoring and staffing should acknowledge and reflect the time and physical resources required to provide quality care across all nursing services, in particular for aged care and the care of complex clients.

In conclusion, we as nurses acknowledge that solutions to the nursing work force shortage are complex and will require multiple strategies at international, national, state and local levels. However, we advocate that much will also be derived from further acknowledging the professional voice of nurses and valuing the nursing experience.

Senator WEST—The issue in health areas that you have all dealt with, I think, is the integration of community as well as acute in-patient services. Are you facing difficulties in attracting nurses into the community area, or do we actually have to blame *ER* and *All Saints* and those sorts of programs for highlighting the perceived 'sexy' bit of nursing as being acute, surgical—usually surgical, anyway—or A and E type theatre work and intensive care? What problems are you actually having in attracting community health staff over and above your general hospital staff?

Ms Cattermoul—Perhaps I can commence and, if Jillian wants to, she can add further comments. We have a very stable work force in our community nursing service. We have a significant ageing population. I speak for Swan and I think that, currently, our average age for community nurses is 50.8 years. We are also faced with the need to review the existing postgraduate qualifications for community health. That is currently being worked through. So I suppose we are in a transition period for nurses wanting to specialise in community health, particularly in a prevention-promotion model. I think we have two points. Because our work force is stable we do not have a lot of movement within our existing work force. It is certainly limited within the metro area and so, potentially, that gives you a limited entry into the specialty area. But, equally, we are currently in a situation where we really need to review and confirm the value of working in community and the complementary educational requirement for that.

Ms Betts—There is a proposed diploma for community health at one of the universities, but the problem is that it costs $7,000 and is over one year, full time. It is going to be very difficult for people who are in the work force and have bills to pay to take a year off without an income, plus pay $7,000. So that is going to be an issue. There is also the issue that we do not have a graduate program either. Entry level is at level 2, so we require some experience. We do not have an entry level at level 1, and that does present problems for us when we need to recruit people. As Moyra said, because we have a very steady work force we do not have a lot of positions coming up. The other thing is that we have not grown as a work force in the last 10 years; we have had no new positions put up.

Senator WEST—Has your workload increased?

Ms Betts—Absolutely, that is a major problem.

Senator WEST—Is that leading to burnout and people getting out?

Ms Betts—Definitely.

Ms Cattermoul—I think that has been recognised by the department in recent years, and moves have been made to start to address that. But, certainly, in the nurses agreement. Trying to come up with a way of monitoring workload is complex and still needs to be commenced, as it would be for community mental health.

Mr Finn—I would like to speak to the issue of community mental health. We have seen a change, particularly in the last 10 years, in the growth of community mental health provision. There has been a move away from the institutional care, particularly in the up to 70s age group, with a devolution of institutions into an explosion of community based services, to the point now where the acuity of patients now being managed in the community is far higher than it has ever been at any time in the past. For example, the old institutions actually had low acuity patients, because they provided a lot of residential accommodation, with very little focus into the community. Now the focus is into the community, and so we actually have a lot of very sick people being managed in the community, often by practitioners who operate independently.

Some of the issues that affect community mental health nurses are quite different from those that affect community health nurses. A good example is the need for things such as clinical supervision. Community mental health nurses are engaged in often very complex interpersonal dialogue with patients, and the management is less focused perhaps on treatment such as medications and more focused on interpersonal interventions. There has not been a recognition in mental health nursing of the need for the provision of clinical supervision. When I talk about clinical supervision I am talking in the same context as that which is available to doctors and psychologists, where supervision is an integral part of their time allocation for professional growth and development.

In the community mental health arena, the community mental health nurses are expected to be able to manage complex cases without the opportunity for clinical supervision or for informal clinical supervision to occur. Some of the difficulties in the metropolitan area are identified. In the country areas it becomes much worse because there are very few support services available for community mental health nurses, particularly in the rural and remote settings where they may be the only mental health service available to a discrete population. Those nurses are in fact less supported and in more need of supervision than their colleagues in the metropolitan areas.

Senator WEST—I have a nursing background, so I had better fess up to that. I think using the word 'supervision' is a little confusing for some people. When we are talking about supervision here we are talking about the ability to have another peer professional with whom a nurse can discuss the case, discuss options and work through their particular feelings about what is going on and how that patient is impacting upon them.

Mr Finn—Certainly, it is on two levels. The peer reflection is important but equally as important is to be able to connect with somebody who is more experienced and more expert so that you can get guidance, direction and mentorship. Those facilities are often not available. Some of the other issues that affect community mental health nurses in practice is that they do

not have equal access to postgraduate education programs. The last program that was offered in Western Australia was several years ago, and it has not been continued—this was one that was sponsored through the health department. The access to community health is very much experientially driven, and it is those people who work in the clinical practice settings in hospitals from whom we draw—or those recruits from overseas or interstate who may have already undertaken community mental health at a postgraduate level.

So the local graduates have got limited access to specialised skill development. Often, they go in with experiential learning, which is the only way they actually get their practice and consolidate it. The difficulty in attracting community mental health nurses is influenced by the fact that many of the people who go into community health come from in-patient areas, where they are already being paid higher than they would be if they went into community health. When I say higher, I mean that they have had access to penalty payments, which increase the level of payment that they receive. The moment they go into a community mental health environment they are, in fact, losing money.

Senator WEST—Does it take a particular sort of personality and individual to actually be able to cope and work well in the community, as opposed to being in an institution? I am not meaning that in any derogatory sense.

Mr Finn—Certainly in the community setting, where there are fewer immediate resources to draw from, community mental health nurses have to be far more flexible in their thinking, far more lateral in their problem-solving skills and far more able to work with an individual. They also must be able to recognise almost immediately what range of resources are available to them to draw from so they can offer a range of options in dealing with whatever problems present. It is often the case that on more complex issues they may have to consult with colleagues, if those colleagues are available. Obviously, for practitioners in rural and remote settings, that is not always the case.

Senator WEST—In the general area, Ms Betts, you said that community health nurses were coming in at level 2. How do they get appropriate and adequate training in community health issues to get the seniority and sufficient experience to get to that level 2?

Ms Betts—Because there is no level 1 entry point and there is not a standardised graduate program that includes primary health, it is extremely difficult to give people exposure and experience in the community setting.

Senator WEST—There seems to be nowhere to gain it that is community health oriented. They have got to gain it in the acute system, which is, from my recollection, somewhat different to the community health system.

Ms Cattermoul—I think that currently there is a range of ways that people can enter community health. For child health, you have to hold a postgraduate certificate in family and maternal child health—there have been a couple of courses. So you have to have an additional qualification.

Ms Betts—Usually midwifery as well.

Ms Cattermoul—Prior to the very recent changes, you had to be a midwife as well. A number of our staff would have very broad qualifications, would be midwives and would have child health experience. However, for other positions, particularly for working in schools, additionally we would be looking for a broad range of skills that would equip them to work independently, to draw on their resources, to respond to situations, to think things through and to be very determined about how they form decisions—and significantly, to understand the importance of teamwork and, I suppose, the context of the family. It is very much an empowerment model. It needs to be seen in the context of the community. Just to confirm, there are a couple of different ways, and one particular part of community health at the moment requires a child health type of qualification. That is what is currently being reviewed—we are just not certain at this stage what the outcome will be.

Ms Betts—That is a proposed diploma which will mix school and child health together so that at the end of that there is a set qualification for community health. But, as you quite rightly say, the experience is gathered in a hospital unless they have done community midwifery in another country, or something like that.

Ms Cattermoul—It could be a range of things. It could be in education forums. You draw from a range of experiences.

Dr Hendricks—Senator West, going back to your question about attracting graduates to the community health and mental health settings, last year at the nursing expo one health service had a display which 400 graduates came through. At least 60 of those were interested in our health service because there was a rumour around that we were offering a graduate program that incorporated community health. While the tertiary system offers minimal exposure to community and mental health, it is significant that 60 of the 400 people who came through our booth were expressing interest in going into community health. We have been looking at offering a graduate program in community health but the question stopping us from moving forward is this: what do we actually do with this person once we have put them through a graduate program? Fundamentally, we can employ only at level 2. At the moment we are thinking laterally about what we can do with a person who has done this program. Is there an opportunity for them to enter the community health area? In mental health they can still go and work in an acute setting as a level 1 mental health nurse. A community nurse cannot do that; they would have to return to the general setting.

Ms Cattermoul—The reason community nurses are on level 2 is the complex situation they work in, and they do work independently. That does need to be considered.

Ms Betts—As Michael said, you need a great deal of ability to think laterally, to problem-solve with people and give them options, and to deal with things like suicide and post-natal depression admissions, self-mutilation and domestic violence. It is not just weighing babies.

Dr Hendricks—I would hope that level 2 nurses everywhere would have that ability to think laterally. While they work within the acute setting they actually have more support services, but we would certainly hope that our level 2s are able to think laterally in relation to the care they give so that we are still able to sustain level 1 nurses who are supported by level 2s and 3s.

Senator WEST—How do you go about giving community nurses the level 1 experience and qualifications that are going to suit them to work as level 2s in community health? I recognise the need for them to be a level 2 when they are actually practising solo. It is not easy. Increased workloads and increasing acuity of patients across all fields of health care provision is an important issue. What is happening to the acuity level of your patients?

Mrs Gluyas—It is increasing, whether you are in the acute sector or the community sector. The community delivery of care is not just about promotion and prevention anymore; it is about patients who are going home from the acute setting who are still acute patients who need to be cared for in the community. That is often a forgotten point. It is definitely increasing.

Senator WEST—What stresses does that place on your community nurses?

Ms Cattermoul—We currently have two groups. What we call primary health or community health traditionally does have a strong focus on prevention and promotion. We are also very much looking at the seamless provision of care from the acute through to the community, so you will also have nurses providing care in the community but it is what I call clinical care. There is a range of different services.

Mr Finn—Certainly, within the mental health setting, a lot of the issues that are affecting community mental health practitioners relate to the increasing acuity and the co-morbidity issues that are occurring within the population that we service. We see huge problems with concomitant drug use, domestic violence and families at risk. The community mental health nurses are going in and often conducting quite complex risk assessments and making quite crucial decisions in respect of whether they are going to act to see somebody hospitalised. Hospital resources are diminishing. In Western Australia the population has increased, yet if you look at the number of available acute mental health beds you see that it has in fact shrunk enormously over the last few years. Whilst there has been a positive push to the community, the growth in population also needs to be serviced in other ways. As a consequence, community mental health nurses are often driven by knowledge of available resources: if there are no beds available, how can I manage this person in the community? The risk assessment practices that they are now undertaking are far more complex than they ever were in the past. The level of risk management that they are engaging in is far more sophisticated than it ever was in the past, and this leads to burnout.

CHAIR—I will not even talk about liability.

Senator KNOWLES—Ms Betts, I want to come back to the workload issue because I think it is an important issue that we have to look at. What is really causing the workload increase? Presumably, in places like the Swan district and other areas there are not extra beds so much as a greater demand on nursing time. Could you spell out how that extra workload is coming about?

Ms Betts—It is the fact of increased population with no increased resources, so you still have one nurse who is responsible for a given workload and, as the population increases, the workload will increase with that. Also we are looking at other programs that nurses need to do besides their screening—there are various programs, also they go home visiting. If we are changing their work practices, we are also increasing their load because as yet there has not

been a decision made as to what they will not do in comparison to what they will do. To a certain extent, people are still juggling what they can do.

If you have an increased population—you might have 250 births—that is a lot of babies, mothers and families. If you are looking at seeing them so many times per year plus you already have an active client load, are undertaking programs plus various other home visits that are related to the programs that you develop, that is where the problem lies because of not having adequate resources in the FTEs. As we were saying, it is not just the mums that they see, it is the rest of the family as well and it is any problems they have within it. There has been increase in the number of young people who are drug abusers, so it is the quality of the time the child health nurse can spend with people and even the clients that they see within the schools.

Senator KNOWLES—Ms Cattermoul, I want to come back to the place in your submission where you have options to make nursing a more family friendly occupation and strategies to improve occupational health and safety. Is this just a log of claims with the hope that something will be picked up? Is it something that has been put forward to the state government in a hard-core form? If so, have you received a response? What sort of feedback are you getting to that?

Ms Cattermoul—Certainly, with the family friendly options, the majority of those initiatives will be covered in the *New Vision, New Direction* document from the Department of Health. That was released fairly recently. We are at the commencement of looking at those recommendations and progressing them. Family friendly organisations and health services are not new concepts, it is more a challenge of what we can do at a local level and then what also needs to be supported at a higher level. I do not think anything there is new or radical. Our paper was very much an accumulation of a number of ideas that nurses put forward.

For occupational health and safety, a number of those issues would vary across different health services. We would have different groups looking at those, such as risk management and occupational health and safety, depending on how the health service is structured. For Swan a number of those issues have been identified. It is a question of what stage they are at, to progress them. Security, respect for nursing and safety of nurses have become increasing issues; I think they are national and international issues, and that has been well-documented.

Senator KNOWLES—So out of those 10 things for occupational health and safety, what have you achieved thus far?

Ms Cattermoul—We have looked at our emergency department as our entry point, looking at putting up a system of video monitoring for staff. We have had several workshops to identify the key issues and there are additional plans to look at screens and some other issues that have been identified and have been put forward in a report. We have identified the need to look at secure parking, but our complete health service site is structured in a way that it is open and not fenced in. This geographic or environmental factor is a major issue for us.

Senator KNOWLES—What are the incidents of trouble that you have had related to parking?

Ms Cattermoul—Break-in and things.

Senator KNOWLES—Is it the cars that you are looking to protect or is it the person going to the car?

Ms Cattermoul—I would say both. Obviously, if I had to have a preference, the priority would be for the staff member going to the car rather than the car.

Senator KNOWLES—One presumes, and not necessarily accurately, that that is more of a problem potentially at night.

Ms Cattermoul—Yes.

Senator KNOWLES—Is it also a problem during the day?

Ms Cattermoul—Not that I am aware of, no. Regarding the debate about dedicated security personnel, because of the size of our health service, we have looked at that at times of increased media focus—we had a time where our emergency department was closed and we actually did have security personnel for that period of time. Staff actually felt that, in general, it was not required. It is something that we should again look at.

Senator KNOWLES—This was on the weekends where you did not have doctors and you were on bypass?

Ms Cattermoul—Yes, that is correct. We had a period of time—about six weeks, I think—where we actually had to close, so it certainly reduced services. It was identified at that point that it had served its purpose and it would be something that we would review, but at this stage it probably would not be seen as a priority—certainly from my understanding.

We are currently reviewing where duress alarms and personal duress alarms are at. When we looked at the safety of the staff in the community, we looked at personal duress alarms and the use of the alarm as opposed to the skill of health professionals in being able to assess a situation, identify and manage situations, and remove themselves from those risk situations. Duress alarms certainly represent one strategy that would be considered.

Senator KNOWLES—What is the incidence of harm or threatened harm to personnel in recent times—say, the last 12 months?

Ms Burns—We have had an increase in the number of disturbed and aggressive patients through our emergency department since the opening of the Swan Valley Centre, which is a mental health secure unit as well as non-secure unit.

Ms Cattermoul—The Swan Valley Centre has some secure beds.

Ms Burns—Staff have been reporting an increase in the incidence of aggressive, difficult patients and people coming into the emergency department out of hours and being very disruptive and difficult to manage.

Mr Finn—Any hospital that has an emergency department is a magnet for untoward behaviour. We see the same thing at the Fremantle Hospital site where we have 40,000 occasions of service a year come through the emergency department—about five per cent of that is mental health related, and a significant number of those presentations involve behaviours that need to be managed, often with the use of security and/or police.

Some of the issues that have been recognised at our site have been addressed on a global scale using some of the guidelines that have been put forward in the UK model where there is zero tolerance, a national zero tolerance policy in respect to violence in health care settings. My personal belief, and this has been communicated within our own health care setting, is that there should be some form of national strategy to look at the growing problem of violence in health care settings and to adopt a similar position of there being funding available at a federal level to allow for education campaigns aimed at the public to alert them to the fact that aggressive behaviour in a hospital or health care setting is not acceptable; that nurses and other health care workers are not targets for aggression and are not the subjects to vent frustrations on for problems with the wider system; and to ensure that there is suitable training available within each of the health care settings to enable people to be provided with the skills that they require to deliver the services that they provide.

We do this with clinical practice. We accept that we have got to train people adequately to deliver the sorts of services that they are required to provide. Yet, with a very apparent problem such as workplace violence, there is a mishmash approach and in Western Australia alone there are God knows how many different approaches in terms of the different local environments—some are very good, some are not so good, and some are totally absent. There is no coordination either at a state or a federal level.

Ms Burns—Due to the shortage of mental health beds, sometimes we find the situation where we are nursing patients that should be admitted to the mental health section of the hospital but are actually nursed in the medical ward. The incidents of threats of aggression against staff and physical assault on staff has increased and it is becoming a major problem for us.

Mrs Gluyas—That is so at our site as well. We have a policy of zero tolerance and we say, 'If they're not mad, they're bad', and we will charge you. But our problem is that the nursing staff then have to go to court and, when you live in the local community, that is a very threatening thing and often the girls will not charge them. We are negotiating at the moment with the police force to have us as an institution charge rather than the staff member charge, but that is a long process. But that issue can be extremely threatening.

Mr Finn—I can cite a particular example that occurred in our health service recently where a community mental health nurse went to conduct a home visit with a patient who was well known to the service and very low risk. Most mental health nurses in the community operate independently; they do not go in pairs. It is just not economically viable or clinically required and this particular nurse went to this person's home, as she had done on many occasions in the past, and a visitor to the premises threatened her with a knife, bailed her up, held the knife to her throat and kept her there for several hours till she was able to extricate herself. She made her way out of the place. We contacted the police. The police were disinclined to take action. In fact, when the nurse went with an advocate from the health service to the police station to lay a

charge, because they are required to make the complaint themselves, the police were unwilling to pursue the complaint because it was a 'nutter'.

Senator KNOWLES—So even those people at such high risk do not have duress alarms?

Mr Finn—With community mental health nurses, it is getting a good system which would protect them. For example, all community mental health nurses have a mobile phone—whether they are in an area that they can operate the phones or whether they are in a circumstance that would make it reasonable for them to operate the mobile phone is another thing entirely.

Senator KNOWLES—If you have got a knife being held to your throat, you are not inclined to say, 'Just a minute. I just need to make a quick phone call.'

Senator WEST—You are not going to be able to push the duress button either.

Mr Finn—And duress buttons are dependent upon there being a system in place that allows them to operate. Within hospital settings, it is not quite so difficult because you can have a hard wire system or you can have a remote system and you can have all of the technology incorporated into the building space. But, the same thing is not available within the broader community.

Senator KNOWLES—Finally, can I move onto some of the these other areas mentioned—that is, adequate staff to patient ratios to reduce manual handling injuries, intact equipment and lift and turn teams. What has been happening with all of that? I thought that all came in with the ark almost. Inadequate as it might be, I thought all of that was in place.

Mrs Gluyas—We have a no-lifting policy at both our institutions so, if the patient cannot move, they are not lifted. We use aids to lift them, but that is resource intensive and you have to have commitment from management to make sure that they are readily available because, when people are very busy, given the choice of having to walk and wait for the hoist to lift the patient, they will lift the patient. So you have got to make sure you have enough of those available and that people are trained in their use and that you really enforce the no-lift policy.

Senator KNOWLES—A lot of technologies have improved that, though, haven't they?

Mrs Gluyas—Sure, absolutely, but it has to be available and it is expensive.

Senator WEST—It is still quicker, isn't it, for two of you to get there and do a shoulder lift?

Senator KNOWLES—What I mean is not necessarily a hoist but people being wheeled from their room into theatre on the one cot and stay there and go back—all of those sorts of things.

Senator GIBBS—It is very skinny. You do not want to move or you can fall off!

Senator KNOWLES—That is why it is better to stay in your cot.

Mrs Gluyas—Even so, that still requires training. You have to make sure that the staff are pushing not pulling, that the cots are ergonomically sound to go around corners correctly, that they are well maintained and that the wheels are not sticking.

CHAIR—There have got to be doors wide enough.

Mrs Gluyas—That is exactly right. There has to be a commitment right across the whole health service to safety with manual handling and moving patients.

Dr Hendricks—Swan Health Service spent a considerable amount of time and energy dealing with manual handling issues at our health service, particularly within the hospital. What we found was that, despite having a no-lift policy and management commitment and sound equipment, our nurses were noncompliant. We then conducted focus groups with all our nurses and what we found was that, while they had a commitment to all of the issues that we had put in place and while they were aware of the policies, it came down to the fact that they found it difficult to say no. When a patient needed to be toileted and they could not get help because there were only three on at that time—because the other three were at lunch or at morning tea—they could not say to the patient, 'No, wait.' I would not want to wait either, if I needed to use the commode. They would then attempt it. So what we found was that they were noncompliant, and they were noncompliant because they felt they could not say to the patient, 'Wait a few minutes.'

We have been spending a lot of time working with them about the nurse having the right to say no. And that stems back to issues that were talked about in terms of the patients becoming more aggressive. It is not just mental health patients that we have difficulty with; it is the normal, run-of-the-mill Joe Bloggs who comes into hospital, who has waited for four hours to be admitted—and they are pretty irate anyway and they are stressed.

Senator GIBBS—You all talk about methods of retaining nurses—education, improved wages and conditions, that sort of thing. What is the main problem: attracting nurses into the profession or retaining them once they are there? Or is it a combination of both?

Ms Cattermoul—It is a combination of both.

Dr Hendricks—It is a combination.

Mrs Bishop—The biggest retention problem is with the new graduates when they come out of their tertiary programs. I do not know what the figures are, but the drop-out rate in the first few years is fairly high. They are disillusioned, there is not enough pay—all these issues which have been brought up. They go off and take a career change.

Senator GIBBS—So one of the main problems is that you are simply not paid enough and you are not paid for the training that you have; that is further educational, university studies, all of this sort of thing.

Ms Cattermoul—In our current agreement, some of those issues were looked at. We did look at bringing our new graduates in at a different increment level so that it was more in line with graduates in other areas.

CHAIR—What is the average beginning wage for a nurse, first year out?

Dr Hendricks—About $32,000.

Mr Finn—That is a full-time rate. One of the problems that we have created for ourselves as employers is we barter. We actually drive people down. We do not give them full-time jobs; we give them seven-hour shifts or six-hour shifts.

Senator GIBBS—Did you say as employers or as employees?

Mr Finn—As employers. Most of us are employers. We employ nurses; we employ new graduates; we employ new recruits. And some of the things that we do in our own management practices actually drive people away from the profession. But some of these things are actually imposed on us. We are encouraged to keep our total staffing establishment at certain levels. We are encouraged not to, perhaps, employ people for a full eight-hour shift—7.6-hour shifts, seven-hour shifts or six-hour shifts are acceptable. These are the things that people do not want. I recently had a nurse who refused a job at a country hospital because it was the difference between a 76-hour fortnight and an 80-hour fortnight. Now that is dumb. If you have somebody who wants to go and work in the area, what is the difference in paying them an extra four hours? That is an attractor; that is an incentive for people to want to come to you. It is an attractive incentive for people to want to stay if they are treated reasonably. Some of our management practices are not good.

Senator GIBBS—Excuse me, before you go rambling on here, you are saying that this particular country place wanted to give her 76 hours and she wanted 80—or is it the other way around?

Mr Finn—She wanted 80 hours, which is what she was enjoying in her current position.

Senator GIBBS—Was she being paid by the hour?

Mr Finn—No, that is her contracted employment.

Mrs Gluyas—For a fortnight, not for a week.

CHAIR—We are pleased to hear that. What you are saying is that the circumstances that the employer was prepared to offer her—76 hours—meant she would effectively be taking a salary cut.

Mr Finn—Exactly.

CHAIR—So she was saying, 'No way.'

Mr Finn—She was taking her business elsewhere.

Mrs Gluyas—I have to say that is unusual. Most of us who are in the situation of employing want anything. If someone is willing to come and work four hours a day we will take them. If

they want to work eight hours a day we will take them. The majority of us are very flexible. If they want to do 10-hour shifts over three days for 30 hours and that fits in with the needs of the ward then, absolutely, we will do that.

CHAIR—You do not have a capped amount for salaries?

Mrs Gluyas—Yes, we do. We have a capped establishment, of course: you have to run within a budget. But not many of us are at establishment.

CHAIR—That is a very important point. How far below establishment are you?

Mrs Gluyas—I am about seven per cent below establishment, and I have to backfill with casuals and agency.

CHAIR—Are others below establishment?

Mr Finn—I am actually at establishment. I have been at establishment for quite some time. I have got zero agency use, and I have a fairly stable work force.

Mrs Bishop—That is one specific area.

Mrs Gluyas—And it is unusual.

Dr Hendricks—It is unusual.

Ms Cattermoul—I think it is important to make the point that it does vary. We also have a fairly stable working force, and we would probably be somewhere between two to four per cent with our vacancy rate. But I do state that we present one picture; there will be other hospitals that would have a much higher vacancy rate.

Senator GIBBS—With retention, there are quite a few things here that you all suggest. One suggestion is that you expose undergraduates to clinical areas within the first six months of the particular course that they are doing, and I guess the idea of that is for them to look at the different specialty areas.

Mrs Gluyas—It is to see if they want to be nurses or not. If they are not exposed early, they have no idea of the reality of the workplace, and, if that exposure does not actually reflect the reality of the workplace, when they come out at the end of their three years they actually do not want to be a nurse.

Senator GIBBS—When they come out at the end of the three years, they actually go into the wards and it is hands on.

Mrs Gluyas—Yes.

Senator GIBBS—So if they go into the wards in the first six months and carry out someone's dirty bedpan and all these sorts of gross things—I have two sisters who are nurses so they tell

me everything; it is revolting, although one is a theatre nurse and she just loves it—they find it is not for everybody, don't they?

Ms Betts—People these days are using it as a first degree because they realise at the end of it they do not want to be nurses. They do not want to waste that so they will use it as a first degree and then go and do a grad. dip. in something else.

Senator GIBBS—Has this actually been suggested to the educational institutions?

Dr Hendricks—We have had discussions with them, but the universities are reluctant to put them out in their first year. Firstly, it increases the amount of money they need to spend on clinical placement and, secondly, the argument is that these are brand-new people who know nothing about nursing, so what are they doing in a hospital?

Mrs Gluyas—Several of the tertiary institutions are actually putting them out much earlier, and one in particular is putting them out earlier for a much more extended time and they are going to the same hospital, where possible, so they are actually getting institutional loyalty, which makes a huge difference. They are getting exposed early to the culture. One university has responded very well, and one of the others has also changed its courses to put them out earlier.

Senator GIBBS—I know that not many people want to go back to an apprenticeship in the way it was before, but isn't this an argument for a combination of the apprenticeship and the university studies?

Mrs Bishop—No; I speak from the education point of view—that is my area. One of the problems with the old apprenticeship system was that the students were part of the work force. Work had to come first, and learning and understanding came a poor second. With the current format, if they are going out very early—and this is one of the reasons that the universities do not like them going out early—they do not have that theoretical basis before they actually are exposed to the patients.

Senator GIBBS—I understand what you are saying, but I do not think you quite understand what I am saying. I am not suggesting that we go back to the old way. What I am suggesting is a merging of both. Maybe when they are accepted into university but a couple of months before they go they could actually go and do work experience—like a lot of the kids do today—to find out whether or not they might like to work in that job. Could there be some way that this could be fitted in very early in the piece, before they go and do the studies which will enable them to be nurses? Because they could study something else.

Dr Hendricks—There are a number of methods that we can look at to combine a university education with hands-on training. I think that, as nurses who work both in the university and in the hospitals, we probably need to look at it quite laterally. Certainly in America there are a number of models that have been suggested in a report that I am looking at. It talks about a number of things; for example, work experience—a year 12 student could be put into a hospital for three months for exposure, and then they could go on to do the course. A number of our private hospitals in this country—Mayne Health, for example—are forging relationships with universities. Mayne Health is forging a relationship where the final clinical placement in the third

year will be in a Mayne Health hospital—the outcomes they have to achieve in their final year of clinical placement will be achieved in a Mayne hospital, and they will be paid through that third year. So they are looking at very interesting strategies to get nurses into their system well before they are registered.

Senator GIBBS—Yes, and then they actually really want to go. But—

CHAIR—We are running out of time so this will have to be the last question, Senator.

Senator GIBBS—I have only got one more question. You also talk about fee-exempt postgraduate courses. Now, as everybody suggests, there is no such thing as a free lunch. If postgraduate courses are free to nurses then other professions will say, 'Hang on, I think I am pretty important too.' If you did that, would it be saying, 'I am a postgraduate nurse—I will go and get my further degree and then I have to work within the industry for so many years,' thereby virtually paying it back? Is that the sort of arrangement you want, or is it just a straight-out 'give it to me free' arrangement?

Dr Hendricks—I think that nurses would look at a number of ways of doing that. Certainly, in the old days, when I registered as a nurse I got a scholarship for $5,000, and part of that was that I had to go and work at Royal Perth—that is, I kept my $5,000 if I did my training at Royal Perth. The other thing to note is that most of the postgraduate nursing courses are full fee paying, which means up-front payment.

Senator GIBBS—Which is very hard.

Dr Hendricks—Yes. Perhaps some of the courses could even be given the option of being HECS paying, which you could defer. If DEETYA identified emergency nursing, mental health or community health, for example, as chronic deficit areas then possibly the first option, as you suggested, would be, 'Yes, this will be a free course because it is an identified shortage area, but you will contractually work in this area to repay your debt.' I think we need to look at a number of ways because fundamentally the nurse wants to be paid—most of us have children, mortgages and cars.

Senator GIBBS—Of course—we all do.

CHAIR—We are out of time, so I would just like to put a few questions to you very quickly—sorry, Senator Gibbs, but this concerns a terribly important point.

Senator GIBBS—That is all right.

CHAIR—Could you provide to the committee evidence of the wage disparity between aged and acute care nurses? Is that something you can easily provide to the committee? Somebody can. Thank you very much. We will not take much time on it here, but I presume a lot of you would know what has happened in Victoria where increasing challenges to get nurses into acute care meant that there was a very big drain from the aged care area. One of the matters causing that was wage disparity.

A number of people, particularly Senator Knowles, have talked about occupational health and safety. Can you tell me of any evidence you have or could provide to the committee on notice about needle-stick and other than needle-stick injuries or cuts? We have had other evidence provided to the committee about the increasing importance of this and, in particular, that in a hospital situation it may be a different challenge from that of people who are, for example, trying to inject the aggressive psychiatric patient with some kind of calming encouragement in the community.

Senator KNOWLES—Part of that on notice, if you would not mind, Madam Chair, is the incidence of usage of retractable needles—utilising new technology.

CHAIR—Thank you, Senator Knowles, and whether that makes any difference. Two other things. I note in the Rockingham Kwinana submission that it states:

The Nursing profession has not embraced new information technology.

That is a pretty bold statement. I do not really want to ask you to tell me now because we are so out of time, but a lot people would say one of the problems being a nurse now is that they do nothing but high technology; they are forever sitting inputting information if they are the ward—I do not know what you now call them; I used to call them matrons or sisters—head. The head honcho nurse in the ward spends a lot time at the computer and not doing patient care. Is this not the situation in Western Australia?

Mrs Gluyas—I do not believe so.

CHAIR—So there is still a big need for information technology for nurses in this state?

Mrs Gluyas—Absolutely, both for them to use and for them to access information that is available.

CHAIR—Good point.

Mr Finn—The health department has recently introduced several initiatives into the hospital system for the provision of clinical information to nurses. So it is not just a case of sitting at a terminal to complete paperwork. If you want to access pathology results—we have just had radiology results put online—or if you want to extract clinical information on patients and interrogate databases to know something about management of patients—

CHAIR—So we are actually in the transition phase, but if there is anything you could offer that would expand that—again I know you are frantically busy; not a PhD thesis or even a page, just some line points if that is adequate—that would really be helpful. Whether that needs to come in at the undergraduate level, we are particularly looking at the Commonwealth's responsibility area here. Of course a lot of that goes into where the state working conditions and so on prevail, but if it is particularly a Commonwealth expenditure—for example, access for nurse students in their undergraduate courses or even postgraduate—that would be helpful. It is probably not so relevant now, but if you were bonded as a student nurse to then serve at Perth Hospital what would happen if you went and worked in South Australia—nobody would chase you to pay back your bond?

Dr Hendricks—I had to pay back the bond. That was part of the contractual agreement, that I was bonded there and if I chose not to be bonded there—

CHAIR—You had to pay it back. Did they ever come after you if you went to South Australia?

Dr Hendricks—I do not know because I did pay it back.

Mrs Gluyas—You need to ask that next question of Beryl who actually knows the answer to that.

CHAIR—Excellent, thank you very much, that is a good point. I hope they remember the question because I might forget to ask it. Importantly, too, I would love to know if you know or perhaps we should ask the next witnesses the wage disparity between Western Australia and other states and if there is a suction towards the east coast. It is all too far, is it, over the Nullarbor?

Dr Hendricks—I do know of nurses who are flying to work agency in the east on a 14-day fortnight. So they are working three or four days here, flying on the cheap flight to Melbourne and working four or five days in Melbourne for the $265 an hour that they can get.

Mr Finn—How much?

CHAIR—$265 an hour!

Dr Hendricks—That is in certain places in Victoria. In five days they could earn $1,400, so a $399 flight is not significant.

CHAIR—We must ask what these nurses are doing and where.

Senator WEST—It is all legitimate.

CHAIR—You mean they are not working as massage parlour workers!

Senator WEST—No, they are working as RNs.

CHAIR—For $260 an hour?

Dr Hendricks—Yes.

CHAIR—Thank you for that; that is a very helpful addition to my knowledge.

Dr Hendricks—It has been in the newspapers.

CHAIR—Notwithstanding all that, it is must have been one of those items in the newspaper that I missed.

Dr Hendricks—It got in and we were asked whether we wanted to go.

CHAIR—In just over 100 years or more we have worked very hard to get wage justice and reasonable conditions for people so that things like 12-hour shifts are an absolute thing of the past. Is it your experience in your areas that they are back again?

Mr Finn—Yes.

Mrs Gluyas—Yes. Often the only way we can cover is for people to double-shift.

Senator GIBBS—That is detrimental to people's health.

Mrs Gluyas—I know it is backward but what else can you do when you have a ward full of patients and you have rung every agency and every casual and every person who is off duty? All you can do is go to the ward and ask them, 'Does anyone want to do a double shift?'

CHAIR—Do they get extra penalty pay for that?

Mrs Gluyas—Yes. But if it is going from an afternoon into a night people are doing a 10-hour night, so that is 18 hours.

CHAIR—It would seem to be particularly ironic that nurses, who are promoters of good health, should actually be practising poor health for themselves.

Ms Burns—That is right.

Mrs Gluyas—It is almost becoming the accepted norm, and that is the big worry.

Senator GIBBS—No wonder they are leaving the profession.

CHAIR—Somebody said, in answer to a question from Senator Gibbs, that one of the reasons you would have a case for early exposure in the clinical sense in your first year would be to see whether people fainted at the sight of blood and whether an absolute throw-up into a bedpan was the way of the future—whether or not little opportunity to test that has anything to do with disillusionment two or three years out. Is it your experience that the reason people are disillusioned two or three years after they have graduated and gone working is that they really did not know they wanted to be nurses beforehand? Or, has it more to do with 12-hour shifts and not too good pay?

Mrs Gluyas—It is reality.

Mr Finn—To have a clinical in undergraduate programs, you have to look at the intake criteria for nursing studies. Many students who come into nursing come in for the wrong reasons. Where in the past there might have been an interview process where you actually identified candidates for nursing training, the universities have now taken carriage of that responsibility and whether or not somebody chooses a particular course is often driven by how many points they got on their TE or TER score. Later, down the track, they discover this is not the course for them.

CHAIR—How many nurses do you know are in the wrong place because of that reason?

Mr Finn—Having taught in undergraduate programs, I know what the attrition rate was like.

CHAIR—What was it?

Mr Finn—About 10 per cent of people did not want to be nurses.

CHAIR—This is in the first year?

Mr Finn—Yes.

CHAIR—That is very useful, and we will follow up that one too.

Ms Cattermoul—For us, I do not think the norm would be 12-hour shifts. I do know, though, that in some specialist areas they have looked at 12-hour shifts and I think that has been seen as desirable by the staff. I think that needs to be the counter to the fact that 12-hour shifts are things of the past. There are some specialist areas, probably such as intensive care, where you will possibly see 12-hour shifts.

Mr Finn—We certainly have one area where the staff elected to go onto a 12-hour rota.

CHAIR—Some people do that because it means that they get a 3½ day weekend or something like that.

Ms Cattermoul—Exactly.

CHAIR—But sometimes people do need to be protected from their own best wishes. We are behind so I hope you do not mind taking those questions on notice. Thank you all very much for being bothered to give us submissions and for coming here today.

[11.47 a.m.]

COSGROVE, Ms Beryl Kathleen, Senior Nursing Officer, Principal Nursing Adviser's Office, Department of Health, Western Australia

PINCH, Ms Caroline Augusta, Project Officer, Principal Nursing Adviser's Office, Department of Health, Western Australia

CHAIR—Welcome. The committee prefers all evidence to be given in public but should you wish to give your evidence, part of your evidence or answers to specific questions in camera you may ask to do so and the committee would give consideration to your request. I have to remind you that the evidence given to the committee is protected by privilege and any false or misleading evidence could constitute a contempt of the Senate. You are not required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy. I now ask you to make an opening statement and then field questions.

Ms Cosgrove—Dr Phillip Della sends his apologies. He is in the eastern states this week chairing the midwifery labour force working party. Their document is due early June, so he has got a three-day meeting sorting that out. We have provided you with our statement and with copies of documents that we think will be of interest to the committee.

The Principal Nursing Adviser's Office has recently concluded a major study into nursing in Western Australia. Consultations were conducted throughout the state and discussions were held with over 1,000 nurses. A copy of the report has been given to you at the inquiry. There are a number of areas covered in the report and an overview of the findings is as follows—

CHAIR—We have all got a copy of that. Can you skip through it rather than read every word? Is it the wish of the committee that the statement be incorporated in *Hansard*? There being no objection, it is so ordered.

The document read as follows—

STATEMENT ADDRESSING THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO NURSING

The Principal Nursing Adviser's Office has recently concluded a major study into nursing in Western Australia. Consultations were conducted over the state and discussions held with over 1,000 nurses. A copy of the report is available for the inquiry. There were a number of areas covered in the report and overviews of the findings are as follows.

The major issues raised by nurses:

Staffing levels

This emerged as a central theme which nurses saw the increasing workloads, reducing the ability for nurses to provide quality care to patients, thereby decreasing job satisfaction. Addressing the issue of staffing levels requires a coordinated approach as this multifaceted issue has implications for all health industry staff. Staffing levels included staff mix and utilisation of the workforce, the major concern for the aged care nurses was seen to be the delegation of work to non regulated workers.

Working Environment

The decreased participation rates of nurses and midwives in the permanent workforce were linked to the conditions of employment. Nurses are choosing agency and casual employment options which provided flexible working hours, days of work and reduced involvement in extra curricular activities such as quality improvement. These issues need to be addressed on a system wide level and include the adoption of family friendly principles.

Workplace stress

Nurses in this study reported that workplace stress had increased and this was associated with the lack of equipment, decreased resources available and inflexible management practices. It was reported that flexibility in employment options in terms of roster selection and days of employment are required. Work place stress cannot be viewed in isolation and associated issues identified included increased patient throughput, staff turnover, staffing levels, skill mix and increased application of medical technology.

The current age profile of nurses is around 42 years of age and nursing employment conditions have been geared to this workforce. In order to attract and retain nurses for the future, new approaches to employment must be developed. The younger generation of nurses have identified the need for decreased job stability and increased employment flexibility.

It is a concern to nurses themselves the high utilisation of agency staff as this impacts on the continuity of patient care and increases the workplace stress for permanent staff, as agency staff competency maintenance is in question.

Child care

Many nurses identified the need for flexible and affordable child-care, this included after-school and vacation care. Childcare initiatives raised included the use of childcare coordinators to assist in accessing childcare and health service sponsored vacation care.

Support

The need to provide support for non-nursing duties especially after hours was identified as a barrier to providing quality patient care. Support in terms of clerical assistance especially after hours when nursing staff numbers are reduced.

Culture of silence

Nurses have felt disempowered when faced with an adverse incident or error. It has been reported that the current culture of health care has been to conceal these events from patients for the purposes of protecting reputations and minimising risk of litigation. The impact on the professional integrity of the nurses has been to leave the workforce. It is imperative that quality improvement systems and incident monitoring processes provide a means for nurses to contribute information based on their unique perspective of processes of health care delivery.

Career Structure

The current West Australian career structure does not meet the needs of the workforce. The career structure has been eroded since its inception and does not reflect the original intent. The work of nursing today requires an educated workforce that can cover a number of emerging specialties. Nurses with clinical expertise wish to be acknowledged and the enhanced role midwife and nurse practitioner roles recognise and value the clinical expertise.

Aged Care Workforce

It may be significant to mention the difficulty in attracting nurses into the aged care sector. The workplace has become more acute in recent years with nurses dealing with advanced technology and difficult clients without adequate material resources, decreased staffing levels and increased number of unregulated workers with no basic education requirements.

The wage disparity between the aged care sector and acute care, coupled with the poor image of the sector, makes recruitment into aged care very difficult.

Rural Sector

The major issues for the rural sector included the perceived inequity of conditions of employment with other rural workers such as police and teachers. The issue of accommodation for nurses was raised at every venue. Many health services accommodate nurses in quarters or shared accommodation. Nurses reported that they were unable to have friends or family to stay or have pets.

Isolation caused by distance from basic social and commercial amenities caused concerns of professional isolation due to lack of access to transport and communication technology.

Education

The major issue identified within the education portion of the study was the need for an effective and supported postgraduate transition period. Graduate programs vary in length and content and are carried out in a variety of settings. However what has been identified is that the quality of the experience has a direct relationship with the retention of these nurses within the profession. New graduates identified that the major influencing factor on their transition was the support and competency of the preceptor. Preceptors on the other hand raised the concern that this role added another burden on the already stretched nurse's workload without compensation and reward. This role does not receive the recognition and value that it deserves considering it will influence students to continue with nursing as a profession and new graduates to remain in the profession.

Preceptor nurses need to be rewarded appropriately not necessarily in monetary terms but recognition for the value of the role. These nurses must be educated to enable them to carry out the role effectively and given time in which they can carry out the clinical teaching role to meet the individual's needs.

Undergraduate Education

Nurses overwhelmingly responded to the need to enhance undergraduate clinical experience. Nurses felt that a better model for clinical experience was required to ensure that the undergraduate students received the best clinical experience. The number of clinical placements are reduced with increasing numbers of undergraduate students, it was therefore seen that utilisation of the calender year for clinical placements would allow greater flexibility.

Student numbers in Western Australia (WA) have been enhanced by the successful marketing campaign "Are you good enough to be a nurse". In January 2002 of the 1,669 students who choose nursing as a preference, 588 students were of-

fered nursing places in WA universities. Of those who missed out 1,081 students 668 applicants listed nursing as their first preference. Total number of nursing students nationally has declined between 1994 – 2000. The Department of Education, Science and Training's report on Nursing Education 2001 states that WA shows a steady increase in the number of enrolments over the past 3 years and projected a 17 percent increase from 2000 - 2001. WA has surpassed expectations and achieved a 22 percent increase. Given that WA has a growing population, additional funded HECS places are required to meet the increase in demand. WA has a lower number of funded places than South Australia, which has a smaller population. Attraction of undergraduate students is important but unless the clinical placement, graduate transition and preceptor issues are addressed, retention of nurses in the profession will remain a problem. Considering the cost of clinical education a coordinated approach is required to address the retention issues identified in the New Vision, New Direction Nursing and Midwifery study.

Retention issues are further highlighted with the increase in registrations on the Nurses Board of WA, a steady increase in the last 5 years (1996 - 24,262, 2000- 25,636) but the average age of a nurse continues to increase demonstrating the lack of participation of younger nurses in the workforce.

While funding of undergraduate places and health industry are allocated from different sources, partnerships developed will ensure that a coordinated approach to clinical placement and graduate transition occurs.

Postgraduate Education

Postgraduate education raised concerns for the nursing profession. Many saw that gaining further qualifications did not increase their earning capacity in proportion to the investment made. This was especially the case for rural nurses where the costs are increased by distance and the need to relocate during the education course.

It has also been demonstrated that in order to attract nurses back into the workforce, fully funded refresher and re-registration courses are required. As a cost benefit analysis this is a cheaper, faster option than the undergraduate process. If retention is to be successful then these courses need to be coordinated and supported.

Enrolled Nurse Education

The enrolled nurse workforce has long been dissatisfied with the award allotted to enrolled nurse education. Along with the qualification awarded this section of the workforce reports that their skills are under utilised. Considering the workforce shortage enrolled nurses' skills and competencies require a comprehensive review. The WA Principal Nursing Adviser has commenced the process to review this part of the workforce.

Scholarships

The Department of Health has allocated a number of scholarships for clinical specialisation as an attraction strategy. This initiative requires substantial funding.

Ms Cosgrove—The major issues raised by the nurses were, first, staffing levels. Nurses are very concerned about the increasing workload and increased use of agency staff. They are also concerned about their working environment, and the previous group did discuss some issues about rostering. Nurses are very concerned about the inflexibility of rostering. The inflexibility of rostering is an issue that is actually driving nurses from the work force. Workplace stress was identified by the nurses across the state.

I would like to add that the 1,000 nurses who were surveyed were in all metropolitan areas and all across the rural area of Western Australia. Carol Pinch was the project officer, and she travelled through Wyndham, Kununurra, Halls Creek, Derby, Fitzroy Crossing, Broome, all the way down the coast as far as Esperance and as far east as Meekatharra. So we got a very good cross-section of nurses and Carol did focus groups with those nurses and came back to Perth with the information.

As highlighted by the previous witnesses, stress is caused by a lack of adequate equipment, whether it be monitoring equipment, especially in the rural areas, or whether it be equipment to ease their workload in the form of appropriate lifting mechanisms or bathing facilities. They saw a lot of their inflexibility in management practices in looking to purchase equipment and making the workload easier. Rural people said the isolation of where they worked caused them a lot of stress and they identified areas where their staffing turnovers, especially in the northern part of the state, are greater than anywhere else and their stress levels could be deemed to be higher.

As you are probably aware, the current age profile of nurses is around 42 years and I was a wee bit shocked when they said they had an ageing population of 50.8 years in the Swan Health

Service. I nearly fell off my chair. I thought, 'Oh my God, this is terrible.' As the nursing work force is 42 and the midwifery work force is about 45 and the mental health work force is about 48 to 50, there is a concern about how we are going to retain younger nurses in the work force for the next few years. Younger nurses are looking for increased employment flexibility; they are not actually looking for job stability. They are quite happy to move from job to job as long as they can get the conditions that they want.

Child care was also identified as a major issue. We are going to be doing a review from our *New Vision, New Direction* document to ascertain what family-friendly initiatives have been implemented across the state and then look to come up with some alternatives for people to implement.

Nurses saw that, with budget cuts, support services to nursing were removed; a lot of clerical after-hours support was taken from the ward areas and nurses were expected to pick up those clerical roles. A lot of cleaning type services may have been reduced from the areas, so that when there were spills that needed addressing nurses had to stop doing patient care to take care of those other issues that arose.

A big issue that came to the front was the culture of silence within the health industry and that nurses are intimidating nurses—we eat our young. Nurses are intimidated by other health professionals. Especially if there has been an incident that has had an outcome that is not satisfactory, nurses are intimidated into not reporting it or into keeping quiet about what the incident may be.

CHAIR—You eat your own young and are eaten by other professions?

Ms Cosgrove—Yes.

CHAIR—Particularly the medical profession?

Ms Cosgrove—Yes.

CHAIR—I need to get the diets right.

Senator GIBBS—We need to think about that.

CHAIR—I think we are aware of it, but it is a very interesting point because it has not come up to this point.

Ms Cosgrove—There are some people in the nursing industry who will tell you that there is no such thing as intimidation in health, but it is alive and well.

CHAIR—Two of us are alive here to say that we know about it.

Ms Cosgrove—In the late eighties, we had a career structure introduced into the Western Australian health care system, and over the last 16 to 18 years it has been altered and the career structure does not reflect what it was meant to reflect when it first came in. That needs to be re-

viewed, because nurses and midwives feel that they are not being valued for their clinical expertise and input into health care.

As to the aged care work force, the aged care sector is having great difficulty in attracting nurses to the work force. We think the wage disparity is probably about 16 per cent at the moment. A lot of aged care facilities are currently renegotiating their pay with the ANF and some aged care providers have a concern that all the ANF is doing is picking components out of the enterprise agreement 2001 for public sector nurses, putting it into the aged care sector and perhaps not looking clearly at what they are trying to do. One of the specific issues is the nursing hours per patient day decision that was handed down in February. Some of the union representatives going out to work sites are trying to impose the same sort of nursing hours per patient day into the aged care sector, so the aged care people this afternoon may make some comment about that.

CHAIR—Nursing hours per patient day; is this a new—

Ms Cosgrove—We call it nursing hours per patient day, whereas in Victoria they called it nurse-patient ratios. We did not want to go down the track of saying that for every six patients you must have one nurse or for every four patients you must have one nurse. We are saying that, if a patient requires x number of hours per day, however many hours add up will require a nurse. So, if you have three patients who require 16 hours of nursing a day, you provide the number of nurses to accommodate that care.

CHAIR—Three 16s are 48—is that two nurses?

Ms Cosgrove—That is just pulling figures out of the air.

CHAIR—What is a nurse day? Is it eight hours?

Ms Cosgrove—It is 24 hours a day, so you look at it over the 24-hour period.

CHAIR—So if three patients needed four hours of care each that would be half a nurse?

Ms Cosgrove—It could be about half a nurse. But there are areas like intensive care where you will have one nurse to one patient because the patient requires care 24 hours a day. There will be different nursing hours per patient days required for different patients. In one ward you may have one nurse looking after two patients, but you may have another nurse looking after four or five patients, depending on the amount of care that is required for those particular patients.

As I have already indicated, the rural sector is under great stress at the moment. The South-West is not as bad as the North-West. The South-West does not have a huge nursing staff turnover and does not have a large usage of agency staff. The Pilbara and the Kimberley have a very large usage of agency staff with large turnovers, and some of the Kimberley's smaller hospitals have as high as a 90 to 100 per cent nursing turnover. The only person who may be permanent and has been in the organisation for more than six months may be the director or manager of nursing health services. Isolation is a factor in nurses not going into those areas to work or to seek permanent employment because basic social and commercial amenities are

lacking. Often there is no transport for the nurse to leave town and communications technology is not always available within the nurse's workplace.

Education has been identified as a major issue. As has already been identified by the previous witnesses, a lot of nurses feel that their graduate nursing education should be given to them free of charge. There is only one graduate nursing program that a nurse requires to practise in his or her field, and that is one in the field of midwifery. To enter division 1 of the register of the Nurses Board of Western Australia to be a midwife, you must have done a graduate diploma in midwifery or a master's in midwifery. All other graduate nursing programs do not require registration with the Nurses Board. The graduate programs that we have running through the universities at the moment actually provide for the student to spend one or 1½ days at the academic institution. The nurses doing their clinical specialty courses are paid at level 1-2 in the ANF nurses agreement. This year the midwives have also had that given to them. That was not given to them prior to this new agreement.

CHAIR—Can I interrupt for one small piece of information. You say the nurses would like to do their postgraduate course at no cost. Would they settle for a HECS course?

Ms Cosgrove—I think they would probably settle for a HECS course, but there is still the feeling out there that as we are nurses and are 'special' we should not have to pay for postgraduate education.

Ms Pinch—A lot of nurses are quite happy to undertake postgraduate education. The problem with paying for up-front postgraduate courses is that there is no remuneration for having done them. Apart from midwifery qualifications, if I complete my master's degree I will not be getting any further remuneration next year because I have that, and there is no opportunity for me to increase that level of earning capacity.

CHAIR—Thank you. We will probably come back to that at questions. I just wanted to be clear about what was meant by what you said, Ms Cosgrove.

Ms Cosgrove—Undergraduate education: industry and the universities are aware that we have a problem with the way education is being delivered to undergraduate nurses at the moment. Nurses working in the work force think that the undergraduates require more clinical experience and better clinical experience. The number of clinical placements available within the hospitals is decreasing because of the increasing number of undergraduate students that we are taking into our universities. We have actually filled all our positions this year in the three universities in Western Australia. We actually had 668 applicants who listed nursing as their first preference and did not get into a program.

Senator WEST—How many places do you offer?

Ms Cosgrove—There were 558 places offered to students in nursing universities this year.

CHAIR—And we are talking about 668 over that?

Ms Cosgrove—Yes. We had 1,669 students who chose nursing, and only 558 could be taken into the programs. Now we actually require more HECS funded positions for undergraduate

nurses because our population is increasing. Conversely, South Australia have a higher HECS placement for undergraduate nurses with a lower population base than we have.

CHAIR—What is your population now?

Ms Pinch—It is 1.1 million.

CHAIR—In WA?

Ms Pinch—No, just in Perth. I am not sure what it is in WA.

Ms Cosgrove—We have discussed postgraduate education. Enrolled nurse education is another large issue. The enrolled nurses are concerned about the certificate 4 that was introduced about 2½ years ago. We are looking at doing a total review in Western Australia of enrolled nurse education and we will be contracting that out to a private, independent group, so neither industry nor TAFE nor the universities can put any bias on what level the enrolled nurse education should be.

Over the next two to three years we are also going to be implementing post-registration courses for enrolled nurses in the roles of maternity care, paediatrics and the operating room. We are going to be looking at what the role of the enrolled nurse is, because we feel that a lot of enrolled nurses' skills are not being used appropriately and they could be playing a larger role within the nursing work force. To assist nurses through their undergraduate and postgraduate education, the Department of Health does allocate scholarships for undergraduate nurses and scholarships for nurses who wish to do clinical specialisation.

As I said, we have two documents here. Most of that is from this document, which is *New Vision, New Direction.* This was launched by the Minister for Health in December 2001. This report actually has in it 61 recommendations which the department is going to be acting upon in order of priority. Carol Pinch is the project officer who is moving this project along.

We also have the document *Enhanced Role Midwife Project*. This is a report that came out from the NHMRC in 1998, which recommended that midwives should be having an enhanced role or that the role that they are currently performing should be recognised. We are the first state that has actually taken this project on and got it this far down the track. This has been approved by the department and by the Minister for Health. We are in the process of writing a submission to go out to tender for an academic institution to write the educational curriculum to allow midwives to act in the enhanced role. They will be recognised in a portion of the nurses register as an enhanced-role midwife.

One of the reasons this report is being enacted is actually to protect the midwives, especially a lot of those working in the country areas, who are ordering tests, interpreting the results and giving medications without the legal protection of either the Nurses Act or the Poisons Act. What happens is that the doctor will actually write a pathology form and just leave it for the nurse to do what he or she wants to with it. The doctor will leave a whole stack there for them. So technically they are working outside the guidelines but, if they did not work outside the guidelines, their client base would not be getting the service that they require.

There is a small pamphlet on the nurse practitioner project that I have given you as well. Phase 2 was launched in October last year and the drafting instructions for the legislation changes to allow us to implement the nurse practitioner role—and it will be a generic nurse practitioner role—are with parliamentary counsel.

CHAIR—Ms Pinch, do you wish to say anything at this time? We are going to ask questions, but if you have something to add please feel free.

Ms Pinch—I just wanted to clarify some of the issues around nurse undergraduate education. Everyone that I spoke to actually supported education in the university sector. Some of the issues that were raised in terms of clinical practice have been noted by the previous witnesses, but the main issue is to do with the clinical practice. They felt that nurses were not getting appropriate clinical practice, so nursing needs to look at the model in which they actually give the undergraduates practice. I think that is important.

Western Australia actually has 1,000 hours of clinical practice, and other states have between 500 and 900. So I think the amount of clinical practice we actually undertake in Western Australia is adequate; it is just the way we are providing it. Because we do not have the supports out there for undergraduate students, we are having that great attrition rate. So there is quite a big difference between attracting them—we are attracting them into the profession—and retaining them. We cannot retain them because we do not have the support and the coordinated support to actually keep them there.

Senator KNOWLES—I have some questions on the issue of retractable needles. I asked the previous group to tell us what was happening there. What has happened across the state, and particularly in government hospitals, about the use of retractable needles?

Ms Cosgrove—We cannot comment on that; we have absolutely no data on that. Until October last year, all of the metropolitan hospitals reported to the Metropolitan Health Services Board and did not report to the department. So the hospitals were under no obligation to inform the department of what they were doing or not doing. Since the Metropolitan Health Services Board has been abolished, they would be reporting to the director-general, but we do not get that sort of information in the Principal Nursing Adviser's Office. I know that there will be some health services that will not be using them because of the cost of actually purchasing them.

Senator KNOWLES—Are the nurses actually pushing for it?

Ms Cosgrove—I think I would be correct in saying that some nurses probably are not even aware that there are retractable needles around—would I be wrong in saying that?—especially in the rural sector. In the rural sector they are not exposed to a lot of this. When reps come along to a hospital with whatever goods they have got, they go to the supply manager first to get permission to enter the hospital to demonstrate their wares. If the supply manager decides that he does not want them in the hospital demonstrating their wares, they do not get in to see the director of nursing or the senior nurse in the organisation. So some nurses may not even be aware that there are retractable needles around. It is dollar driven; they do not look at it from the other side.

Senator KNOWLES—I understand that. The thing is that we are looking at the safety of those who use them, both in a medical sense and also in a drug use sense, in needle exchange programs. The drug users are the very people who do not give a hoot about who stands on a needle or who gets injured by a needle after they have used it. I was interested to know from each state what their policy position was on buying these needles for the state government hospitals, but you do not have that information, do you?

Ms Cosgrove—No, I do not have that information. The witnesses from the Royal Perth Hospital and the Sir Charles Gairdner Hospital may be able to answer that question this afternoon.

Senator KNOWLES—I have flipped through this very quickly. One of the issues that I raised with the first group that was with us this morning was the issue of accommodation in country towns. I notice that you have a recommendation in there in almost identical words to what we were using this morning when we said that nurses are not treated in the same way as police officers or teachers. With all of these recommendations is this the same as, say, a report that this committee prepares, in that the report goes to the government and the government can adopt what it likes?

Ms Cosgrove—No, we have been directed by the Minister for Health to implement the recommendations in this report.

Senator KNOWLES—So we might actually see better accommodation in country towns.

Ms Cosgrove—We have to report to the minister on a regular basis as to where we are at with our implementation of the recommendations.

Senator KNOWLES—So who undertakes that particular task? Take that one issue in isolation, for example. What do you do about that? Who goes and looks at the town and finds out whether there is sufficient identifiable accommodation there or whether accomodation has to be brought in and whether they are transportables or whatever.

Ms Pinch—On that issue, particularly, that would actually be up to the general manager of the health service. He would apply to the facilities and assets manager of the Department of Health for funding. Last year, before we started the project, we did allocate a substantial sum of money to go towards a review of accommodation, particularly in the north-west because they are the ones that are suffering the most. So I guess they will be reporting back in terms of what needs to be done and what new things will be accomplished.

Senator KNOWLES—So a decision, for example, about the Kimberley will be taken by the area health manager in Derby.

Ms Cosgrove—We are not quite sure at the moment. There is a restructure that will be occurring within the rural areas which will be different from the current structure and we are not sure what that structure will be. We probably will have to end up doing some type of audit across the state as to what accommodation there is. The accommodation in some of the towns is not good. I spent a bit of time in the north-west last year and the year before. I went to one site to assist a director of nursing with policy procedure development. I was there for two weeks,

staying in a very nice motel. But if I had arrived in town and been put into the accommodation that I had been expected to stay in, I'd have been on the next bus out.

Senator KNOWLES—I really do not blame them. I have seen it too, and I think it is just appalling.

Ms Cosgrove—I think we will have to do an audit trail. There is some inference that money that does get allocated for accommodation goes to medical staff accommodation prior to being allocated to either nursing or allied health accommodation.

Senator KNOWLES—One of the other areas that I have not seen in here—and that is just, as I say, from the superficial look that I have had—is the question about protection from litigation of nurses, particularly in country towns where the doctor is not there or off duty and people come in and want treatment. I know that many nurses sit in fear of being sued if something goes wrong and yet I do not see any evidence in there. Is there?

Ms Pinch—Yes.

Senator KNOWLES—Whereabouts?

Ms Pinch—There is a section on culture. It is in the work force part because it did not really sit particularly well in any other part. It is on page 22 at 4.9. We talk about it as the culture of silence. It is particularly a problem for rural nurses where they are working with the doctor. They live in the community and they have made friends in the community, but they have no process by which to deal with any problem, or no support. Up to date, support from the department or from any other peer professional group have been quite lacking. Part of that culture of silence also is part of the disempowerment of nurses as a whole. We have no professional leadership. We have no voice in terms of action, of being able to come out and either defend ourselves or make comment on issues.

Senator KNOWLES—Thank you for leading me into that. I have to ask the obvious question: why isn't there a recommendation attached to 4.9?

Ms Pinch—There was quite a bit of debate within the committee about having a recommendation on that. I am trying to choose my words carefully here. Part of it could be seen that we were pointing the finger at different groups within the health industry. This document is an endeavour to work within our health industry with the multidisciplinary team to empower nurses. We did not see that there would be any value in making a recommendation that would be difficult or almost impossible to implement without causing problems.

Senator KNOWLES—Would it be viewed as almost impossible to implement if it were structured around the principle of protection of the work force from that type of litigation in primary health care? A lot of other people have to take out their own protection but, in those country towns, nurses are sometimes required to do something for which they are not trained. They do their darnedest to get it right.

Ms Pinch—Although it is not so obvious, one of the things to look at is legitimising the roles that they are doing, like the *Enhanced Role Midwife Project* . She is actually carrying out those

tasks now but we cannot legitimately cover her for those tasks. So that is one. We have to look at nurse practitioner roles where they are trained and fully equipped to do that. We have to look at clinical governance mechanisms where nurses can be part of the process of making sure that clinical practice is safe and that they have backing for it. And we can look at processes where reporting mechanisms can go towards dealing with issues rather than hiding them.

Senator KNOWLES—Do you know of any other state that has a policy of protection from litigation for remote or rural nursing.

Ms Pinch—No.

Ms Cosgrove—We have got a document that is in the process of being reviewed. The third edition is out and the fourth one will be out, probably in the middle of June. It is called *The Remote Area Nursing Guideline: Emergency Guidelines*. They cover all possible clinical situations that we could think of. Those manuals are distributed to every health site and every remote area nursing post within Western Australia. There is legal advice in the front that indicates that nurses in hospitals and nursing posts that are not remote area nursing posts cannot administer the medications that the nurses in remote area nursing posts can. If there is not a doctor in the town, they use a logarithm methodology to allow the nurse to do an assessment on a patient and then to refer the assessment to the next town's GP or to a metropolitan hospital GP for advice as to the medications the doctor would give or to evacuate the patient. So they have got logarithms and it goes from unconsciousness, earache, invenomation and burns. Nurses in areas that are not remote area nursing posts cannot give the medications without a doctor's order. In remote area nursing posts they can give the medications because, under the Poisons Act and regulations, they are allowed to. That does provide them with some protection. If they follow all those guidelines and make the appropriate telephone calls, they have covered what we see as appropriate.

Senator KNOWLES—This issue was raised with me a couple of years ago, after a very bad crash on the road to the Tanami desert. The nurses were very worried that someone could ultimately sue them for what they had tried to do in simply saving lives.

Ms Pinch—I guess it is not within our bounds, but there are certain protections for a nurse. If I am in clinical practice, I can do what I see as a reasonable thing to keep that patient alive. So, if I am out in a remote area, I would do my utmost to keep a patient alive. This would be quite different to something that I would be required to do in a metropolitan hospital with the support that surround that. Certainly, in places like Fitzroy Crossing, nurses have had to intubate people on the road, which they would not be required to do down here or would never have the need to do. But they would be legally protected, if it was within the context of them being able to do it—they are clinically able to—and there was no other way of maintaining that patient's life. The law does allow some sort of common practices.

CHAIR—If I were a doctor who turned up at that accident, even if it turned out to have gone badly and I was sued, the medical indemnity or medical insurance that I as a doctor would have would mean that people from that organisation would take up the case on my behalf. If I were found guilty or liable, then the payment would be made.

Ms Cosgrove—Correct.

CHAIR—In most cases, I would probably continue practising as a doctor. Is there something similar for nurses?

Ms Pinch—They would be protected under the health service; they would not be sued as an individual nurse. They would be sued as an employee of the health service.

CHAIR—Of the Western Australian Health Service?

Ms Pinch—Of whichever health service she is employed with.

CHAIR—Okay. So that service would have lawyers who would take up the case in the court?

Ms Pinch—Yes.

CHAIR—If there was a liability payment, it would go out.

Ms Cosgrove—As long as she was rostered on duty.

Senator KNOWLES—There is another trick, though. If they are off duty and come across something, it is hands off, isn't it?

Ms Cosgrove—Because they are not employed and working in their role as a nurse, the department's insurance risk cover would not cover them for that. If I were to stop on the side of the road at an accident, and I was not on duty or was not going on business from one point to another point as a nurse, I would be seen as a citizen, who is a nurse, doing that. I am not employed.

CHAIR—A doctor would be covered.

Ms Cosgrove—Yes, because they have their own personal medical indemnity.

Senator KNOWLES—They have their own cover. That is where a nurse who is not on duty could quite easily—

CHAIR—Is that the same for a policeman who is not on duty?

Ms Cosgrove—I do not know.

Ms Pinch—I do not think so.

CHAIR—Thank you.

Senator GIBBS—I have got a few quick questions. What is a 'preceptor'?

Ms Pinch—A preceptor is a registered nurse, usually, or it could be an enrolled nurse, but they are someone with experience. They take on a student and look after them, do the clinical teaching-mentoring, all the clinical education and are basically a support. Some people call

them a mentor but we are looking at the actual clinical teaching, and we have given the name 'preceptor'. If I were a registered nurse who had been allocated a student, I would be the person that that student would come to if she had a problem, and I would make sure she was guided.

Ms Cosgrove—'Preceptor' is also used in the Western Australian context for when the graduate nurse commences their employment, and they are given a preceptor for a period of time. They work the same shifts as that preceptor so that they are getting constant information and constant clinical supervision from one person.

Senator GIBBS—Are they paid extra money for doing that?

Ms Cosgrove—No.

Senator WEST—Do they get a reduced workload?

Ms Cosgrove—No.

Senator WEST—They do not become supernumerary.

Ms Cosgrove—No.

Senator WEST—This is on top. It is like the old system when you had new staff—you still carried the same workload and carried them as well.

Senator GIBBS—Do they have a choice or are they told, 'This is what's going to happen'?

Ms Cosgrove—Subtle pressure would be placed upon certain members of staff to perform the role.

Senator GIBBS—I see.

Senator KNOWLES—Not a head roll.

Senator GIBBS—There are big problems in the nursing industry, aren't there? It is quite a violent place.

Ms Cosgrove—One of the issues that impacts on it is that we have a very large proportion of our work force that works part-time. The full-time people who are on the roster are encouraged to precept the full-time new graduate so they get consistency for the first few weeks of their employment. If you cannot do that, you try and get two part-time workers to provide the preceptoring for the one student. They do get information conflict. I would do something one way and Carol would do it another way. There is nothing wrong with the way either of us do it, but it does cause confusion for a beginning practitioner.

Senator GIBBS—Of course. It is like solicitors. They have different points of view on the one issue.

Senator WEST—They may have the same point of view; it is how to go about it.

Senator GIBBS—But it is not necessarily wrong. You said before that, within the aged care sector, there was a 17 per cent disparity in wages.

Ms Cosgrove—Yes, it is about that.

Senator GIBBS—This happens in Queensland too, where aged care workers are paid less. Is it because here they are reclassifying them—they are nurses but they are being reclassified—or is it because a nurse who works in the aged care sector is simply not paid the same as a hospital nurse?

Ms Cosgrove—Each aged care sector negotiates on an individual basis with the ANF. If you were to go to four or five different nursing homes, you may find that there are four or five different salary structures for the nursing homes. You may go to a private organisation and the ANF strikes a deal with them—the nursing homes and the ANF may negotiate by themselves—whereas another private organisation may decide to utilise the skills of the Chamber of Commerce industrial relations person, who may do the negotiating with the union. So not each aged care sector nurse will have the same salary because they are all on different enterprise agreements.

Senator GIBBS—Is that right?

Ms Cosgrove—You will find that there are some aged care facilities here that are paying above the award to try and encourage nurses to work for them.

Senator GIBBS—Because there is a shortage.

Ms Cosgrove—Also, if they can increase the wage to be equal to that of the government's enterprise agreement, they feel they may be able to attract the men. Who is going to go somewhere and work for 16 or 17 per cent less?

Senator GIBBS—Absolutely. That is exactly right. In Queensland, because nurses can be re-classified as aged care workers instead of RNs, they are under a different award structure, so they are paid very much less. That destroys their ability to work later on as a nurse because, if they stay there too long, they lose their classification as a nurse. Is that happening here?

Ms Cosgrove—No. In Western Australia, if you are a registered nurse or a registered enrolled nurse, you are on either division 1 or division 2 of the register. Regardless of what area you work in, as long as you are practising as a registered nurse or an enrolled nurse, you maintain your registration, which licenses you to practise as a nurse. The pay section must be a totally different issue. I was not aware of that, but we do not have it in this state. If you are a registered nurse or an enrolled nurse working in the aged care sector, you come under the ANF for the registered nurses award and under the Liquor, Hospitality and Miscellaneous Workers Union enrolled nurses award for their salary payments.

CHAIR—Does the LHMWU cover any of the mental health workers or community health nurses?

Ms Cosgrove—No.

CHAIR—Did it ever?

Ms Cosgrove—The enrolled mental health nurses are covered by the ANF award, but they used to be covered by the LHMWU. Registered mental health nurses are covered by the ANF. The ANF is trying to poach as many enrolled nurses from the Miscellaneous Workers Union as they can, but they are not being particularly successful.

CHAIR—From which particular part of the MWU coverage?

Ms Cosgrove—That is enrolled nurses (general). It is enrolled nurses (mental health) that are covered by the ANF and enrolled nurses (general/comprehensive) are covered by the MWU.

CHAIR—And where do they work, by and large?

Ms Cosgrove—Enrolled nurses work across the state, largely in country hospitals. Different metropolitan hospitals have different quantities of enrolled nurses.

CHAIR—So you could actually have two unions covering the nurses in one hospital?

Ms Cosgrove—Yes; you could have about 16 to 20 unions covering health care workers on one site.

Senator GIBBS—Has the difference between the enrolled nurse and the registered nurse changed now?

Ms Cosgrove—No.

Senator GIBBS—Do people still become enrolled nurses?

Ms Cosgrove—Yes. They do two years of training at TAFE and they come out with a certificate for qualification. They must always work under the supervision and direction of a registered nurse. A registered nurse in this state does a three-year or a three-and-a-half-year undergraduate university degree and then, if they pass their exams and meet the clinical competencies set down by the board, they are able to be entered onto the register.

Senator GIBBS—Okay, because I notice that in one of the documents you were saying that the average age of an enrolled nurse was 41—or 42, or something—and that there was an ageing problem. I thought that maybe they were dying out.

Ms Cosgrove—They did reduce the intake into the schools a couple of years ago, but they are now going to actually increase the intake of student enrolled nurses into TAFE to meet the demands of the aged care and acute care work force.

CHAIR—Can an enrolled nurse easily become a registered nurse?

Ms Cosgrove—They have to go to university and complete an undergraduate program. They do get recognition for prior learning, and Curtin University has developed a bridging program to allow them to enter into the second year of their studies.

Senator WEST—That was a question I was going to ask, because I am aware that a number of universities are not offering any bridging across from EN to RN classification, which is interesting. How are the AMA and the Rural Doctors Association reacting to the Nurse Practitioner Project?

Ms Cosgrove—When it was first launched in 2000, the Nurse Practitioner Project was called the Remote Area Nurse Practitioner Project. When the Labor government came into power in February last year, their policy platform included the policy that nurse practitioners would not be restricted to remote areas—it would be nurse practitioner (generic)—and health services could apply for a nurse practitioner to work in their organisation.

When the original report came out in 2000, even though the AMA and the Rural Doctors Association had sat on the committee, they were not happy with the report. Judge Antoinette Kennedy, who chaired the committee, told them that if they were not happy with the report they should go away and write their own. They did not come back. The AMA is aware that the nurse practitioner term is now nurse practitioner (generic). They keep asking for the draft legislation, which we are not at liberty to give them. Once the draft legislation becomes public we expect the AMA and the Rural Doctors Association to become quite active in opposing it.

Senator WEST—When will that be?

Ms Cosgrove—It is with the committee. Hopefully it will come back to us by the end of this week or next week for review, and we understand that we have got a very high rating in the legislative program for the next 12 months.

Senator WEST—I wish you luck with it. We have actually got it going in New South Wales. I still get the odd letter from irate doctors asking why I think it is a good thing, but I guess that is a personal opinion as an ex-RN.

Ms Cosgrove—Doctors in the rural setting will think it is a wonderful thing when they go away on the weekend, because they will have a nurse practitioner who can actually order tests, do x-rays and interpret them, and give out a certain set of medication. I imagine that when a doctor leaves town on Friday morning and comes back on Monday afternoon it will be fine to have someone in that role, but I imagine that when the doctor gets back to town they will not want them.

CHAIR—So young for such a cynical approach!

Ms Pinch—I am not ageing well at all! They are using nurse practitioners quite successfully in London to reduce the costs of people going through accident and emergency, so there is quite a big benefit in cost savings to all areas of nursing if you have a highly qualified nurse.

Senator WEST—Yes. Senator Crowley and I heard about that when we there last year. I am also aware that in the ACT, and I think in New South Wales, that there are telephone health line

facilities—I suppose a call centre line situation—where you actually have a bank of RNs taking queries over the phone. Have you started to utilise that here or not?

Ms Cosgrove—We have a Health Direct set-up where the community can ring in to Health Direct and get advice from nurses who have all the information on the screen. They scroll down to the appropriate information and then the nurse gives the information that is on the protocol—to go to Princess Margaret Hospital if it is a child with whatever, go to a GP tomorrow or go to the emergency department. There is one hospital in Perth that is working with the department to develop an advanced practice nurse in the emergency department in aged care until we can actually get nurse practitioner legislation through. That is to try and ease the aged client who comes to the emergency department back out into the community system, so there would be an advanced practice community nurse in the community to go in and support the client in their home. Lots of aged care clients do not really require hospital accommodation; they require alternatives to be found for them in the community. We are just in the discussion stages of that at the moment.

Ms Pinch—There is also a project called TeleHealth, which the Department of Health is doing, where they can ring in, and there is a video screen from which they can talk to them. They are developing that with Royal Perth Hospital, so they will have access to nurses and doctors for diagnosis.

Ms Cosgrove—With the comment about the community mental health nurses requiring that—and I would not have used the term he used; I would have probably said 'professional clinical support'—they can actually use TeleHealth for that in the rural sector as well. If you are in the Kimberley and you want to discuss something professionally, you could hook up with the nurse in another area, or a clinical psych, to talk through your client problems.

CHAIR—I want to conclude by asking a few questions about education. Because we are from the Commonwealth, our focus necessarily in this report has to be on what recommendations we might want to put to the Commonwealth government. By and large, it is not appropriate for us to be recommending to the state, which would give us a lid and a flip anyhow. Are your education recommendations on pages 64 and 65 in priority order or will you implement them all at once? Answer that question first, I suppose.

Ms Cosgrove—Regarding recommendation 1, once the nursing education review discussion document becomes the document, we will be looking to the director-general to instruct us to go about applying for more HECS undergraduate positions.

CHAIR—Then these will follow?

Ms Cosgrove—I have already applied for funding for continued graduate transition programs—a very large amount of money—for the next financial year and for the three years afterwards, so that is in the budget process.

CHAIR—To cover exactly what?

Ms Cosgrove—To cover the costs of inducting the new graduate into the program and to perhaps look at an incentive for preceptors to get down time so you can employ another nurse

half-time to pick up the clinical practice load so the preceptor can work with a graduate for a set period of time.

CHAIR—I understood you to say that you had made a recommendation for an amount of money from the budget.

Ms Cosgrove—Yes.

CHAIR—So that amount of money is your secret.

Ms Cosgrove—I prefer not to say.

CHAIR—You mean you can?

Ms Cosgrove—No, I probably can't say, either, because it is pre-budget.

CHAIR—I wondered if that was the case. But you did suggest it is a significant amount of money.

Ms Cosgrove—Yes, it is a significant amount of money.

CHAIR—Because you are serious in this recommendation.

Ms Cosgrove—Yes.

CHAIR—Of your education challenges, and there seem to be plenty—getting the balance right, getting the HECS arrangements right and so on—how do you negotiate? Do you negotiate with your federal colleagues or do you negotiate with each individual university? How do the nursing needs in the state negotiate and talk about education needs with the federal area?

Ms Pinch—From the Department of Health point of view, we have a set-up called the Education Liaison Group which is made up of all the metropolitan directors of nursing, plus the university sector, so if there are particular issues that we want to discuss with the universities we would call that group together and have an agenda of set items.

CHAIR—Say the issue is something like the number of places and HECS allocation, for example, and addressing the costs to nurses after their undergraduate course. You either pay up-front fees or you are in trouble—unless you can get a scholarship, which we have been told so far is a very big turn-off for a lot of people proceeding to postgraduate nursing. Who does that? The same committee or do you actually have different people to talk to then?

Ms Cosgrove—We would have to talk to DETYA. We would actually put a submission up to DETYA for that.

CHAIR—Who would talk to DETYA?

Ms Cosgrove—Probably Dr Della, Principal Nursing Adviser, would start the ball rolling, or the director-general.

CHAIR—Would the minister?

Ms Cosgrove—I think he would probably direct the director-general or Dr Della. I am just assuming that—I am not sure that the minister would.

CHAIR—Have you ever had any awareness or understanding of whether the state and the federal representatives from WA would put in a joint submission to the Commonwealth?

Ms Cosgrove—No.

CHAIR—We could go on for a long time, but we have passed our time. Thank you very much. First of all I would like to say thank you to both of you for being excellent witnesses. We are very often given the best help we can get, but not often is it succinct and to the point—in fact, in a few cases, splendidly just beyond the point. That was much appreciated, thank you.

We wanted to ask you and we were advised by earlier witnesses—and if I cannot remember the questions, the secretary and other colleagues may give me some assistance—whether you could provide us with some information about pay scales: what are the ENs and the RNs getting at level 1, level 2 et cetera and how far can they go? If that is not a major exercise—if you can easily provide that to the committee—we would appreciate that very much. Could you also assist us with a map of educational opportunities for people who decide they want to be a nurse? It seems to me that you would need somebody to guide you through it if you were 16 or 17 and thinking of perhaps becoming a nurse and wondering what can you do—you could go there or you could do this or you could do the other.

Ms Cosgrove—We have a very good system in the department. We have got a campaign going called 'Are you good enough to be a nurse?' That has been running for three years, which probably accounts for our full academic quota this year. We have a project officer who is a young nurse with a marketing graduate diploma who plans the new marketing strategy for next year. She goes out into the high schools on invitation in the middle of March to talk to students. She travels across the whole of the state from Broome, where she does the Kimberley Expo, to Kalgoorlie, down south and places east. She provides information via the nursing Internet and also education kits to careers advisers in the high schools. She goes out with the aim of attracting students in year 8 and year 9 so that they know what subjects to get themselves into for years 10 and 11. She is available, as I said, via the Internet and also via the phone, so her contact number is with all the careers advisers in the education system.

CHAIR—That is very useful. Thank you very much. If I were thinking of doing this or my mother or father were thinking I should do it and I was approaching 13, would I go on the Net or would I be able to ring somebody and get a pamphlet sent to me?

Ms Cosgrove—If you were a child you would go on the Net, but if you were the parent you probably wouldn't!

Senator KNOWLES—Very good—touche.

Ms Cosgrove—Often the phone call comes to the switchboard at the department and when someone says they want anything about nursing it comes through to the Principal Nursing Adviser's Office. If it was for career advice, it goes straight to the project officer nurse marketing. She goes to all the career expos around the state and has all her pamphlets with her. So we send out information.

CHAIR—If there were some pamphlets, would you be able to make some available to the committee? Listening to earlier witnesses, it seemed as though it could be a bit of a challenge to get through the various ways in which you could get into and then progress in nurse education. So it would be very useful for us to have that information.

Ms Cosgrove—The project officer discovered when she started in the role last year that, after the first couple of careers expos she went to on the weekend, we did not have any information for mature age students who wanted to enter nursing. So she has done a separate pamphlet for mature age students.

CHAIR—Re-registration: I think, in shorthand, we have understood a bit today that the problem is not initial enrolment or intake of nurses but maintaining the nurses in the profession and then making it friendly for people after children or after time out of the nursing profession. You are agreeing with that assessment?

Ms Cosgrove—Yes. We fund re-registration programs for registered nurses and enrolled nurses to re-enter the work force and we fund refresher programs for nurses to re-enter the work force. This financial year we will have spent $180,000 in the process of doing that.

CHAIR—That would probably make sense. Do you have any information about how the salaries in Western Australia compare with the salaries in other states? If not, please just say no and we will try and chase that down from other places.

Ms Cosgrove—I do not personally.

Senator GIBBS—We could do it state by state as we go around.

CHAIR—Of course we can. I would not ask you to do it if you do not have it.

Ms Cosgrove—I have just got Western Australian information. I will give it to you.

CHAIR—If we could have that then, that would be wonderful.

Senator GIBBS—We will ask state by state.

CHAIR—We have also had people who have said that nurses are coming from England—people are being recruited. Can you provide us with any information on the number of nurses being recruited from overseas? Is that a steady ongoing flow or does it come in peaks and troughs as something happens? Do not worry about answering that now: take that on notice. Do not make that a long answer. I am not wanting to put much pressure or work on you.

Ms Pinch—A short answer to that is that we do actually rely on overseas registrations to make up our normal registration. There are about 400 a year.

CHAIR—Which is what percentage?

Ms Pinch—It is 400 out of 25,000 nurses registered.

CHAIR—That is about two per cent.

Ms Cosgrove—We also rely on nurses from the eastern states coming to work in Western Australia, as they do conversely.

CHAIR—It would be very useful if you could tell us from which eastern states.

Ms Cosgrove—We will not be able to get that information.

CHAIR—Okay. But how many, and what percentage? Do you get another 400 from the eastern states?

Ms Cosgrove—No. We could not get that information unless we went to each individual hospital and said, 'What nurses did you recruit from Victoria and New South Wales?' We can get the information on overseas nurses because of the number of visas that are released to the hospitals.

CHAIR—Would you be able to provide to the committee where those nurses are from and any information about whether you target one country as opposed to another to recruit nurses? And is that done by the department?

Ms Pinch—No.

Ms Cosgrove—No. Unfortunately at the moment it is done individually, but there is a recommendation that it comes back under one umbrella, and that be the umbrella of the department, so four or five hospitals are not off recruiting at the same time which is a very expensive exercise.

CHAIR—If it came back under the department—it sounds as if it came back; we have done this before—do you then target a country or would you be advertising widely?

Ms Cosgrove—We would be targeting countries that we are allowed to. We would not be targeting any Third World or developing countries.

CHAIR—That means not the Philippines?

Ms Cosgrove—That means not the Philippines and it means not the African continent.

CHAIR—It does mean the UK—

Ms Cosgrove—The UK, Canada and the United States.

CHAIR—That is very useful. I would like to thank you again. We are well past time. If there are other questions—I have a couple just here—and I cannot get them to come back from earlier evidence, would we be able to seek further information from you?

Ms Cosgrove—Yes.

CHAIR—Once again, I thank you very much for your very succinct and useful contribution.

Proceedings suspended from 12.43 p.m. to 1.33 p.m.

TEDMAN, Mrs Simone Elizabeth, Manager, Staff Services, Aegis Health Care Group

ABBOTTS, Ms Susan, Nurse Coordinator, Cancer and Gastrointestinal Divisions, Royal Perth Hospital; and Chairperson, Nursing Executive Council, Royal Perth Hospital

LESLIE, Dr Gavin David, Director, Nursing Professional Development Unit, Royal Perth Hospital; and Member, Nursing Executive Council, Royal Perth Hospital

DAVIS, Ms Sue, Coordinator of Nursing Services, Sir Charles Gairdner Hospital; and Member, Nursing Executive Group

SINGH, Mr Meih, Nurse Co-Director, Cancer Clinical Service Unit, Sir Charles Gairdner Hospital; and Member, Nursing Executive Group

TWIGG, Ms Diane Esma, Executive Director, Nursing Services, Sir Charles Gairdner Hospital; and Chair, Nursing Executive Group

CHAIR—We welcome representatives from the Royal Perth Hospital Nursing Executive Council, the nursing executive from Sir Charles Gairdner Hospital, and the Aegis Health Care Group. Do you have any comments to make on the capacities in which you appear?

Dr Leslie—I also hold the joint appointment of Associate Professor Critical Care Nursing at Royal Perth Hospital and Edith Cowan University.

CHAIR—The committee prefers all evidence to be given in public but, should you wish to give your evidence, part of your evidence or answers to specific questions in camera, you may ask to do so and the committee will give consideration to your request. I also remind you that the committee is protected by parliamentary privilege and if any of the information you give us is false or misleading it could constitute a contempt of the Senate. The committee has before it your submissions Nos 706, 730 and 359. Do you wish to make any alterations to your submissions?

Ms Twigg—I do.

CHAIR—To which page?

Ms Twigg—It is the last dot point on page 2 of the Sir Charles Gairdner Hospital submission. The sentence in the middle of that paragraph which says the hospital runs certificate and graduate certificate courses has '(Level 4 ANF)' and '(Level 8 ANF)'. I need those two deleted as they are inaccurate.

CHAIR—Is there anything further?

Ms Twigg—No.

CHAIR—I will ask each of you to make a brief statement. We are catching a plane, so we do not have any freedom or options at the end of this session. Could you make your opening comments brief and then field questions, but no so brief that you feel that you have not been fairly represented.

Dr Leslie—In addressing the submission that we put forward, I would like to indicate that we support the submission as tabled. The submission was made in June last year. We believe that the situation that exists at this stage in terms of the nursing work force is worse than it was at that time. Nevertheless, the deterioration that we have seen since that point in time is reflective of the submission we put forward. We believe that there have been some efforts to address issues, particularly those we have control of within nursing. Some positive signs of late have been that all the university offered positions for this year in this state at the undergraduate level have been filled. The recently completed EBA negotiations in this state also have, in some way, started to address some of the conditions issues which we have alluded to in our submission and which I think are alluded to in other submissions. However, there are a number of issues in terms of shiftwork that remain problematic and almost unique to nursing.

I would like to point out to the review, in addition, that there is ongoing concern over the national view on registration. As I am sure you are aware, registration for nurses is carried out as a state based concern. There is a mutual recognition situation in place whereby through the Australian Nursing Council Inc. we now have a national view on registration. However, particularly in the enrolled nurse area, there are substantial variations. We believe that there needs to be further work at a national level to try and coordinate the requirements for registration to ensure that we get less variation in what we see as a new graduate from either registered or enrolled nurse programs. That also applies, I believe, to the situation where New Zealand graduates can access our registration in Australia.

The transition from undergraduate to clinical practice is a critical element for the committee to consider. We have made points with regard to that. I think the view of our group at this stage would be that this transition really requires a fourth year in a program, and whether that is offered in a compulsory form by industry or as an extension of the university program is certainly something that needs to be debated. But to prepare a comprehensive graduate, which we are great supporters of, we find that we could not see that occurring where you have an 'industry ready' nurse—as the term is—at the end of three years. Various models have been put forward, but certainly a fourth year of supported practice, which occurs in an informal sense through graduate programs at the moment for some nurses, is something that we believe should be looked at in a more comprehensive form.

Support for postgraduate education has changed recently with the introduction of the PELS scheme. While we believe the PELS will assist nurses at the postgraduate level to be able to take on the debt of full fee paying courses, it does have a sting in its tail in that if you pay up front through your own mechanisms you are able to claim it as a tax deduction, but if you choose to use the PELS scheme no tax deduction is available as far as we are aware.

Senator WEST—What is the PELS scheme?

Dr Leslie—It is the Postgraduate Education Loans Scheme that has been introduced through DETYA in the last year. So that is an interesting situation. In concluding, there are still a

number of issues that nursing needs to deal with, including models of care delivery and the academic service delivery liaison. But I would like to emphasise the point that, in our view, leadership in nursing and the role that nursing plays in the delivery of health care services are not reflected in the bureaucracy that is necessary to manage health care, and that is at both the federal and the state levels. We believe there is a necessary place for nursing to be recognised in both the federal and the state arenas in a greater context in the design, delivery and management of health care services.

CHAIR—Thank you. Ms Twigg, would you like to make an opening statement?

Ms Twigg—Yes. I think that, while our submission was put in June last year and some of the nuances might have changed had we done it again yesterday, the core issues remain the same. Some of the nursing education and training labour force needs coming out of that are that we are very much a practice based discipline and that the current funding arrangements for universities and the health system for the support of a good, strong clinical exposure throughout the program are insufficient. I think that, whilst education and industry have perhaps argued who has the prime responsibility for that, neither of us is practically funded to support such a clinically based discipline. That is a key issue. It does limit the early and consistent exposure that industry has asked for students to have in their undergraduate program, because of the actual cost related to providing that sort of support. Also, we see the opportunity for linking the work that most undergraduate students have to undertake to support themselves personally to the health environment so that, in some sense, that work experience contributes to their learning and understanding of things like the health culture and how it works, the team that provides health care and those sorts of issues.

The other major concern in the preparation of nursing to meet labour force needs from our perspective is that the number of DETYA places for undergraduate students in Western Australia makes up about 50 per cent of our register. So, if you look at that, we potentially train only 50 per cent of our state requirement in terms of the nursing work force, based on that allocation. Obviously, that means that, in environments like this where you have a significant nursing shortage, we feel very much at the pointy end of trying to attract sufficient nurses, because we are not actually meeting our forecast work force needs through training at the state level.

In terms of marketing for nursing, and again looking at labour force needs to attract people into our profession, we believe that the diversity of careers within nursing prepares people to do a lot of things in nursing, in health and more generally. They are very transportable skills, which we see from nurses very easily getting promotional positions and changing career paths quite easily because of the grounding nursing gives them. A modern society seems to accept that people will have several careers and we need to promote that rather than try to hide it, because it may increase the flow of people choosing nursing as a first career choice.

In postgraduate nursing programs we believe that we need to get a balance between clinical and academic rigour. Again, built on that notion of being a very clinically based discipline, we need to make sure that there is good clinical rigour in the programs that we promote at the masters and higher degree levels as well as at the undergraduate level. That is achieved through a model of collaboration and articulation between the major health providers and the universities concerned. That is always difficult when the education sector is predominantly run

through Commonwealth arrangements and funding and the state health system is predominantly funded through the state. I know we could get into a lot of argument about that but, in reality, it does add additional challenges to managing a good partnership at the local level because of those different reporting mechanisms, different policy frameworks and different funding issues.

We believe the interface between the universities and the health system more generally needs to be built on a partnership model. There is an issue of depth versus breadth in the undergraduates' exposure. We believe that it may be possible, while hanging on to the idea of a comprehensive program, to review whether we focus more on the depth of experience than on the greater breadth of experience we are trying to provide at an undergraduate level at the moment through the educational experience and competence nurses acquire in their undergraduate program. This is not stepping away from a comprehensive training and undergraduate preparation of nurses; rather, it is saying that if we can identify some of the core competencies we can narrow those down to give them a better depth of clinical exposure.

We also believe there needs to be a significant investment in research infrastructure for nursing particularly. In competing in the broader grant process for health, funding tends to go more towards the basic sciences and medicine. We are a clinically based discipline, so it is very hard to establish an active research program that focuses more on standards of care and evidence based practice than, necessarily, on coming up with some new gene or something that is going to significantly aid the management of cancer. So for us to move to a very evidence based practice where we establish our standards appropriately there needs to be dedicated funding support for research. Again, that needs to give priority to that partnership between your clinical home and the academic researchers who need an academic home as well and to promote an infrastructure that would support very clinically oriented research that is looking at nursing outcomes and the value of getting the balance of quality in nursing right in terms of overall patient outcomes.

In terms of strategies to retain nurses in the work force and perhaps to attract nurses back, the state has moved forward in some of those areas already referred to by Royal Perth. The fundamental issues that we need to get better at are workload management and establishing benchmark standards and targets for staffing, independently of whether we have many or few nurses. Until we establish those standards and can clearly say to nurses at a grassroots level what we believe we need, they cannot make judgments about whether they will hang in here because we are actually trying to do something about it or whether we are just pushing it under the carpet because there are not enough nurses. We need a better way of providing ongoing education. While I think we have done that in terms of postgraduate programs and higher degrees, the environment and culture of clinical learning are less supported. Nurses have less time to continue to grow in their profession in terms of both research and education than those in other health disciplines where they have more structured time away from direct patient care. We have to look at a career path that values clinical leadership at all levels in the organisation, including at the highest levels. At the moment we tend to siphon people off into what are seen as purely managerial roles.

The final thing we would put forward is the need for recognition of nursing leadership and the fact that whether you look state structures, hospital executive structures or commonwealth structures, nursing does not have a visible voice where we can routinely get these issues across. It is that invisibility, perhaps, that has let things get to the state they are in at the moment, where the nursing shortage is both national and international. Certainly, it is a significant problem in

every developed country and it will be a major deterrent to the delivery of health care as we would like it, I think, over the next decade or two. Some of that is because there is not a structured voice for nursing at a commonwealth or state level to seriously get any of these issues on the table in a consistent way.

Future developments need to provide a framework for the development of nursing leadership, but a development of nursing leadership that does not lose touch with the clinical home of nursing, which is always patient care, and one that recognises a legitimate role in influencing health agendas, because we are a significant part of the work force that actually provides health care. So that would be our summary. Thank you.

CHAIR—Thank you.

Mrs Tedman—From my perspective, nothing has changed from when the submission was written. Most of the issues have already been covered in the other opening statements but, obviously, for aged care there are a number of other issues that need to be taken into account as well, which are in the submission. A particular issue is the fact that aged care nurses are now about 28 per cent behind in wages in comparison with our acute sector colleagues. That is the first thing. The other thing is that our funding is different because of the need to categorise patients or residents. To be able to get the funding we need to provide the care creates huge problems for aged care nurses, because they have to spend so much time documenting and justifying the care that they give they are not spending the time that they should be providing the care to the residents. So those two issues are different for aged care nurses as opposed to our acute care colleagues. Everything else has basically been said, I think.

Senator KNOWLES—I was interested that all submissions in some respect focus on education. We have a difficulty in this inquiry because basically nursing is a state issue, primarily, other than the education side of it. I was interested to read the proposals for education and how they can dovetail with some of the strategies that have been put in place. Mrs Tedman, in your submission you talk about options to make a nursing career more family friendly—flexible working hours and time-off options for school holidays and so forth. There are lots of people in the work force who would love to have that, not just nurses. How far have you gone with the state government in trying to come to some arrangement with those types of issues and are you still pushing it with the state government?

Mrs Tedman—Obviously Aegis is a private sector organisation and so we, through our focus groups, push in all directions where we can. We are trying to look at it again because the people who want to come and work in nursing want to work during the day, during the week, when their children are at school. It is very difficult to find people who are willing to work shift work and, obviously, in aged care, as well as everything else, it is a 24 hour thing. We have not got very far with that. We have actually been looking at trying to do something on our own but it is early stages at the moment.

Senator KNOWLES—Have you put a formal submission to government yet?

Mrs Tedman—No, not that I am aware of.

Senator KNOWLES—When do you plan to do so, if you say that you are going to have another look at it? Has the state government previously looked at it and rejected it?

Mrs Tedman—As far as I am aware, they have not. And I am not sure when that is going to come about. I know we have talked about the fact that we need to push this further, so it is something that will be looked at, hopefully sooner than later, given that we are really struggling to attract staff.

Senator KNOWLES—The Royal Perth submission mentions in 5.2, under health and safety, a fair deal about violence, violent confrontation and counselling. I would have thought that, in one of the primary hospitals of Western Australia, such training would be in place already. Are you telling us that that sort of training is not available?

Dr Leslie—The training is available, but it is a resource issue as much as anything. The issue that to a certain extent we wanted to emphasise is that we believe there is underrecognition of the risk that nurses particularly working in emergency departments face. My recollection is not entirely clear as to the origin of the survey, but recently nursing was identified as one of the top two occupations in which you may encounter violence in the workplace—it was up there with police work. I do not think people see nursing in that light, but that is the reality of nursing work. The other thing is the social expectation that as a health care worker you would not react as a policeman possibly would react. You do not have the legislation, the assistance or the training to react to that type of behaviour, yet you are confronted with the same type of situation.

Whilst you can train someone as much as you like to try and deal with violence, in the end it is the support structures which are entirely necessary and which, of course, divert resources that were previously used for other aspects of health care management. We have a security force in the hospital now which we had nothing like 10 years ago—we would have called an orderly for assistance. Now we have to have specifically trained security people. We have tried locating police within the emergency department but we found that that was possibly more inflammatory than not having them visible there. Those are the types of issues that are now current and are a reflection of society in general, and that I think need emphasising in nursing. Nurses really are not in a position to respond to violence in the way that people who are specifically employed or trained for that are.

Senator KNOWLES—That is the precise reason I am asking questions in relation to what you have put here: 'Nurses need to be trained in dealing with violent confrontation.' I would have thought A and E nurses would, in fact, be given some training precisely on that issue for a whole variety of reasons because of the people who are going to present themselves to Accident and Emergency. Are you saying to me that that is partly done but there is still a long way to go, or that it is only done on an ad hoc and not on a formal basis?

Dr Leslie—It is now done on a formal basis, but, as I said, it becomes a resource issue. As a director of an education area, I have had to divert resources which we would have used for other education into providing violence education, because it has now become such a priority issue.

Senator KNOWLES—When you say the police should be aware of the high-risk nature of nursing, to what are you referring precisely?

Dr Leslie—Police are part of the community, and the community attitude would be generally that nursing is not a high-risk occupation in terms of violence.

Senator KNOWLES—Are you saying they have been slow to respond to calls?

Dr Leslie—I am saying in that regard that I believe at times we have been in a position where that has been the case.

Senator KNOWLES—In the hospital?

Dr Leslie—In the hospital.

Senator KNOWLES—Do they give an explanation for that? Do they say it is a lack of resources on their part or, 'It'll be all right, it is down at Royal Perth Hospital—who cares?'

Dr Leslie—I would prefer not to comment because I cannot make a direct quote, apart from the fact that I think both those issues you have raised are reflected in what has been reported.

Senator KNOWLES—And also the fact that you say agencies should support staff in prosecuting violent offenders. We have had evidence today that invariably it is the nurse who does not want to continue litigation or any legal procedures because of the fact that they fear that they are the one who is going to be put under the microscope instead of the offender.

Dr Leslie—I think that is quite a true comment, and that is where I think the agency's support is critical. If the nurse is left to feel that they as an individual are exposed in that situation then you almost get this conflict between being a person in a caring profession and prosecuting the person you actually felt you should be caring for. That is where I think the agency has a major role in supporting the person through that process.

Senator KNOWLES—Can I ask all three groups about retractable needles. I asked the Department of Health before lunch whether or not it was a state government policy to provide retractable needles. They, like many others, said that it is really an individual choice from hospital to hospital but it is also a cost factor. I understand the cost factor; what I cannot understand is whether or not people just treat it as a matter of choice about using such technology now that it is available.

Dr Leslie—From Royal Perth Hospital's perspective, we use a needleless injection system throughout the organisation but that does not mean that needles do not exist. There are clinical situations and particular types of medication which you still need to use a needle for.

CHAIR—What is a needleless injection?

Dr Leslie—It is basically a system that does not involve a sharp steel or metal needle.

CHAIR—That is good, that is what it is not, but I still do not have any idea what it is.

Dr Leslie—It usually involves a plastic cannula which is quite blunt for inserting into intravenous lines and it does not have a sharp tip. It is called needleless because it does not actually have a needle as such.

CHAIR—So already having cannulated the vessel, you actually use something else to stick it in.

Ms Abbotts—I would say that the vast majority of injections given in hospitals tend to be intravenous rather than intramuscular.

CHAIR—Yes, but you were just saying that there are a number of times when needles are used, and Royal Perth does or does not use retractable needles?

Dr Leslie—We have retractable IV cannulas where the needle which you used to cannulate the vessel to start the intravenous drip is used and then the needle retracts so that the inserter is protected in that regard. But there still exist situations when needles are used and there is not an alternative technology to using a needle. So needles have not been removed entirely from the clinical situation.

Senator KNOWLES—What I am asking, I suppose, is why the new technology of the retractable needles has not been utilised and in fact a lot of hospitals are still choosing to use admittedly the cheaper version of the old needle and syringe?

Dr Leslie—As I said, at Royal Perth Hospital at least the preferred use technology is needleless where possible. Unless the clinical situation demands otherwise, we would prefer people to use needleless technology, and it is available.

Ms Davis—One of the last incidences of needle-stick injury at Sir Charles Gairdner was removing subcutaneous butterfly needles, so we use a retractable system for butterfly needles.

CHAIR—For the benefit of all of us, can we have an explanation of subcutaneous butterflies? Some of us know but many of us may not.

Ms Davis—It is a little needle that looks like a butterfly and it is something that is often put in and left in for a period of time. It has a little bit of tubing attached to it so when you take it out it tends to flip back. I have had three needle-stick injuries from butterflies flying back and hitting me in the hand. So we have a needleless system for the butterflies, because we recognised that it was one of the high-risk needle-stick injury areas in nursing. That is what we have in terms of needleless systems at the moment. You put it in, you pull back, and the needle retracts into a little cannula and you are just left with a little plastic bit underneath.

CHAIR—Aegis?

Mrs Tedman—We do not use that system. We do not use a lot of injections.

CHAIR—Do any or each of you have any idea of the number of needle-stick injuries in your hospitals?

Ms Abbotts—Yes, we do have a system of recording that. The number of needle-stick injuries has been reduced dramatically by using the needleless system.

CHAIR—From what to what?

Ms Abbotts—I am sorry, I do not have that.

CHAIR—Can you provide that for us?

Ms Abbotts—I can try to get it for Royal Perth Hospital as a whole. I can certainly get it for my divisional area.

CHAIR—The important point that Senator Knowles makes is that people are using the old system because it is cheaper but, if you have dramatically reduced your occupational health and safety claims, the cost benefit may easily be on the side of the safe needles.

Senator KNOWLES—Is there any evidence of people not reporting it? I have been told many times that needle-stick injuries are not necessarily reported because people have been told how to use them safely and they feel a bit of a goose when they do not. Therefore, the level of reported needle-stick injuries does not necessarily reflect the level as accurately as it should.

Ms Abbotts—My impression is that the health issues are so important that these days almost everybody would report if they had a needle-stick injury, particularly if it was a dirty needle.

CHAIR—Aegis and Sir Charles Gairdner—injuries?

Ms Twigg—I do not have the data with me but we do have data on that and it could be made available. I think the broader issue is more occupational health and safety, generally. The needleless system is one example of where you can minimise risk but there is a whole range of occupational health and safety issues that face nurses and any health care worker. I think it is broader than just that particular area but we are able to provide figures on it.

CHAIR—If you could provide figures, without too much effort, we would appreciate that.

Mrs Tedman—I am aware of three needle-stick injuries in the last 12 months only. They are reported, but we also treat injuries from razor blades the same way as needle-sticks and I would suggest that probably the majority of those have been related to razor blades as opposed to needles.

Senator WEST—What about getting the top off ampoules—I always found that was more dangerous than sticking yourself with a needle unless you had it wrapped up in some gauze or a peripad or something?

Dr Leslie—I guess the issue, firstly, is that the occupational risk is substantially lower because you are not generally exposed to a contaminated item. The introduction of plastic medication containers, to a large degree, have removed the glass ampoule. There are still certain

medications provided in glass ampoules but, by and large, the largest use items have moved entirely to plastic ampoules and therefore removed that risk.

Senator WEST—I would like to turn to Aegis. You were talking about the paperwork and the time spent documenting for the RCS. I have had it put to me that RNs, registered nurses, in intensive care units actually have to do less paperwork documentation than aged care nurses have to do for the appropriate forms for the RCS.

Mrs Tedman—I cannot speak for an intensive care nurse; I have no idea how much paper work they would do. I know from my experience in aged care that there is a huge amount of time spent documenting for the RCS because we have to get the best possible categories for your residence to enable you to staff your facilities because your funding comes from there. I would suggest that it would probably take two hours of every RN's afternoon to do that.

Senator WEST—For how many patients?

Mrs Tedman—It would vary but on average 60 residents. For a bigger facility more time would be required because, again, your staffing comes from the funding from your RCS, so there is a lot of time spent with documentation.

Senator WEST—You said also that nurses were 28 per cent behind in wages.

Mrs Tedman—Yes.

Senator WEST—Do you have a salary schedule you can provide us that indicates that?

Mrs Tedman—I do not have one with me but I certainly could do that.

Senator WEST—That would be appreciated, because we have been asking other people and we have heard varying figures as to what the differential is. I would appreciate it if you could provide us with the paperwork that indicates that. What work has been done on whether the transition to clinical practice in the fourth year should be compulsory, industry driven or university driven?

Dr Leslie—That is a very good question. I think very little work has been formally done in terms of looking at that particular issue. It reflects the dichotomy that exists between the current fourth year, or the first year of practice, which is fully paid by the state, and up until that point where it is funded federally. We have participated recently in a project within Western Australia—and I am sure the Health Department would have put this in their submission, in their *New Vision, New Direction* document—looking specifically at this issue. We draw together the points which have been made in the submissions that are here today, and I am sure you have received elsewhere, about the issue of clinical practice transition.

Obviously clinical practice transition has to be offered within the undergraduate program; I think there is no argument on that. How much is offered is certainly of great contention and relates to the time available for that to occur and then to what is available once people leave. I would draw a parallel with those in the medical system, whereby five years of their time is

spent largely in academic preparation and then they have a compulsory internship year if they are going to practice clinically. I do not believe that is dissimilar to what we have in nursing.

Unfortunately, at this stage the graduate year placements are not compulsory. We do not believe that the undergraduate clinical placement is sufficient to support an industry-ready nurse at the end of third year. I think our preferred position now, from an industry perspective, is to see a compulsory fourth year offered and for there to be sufficient positions to accommodate all newly graduating nurses in that. We also think that should be offered in some form to enrolled nurses as well because they suffer a similar situation.

Senator WEST—Is it a problem that each of the universities has differing clinical experience and hours that it actually provides the undergraduates? Are you getting differing levels of clinical experience when nurses arrive in the wards to actually start doing their first year after graduation?

Dr Leslie—Certainly I would say that in Western Australia there is not a significant difference between Curtin University and Edith Cowan University. There is a small program run at Notre Dame University on a very different model. I think it is far too early to comment on that model because they have not yet graduated their first group of students. It is also a very selective school of a very small size—a 'boutique' school of nursing if you like—where they can obviously try different approaches in a very much less structured fashion than a school of nursing which has to accommodate up to a thousand students. But in Western Australia with only the three undergraduate schools, the variation—putting aside Notre Dame—is not substantial.

Senator WEST—Do you know what the drop-out rate is for any given year?

Dr Leslie—For undergraduates?

Senator WEST—Yes.

Dr Leslie—It is around 10 per cent, I believe. I can confirm that.

Senator WEST—Yes, could you take that on notice. Going back in history, what was the drop-out rate for the old apprenticeship style? I have a great recollection of a swag—

Dr Leslie—It varies hugely. I know from my own school—I was hospital trained—it was about 15 per cent in just the small group I was in. Di, you might be able to comment on that more than I can.

Ms Twigg—I can only do it from my own personal training. I think it was one out of 30, so whatever that makes it. I do not know; I do not have the statistics anymore.

Senator WEST—With regard to the call for greater clinical experience and practice, are there places available for that to actually happen? It is fine to say that we need more clinical practice and that we need more clinical skills being built up before the new nurses are let loose without supervision, but are there enough beds and RNs already graduated to provide the preceptoring and to provide the experience?

Dr Leslie—I do not believe so and that is why we believe that a fourth year of supervised clinical practice in a graduate program is a better option than trying to squeeze extra undergraduate places. We at Royal Perth are the largest provider of undergraduate placements in the state at the moment—or we have been—and we offer upwards of 1,500 placements for undergraduate students each year.

Senator WEST—That is across three years?

Dr Leslie—Yes, that is across three years. There are periods where there are not students within the organisation, and they usually link into the academic calendar. But in the end we do not have sufficient staff or facilities to increase the number of placements anyway.

Ms Twigg—I would like to put some counterviews to some of that. We currently place about 600 students a year, on average, based on request. I think there are multiple ways of tackling this issue. For example, the academic year is 26 weeks, based on the two-semester system. I know the Northern Territory, for example, has introduced a trimester system of graduating nurses in two years rather than three. There are big chunks of the year where we have no students at all because everyone runs on an academic calendar year. So there is half a year that we do not use for clinical placements.

There are also different models. So if you look at that depth versus breadth argument again and look at the type of exposure that we require them to have in terms of curriculum development and the undergraduate program, there are lots of solutions to address this issue rather than necessarily adding a fourth year to the program before they can register and practise their profession. As a nursing executive, we quite strongly feel that there are other ways of dealing with this issue, and using the full year is one of them. Another is looking at more block placements so that there is better ownership of students and some affinity with the health services—the hospital feels a sense of ownership and there is belonging of students over time. When you look nationally, there is quite a lot of diversity in the various models and other quite big institutions have managed some of that flexibility. I think there are opportunities for a lot of changes before we would extend the time before you could qualify as a nurse, as a first preference.

CHAIR—In relation to this fourth year, I was not clear whether you were suggesting that you should have a four-year undergraduate course, all picked up by the one HECS cost, or whether you were suggesting that you would like to follow the medical model where, once they have had their three years, they then go in as an intern—they are actually salaried work force but under supervision.

Dr Leslie—The latter is what I am really advocating. They should join the work force in that fourth year.

CHAIR—Don't they do that now?

Dr Leslie—They do. However, there are not enough places in graduate programs in hospitals, and the funding is very variable. I am aware the hospitals in Victoria get substantial funding for their first-year graduate placements. We get a few hundred dollars per student.

CHAIR—Do you know how Victoria gets that money? Is it per student or per preceptor or per hour of preceptor work?

Dr Leslie—No, I could not tell you off the top of my head.

CHAIR—It is useful. We are going there tomorrow, so we will find out if we can.

Dr Leslie—Yes, I would definitely ask them what their funding allocation is, but I understand that it is many thousands of dollars per student for a graduate year placement. So there are not enough graduate year placements. I certainly feel that nurses are ready to work in practice at the end of three years, but they need continued support in that transition to practice. Not all nurses are offered that opportunity or are able to take that opportunity up. Those that do not maybe practise in areas outside of their level of expertise.

CHAIR—Do you mean in jobs in the city or out of the city?

Dr Leslie—I mean both. You can join an agency the moment you register and, whilst it is certainly not encouraged, there is no formal rule to stop that occurring and stop you possibly working in an intensive care unit the next day—if you are foolhardy enough.

CHAIR—You do raise a bit of a challenge. Do you know how many would be in intensive care tomorrow?

Dr Leslie—I am not suggesting that currently happens. I am just using that as an example.

CHAIR—We are really here for more fact than hypothesis. I appreciate the point you are making, and I am not really trying to be too snitchy, but what examples can you give us of nurses who get to work above their skill—or would you like to take it on notice? I would be surprised if too many people went into intensive care. I would have thought there had to be some kind of questioning of recruitment ability, but if I am wrong on that please tell me. Are you talking more about them getting into wards where there is nobody to supervise them?

Dr Leslie—Yes, so they may join an agency, and then the agency is contracted to provide a staff member. The agency offers you a staff member—

CHAIR—Back to your hospital?

Dr Leslie—Yes.

CHAIR—What percentage of your staff are agency nurses?

Dr Leslie—They are not our staff. They belong to the agency, so it would vary.

CHAIR—What percentage of the people who are working in your hospital are agency staff?

Ms Abbotts—Possibly, very roughly, 20 per cent.

Dr Leslie—It would be up to 20 per cent on a shift.

CHAIR—So they are actually working in your hospital but they are not called your staff?

Ms Abbotts—That is right.

Dr Leslie—That is right.

CHAIR—That is a very tricky one for ordinary players like me. Is that the case at Charles Gairdner?

Ms Twigg—Ours is 6.13 per cent in terms of rostered coverage in clinical areas.

CHAIR—Six per cent are actually nurses that the hospital hires or acquires through an agency?

Ms Twigg—Yes, but not on an ongoing basis. In an ideal world, where you did not have a nursing shortage, you would recruit your permanent staff to the level you would want. Agencies are primarily used for unpredicted demands, so you would use them to replace nurses who call in sick so that the workload was still manageable. You would use them for high acuity, for patients who come back, are very sick and need a one-on-one nursing presence. You would probably put your more experienced ward nurse in there but use the agency to backfill to care for other patients in that ward. You use them for those sorts of circumstances. At the moment ours is about 6.13 per cent of the total.

CHAIR—What is it at Perth?

Dr Leslie—I cannot give you the average figure. We certainly can provide it for you.

CHAIR—That would be useful. We are getting very close to cut-off point and there are a couple of other things. I am sorry to be rushing. It seems to us, from the evidence we have been given, that a lot of people get postgraduate qualifications by scholarship, by hook or by crook or by paying up-front and getting the tax deduction versus the unfair no tax deduction for PELS—a good point actually. But we have also been told, as I understand it, that most nurses who get postgraduate qualifications enjoy a large outlay of costs for no increased remuneration. Is that true?

Ms Twigg—That is partially correct, Senator. Under our state EBA system, in the last enterprise bargaining agreement there was a qualification allowance which reinstated something that was lost in 1987 when the career structure was implemented. However, what it does do is give them better access to promotional positions, but they are limited in number. So there was no automatic linkage—until the last EBA, which was settled only last November—to the effect that, if you obtained a 12-month postgraduate program, you would receive any additional payment. And the payment in the EBA is a one-off payment of allowance; it does not, as with other professional groups, increase the base salary and maintain that. It is a one-off payment. So there is no financial incentive in the current system

CHAIR—So why would any nurse do postgraduate study?

Ms Twigg—Because they love their chosen specialty—out of love, not out of any financial benefit.

Senator WEST—The way it is with most things in the profession, isn't it?

CHAIR—It would seem to me an inbuilt, significant disincentive for people in the nursing profession who do love their profession and who are being faced by obstacle after obstacle about staying in it, about getting better in it, about continuing to be able to live in it while they continue to love it.

Ms Twigg—I would support that view. We have a hospital that runs a series of postgraduate programs that we articulate with the universities, and they are basically free. I would like to think that the quality of the programs is a major contributor to their 100 per cent uptake. But I also think that the fact we pay students while they undertake those programs and they have significant advanced standing towards their postgraduate studies, if they want to go on to a formal master's or higher degrees, is a real incentive for us to train specialist nurses in the area of intensive care, emergency nursing, neuroscience et cetera.

CHAIR—We are almost out of time, but I want to ask a couple more questions. Do you recruit directly? Do you advertise overseas?

Ms Twigg—Yes.

CHAIR—And do you?

Mrs Tedman—Yes.

CHAIR—And do you?

Dr Leslie—Yes.

CHAIR—Is that something you would prefer to do or would you prefer that the state did it? We heard this morning that the state is minded to start saying that each hospital doing its own recruiting and advertising is needlessly complicated or not efficient.

Ms Twigg—I think there has to be a balance. If you are looking at overseas recruitment, or major initiatives like that, there is a strong role for state coordination. However, nurses choose to work in hospitals or particular health settings, and the culture of that hospital or health setting will influence their choice as much as other factors and career opportunities. To do that at a state level reduces some of the things you can do locally.

CHAIR—Could you provide for us the percentage of your staff or nurses who were obtained from overseas recruitment?

Dr Leslie—We will take that on notice.

CHAIR—6.23—

Ms Twigg—Over the last 12 months, no. I wrote down some figures that I thought you might ask me.

CHAIR—I very much appreciate that, Ms Twigg. I thought you would have the answer to this one too.

Ms Twigg—We have 42 people from formal recruitment programs, but it is almost three times that figure—I will confirm these figures—with informal recruitment through recruitment agencies.

CHAIR—Only from certain areas, or from anywhere?

Ms Twigg—We have particularly targeted the UK.

Dr Leslie—That is exactly the same situation—

CHAIR—Do you take nurses from Africa or the Philippines?

Mrs Tedman—No.

Ms Abbotts—Yes, from Africa and from New Zealand.

CHAIR—Yes, from Perth; no, from Aegis—

Ms Twigg—We do not formally recruit from those areas. If they are registered with the Nurses Board of Western Australia and they knock on our door for a job, we will give them one.

CHAIR—Okay. So we might need a sub plot to the data you could provide for us.

Mrs Tedman—With regard to recruitment from overseas, we actually did try that last year in particular with a South African nurse who wanted to come to work for Aegis. We ended up with all sorts of difficulties through the immigration department because they tried to tell us that we did not have a shortage of nurses. So we did not get very far with that scenario.

CHAIR—If there is anything further that you can tell us about that and the state of play with you and the immigration department on such issues—and whether or not Charles Gairdner in Perth have to advance the case that they have a shortage of nurses, which is why they are actually trying to bring people in—the committee would appreciate that very much.

Ms Twigg—The state health department made an agreement with the local immigration presence on the overseas recruitments. Out of the 200 or so nurses that we could recruit for the life of that agreement, only 60 of those could be offered permanent residency. Most are coming on one-year or two-year temporary visas, which means that you spend a lot of time getting them familiar with your state health system and they return in two years time, unless during that time they can actually convert to permanent residency.

CHAIR—That is really useful for us to know, because we do understand that there is a shortage of nurses. It is interesting that there is a full intake of beginning nurses but a wastage some two, three and four years into nursing. Then there is the challenge of getting people back into nursing after they have had some period out of it for whatever reason. Also, as you said, Ms Twigg, there is a notion that people change careers—so if you started off as a nurse but you are now a scientist or a teacher or something, you may well think of coming back to nursing after you are 25 or 35, which is interesting. With regard to some of those questions on notice, I would appreciate anything further that you could provide to the committee.

This is absolutely the last question, and it will take one minute. I just wanted to know, in one line, the way you best see the challenge of nurse education. It seems to me that we have talked a bit about a fourth year—whether that is under the one undergraduate program or not—and also about HECS versus in-hospital and paid, but differently perceived, postgraduate qualifications. All of these things are sometimes seen to be very good for getting the professional standards up, but from other points of view they can be barriers to entering the profession. What is your biggest challenge in the educational area, apart from the work force area? We are here on behalf of the Commonwealth and we are looking more at the educational requirements—except in aged care, where the work force criterion is very much an issue.

Dr Leslie—One very positive thing has been the recognition across levels of education so that up to 70 per cent of our new enrolled nurse work force can now make the transition to RN if they choose—this is because certificate IV articulates with university entry as an alternative. I think that we will see some benefit of that in the next few years. It certainly has not bitten in yet, and I do not think that people are necessarily aware enough of that particular issue. So that has been a good thing.

CHAIR—Would you argue that there is a benefit in making postgraduate qualifications for nurses entirely HECS available? It seems that PELS is there for some, but others pay up-front fees. Are there sufficient scholarships and HECS type funding schemes to get people in?

Dr Leslie—I do not think there are sufficient scholarships at all. I think scholarships are the way to go because it is a way of managing the work force, by offering the scholarships in areas of greatest need.

CHAIR—Are those scholarships Commonwealth or state, or both?

Dr Leslie—Mainly state.

CHAIR—Do you believe they should continue to be from the state?

Dr Leslie—I am not particularly adverse to where they come from, as long as we get them.

CHAIR—We have run out of time. Thank you very much for your submissions and for your time here today.

Committee adjourned at 2.33 p.m.